

Audit & Risk Committee

Mon 12 December 2022, 15:00 - 17:00

Virtual Meeting Via Teams

Agenda

15:00 - 15:05
5 min

1. PRELIMINARY MATTERS

Information Patsy Roseblade, IM & Chair of Committee

1.1. Welcome & Introductions

Information Patsy Roseblade, IM & Chair of Committee

1.2. Apologies for Absence

Information Patsy Roseblade, IM & Chair of Committee

1.3. Declarations of Interest

Information Patsy Roseblade, IM & Chair of Committee

15:05 - 15:10
5 min

2. CONSENT AGENDA

2.1. FOR APPROVAL

2.1.1. Unconfirmed Minutes of the Meeting held on 24th October 2022

Patsy Roseblade, IM & Chair of Committee

 2.1.1 Unconfirmed Minutes CTMUHB Audit Risk Committee 24 October 2022 ARC 12 December 2022.pdf (9 pages)

2.1.2. Declarations of Interest and Gifts Hospitality Report

Cally Hamblyn, Assistant Director of Governance & Risk

 2.1.2a Declarations of Interest and GHS Register - Cover Report ARC 12 December 2022 - CH.pdf (4 pages)

 2.1.2b Appendix 1 Board Member Hard Copy Non Board Member DOI Spreadsheet 2022-2023.pdf (3 pages)

 2.1.2c Appendix 2 Register of Gifts Hospitality and Sponsorship 2022-23 ARC 12 December 2022.pdf (1 pages)

2.2. FOR NOTING

2.2.1. Audit & Risk Committee Annual Cycle of Business

Information Cally Hamblyn, Assistant Director of Governance & Risk

 2.2.1a Audit & Risk Committee Cycle of Business - Cover Paper ARC 12 December 2022.pdf (2 pages)

 2.2.1b Audit Risk Committee Cycle of Business ARC 12 December 2022.pdf (4 pages)

2.2.2. Audit & Risk Committee Forward Work Programme

Cally Hamblyn, Assistant Director of Governance & Risk

 2.2.2 Audit & Risk Committee Forward Work Plan ARC 12 December 2022.pdf (1 pages)

2.2.3. Audit & Risk Committee Effectiveness Self Assessment

Cally Hamblyn, Assistant Director of Governance & Risk

 2.2.3 ARC Themed Survey Action Plan ARC 12 December 2022.pdf (8 pages)

2.2.4. Clinical Audit Annual Report

Information *Dr Nerys Conway, Assistant Medical Director for Medical Workforce*

 2.2.4a Clinical Audit Quarterly Report - 2022NovVer1_0 ARC 12 December 2022.pdf (7 pages)

 2.2.4b Clinical Audit Annual ReportV1_4 ARC 12 December 2022.pdf (18 pages)

15:10 - 15:15 3. MAIN AGENDA

5 min

3.1. Audit & Risk Committee Action Log

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

 3.1 Audit & Risk Committee Action Log ARC 12 December 2022.pdf (6 pages)

3.2. Matters Arising not contained within the Action Log

Discussion *Patsy Roseblade, IM and Committee Chair*

15:15 - 15:45 4. SUSTAINING OUR FUTURE

30 min

4.1. Local Counter Fraud Report

Discussion *Matthew Evans, Local Counter Fraud Specialist*

 4.1a Local Counter Fraud Update Report ARC 12 December 2022.pdf (2 pages)

 4.1b Local Counter Fraud Update Report ARC 12 December 2022.pdf (4 pages)

 4.1c Appendix 1 Counter Fraud Benchmarking Performance Report ARC 12 December 2022.pdf (4 pages)

 4.1d Appendix 2 Proactive Exercise - Temporary Staffing Covid Intake ARC 12 December 2022.pdf (6 pages)

 4.1e Appendix 3 Counter Fraud Investigations Update ARC 12 December 2022.pdf (11 pages)

4.2. The National Fraud Initiative in Wales 2020-21: National Fraud Initiative (NFI) Self-Appraisal Checklist

Matthew Evans, Local Counter Fraud Specialist

 4.2a NFI Self-Appraisal Checklist ARC 12 December 2022.pdf (2 pages)

 4.2b NFI Self-Appraisal Checklist ARC 12 December 2022.pdf (13 pages)

 4.2c The_National_Fraud_Initiative_in_Wales_2020_21 ARC 12 December 2022.pdf (25 pages)

4.3. Procurement and Scheme of Delegation Report

Discussion *Sally May, Executive Director of Finance*

 4.3 Scheme of Delegation Report ARC 12 December 2022.pdf (6 pages)

4.4. Losses & Special Payments Report

Discussion *Sally May, Executive Director of Finance*

 4.4a Losses Special Payments Report ARC 12 December 2022.pdf (11 pages)

 4.4b Report Appendices Sept 22 ARC 12 December 2022.pdf (10 pages)

4.5. Consultant Job Planning

Nerys Conway, Assistant Medical Director

 4.5 Consultant Job Planning ARC 12 December 2022.pdf (4 pages)

4.6. Medical Rostering

Nerys Conway, Assistant Medical Director

 4.6 Medical Rostering audit update Nov22 ARC 12 December 2022.pdf (4 pages)

15:45 - 16:20
35 min

5. IMPROVING CARE

5.1. Organisational Risk Register

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

 5.1a Organisational Risk Register Review November 2022 - ARC 12.12.2022.pdf (5 pages)

 5.1b Appendix 1 Master Organisational Risk Register Final November 2022.pdf (14 pages)

5.2. Audit Recommendations Tracker

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

 5.2a Audit Recommendations Tracker Update Report ARC 12 December 2022.pdf (6 pages)

 5.2b Appendix 1 Internal Audit Recommendations Tracker 2 ARC 12 December 2022.pdf (25 pages)

 5.2c Appendix 2 External Audit Recommendations Tracker (2) ARC 12 December 2022.pdf (5 pages)

5.3. INTERNAL AUDIT

5.3.1. Internal Audit Progress Report

Discussion *Paul Dalton, Head of Internal Audit*

 5.3.1 IA CTM -Progress report - December 2022.pdf (9 pages)

5.3.2. Internal Audit Review Decarbonisation

Discussion *Internal Audit*

 5.3.2 IA FINAL All-Wales Decarbonisation report CTMUHB (1) ARC 12 December 2022.pdf (13 pages)

5.3.3. Internal Audit Review iCTM - Improvement team

Discussion *Internal Audit*

 5.3.3 IA iCTM - Quality Improvement ARC 12 December 2022.pdf (23 pages)

5.3.4. Internal Audit Review Clinical Service Group – Radiology

Discussion *Internal Audit*

 5.3.4 IA CTMUHB 22.23 03 Radiology CSG Final report ARC 12 December 2022.pdf (46 pages)

5.3.5. Internal Audit Review Wellbeing

Discussion *Internal Audit*

 5.3.5 IA CTMU2223.09 Staff Wellbeing Final Internal Audit Report.pdf (16 pages)

5.4. AUDIT WALES

5.4.1. Audit Wales Audit & Risk Committee Update

Discussion *Audit Wales*

 5.4.1 AW CTM AC Update December 2022 (1) ARC 12 December 2022.pdf (12 pages)

5.4.2. Making Equality Impact Assessments more than just a tick box exercise

Discussion

Audit Wales

 5.4.2a AW Equality Impact Assessments ARC 12 December 2022.pdf (44 pages)

 5.4.2b CTM EIA Management Response ARC 12 December 2022.pdf (2 pages)

5.4.3. Review of Commissioning and Contracting Arrangements (CTM & Swansea Bay)

Discussion

Audit Wales

 5.4.3 AW CTMSB SLA Review 1 ARC 12 December 2022.pdf (20 pages)

5.4.4. Transforming Leadership Partnership Board Baseline Governance Review

Discussion

Audit Wales

 5.4.4 AW TLPB Baseline Governance Review ARC 12 December 2022.pdf (24 pages)

16:20 - 16:25

5 min

6. ANY OTHER BUSINESS

Information

Patsy Roseblade, IM and Committee Chair

16:25 - 16:25

0 min

7. Committee Highlight Report to Board

Patsy Roseblade, IM and Committee Chair

16:25 - 16:30

5 min

8. HOW DID WE DO IN THIS MEETING

Discussion

Patsy Roseblade, IM and Committee Chair

16:30 - 16:30

0 min

9. DATE AND TIME OF NEXT MEETING

Information

Patsy Roseblade, IM and Committee Chair

**Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB)
Audit & Risk Committee held on the 24 October 2022 as a Virtual
Meeting via Microsoft Teams**

Members Present:

Patsy Roseblade	Independent Member (Chair)
Jayne Sadgrove	Health Board Vice Chair
Carolyn Donoghue	Independent Member
Ian Wells	Independent Member

In Attendance:

Darren Griffiths	Audit Wales
Paul Dalton	NWSSP – Internal Audit & Assurance
Emma Samways	NWSSP – Internal Audit & Assurance
Martyn Lewis	NWSSP – Internal Audit & Assurance (In Part)
Eifion Jones	NWSSP – Internal Audit & Assurance (In Part)
Sally May	Executive Director of Finance
Georgina Galletly	Director of Corporate Governance
Owen James	Head of Corporate Finance
Matthew Evans	Head of Local Counter Fraud
Amanda Legge	All Wales Post Payment Verification Manager
Sarah Jeremiah	Post Payment Verification Team
Cally Hamblyn	Assistant Director of Governance & Risk

1.0.0 PRELIMINARY MATTERS

1.1 Welcome & Introductions

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

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

1.2 Apologies for Absence

Apologies for absence have been received from:

- Sara Utley, Audit Wales
- Hywel Daniel, Executive Director for People
- Emma Walters, Meeting Secretariat

G Galletly noted that H Daniel is invited upon request and therefore his apologies do not require formally noting at each meeting.

1.3 Declarations of Interest

No declarations of interest were received prior to the meeting.

2.0.0 CONSENT AGENDA

2.1 FOR APPROVAL

2.1.1 Unconfirmed Minutes of the Meeting held on the 22 August 2022

Resolution: The minutes were **APPROVED** as a true and accurate record.

2.1.2 Audit & Risk Committee Terms of Reference

Resolution: The Terms of Reference were **APPROVED**.

2.2 FOR NOTING

2.2.1 Audit & Risk Committee Annual Cycle of Business

Resolution: The report was **NOTED**.

2.2.2 Audit & Risk Committee Forward Work Programme

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

3.0.0 MAIN AGENDA

GOVERNANCE

3.1 Audit & Risk Committee Action Log

G Galletly presented Members with the action log drawing attention to item 5.4.5 (22.8.2022) and advising that H Daniel will provide a written update outside of the meeting.

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

Action: H Daniel to provide an update on the concerns raised on the Management Response for the Internal Audit Review Medical & Dental Rostering outside the meeting.

3.2 Matters Arising not contained within the Action Log

There were no further items identified.

4.0.0 SUSTAINING OUR FUTURE

4.1 Local Counter Fraud Report

M Evans presented the report drawing particular attention to the following areas:

- The review undertaken by the NHS Counter Fraud Authority Quality Assurance Inspector.
- The plans for the Health Board in terms of its participation in International Fraud Awareness week in November 2022.
- Counter Fraud Investigations Update.

In considering the Overpayment of Salary Cases presented in item 4.1b, I Wells queried whether there is a trigger point for when overpayments of salary reach the threshold for fraud investigations to commence and what remedies are implemented. In response, M Evans advised that any overpayments of three months or more are referred into the Counter Fraud Team for initial enquiries. He stressed that the majority of cases are referred back into the Finance Recovery arrangements, however, those that indicate that there is potential dishonest knowledge may lead to an offence under the Theft Act and will proceed on that basis if there is also an appropriation of the property i.e. the money is spent.

J Sadgrove queried why the case on page 8 of the Counter Fraud Investigations Report (INV/22/00664) has not been regarded as dishonest knowledge. M Evans advised that there was no intent to deprive others of these funds as they had not been spent and therefore the case was referred to the Financial Investigators to initiate simple recovery.

P Roseblade commented that the All Wales Audit Chairs are taking a particular interest in Counter Fraud activity. M Evans welcomed this increased visibility in ensuring that activity is prominent at Board level.

P Roseblade reflected that the utilisation of bank and agency workforce into the service appears to present a risk in terms of opportunities for error and based on the report at 4.1c areas of dishonesty. In response, M Evans advised that there are local proactive exercises underway to reduce the risk as well as learning from other Health Boards who are undertaking activity in this area. P Dalton commented that this is captured on the IA Work Programme Cycle and is likely to form the basis of a future Internal Audit review.

S May noted that there is a value and effectiveness programme underway to strengthen the control around nurse agency activity.

Resolution: The report was **NOTED**.

4.2 Procurements and Scheme of Delegation Report

S May presented Members with the Procurement and Scheme of Delegation Report as well as drawing the Committees attention to the Health Boards performance as outlined in the comparative findings report "Preventing Procurement Fraud in the NHS" (Agenda item 4.2b), commenting on the activity being taken forward by the Health Board.

P Roseblade sought an update on the action from the previous Scheme of Delegation Report as captured in the action log at 3.1. In response, S May agreed to address this outside of the meeting and provide an update to the Committee.

J Sadgrove commented that the lack of resource in the Bank Office will not only be impacting invoices but also the efficient running of the bank service. In response, G Galletly advised that Dilys Jouvenat as Chair of the People & Culture Committee is meeting with the Executive Director for People and the Executive Director of Nursing to discuss the entire arrangements for managing the bank service. S May further noted that the capacity issues have been addressed and therefore improvements should be noted in that regard as the vacancy factors are reduced.

Resolution: The report was **APPROVED**.

Action: S May to follow up on any outstanding actions on the action log regarding the Scheme of Delegation report received in August 2022 where a verbal update was required in the meeting.

4.3 Post Payment Verification (PPV) End of Year Update

A Legge joined the meeting and provided a detailed update in relation to the Post Payment Verification activity and the position on PPV visits.

P Roseblade sought clarity on the process PPV visits and A Legge advised as to the process for visits and triggers for revisits.

Following the update, I Wells queried the action taken by the PPV Team where there is a high rate of errors triggered. In response, A Legge advised that the PPV function is proactive in its support, guidance and training to aid with improvement and support learning.

Resolution: The report was **NOTED**.

5.0.0 IMPROVING CARE

5.1 Organisational Risk Register

G Galletly introduced C Hamblyn to present the report in light of the work ongoing to transition the risks on the Organisational Risk Register to the new Operating Model.

C Hamblyn presented the Organisational Risk Register noting that over the next few weeks she is meeting with each of the Care Group Directors and Nurse Directors to review all risks on the Organisational Risk Register to ensure they are appropriately aligned to the new Care Group structure with the appropriate ownership. The Committee were asked to afford some flexibility in terms of timely reviews whilst this process is undertaken. It was noted that phase one of this review will focus on the high risks escalated to the Organisational Risk Register and the phases that follow will review the service level risks.

I Wells requested an update on the following risks, which C Hamblyn responded to in the meeting whilst agreeing to share the feedback with the respective risk owners outside the meeting.

- Risk ID 4888 - C Hamblyn agreed to ensure the rationale for de-escalation has been captured in the Datix System as not explicit within the Organisational Risk Register.
- Risk ID 4632 - C Hamblyn explained that the individual stroke risks reflected in the Organisational Risk Register have been appropriately amalgamated into an overarching Health Board wide Stroke Risk. This risk is held by the Executive Director of Therapies and Health Sciences as the Strategic Risk Owner and updated via the Stroke Improvement Programme.
- Risk ID 4743, C Hamblyn agreed to ensure this risk is appropriately allocated through the transition to the new Care Group Model and a progress update captured.
- Risk ID 4887 – in response to I Wells query as to whether non hospital sites have been considered for the transfer of paper medical records, C Hamblyn advised she will link in with the risk owner to ensure this is captured in the update for the risk due on the 1st November.
- Risk ID 4664 – recognising I Well's comment on the impact of the recent cyber-attack on this risk, C Hamblyn advised that she will ask the risk owner to ensure the learning from the incident is reflected in a review of the risk controls and mitigation.
- Risk ID 4479 – C Hamblyn to ask the Infection Prevention and Control Team to reflect whether the level of confidence in the continuation of JAG accreditation has been taken into account in terms of the risk scoring.

The Committee recognised the need to ensure lessons in respect of the Northern Ireland Cyber Incident are shared. The recent internal Cyber Awareness Event was noted as being well received in terms of awareness and learning. Members commented that Cyber Awareness is a key feature on the work programme of the All Wales Audit Chairs and All Wales Vice Chairs networks.

Resolution The report was **REVIEWED**.

Action: Updates on risks 4888,4632,4887,4664, 4743 and 4479 to be taken forward outside of the meeting and captured as appropriate in the next iteration of the Organisational Risk Register received by the Committee.

5.2 Audit Recommendations Tracker

G Galletly presented the report confirming that the workshop to consider the long standing recommendations with Executive Leads was held in October 2022, which has led to progress being made with movement on recommendations clearly reflected in this latest tracker.

J Sadgrove welcomed the significant progress and focus on the tracker since the last meeting.

P Roseblade queried whether explicit agreement has also been sought from External Audit in relation to the closure of the Clinical Coding Follow Up Review 03. In response, G Galletly agreed to liaise with Sara Utley outside of the meeting to seek support on the closure of the long standing recommendations relating to this external audit review.

Resolution: The report was **NOTED**.

Action: G Galletly to liaise with S Utley at Audit Wales on the closure of the recommendations captured in the Clinical Coding Follow Up Review 03 audit.

5.3 INTERNAL AUDIT

5.3.1 Internal Audit Review Progress Report

P Dalton presented the report recognising the timely responses being received from Health Board Officers in relation to the sign off of management responses.

P Dalton also drew attention to the Internal Audit programme at Appendix A noting that there is significant activity planned for quarter four which will require the Health Board Officers and Internal Audit Colleagues to work closely to ensure the timetable for the fourth quarter is achieved.

Resolution: The report was **NOTED**.

5.3.2. Internal Audit Review – Digital Operating Model

M Lewis presented the report which had been allocated a limited assurance rating. M Lewis reflected the positive reflections in the report and recognised the significant restructure activity underway within the Digital and Data Function.

C Donoghue commented that the Digital and Data update provided by the Director of Digital at the Board Briefing Session on the 20th October was timely

in terms of providing Board Members with the assurance on the activity that is underway in this area. C Donoghue also suggested that the Digital and Data Function consider escalating the ICT Kit Risk to the Organisational Risk Register in recognition of the scale of the problem and resource required. In recognising, the reference to digital literacy and the assumption of a minimum level of digital literacy captured during recruitment, C Donoghue noted that this is a careful balance to not limit recruitment options.

In response to I Wells comment in relation to the resource support for Office 365. S May advised that as part of the business case for Office 365 a Team had been created within Digital Health Care Wales who provide support to Health Boards. She also reflected on the concerns in relation to the financial position relating to the procurement of ICT kit which she recognised as a year on year challenge with an aging estate and limited capital.

P Roseblade suggested that recommendation 6.1 is reframed as the allocation of funding is not within the gift of the Director of Digital. S May also commented that it was problematic where audit recommendations directed additional spend given the challenging financial position and the need for the Health Board to prioritise. In light of these comments, it was suggested that a referral to the Digital and Data Committee is made to consider the recommendations and management response prior to them being captured in the Audit Tracker.

- Resolution Actions
- The report was **NOTED**.
- Director of Digital to consider the escalation of a risk relating to ICT Kit to the Organisational Risk Register.
 - Committee referral to the Digital and Data Committee to provide the scrutiny on the management responses to ensure that they provide the assurance that the actions agreed will address the issues which have been identified.

5.3.3 Internal Audit Review – Medical Records Management

M Lewis presented the report which had been allocated a reasonable assurance rating.

I Wells expressed concerns in relation to matter arising seven regarding file quality and the misfiling of records in terms of information governance and patient care risks.

- Resolution:
- As with item 5.3.2 on the agenda the Committee requested this report be referred to the Digital and Data Committee to consider the recommendations and management response prior to them being captured in the Audit Tracker, particularly refining the areas where there is partial agreement on recommendations.

- Resolution Action
- The report was **NOTED**.
- Committee referral to the Digital and Data Committee to provide the scrutiny on the management responses to ensure that they provide the assurance that the actions agreed will address the issues which have been identified.

5.3.4 Internal Audit Follow Up Review – Prince Charles Hospital Redevelopment: Phase 1b Final Account

E Jones presented the report which had been allocated a substantial assurance rating.

Resolution: The report was **NOTED**.

5.3.5 Internal Audit Follow Up Review – Prince Charles Hospital Validation of Management Actions

E Jones presented the report which had been allocated a substantial assurance rating.

Resolution: The report was **NOTED**.

5.4 AUDIT WALES

5.4.1 Audit Wales Audit & Risk Committee Update

D Griffiths presented the report and provided an apology to Members for the omission in previous reports on the review undertaken in the Minor Injuries Unit, noting that the review is now at clearance stage.

D Griffiths thanked Health Board Officers for the submission of the Self Assessment and Intel Request for the Joint HIW and Audit Wales Review and drew particular attention to the changes in the timetable in relation to the field work to allow for the new operating model to embed.

Attention was drawn to the national publications noting that relation to the Pan Sector EQIA recommendation that the Health Board is currently preparing a management response which will be presented to a future meeting of the Committee.

Resolution: The report was **NOTED**.

6.0.0 ANY OTHER BUSINESS

6.1.1 How Did We Do?

There was no other business to report. The Committee Chair advised that she would welcome feedback from Members outside the meeting as to how they felt the meeting went.

6.1.2 Farewell to George Galletly

P Roseblade expressed thanks to G Galletly personally and on behalf of the Committee in recognition of her invaluable guidance and input into the Committee. She exclaimed that G Galletly should leave feeling proud of the

achievements she and her Team have made to date and wished her all the very best in her new role

7.0.0 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Monday 12 December 2022.

8.0.0 CLOSE

Unconfirmed



AGENDA ITEM

2.1.2

AUDIT & RISK COMMITTEE

**DECLARATIONS OF INTERESTS, GIFTS, SPONSORSHIP, HOSPITALITY
& HONORARIA**

Date of meeting

12/12/2022

FOI Status

Open/Public

**If closed please indicate
reason**

Not Applicable - Public Report

Prepared by

Emma Walters, Corporate Governance
Manager

Presented by

Cally Hamblyn, Assistant Director of
Governance & Risk

Approving Executive Sponsor

Chief Executive

Report purpose

ENDORSE FOR BOARD APPROVAL

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

Committee/Group/Individuals

Date

Outcome

Executive Leadership Group

05/12/2022

Reviewed

ACRONYMS

DOI

Declarations of Interest

1. SITUATION/BACKGROUND

- 1.1 In accordance with the requirements of the Health Board's Standing Orders and Standards of behaviour Framework Policy, a report is required to be received by the Audit & Risk Committee as a standing agenda item which will detail the Declarations of Interest, Gifts, Hospitality and Sponsorship etc. activities approved within each Health Board. A similar report will also be considered by the Strategic Leadership Group.

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

- 2.1 The form in the Standards of Behaviour Framework policy or online via SharePoint should be used to declare interests and/or seek approval for receiving hospitality/sponsorship/gifts and this should help or prevent the omission of crucial information that the authorising officer requires making an informed decision on approval or rejection. The authorised signatories should also be scrutinising the declarations prior to authorisation, in order to ensure the correct information is captured on the form before it is submitted to the Corporate Governance Team.
- 2.2 In early May an email to all Board Members requesting their annual Declarations of Interest was sent. As at July 2022, all returns have been returned and approved. Board Members compliance – 100%. Since the last report, in year amendments have been received by Board Members which have been reflected in red in Appendix 1.
- 2.3 An email was issued in May to 547 members of staff (included all Consultants, Very Senior Managers, Board Members and Staff at Band 8d and Band 9). To date we have received 194 returns equalling a 35.5% return rate. It should be noted that some of the returns received in this period may have been received from individuals that did not receive the targeted email as there is an onus on all employees to declare interests.
- 2.4 In summary there have been:
- **67** new declarations of interest received and entered on the Declarations of Interest Register for the period 1 August 2022 – 30 November 2022.
 - **8** new entries on the Gifts, Hospitality and Sponsorship Register.
- 2.5 The appendices to this report include the new entries received up to the 30 November 2022 as follows:
- Appendix 1 – Declarations of Interest received 1 August 2022 – 30 November 2022.
 - Appendix 2 – Gifts, Hospitality and Sponsorship Declarations received 1 August 2022 – 30 November 2022.

The entire registers for 2022-2023 to date is available upon request.

- 2.6 Since the ELG met communication from Welsh Government has been received suggesting that the following wording is added to the self declaration section of the Declaration Forms to align with the amendments made to the ESR system:

2 Update to the Employee Self Service Conflict of Interest Declaration Wording

The wording for the checkbox on the employee Declare a Conflict of Interest form has changed from:

I give my consent for this information to be published on registers that my Organisation holds. ☐

to:

Declarations will be published unless there are exceptional circumstances as to why they should not be. If you feel this is the case you will need to untick the box. If you do this you will be contacted to establish if you have reasonable grounds for your declaration to be excluded on registers that the Organisation holds. ☐

- 2.7 The Audit & Risk Committee is asked to endorse this change to the Declaration of Interest Form and where appropriate to the Gifts, Hospitality, Honoraria and Sponsorship Form.
- 2.8 Following advice from the Interim Head of Information Governance, it is suggested that any information published on the register, which is then published in the public domain, excludes first and last names and includes job title only. This has been actioned in terms of the appendices to this report.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

- 3.1 Please refer to the register for the Declarations of Interest Register Declaration included at Appendix 1 and the Gifts, Hospitality and Sponsorship at Appendix 2.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	The Register and Declaration of Interests is the method by which the Health Board safeguards against conflict or potential conflict of interest where private interests and public duties of members of staff do not concur. The Health Board must be impartial and honest in the conduct of its business and must ensure that employees remain beyond suspicion at all times.



Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below)
	If no, please provide reasons why an EIA was not considered required in the box below.
Legal implications / impact	Not required.
	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The report is open to the Audit & Risk Committee are asked to:

- **REVIEW** and to examine any entries on the register in full.
- **ENDORSE FOR BOARD APPROVAL** – The changes to the Declaration of Interest Form outlined in sections 2.6-2.8.

Targeted DOI Request Sent	Received	FullName	Designation	Declarations	Period of Involvement	Financial Benefits/In Kind	In Year Amendments	Request for Changes March 2023	Annual Eligibility Form and Indemnity Check - next due March 23.
3.5.2022 - Email sent from CH.	Hard Copy for received and signed 27.6.2022	James Hehir	Independent Member	1) Non-Executive Director, Llandarcy Park Ltd. 2) Trustee Neath Port Talbot Contact Centre. 3) Vice Chairman, Neath Port Talbot Group of FE Colleges. 4) Solicitor of the Supreme Court. 5) Honorary Vice President, West Glamorgan Magistrates Association. 6) Associate member, magistrates Association. 7) Patron Neath YMCA. 8) Interim Chair of the WHSSC All Wales IFPR Panel □	1) 14/6/2018 ongoing. 2) 1/5/2007 ongoing. 3) 29/3/2006 ongoing. 4) 14/2/1984 to 31/8/2016. 5) 16/10/2017 life time appointment. 6) 1/6/1993 ongoing. 7) April 2015 ongoing. 8) 27/07/2022 for 6 months to 27/01/2023. Extended until March 2023.	Nil for all entries.	As at 30.9.2022 - James Hehir advised that there will be some potential links between his roles with Llandarcy Park Ltd and NPTG in terms of opportunities for NHS Wales Commissioning. James Hehir receives no financial or any other benefit for these roles. Also noted Chair of the WHSSC IFPR Panel. 21.11.2022 - Confirmed the Chair of the WHSSC All Wales IFPR Panel will be extended until March 2023. James Hehir advised by Sian Lewis, Managing Director, WHSSC that she saw no conflict of interest involving role as interim chair of IPFR panel and role at Llandarcy Park Ltd.		
3.5.2022 - Email sent from CH.	10.05.2022 (and 24.10.22 - amendment confirmed by CD as correct)	Carolyn Donoghue	Independent Member	1. Lay Governor - University West of England 2. Chair - Welsh Wound Innovation Centre	1.Since March 2021 2. Chair since July 2020	1. Nil 2. One off payment for each Board Meeting.	Carolyn emailed on 24.10.22 to confirm her son Edward Donoghue works for Hillrom a medical supply company. Whilst she was not aware of any conflict she was aware that they had been working with RGH and PoWH recently. DOI form amended and sent to Chair - approval received from Chair on 25.10.22.		
3.5.2022 - Email sent from CH.	Online Completion 5.5.2022	Kelechi Nnoaham	Executive Director Public Health	1. Honorary Professorship Cardiff University 2. Honorary Professorship Plymouth University 3. Spouse works in Blood Sciences Laboratory in the Royal Glamorgan Hospital	1. From 2015 to date 2. From 2021 to date 3. From 2017 to date	1. Nil 2. Nil 3. Yes -Salaried Position	Kelechi Nnoaham departure from CTMUHB with effect from 30.11.2022. Checked accuracy of DOI on departure via email 21.11.2022 and confirmed no change.		
3.5.2022 - Email sent from CH.	17.5.2022 - Hard Copy Form	George Galletly	Director of Governance	1. BROTHER - Consulting Practice Lead for M365, Microsoft Industry Solutions (UK, France, Middle East, Africa)	1. Since October 2021	1. Salaried Role.	George Galletly departure from CTMUHB with effect from 14.11.2022 - Secondment to WG. Checked accuracy of DOI on departure via email 21.11.2022 and confirmed no change.		

Received	Designation	Declarations	Period of Involvement	Financial Benefits/In Kind	In Year Amendments
28.11.2022	Perinatal Mental Health Nurse	Nil Interests Declared	N/A	N/A	
3.8.22	Staff Nurse	Nil Interests Declared	N/A	N/A	
3.8.2022	Staff Nurse	Nil Interests Declared	N/A	N/A	
5.8.2022	Health Care Support Worker	Nil Interests Declared	N/A	N/A	
7.8.2022	Staff Nurse	Nil Interests Declared	N/A	N/A	
8.8.2022	Healthcare Support Worker	Nil Interests Declared	N/A	N/A	
8.8.2022	Staff Nurse	Nil Interests Declared	N/A	N/A	
11.8.2022	Healthcare Support Worker	Nil Interests Declared	N/A	N/A	
15.8.2022	Staff Nurse	Nil Interests Declared	N/A	N/A	
16.8.2022	Assistant Head of Physiotherapy	Nil Interests Declared	N/A	N/A	
17.8.2022	Healthcare Support Worker	Nil Interests Declared	N/A	N/A	
22.8.2022	Staff Nurse	Nil Interests Declared	N/A	N/A	
22.8.2022	Staff Nurse	Nil Interests Declared	N/A	N/A	
23.8.2022	Healthcare Support Worker	Nil Interests Declared	N/A	N/A	
02.09.2022	Healthcare Support Worker	Nil Interests Declared	N/A	N/A	
02.09.2022	Healthcare Support Worker	Nil Interests Declared	N/A	N/A	
03.09.2022	Healthcare Support Worker	Nil Interests Declared	N/A	N/A	
05.09.2022	Healthcare Support Worker	Nil Interests Declared	N/A	N/A	
05.09.2022	Community paediatric consultant and strategy group director for CYP	Nil Interests Declared	N/A	N/A	
05.09.2022	Healthcare Support Worker	Nil Interests Declared	N/A	N/A	
05.09.2022	Staff Nurse	Nil Interests Declared	N/A	N/A	
05.09.2022	Staff Nurse	Nil Interests Declared	N/A	N/A	
05.09.2022	Healthcare Support Worker	Nil Interests Declared	N/A	N/A	
05.09.2022	Healthcare Support Worker	Nil Interests Declared	N/A	N/A	
05.09.2022	Healthcare Support Worker	Nil Interests Declared	N/A	N/A	
05.09.2022	Staff Nurse	Nil Interests Declared	N/A	N/A	
07.09.2022	Healthcare Support Worker	Nil Interests Declared	N/A	N/A	
07.09.2022	Healthcare Support Worker	Nil Interests Declared	N/A	N/A	
07.09.2022	Staff Nurse	Nil Interests Declared	N/A	N/A	
07.09.2022	Healthcare Support Worker	Nil Interests Declared	N/A	N/A	
09.09.2022	Staff Nurse	Nil Interests Declared	N/A	N/A	
11.09.2022	Staff Nurse	Nil Interests Declared	N/A	N/A	
12.9.22	Registered General Nurse	Mother works as a Hotel Services Manager	N/A	N/A	
13.09.2022	Healthcare Support Worker	Nil Interests Declared	N/A	N/A	
13.09.2022	Healthcare Support Worker	Nil Interests Declared	N/A	N/A	
16.09.2022	Staff Nurse	Nil Interests Declared	N/A	N/A	
16.09.2022	Healthcare Support Worker	Nil Interests Declared	N/A	N/A	
16.9.2022	Consultant Respiratory Physician	1. The Lung Health Check Operational Pilot being delivered in CTM UHB, for which I am Clinical Lead, has been supported financially by Bristol Myers Squibb, Roche (with funding via Tenovus), MSD and Novartis. My role is funded solely by NHS Wales Collaborative/Wales Cancer Network. 2. Spouse is Primary Care Cancer Lead at Swansea Bay UHB, and a practicing GP at the New Surgery, Pencoed. 3. I am a member of the following group, which are unpaid roles: NICE Expert Advisers Panel, UK Lung Cancer Clinical Expert Group, Respiratory Health Implementation Group, British Thoracic Society, Welsh Thoracic Society, British Thoracic Oncology Group	(1) Consultant Respiratory Physician at Royal Glamorgan hospital, since 2016; (2) Clinical Lead for Lung Health Checks in Wales, Wales Cancer Network, since 2019; (4) Affiliated Consultant of Respiratory Innovation Wales, since 2021	(3) Honoraria received from Novartis, July 2022, for speaking at an educational event;	
22.09.2022	Advanced Nurse Practioner	Nil Interests Declared	N/A	N/A	
23.09.2022	Ward Manager	Nil Interests Declared	N/A	N/A	
26.09.2022	Healthcare Support Worker	Nil Interests Declared	N/A	N/A	
27.09.2022	Senior Public Health Intelligence Analyst	Nil Interests Declared	N/A	N/A	
6.10.2022	Radiographer	Nil Interests Declared	N/A	N/A	
6.10.2022	Healthcare Support Worker	Nil Interests Declared	N/A	N/A	
7.10.2022	Radiographer	Nil Interests Declared	N/A	N/A	
10.10.2022	Ward Manager	Nil Interests Declared	N/A	N/A	
10.10.2022	Pharmacist - Prescribing Advisor	1. Director of South Wales Single Ply Roofing Ltd. 2. Undertook paid pharmacist locum work for Dowlais Pharmacy Ltd 3. R3ACT Ltd	1. 2013 - present 2016 - 2021 2018 - present 2. 3.	1. Salary & dividend 2. Nil at present (income 2016 - 2021) 3. N/A	
12.10.2022	Staff Nurse	Nil Interests Declared	N/A	N/A	
13.10.2022	Pharmacist	Nil Interests Declared	N/A	N/A	
13.10.2022	Healthcare Support Worker	Nil Interests Declared	N/A	N/A	
13.10.2022	Healthcare Support Worker	Nil Interests Declared	N/A	N/A	
17.10.2022	Rotational Physiotherapist	Nil Interests Declared	N/A	N/A	
19.10.2022	Rotational Physiotherapist	Nil Interests Declared	N/A	N/A	
23.10.2022	Staff Nurse	Nil Interests Declared	N/A	N/A	
24.10.2022	Healthcare Support Worker	Nil Interests Declared	N/A	N/A	

Received	Designation	Declarations	Period of Involvement	Financial Benefits/In Kind	In Year Amendments
27.10.2022	Staff Nurse	Nil Interests Declared	N/A	N/A	
27.10.2022	Clinical Lead Physiotherapist	Nil Interests Declared	N/A	N/A	
2.11.2022	Healthcare Support Worker	Nil Interests Declared	N/A	N/A	
7.11.2022	Healthcare Support Worker	Nil Interests Declared	N/A	N/A	
7.11.2022	Healthcare Support Worker	Nil Interests Declared	N/A	N/A	
11.11.2022	Acute Clinical Lead Dietitian	Nil Interests Declared	N/A	N/A	
11.11.2022	Dietician	Nil Interests Declared	N/A	N/A	
14.11.2022	Special School Nurse	Nil Interests Declared	N/A	N/A	
16.11.2022	Clinical Psychologist	1. Company Officer, H R Clothing limited EMDR Wales Representative2.	1. Ongoing Ongoing2.	1. Payroll N/A Voluntary2.	

Date Received by Corporate Governance	Designation / Department	Provided by / From	Date Received	Details	Gift/Hospitality and or Sponsorship	Accepted or Declined
18.10.2022	Head of Value Based Health Care	Huma Technologies	24.10.2022-25.10.2022	Attendance at HSJ awards, Patient Safety Awards – Huma Project shortlisted. Awards ceremony held in Manchester – 24th October 2022 including Overnight stay and travel. Huma Technologies sponsored Return train travel, standard class and overnight hotel stay and attendance at awards. Train Travel - £29 each way – total £58 Accommodation - £120 Conference Fees - £Unknown – attendance at HSJ Patient Safety Awards	Sponsorship	Accepted - supported by Director of Improvement 18.10.2022
28.10.2022	Radiology Manager	BVM Medical	2.11.2022 - 4.11.2022	Sponsorship and Hospitality to attend the BSIR Annual Meeting in Glasgow. BVM covered the following: - Travel £213 - Accommodation £224 - Meals / Refreshments £100 - Conference/Registration Fees £450 Study Leave form completed.	Sponsorship and Hospitality	Accepted - Supported by Diagnostics, Therapies and Specialities Care Group Director 28.10.2022
28.10.2022	Deputy Radiology Manager	BVM Medical	2.11.2022 - 4.11.2022	Sponsorship and Hospitality to attend the BSIR Annual Meeting in Glasgow. BVM covered the following: - Travel £213 - Accommodation £224 - Meals / Refreshments £100 - Conference/Registration Fees £450 Study Leave form completed.	Sponsorship and Hospitality	Accepted - Supported by Diagnostics, Therapies and Specialities Care Group Director 28.10.2022
18.10.2022	Consultant, Respiratory in RGH	Novartis	30.06.2022	Speaker Fee/ Honorarium and Travel expenses funded by Novartis in relation to the Novartis Oncology Masterclass at the St Pancras Hotel in London. Undertaken outside of CTM Working Hours. Travel: £163.28 Honorarium: £1170	Sponsorship and Honorarium	Accepted - Supported by CSG Manager as part of the DOI Completion received 16.9.2022.
2.11.2022	L&D Business Partner. L&D Business Partner. Senior Learning & OD Manager. AD OD & Wellbeing	EDUC8	10.11.2022	Rhian Lewis, L&D Business Partner nominated by EDU8 (Associated Training Provider) and was recently shortlisted as a finalise in the National Training Federation for Wales (NTFW) Awards. Staff have been invited to accompany Rhian Lewis as guests to attend the awards dinner with other finalists and their guests at The Custom House in Cardiff. The event is being held virtually, however the training provider who nominated Rhian Lewis felt that a celebration of all its finalists was needed hence the hospitality at The Custom house. Educ8 provide Welsh Government funded apprenticeships to HCSW in CTM. There was no exchange of money involved in relation to this event. Value is approx. £50pp.	Hospitality	Accepted. Supported by Deputy Director for People on the 31.10.2022.
2.11.2022	Director of Digital	Digital Supplier	12.11.2022	Invite received from Digital Supplier to attend the Wales v Argentina Game in a Private Box. 12th November 2022 Invite to Wales V Argentina – Autumn International at the Principality Stadium	Hospitality	N/A Declined.
17.11.2022	Head of Value Based Health Care	Huma Technologies	17.11.2022	Attendance at HSJ awards, Patient Safety Awards – Huma Project shortlisted. Awards ceremony London Victoria 17th November 2022 Overnight stay and travel. Travel £69.00, Accommodation £120.00	Sponsorship	Accepted - supported by Director of Improvement 16.11.2022.
17.11.2022	Head of Innovation	Cardiff University	15.11.2022	Attendance at Wales - Georgia Rugby Match 19th November. Lunch and ticket via the private box courtesy of Cardiff University. Approximate Value £120.00. <i>The Assistant Director of Corporate Governance advised the Team that this hospitality was considered "Unacceptable Hospitality" under the Standards of Behaviour Framework Policy and should not have been accepted. The Director of Improvement & Innovation agreed to feed this learning back to the team and revisit the policy in terms of future requests to ensure compliance.</i>	Hospitality	Accepted - Supported by Director of Improvement 17.11.2022.



AGENDA ITEM

2.2.1

AUDIT & RISK COMMITTEE

AUDIT & RISK COMMITTEE CYCLE OF BUSINESS

Date of meeting

12/12/2022

FOI Status

Open/Public

If closed please indicate reason

Not Applicable - Public Report

Prepared by

Emma Walters, Corporate Governance Manager

Presented by

Cally Hamblyn, Assistant Director of Governance & Risk

Approving Executive Sponsor

Chief Executive

Report purpose

FOR NOTING

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

Committee/Group/Individuals

Date

Outcome

ACRONYMS

1. SITUATION/BACKGROUND

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

1.2 The Cycle of Business covers the period 1 January 2022 to 31 December 2022.

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

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

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 Please refer to **Appendix 1** – Audit & Risk Committee Cycle of Business for further detail.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Evidence suggests there is correlation between governance behaviours in an organisation and the level of performance achieved at that same organisation. Therefore ensuring good governance within the Trust can support quality care.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below)
	Not required.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Committee is asked to **NOTE** the Committee Cycle of Business.

Audit & Risk Committee

Cycle of Business (1st January 2022 – 31st December 2022)

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

The Cycle of Business covers the period 1st January 2022 to 31st December 2022.

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

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

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

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

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

Audit & Risk Committee Cycle of Business (1st January 2022 – 31st December 2022)

Item of Business	Executive Lead	Reporting period	Jan 2022	Feb 2022	Mar 2022	April 2022	May 2022	June 2022	July 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022
Consent Agenda														
Minutes of the previous Board Meeting	Director of Corporate Governance	All Regular Meetings		✓		✓		✓		✓		✓		✓
Action Log	Director of Corporate Governance	All Regular Meetings		✓		✓		✓		✓		✓		✓
Audit & Risk Committee Annual Cycle of Business	Director of Corporate Governance	All Regular Meetings		✓		✓		✓		✓		✓		✓
Committee Forward Work Programme	Director of Corporate Governance	All Regular Meetings		✓		✓		✓		✓		✓		✓
Audit & Risk Committee Annual Report	Director of Corporate Governance	Annually								✓				
Audit & Risk Committee Annual Self-Assessment	Director of Corporate Governance	Annually												✓
Audit & Risk Committee Terms of Reference	Director of Corporate Governance	Annually								✓ Not due for review until Oct		✓		
Declarations of Interest and Gifts & Hospitality Report	Director of Corporate Governance	Quarterly				✓				✓				✓
Clinical Audit Annual Plan	Medical Director	Annually				✓								
Clinical Audit Annual Report	Medical Director	Annually										✓ Defer to Dec		✓
Governance														
Annual Financial Accounts	Director of Finance	Annually						✓						
Accountability Report (Including the Governance Statement)	Director of Corporate Governance	Annually						✓						
Annual Review of the Risk Management Strategy / Board Assurance Framework	Director of Corporate Governance	Annually				✓								
Sustaining our Future														
Losses & Special Payments Report	Director of Finance	Quarterly		✓				✓		✓				✓



Item of Business	Executive Lead	Reporting period	Jan 2022	Feb 2022	Mar 2022	April 2022	May 2022	June 2022	July 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022
Procurements & Scheme of Delegation Report	Director of Finance	All Regular meetings		✓		✓		✓		✓		✓		✓
Local Counter Fraud Report	Director of Finance	All Regular Meetings		✓		✓		✓		✓		✓		✓
Counter Fraud Annual Report	Head of Local Counter Fraud	Annually				✓								
Counter Fraud Annual Self Review	Head of Local Counter Fraud	Annually				✓								
Counter Fraud Draft Work plan	Head of Local Counter Fraud	Annually				✓								
Post Payment Verification Annual Report	Post Payment Verification Manager	Annually				✓						✓		
Post Payment Verification Mid-Year Update	Post Payment Verification Manager	Annually										✓		
Improving Care														
Audit Recommendations Tracker	Director of Corporate Governance	All regular meetings		✓		✓		✓		✓		✓		✓
Organisational Risk Register	Director of Corporate Governance	All regular meetings		✓		✓		✓		✓		✓		✓
Consultant Job Planning	Medical Director	Bi-Annually				✓						✓ Deferred to Dec		✓
Medical Rostering	Medical Director	Bi-Annually				✓ Deferred to June		✓ Deferred – Follow Up Review undertaken				✓ Deferred to Dec		✓
Internal Audit Progress Report	Head of Internal Audit	All Regular Meetings		✓		✓		✓		✓		✓		✓
Internal Audit Annual Audit Plan	Head of Internal Audit	Annually				✓								
Internal Audit Reviews	Head of Internal Audit	All regular meetings		✓		✓		✓		✓		✓		✓
Head of Internal Audit Opinion and Annual Report	Head of Internal Audit	Annually						✓						
Audit & Risk Committee Update	Audit Wales	All regular meetings		✓		✓		✓		✓		✓		✓

Item of Business	Executive Lead	Reporting period	Jan 2022	Feb 2022	Mar 2022	April 2022	May 2022	June 2022	July 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022
Audit Wales Review Reports (as relevant)	Audit Wales	All regular meetings		✓		✓		✓		✓		✓		✓
Audit Wales Annual Audit Report	Audit Wales	Annually												✓ Deferred to Feb 23
Audit Wales Audit Plan 2022	Audit Wales	Annually				✓								
Audit Wales Audit of the Financial Statements (ISA 260) Report (Including the letter of representation and Audit Opinion)	Audit Wales	Annually						✓						
Structured Assessment	Audit Wales	Annually												✓ Deferred to Feb 23
Audit of Financial Statements Addendum Report (if required)	Audit Wales	Annually								✓				
Hosted Bodies														
WHSSC Internal Audit Recommendations Tracker	WHSSC Director of Finance	All regular meetings		✓		✓		✓		✓		✓		✓
WHSSC Corporate Risk Assurance Framework including the risk register.	WHSSC Committee Secretary/Head of Corporate Services	All regular meetings		✓		✓		✓		✓		✓		✓
WHSSC Governance Statement	WHSSC Committee Secretary/Head of Corporate Services	Annually						✓						
EASC Risk Register	Chief Ambulance Services Commissioner	All regular meetings		✓		✓		✓		✓		✓		✓
EASC Governance Statement	Chief Ambulance Services Commissioner	Annually						✓						
WHSSC & EASC Annual Accounts	WHSSC/EASC	Annually						✓						
National Imaging Academy for Wales Hosted Compliance Statement.	Director of the National Imaging Academy	Annually						✓						



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Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Agenda Item 2.2.2

AUDIT & RISK COMMITTEE – FORWARD WORK PLAN

Origin of Request	Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)	Item Title	Lead Officer	Intended Meeting Date
Email request received from Georgina Galletly on 21/06/2022	Additional Item	Transforming Leadership Partnership Board Baseline Governance Review	Director of Strategy & Transformation	22 August 2022 – On agenda
Proposed approach suggested by the Director of Corporate Governance	Additional Item	Endoscopy JAG Accreditation Closure report - Progress and Associated Risk Mitigation	Chief Operating Officer	15 February 2023
Email request from the Assistant Director of Governance & Risk on 1/11/2022	Additional Item	National Fraud Initiative Self-Appraisal Checklist	Local Counter Fraud Specialist	12 December 2022 – On agenda
Action agreed at the April 2022 meeting	Additional Item	End of Year Post Payment Verification Report	All Wales Post Payment Verification Manager	11 October 2022 – Completed

AUDIT & RISK COMMITTEE

OUTCOME REPORT: AUDIT & RISK COMMITTEE EFFECTIVENESS SURVEY

DATE OF MEETING	12/12/2022

PUBLIC OR PRIVATE REPORT	PUBLIC

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Emma Walters, Corporate Governance Manager & Cally Hamblyn, Assistant Director of Governance & Risk

PRESENTED BY	Cally Hamblyn, Assistant Director of Governance & Risk

EXECUTIVE SPONSOR APPROVED	Chief Executive

REPORT PURPOSE	FOR NOTING

ACRONYMS

N/A

1. PURPOSE

1.1 The Chair of the Audit & Risk Committee is required to present an annual report outlining Audit & Risk business through the financial year to the Health Board to provide an assurance on the monitoring and scrutiny undertaken of Cwm Taf Morgannwg University Health Board (CTMUHB) performance in relation to Audit & Risk. As part of this process the Committee are required to undertake an annual self-assessment questionnaire, which was completed during November 2022.

1.2 The purpose of this report is to share with the Committee an update on the actions identified as an outcome from the self-assessment questionnaire.

1.3 At total of 8 out of 15 responses were received giving a 55% response rate.

2. SUMMARY REPORT

Positive Assurance	Committee Effectiveness: It was clear that the majority of Members/Attendees were aware that: • There were approved Terms of Reference in place defining the role of the Committee that were reviewed annually. • A Committee Highlight Report is produced following each meeting that is submitted to the next Health Board meeting. This is the mechanism that the Committee Chair uses to provide information on activity, areas or assurance and/or areas of escalation. • An Annual Committee Report is also received by the Board. All Board and Board Committee Agenda and Papers are shared on the website and are available to the public and organisation as a whole; • There was now an Annual Cycle of Business and Forward Work Programme in place which were being presented to each meeting. Committee Business • Committee members felt that meetings were held sufficiently frequently to deal with planned matters identified via the Annual Cycle of Business and felt that enough time was allowed for questions and discussions. Committee members also felt that the atmosphere at committee meetings was conducive to open and productive debate; • Committee members felt that the behaviour of all members and attendees was courteous and professional; • Private meetings of the Committee – overall members felt that private meetings had been used appropriately on the rare occasions that they had been established and only by exception; • Closure of agenda items – overall it was felt that agenda items were closed off appropriately, and noted that where agenda items had not been closed off they were subsequently added to the action log; • Virtual meetings – Members agreed that the experience of holding virtual meetings had been positive. One member commented that virtual meetings had achieved good attendance at meetings; • Integration with other Committees reviewing risk – members felt that Committee had formally considered how it integrated with other Committees reviewing risk, recognizing that the Audit & Risk Committee received the risk register in its entirety, whilst other Committees received their assigned risks only;

- Members felt that the Committee had reviewed the robustness and effectiveness of the content of the organisation's system of assurance;
- **Timeliness and format/content of reports** – Overall members considered that reports were received in a timely manner and in the right format/content and that further work was being undertaken to improve format and content of reports;
- **Committee Leadership and Support** – Members felt that meetings were chaired effectively, with clarity of purpose and outcome; felt that the Chair provided clear and concise information to the Board on the activities of the Committee; felt that the Committee was adequately supported by the Committee Secretariat;
- **Additional training** – it was felt that training could be provided to new Independent Members particularly in relation to the role of committee members, new legislation etc;

Internal Audit

- The Committee reviews the **Internal Audit Plan** and agrees any material changes outside the meeting should they arise and the plan is derived with engagement from the Health Board and as the Organisational Risk Register evolves there will also be an opportunity to inform the plan based on the high level risks faced by the Health Board;
- Members felt that Audit Plans were derived from clear processes based on risk assessment with clear links to the system of assurance. Members confirmed that the Committee received periodic reports from the Head of Internal Audit;
- The Committee has a role in investigating the reason for management **refusal to accept audit recommendations** should the situation occur, with encouragement being given to management to ensure the recommendations are achievable and address the issues identified;
- Members agreed that the Head of Internal Audit had a direct line of reporting to the Committee and its Chair;
- The Committee **reviews the effectiveness** of Internal Audit and the adequacy of staffing and resources within Internal Audit through regular review of the Internal Audit Plan outlining progress and performance. The Chair of the Audit & Risk Committee also meets separately with Audit colleagues as required. This matter has not arisen or been a cause for concern during this period of self-assessment;
- The Committee receives and reviews the **Head of Internal Audit Annual Report and Opinion.**

External Audit

- The Committee receives and reviews the Auditor Generals Audit Plans and Strategy for consideration. The Committee also considers the Auditor Generals Annual Audit Letter;
- The Committee receives and monitors actions taken in respect of prior year's reviews;
- The Committee assesses the quality and effectiveness of External Audit work (both financial and non-financial).

Counter Fraud

- The **Counter Fraud Work Plan** is reviewed and approved by the Committee;
- The Committee were able to approve any material changes to the **counter fraud plan** although it was noted by one member that there had been no changes required to date;
- Periodic reports were received by the Committee from the Local Counter Fraud Specialist, with one Member commenting that the reports were well structured and informative;
- The Local Counter Fraud specialist has a **right of direct access** to the Committee and its Chair;
- The Committee received and reviewed the **Local Counter Fraud Specialist's Annual Report of Counter Fraud Activity and Qualitative Assessment**.

1. Committee Effectiveness

For new members and attendees it is important to note the following routine business relating to Committee that is also captured in the Forward Work Programme and Committee Cycle of Business:

2. The Terms of Reference are reviewed on an annual basis considered by the Committee and then approved by the Health Board.

3. Committee Business

4. **Welsh Language** at meetings – Whilst some members supported greater use of welsh language, some members advised that they would support the greater use of welsh language if this was a requirement from Members;
5. Whilst the majority of Members felt that the Committee reviewed assurance and **regulatory/legislative compliance** reporting processes,

**Areas
Requiring
Further
Assurance**

one member indicated that they did not think this had happened with one Member indicating that they did not know if this had happened;

6. Internal Audit

7. Members felt that the Committee to some extent effectively monitored the implementation of management actions from audit reports, with one member commenting that improvements could be made by the Committee in relation to holding Executives to account when there were long delays;
8. Whilst the majority of Members felt that the Committee had agreed a range of Internal Audit Performance measures to be reported on a routine basis, one Member advised that they could not recall this taking place;
9. It was unclear within responses whether Internal Audit **complies** with the **Public Sector Internal Audit Standards (PSIAS)**. It is important to note that In the Internal Audit Annual Plan presented to the Audit & Risk Committee earlier in the year stated: *"Once every five years, our internal audit provision must be the subject of an External Quality Assessment (EQA). This assessment is required by the PSIAS and was undertaken by The Chartered Institute of Internal Auditors (IIA) in February and March 2018. The EQA report concluded that: "It is our view that NWSSP Audit and Assurance Services conforms to all ... 64 fundamental principles ... and it is therefore appropriate for NWSSP Audit and Assurance Services to say in reports and other literature that it 'conforms to the IIA's professional standards and to PSIAS.'" ..."*

10. External Audit – Audit Wales

In relation to reviewing the nature and value of **non-standard/discretionary work** e.g. Healthcare Inspectorate Wales and Audit Wales Joint Review, some members indicated they were unsure as to whether the Committee had reviewed this. A Progress report and action plan on the Healthcare Inspectorate Wales/Audit Wales Joint review was presented to the Committee in August 2021 with regular updates being presented to the Committee via the Audit Recommendations Tracker.

11. Counter Fraud

- Whilst the majority of Members felt that the Committee satisfied itself that the work plan adequately each of the seven generic areas defined in the NHS Counter Fraud Policy, some members indicated that they were unsure of this. In response to this point the process is outlined for assurances purposes as follows; the seven generic areas are derived from the requirements of the Welsh Government Directions to NHS Bodies on Counter Fraud Measures. The Health Board is also expected to comply with NHS Counter Fraud Standards. The annual Counter Fraud Work Plan is devised to meet responsibilities in relation to these

legislative/governance requirements. The work plan is set around four strategic areas which are mapped to the seven generic areas set out in the Health Board Policy and Welsh Government Directions. For future Counter Fraud Work Plans activity can be overtly mapped to the seven generic areas for assurance these are met.

- Whilst the majority of Members felt that Counter Fraud Plans were derived from clear processes based on risk assessment, some members did not know if this was the case; in response to this point, it is useful for members to note that Counter Fraud Work Plans are derived from a high-level organisational risk assessment. The new NHS Counter Fraud Standards require comprehensive local risk assessments to be undertaken which are then managed in line with local risk management policy and procedure. Going forward there will be a blend of these two approaches that inform Work Plan development.
- Whilst the majority of Members agreed that the Committee effectively monitored the implementation of management actions arising from Counter Fraud reports, some members advised that they did not know; For awareness management actions and recommendations arising from Counter Fraud reports are monitored via the Recommendations Tracker when outstanding.
- Overall Members felt that the Committee had reviewed the effectiveness of the Local Counter Fraud Service and the adequacy of its staffing resource, one member commented that it might be an opportune time to review this again. In response, the LCFS has confirmed that Counter Fraud staffing resource is reviewed continually. Annually resource levels are agreed via the Service Level Agreement with Swansea Bay UHB. This presents an opportunity to discuss resource levels. The Health Board maintains a resource of 0.20 WTE Counter Fraud Specialists per 1000 staff; that is in line with the All Wales Average of 0.28. Resource levels across NHS Wales are tracked via quarterly statistic submission. This can be included in the statistical benchmarking reports brought to Committee periodically.
- Overall members agreed that the Committee had received and discussed reports arising from quality inspections by NHS Counter Fraud activity, one Member commented that they could not recall this happening. In response to this point Quality Inspections have evolved from full inspections of compliance with NHS Counter Fraud Standards to thematic assessments of particular standard areas. The last report issued by NHS Counter Fraud Authority following a thematic assessment was February 2020. This reviewed the compliance with previous NHS Counter Fraud Standards 3.4, 3.5 and 3.6 with focus on the relationship between NHS Wales Health Boards and NWSSP. A report following recent inspection visit in September 2022 by the NHS

	Counter Fraud Authority, which focused on the outcomes of the 2020 report and approach to risk assessment, is due imminently and will be brought to Committee at the next available meeting following issue.
Areas Requiring Further Action	• Committee Business • The Committee considered whether they were adequately supported by Executive Directors in terms of attendance, quality and length of papers and responses to challenges and questions. Feedback reflected that overall, the support was very good; however, this could be improved upon by ensuring robust preparedness in advance of meetings. • Whilst the majority of Members felt that the Committee had a mechanism in place to ensure awareness of topical, legal and regulatory issues, one Member commented that this was not happening as systematically as might be desirable. Some members recognised that this was being captured in the cycle of business, within any other business and via Board Briefings and Board Development Sessions;
Action Plan	1. Committee Business • All meeting participants are encouraged to ensure they are fully briefed and prepared for meetings in advance. The Independent Member (IM) Scrutiny Toolkit is a helpful reference point for IM's and Executive Leads in clarifying their roles in terms of Board Committee meetings and this is attached at Appendix 1 should it be helpful to revisit. • Board Development Sessions and Board Briefings will continue to be the mechanism for legislative and regulatory updates for all Board Members. Updates relevant to the remit of the Audit & Risk Committee can be planned throughout the year as and when required. • Counter Fraud • For future Counter Fraud Work Plans, activity can be overtly mapped to the seven generic areas for assurance these are met. • Local Counter Fraud Staffing Resource will be included in the statistical benchmarking reports brought to Committee periodically.
Appendices	Independent Member Scrutiny Toolkit available upon request.

3. Recommendation

- 3.1 The Committee are asked to **NOTE** this report and the updates to the areas identified for improvement.



AGENDA ITEM

2.2.4

AUDIT & RISK COMMITTEE

**CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD (CTMUHB)
NATIONAL CLINICAL AUDIT PROGRAMME UPDATE 2020-2021**

Date of meeting	12/12/2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Mark Townsend – Head of CA&QI, Natalie Morgan - Thomas Deputy Head of CA&QI & Lead Nurse for Clinical Effectiveness & Lauren Dyton – Clinical Audit & Effectiveness Manager
Presented by	Dr Dom Hurford – Executive Medical Director
Approving Executive Sponsor	Executive Medical Director
Report purpose	FOR NOTING

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

Committee/Group/Individuals	Date	Outcome
Quality & Safety Committee	15/11/2022	NOTED

ACRONYMS

CTMUHB	Cwm Taf Morgannwg University Health Board
TARN	Trauma Audit Research Network
NHFD	National Hip Fracture Database
CA&QI	Clinical Audit & Quality Informatics Department
NACEL	National Audit for Care at the End of Life
NAIF	National Audit of Inpatient Falls

1. SITUATION/BACKGROUND

- 1.1 The purpose of this report is to provide an update for the Audit & Risk Committee on progress against the CTMUHB Clinical Audit Forward Plan 2022-2023 aligned to the National Clinical Audit and Outcome Review Plan for 2022/23, which is also available via the Welsh Government website: <https://gov.wales/national-clinical-audit-and-outcome-review-plan-2022-2023>, published June 2022.
- 1.2 **29** out of 35 national audits and 9 clinical outcome reviews (tier 1) are green fully compliant and **5** amber where the audits are delayed, a backlog exists but a plan is in place to comply with the national audit deadline. **1** clinical outcome review audit is red because the deadlines has passed, and we were only able to achieve limited participation (NCEPOD Epilepsy Study).
- 1.3 The reduction in the Clinical Audit overall budget allocation for 2022-23 by approximately £100k, which resulted in the loss of the 3 substantive posts and the requirement to manage the increase in mortality activity within the constraints of the existing clinical audit budget continues to impact on the organisations compliance with the national audit programme resulting in significant backlogs developing in a number of clinical audits e.g. TARN, NHFD, Heart Failure.
- 1.4 A further reduction of organisation priority (tier 2) audits is in under review.
- 1.5 The AMaT ward and area module providing ward and community team regular monthly audit assurance is progressing. After completion of the rollout to all 25b nurse staffing act wards the focus is currently on the roll out to emergency departments Health Board wide.

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

- 2.1 **Clinical Audit Forward Plan 2022-2023 Current Position**
The NACEL end of life audit was completed successfully in September 2022, as planned. Therefore, compliance has been revised from amber to green. The Lead Nurse for Clinical Effectiveness within the Clinical Audit department completed all acute casenote reviews and medical staff from YCR undertook the community hospital reviews, due to the clinical pressures on the palliative care team, who were unable to participate.

A clinical lead remains outstanding for the COPD National audit for PCH.

The NEIAA (Arthritis) audit is amber, but good progress is being made to achieve compliance. The current focus for the audit team in quarter 3 and

4, 2022-2023 is to recover the NAIF, TARN, NHFD and Heart Failure non-compliance positions. The following actions are being taken:

- National audit target compliance reduced from 100% to 80% (minimum accepted compliance for national audits that require clinical audit staff input. This will release experienced clinical audit staff time for additional TARN sessions.
- Continue with set TARN only audit days across all 3 sites and priorities TARN cases when there is a gap in other audit compliance sessions.
- Identified a Senior Clinical Audit facilitator with a clear focus on TARN quarterly targets.
- Prioritising current TARN quarter over previous quarters where the deadline has already been missed.
- Reallocation of resources to cover NHFD
- Reviewing more timely case identification sources other than clinical coding, which has historically been a cause of national audit delays particular in relation to identification of heart failure cases.
- Overtime being offered to staff, funding permitting.
- Looking to secure additional band 3 cover to undertake basic admin tasks to release experienced band 5 clinical audit facilitator time for national audit key tasks.

Noting the above exceptions the clinical audit team are working to ensure completion of the full CTMUHB Clinical Audit Forward Plan 2022-2023, by the end of March 2023.

2.2 Key clinical audit publications, findings and actions

FFFAP - Falls & Fragility Fracture Audit - National Hip Fracture Database (NHFD) Annual Report (2021 data): Improving understanding Based on data from England and Wales, the report encompasses both 2020 and 2021 data and presents how current care 'since COVID-19' compares with the baseline of 2019 'before COVID-19'.

The report found that services have generally succeeded in getting patients out of bed by the day after surgery (81% in both 2019 and 2021) and then returning them to their original residence (71% in 2019 and 70% in 2021).

The provision of orthogeriatric assessment and screening for/prevention of postoperative delirium both temporarily deteriorated, in parallel with successive waves of the pandemic, but have since returned to baseline.

A more progressive and persistent deterioration in the promptness with which patients receive surgery, and the extent to which the operation is consistent with the recommendations of NICE was highlighted (down from 74% in 2019 to 71% in 2021).

CTM update – Findings from the report are being reviewed by the multidisciplinary team to draw up a local action plan for improvement.

Trauma and Audit Research Network (TARN)

The 4th Biennial National Severe Injury In Children Report - 2019-2020 (England & Wales)

During January 2019 to December 2020 there were 1637 severely injured (ISS > 15) children treated in England & Wales. Pedestrian injury resulting in traumatic brain injury is still the commonest cause of severe injury and mortality after the age of 1 year, Suspected Physical Abuse (SPA) being the predominant cause in the first year of life. Other types of road traffic incident and falls are also common. Despite being uncommon injury mechanisms, the highest case fatality rates were for asphyxia and drowning. This is shown in the new data on the injury mechanisms and in the breakdown of patients injured in road traffic incidents.

The number of severely injured children follows a well-known seasonal pattern (peaking during the summer) and weekly pattern (more cases occurring at weekends) and daily pattern (a small morning and larger late afternoon / evening peak). The pattern of arrival of severely injured children has not changed and still implies that staffing for paediatric trauma needs to be focussed 'out of hours' to match high rates of arrival in the evening and at weekends. There continued to be few patients arriving after midnight.

CTM update – Findings from the report are being reviewed by the multidisciplinary team to draw conclusions from the report and develop a local action plan for improvement.

- 2.3 Key issues affecting clinical audit data inconsistencies as detailed in the *Resource Evaluation to Improve Data Quality across CTMUHB for National Clinical Audits SBAR*, approved in the December 2019, Management Board.

Development of clinical dashboard for real-time monitoring and validation of inconsistencies in patient data between systems before the data leaves the organisation.

The proposal was to increase the organisations available Qlik Sense development resources to support the development of a number of specialist Qlik Sense dashboards for the monitoring and reporting of compliance against national clinical audits that are dependent on information from operation clinical and administrative information systems.

National Maternity & Perinatal Audit (NMPA) Dashboard

A clinical dashboard is currently under development and first iteration released for review in quarter 3, 2022-23 to support improved data quality

for the NMPA national audit. The dashboard includes key metric from the NMPA to identify any inaccuracies of data being recorded between the casenotes (via clinical coding data) and Maternity Information System (MITS). This will enable identification of inconsistencies in the data that can then be rectified for improved clinical outcomes and reduce the risk of the organisation being identified as an outlier due to a data quality issue.

Quality Metrics Dashboard

A quality dashboard to reflect the organisation metrics presented in the quarterly quality dashboard report to Quality and Safety Committee. This development has been delayed awaiting the establishment of the link between the new Datix system and the Health Board data warehouse. No date available when this interface will be re-established, so development on hold.

Rapid Response & Cardiac Arrest Dashboard (new development request)

A review underway to consider the development of a new dashboard based on a regular ward audit undertaken across the organisation that look at the timely and appropriate response to cardiac arrests.

2.4 Clinical Audit Training

In July 2022, a programme of bespoke clinical audit and effectiveness training for year 2 Student Nurses commenced. Student nurses spent two weeks gaining an insight into the portfolio of the Clinical Audit & Quality Informatics Department. Initial feedback has been positive.

Bespoke clinical audit training was delivered to Primary Care-based Nurse practitioners in August 2022, the afternoon covered the key principles of clinical audit and was well received by the attendees.

Examples of feedback from the session: *"It has changed my view on clinical audits, in a positive way, giving me a better understanding of clinical audits and the importance of them", "Content and delivery of the course was excellent. It met all the intended aims, objections and expectations. The clinical audit process is much clearer following the session and I know feel I understand the process more with a clear framework to follow"*.

2.5 Clinical Audit & NICE Monitoring System (AMaT) Implementation

With the implementation of AMaT the organisation is now able to monitor the CTMUHB Clinical Audit Forward Plan in real-time and compliance with NICE guidelines, standards and focus at present is on the ward and area audit module rollout.

The AMaT ward and area module rollout is progressing well with a health board wide focus on Emergency department services by Christmas 2022.

Mental Health and Therapy departments currently under review for inclusion in the rollout plan for quarter 4 2022.

2.6 **NICE Compliance Programme of work**

The CTMUHB NICE Reference Group (NRG) established in September 2021 has been suspended due to funding issues and senior management restructuring removing the dedicated clinical lead post to support this function within the Clinical Audit and Quality Informatics department.

The assurance oversight, scrutiny and a governance function in relation to NICE guidance within CTMUHB will now remain with directorates and individual clinical leads.

A review of the Clinical Audit policy and Strategy is being undertaken to reflect this.

3. **KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE**

- 3.1 Reduction in the Clinical Audit budget allocation by approximately £100k for 2022-23, associated restructuring and increase in mortality review activity will mean a need to focus limited clinical audit resources on tier 1 priority national audits and a further reduced programme of tier 2 organisation priority audits for 2022-23. It will also require directorates and lead clinicians to take responsibility for all NICE compliance monitoring activities.
- 3.2 A lack of early detection of 'outlier status' or assurance around the monitoring of NICE clinical guidance and standards and risk of failure to comply with national audit programme tier 1 targets.
- 3.3 The detrimental impact of poor data quality submission to national audits has a cost to organisational reputation, loss of confidence of the service users and time spent on retrospective data validation and resubmission.
- 3.4 A lack of reliable benchmark data can result in a failure to identify key areas for improvement as in the report on Health Boards Maternity services.
- 3.5 The quality of the clinical casenote and scanned version currently available as part of the digitization project is increasing the time to review national clinical audit documents and impacting on the audit teams ability to achieve national targets or provide assurance around the submitted data.

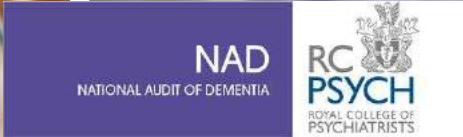


4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Effective Care
	If more than one Healthcare Standard applies please list below:
Equality impact assessment completed	No (Include further detail below)
	Not required for this compliance position.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goal	Improving Care

5. RECOMMENDATION

- 5.1 That the committee **NOTE** receipt of the compliance position and mitigating action being taken to achieve compliance for the CTMUHB



 **HQIP**

Evidence
Q

Guidance
↗

Quality standards
✓

Improved outcomes
👍

NICE
National Institute for Health and Care Excellence



Clinical Audit and Effectiveness ANNUAL REPORT 2021-22

Clinical Audit &
Quality Informatics Department
Information for Improvement

Content

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Deputy AMD for Clinical Audit & Effectiveness

The National Clinical Audit and Review Outcome Plan confirms the National Clinical Audits and Outcomes that health boards are expected to participate in. This annual rolling program shows how findings from audits and reviews will be used to evaluate and improve healthcare quality and safety in Wales.

Clinical Audit is an integral part of the process for measuring the quality of services against set standards for comparison and identification of improvement opportunities.

Considering the challenges the Health Service is now facing across Wales being able to identify improvements and optimise efficiency has never been more important. When working in partnership with multiple disciplines, managers and policy makers the NCAROP enables objective assessment of the quality of healthcare to guide decision making.

The Clinical Audit and Quality Informatics Department champions education and engagement with the process at every level within the Health Board. There are clear lines of communication to ensure escalation to the Executive board and Medical Director as well as dissemination to all relevant departments.

The Mortality Review process, which continues to expand in scope and demand, is also being run by the Audit Department to great effect.

I wish to commend and recognise the hard work and dedication of our Clinical Audit and Quality Informatics Department who have produced all of this against a challenging backdrop of squeezed budgets, decreased staffing and increased demand. I also wish to thank the Clinical Audit Leads, the Medical Director and all those who have participated in the Audit process for their engagement and enthusiasm.

The Department



The Clinical Audit and Quality Informatics (CA&QI) Department is responsible for facilitating all clinical audit projects, incorporating both national, organisation and local priorities, throughout CTMUHB. It is an integral part of the Medical Directors Office which is accountable to the Executive Medical Director and Executive Board.

The department provides expertise and support to clinical specialties to monitor and

improve patient care through:

- Clinical audit training, awareness and support to all clinicians
- Support and facilitation to clinicians and other relevant staff conducting and / or managing clinical audits
- A formal review of the Clinical Audit & Effectiveness Programme to ensure that it meets the organisations aims and objectives as part of the wider quality improvement agenda.

Findings from national audits are presented quarterly to the Clinical Audit, NICE and Effectiveness Group (CANE) prior to inclusion in update reports to the Quality & Safety Committee. The Quality and Safety Committee is responsible for receiving assurances for all national audits.

A report is also provide annually for the organisation Audit Committee on clinical audit activity.

Clinical directorates hold bi-monthly Clinical Audit / Quality Assurance and Governance meetings at which they cover

standing quality agenda items which include clinical audit. The meetings are also used to plan how the directorates will implement the recommendations made as a result of national clinical audits.

The CA&QI department also manages the organisation's Mortality Review process, VTE/HAT monitoring, NICE Compliance, Ward Audits (including compliance with the Nurse Staffing Act) and provision of an informatics service from ward to board.



Workforce

Staff Development

Staff retention and development remains a key goal and through succession planning four staff have secured promotion and one has been supported in extending their secondment to the Medical Directors Office.

17 staff attended formal clinical audit training, with five successfully attaining accreditation.

3 staff have completed CMI Level 7 course.

A number of individuals with the team have also achieved:

- BSc in Computer Studies (1st)
- ILM Level 5 (NVQ) in Leadership and Management
- Won the prestigious Woodford TARN Audit Coordinator of the year Award

Investment in new posts, this year

0.5

WTE

For National Audit dashboard developments



No. of development opportunities(internal)

4

/1

External to department



No. National Audit Workshops attended

1

/4

Total staff Attendance



No. PDR identified courses supported

23

Qualified or Completed in 2021-22



Training Programme

Total clinicians
Trained 2021-22

Clinical
Audit

115

Ward &
Area
Audit

245

In addition to the standard package of training the following tailored group sessions were provided:



June 2021

Clinical audit session for
Pharmacy Technicians

September 2021

Clinical audit & AMaT training
session for F1 / F2 Doctors



December 2021

Clinical audit & AMaT session for
Pre-registration Pharmacists



November 2021 to March 2022

AMaT ward audit training for nursing staff



Workshop-based group training spread over 4 sessions has been provided that covered clinical audit techniques from inception to presentation. The core topics are;

- (1) Clinical audit overview;
- (2) Identifying your audit criteria;
- (3) Preparing an audit proforma and data collection;
- (4) Analysing audit results;
- (5) Preparing for presentation and sharing the findings (report writing and action planning).

Training sessions have been adapted for delivery using MS Teams in a condensed format and tailored to the needs of clinical teams. In addition to formalised training sessions, all clinical audit staff are able to provide clinical audit advice, support and training on an ad-hoc basis.

In addition, training sessions have been provided for clinicians on the use of the Audit Management and Tracking (AMaT) system. Demonstrations are a regular feature of clinical audit meetings, to ensure that clinical staff are able to register audits and upload audit information on the new system.

Sharing the learning from Clinical Audit

Since October 2021, a clinical audit newsletter is published on a quarterly basis to publicise key national audit findings, information on clinical audit services and to provide evidence of any associated improvement work.

Clinical Audit Newsletter



Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Quarter 3

Oct - Dec 2021

Welcome to our new Senior Clinical Audit Facilitators



We are excited to announce our new appointments, as November 2021 saw our new Senior Facilitators take their posts. Debra Townley (Bridgend) and Sean Thomasson (Merthyr & Cynon) join Fiona Weston (Rhondda & Taff Ely) to make up our team of senior clinical audit facilitators.

Congratulations to Debra & Sean!

CANE Group established

Clinical Audit, NICE & Effectiveness (CANE) Group

The CANE Group was officially launched on 14th December at the inaugural meeting chaired by Mr Dai Morgan, Assistant Medical Director. Audit Leads from across the Health Board were invited to attend to set the direction for Clinical Audit for the months to come.



At the meeting the role and responsibilities of the CANE Group were set out, which include:-

- Review reports to Audit & Risk Committee and Quality & Safety Committee
- Support development of annual Clinical Audit Programme
- Identify Health Board priority clinical audit topics to register on the Clinical Audit Programme
- Monitor national clinical audit recommendations and action plans
- Receive summaries of national clinical audit reports and completed baseline assessments to agree recommendations and actions
- Receive completed local clinical audit reports and recommendations
- Review progress of Health Board and ILG Clinical Audit Programmes and escalate concerns to Audit and Risk and Quality and Safety Committee
- Receive NICE & Royal College Guidance compliance reports from the NICE Reference Group



ILG Clinical Audit & Effectiveness Leads were also introduced and the structure of the Clinical Audit Department was discussed. An update was provided on the features of AMaT (Audit Management and Tracking) software. Developments with NCEPOD studies, key national audit activity and the latest national audit publications were also outlined.

Updates from the Team

Accredited Clinical Audit Training

On 1st November 2022 virtual clinical audit training was delivered by Tracy Ruthven and Stephen Ashmore from the Clinical Audit Support Centre for our Team. The training covered all the essential elements of undertaking a clinical audit. For more information on the work of the Clinical Audit Support Centre visit the website: www.clinicalauditsupport.com



TARN Co-ordinator Success Story

We are pleased to announce that Nichola Jenkins, TARN Co-ordinator based in the POWH Clinical Audit Team has recently been appointed as chair of the South Wales Trauma Network TARN Co-ordinators' Forum. Encouraging conversations on this key national audit both within the network and across Wales.

Support for the Community Vaccination Centres



Over the Christmas period staff from the Clinical Audit Department ably supported the COVID-19 Booster campaign at our Community Vaccination Centres across the localities. Our staff were involved in welcoming members of the public to the centres, manning the reception desks and our clinical staff administered vaccinations.



New National Clinical Audit Reports

Quarter 3 was a busy period for national clinical audit reporting, with a high number of publications released covering broad subject areas. Local action planning based on these reports will take place with audit facilitators and clinical teams during Quarter 4.

National audit reports released in October were predominantly in the field of maternity & child health and cardiac care:-

- National Pregnancy in Diabetes (NPID) Audit
- MBRACE-UK Perinatal Mortality Surveillance Report 2019
- National Maternity and Perinatal Audit Clinical Report 2021
- National Perinatal Mortality Review Tool 3rd Annual Report
- National Heart Failure Audit (2021)
- National Audit of Cardiac Rhythm Management
- Myocardial Ischaemia National Audit Project (2021)

November publications:

- National Emergency Laparotomy Audit (NELA) – 7th Annual Report
- National Audit of Inpatient Falls Annual report 2021 - The Falls and Fragility Fracture Audit Programme (FFFAP)
- Ethnic and socio-economic inequalities in NHS maternity and perinatal care for women and their babies - National Maternity and Perinatal Audit (NMPA)

December publications:

- National Oesophago-Gastric Audit Annual Report 2021
- Sentinel Stroke National Audit Programme Annual Report 2020/21

Looking ahead

Development of Clinical Audit Forward Plans (2022/23) will take place from January with our audit leads and facilitators.

Standardised Clinical Audit meeting agenda template is planned for release in February 2022 to allow greater consistency.

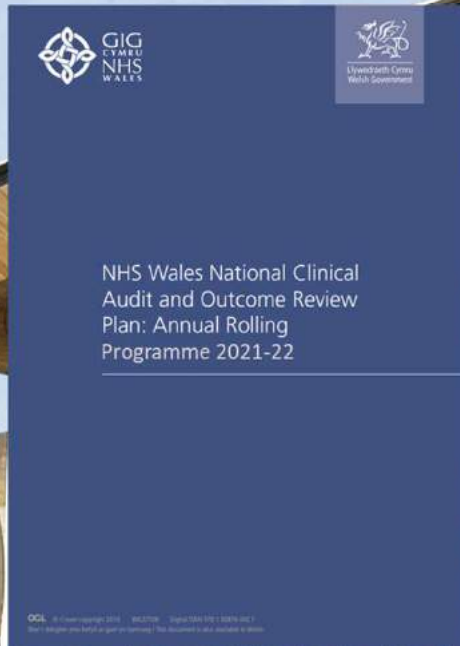
Relocation of the Clinical Audit offices at PCH to take place in January.

For further information on Clinical Audit contact Natalie Morgan-Thomas, Deputy Head & Lead Nurse for Clinical Effectiveness: Natalie.Morgan-thomas@wales.nhs.uk



Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

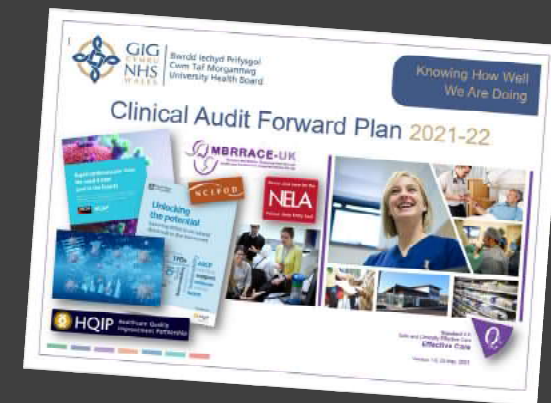
NHS Wales National Clinical Audit and Outcome Review Plan 2021-22



All organisations in Wales are required as part of their Quality Strategy to have an annual **Clinical Audit Forward Plan** in place to fully participate in all relevant national clinical audits and outcome reviews listed in the annual National Clinical Audit & Outcome Review Annual Plan.

The Cwm Taf Morgannwg University Health Board (CTMUHB) Clinical Audit Forward Plan identifies all of the clinical audit projects from the National Clinical Audit and Outcome Review Plan for 2021-22 that must be undertaken by CTMUHB.

Clinical audit is a fundamental component of the



organisations quality assurance process, based on transparency and candour. Quality assurance provides a systematic approach to maintaining consistently high quality by constantly measuring and reporting on effectiveness, highlighting the need for improvement and enabling the sharing of good practice.

The CTMUHB Clinical Audit Forward Plan sets out a programme of prioritised continuous improvement activities, including clinical audit, and is designed to help to embed the above principles into the everyday working practice of individuals and clinical teams to improve clinical outcomes for patients, through focused and structured work. The plan for 2021-2022, was determined at both corporate, locality and directorate level based around priority categories established by the Healthcare Quality Improvement Programme (HQIP) and defined as:

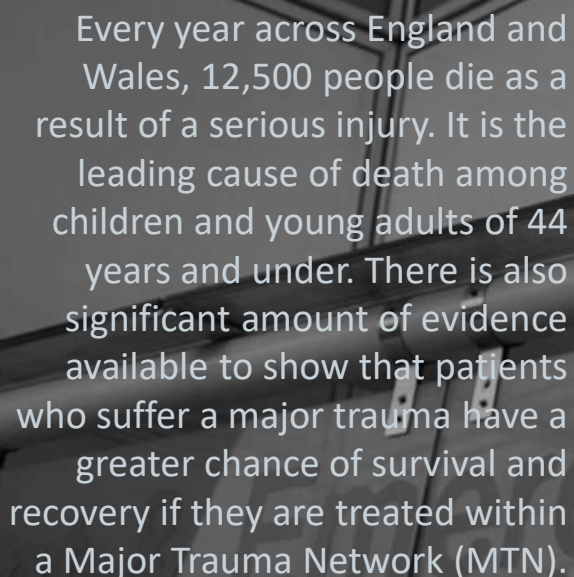
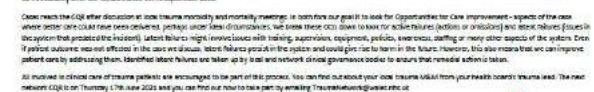
1. External “must do” - Externally monitored audits that are driven by commissioning and quality improvement are treated as the priority and appropriate resources are provided to support these. Failure to participate or deliver on these externally driven audits may carry a penalty for the Health Board
2. Internal “must do” - Based on the classic criteria of high risk or high profile identified by health board management. They may include national initiatives with health board-wide relevance but no penalties exist for non-participation. Many of these projects will emanate from Health Board governance issues or high profile local initiatives.

The 10th annual National Clinical Audit and Outcomes Review Plan was delayed due to purdah and the transfer of responsibilities for the NHS Wales National Clinical Audit & Outcome Review Plan (NCA&ORP) from Welsh Government to Digital Health and Care Wales.

A key component of the work undertaken in 2021-22 was to align audit activity to the Integrated Locality Group structure. Clearly identified responsibilities and timeframes for completion of audit work and continuous monitoring of progress against the plan has ensured the improved compliance position for CTMUHB. The weekly national audit monitoring of compliance that was introduced in April 2019 and the implementation of the Clinical Audit & NICE Compliance Management system from April 2020 has ensured that the organisations compliance with all national audits has improved at a time of extreme pressure due to the pandemic.

Pages 10 to 14 of this report provide some examples of the national audits undertaken by the organisation as part of the CTMUHB Clinical Audit Forward Plan. A full list of national audits that the organisation participates in can be found in the published CTMUHB Clinical Audit Forward Plan 2021-22.





In March 2018, CTMUHB as part of the South Wales region was approved for the establishment of **Major Trauma Centres (MTC)** at the Princess of Wales and Prince Charles hospitals, with the aim of enhancing clinical care and patient experience through introduction of specialist teams

and a major trauma pathway.

TARN is the national clinical audit for traumatic injury and forms part of the **National Clinical Audit and Outcome Review Plan** for Wales. CTMUHB participates in the TARN audit that informs the major trauma programme of work.

The team are responsible for ensuring that all TARN cases are identified and input onto TARN within 28 days of discharge from hospital.

Compliance with TARN quarterly reporting deadlines has not been achieved in 2021-22 compared to full compliance in 2020-21 due to the additional unplanned Major Trauma activity at the RGH.

A business case to secure an additional band 4 TARN Coordinator, has been submitted as part of the proposal to recognise RGH as a MTC.

National Paediatric Diabetes Audit (NPDA) Annual report 2019-20 (Published in June 2021)

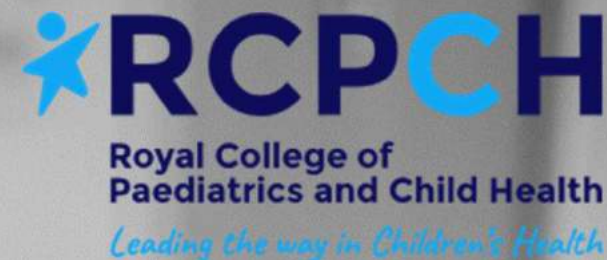
The audit covers the health checks and outcomes for children and young people with diabetes who have attended PDUs (paediatric diabetes units) from 1 April 2019 to 31 March 2020.

Findings

There were a number of positive findings that included establishment of CTMUHB Diabetes Team to restructure service and standardise care across all three sites; participation in Diabetes QI project by the Royal College of Paediatrics and Child Health (RCPCH), which has emphasised a focused on the management of newly diagnosed patients and high completion rates noted for certain care processes e.g. blood pressure, urine, retinopathy and feet checks.

Actions:

- High number of patients with levels of HbA1c >69 and this number has been increasing. (New policy in development to address this matter)
- Inability to offer 4 Consultant led clinics a year for each patient and perform 4 HbA1c measurements a year. (Lead clinician from each ILG identified who is responsible for ensuring this is completed).
- High DNA rates (A new DNA policy has been developed and implemented).
- Lack of Psychology service provision for the patient group. (Funding approved for 1WTE post to provide a psychology service for paediatrics)



The National Audit of Care at the End of Life (NACEL)

NACEL is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in acute hospitals, community hospitals and mental health inpatient providers in England, Wales and Northern Ireland.

Round 3 of NACEL took place between April and October 2021, where members of the Palliative Care Team undertook detailed case note reviews, looking closely at the quality of care provided by clinical teams across Cwm Taf Morgannwg UHB (Acute, Community and Mental Health services) during April and May 2021.



National Audit of Care at the End of Life

Learning points

There were a number of key learning points identified that included:

Acute setting

Need for clear treatment plans, requirement for face-to-face Palliative Care team involvement in patient care and DNACPR documentation to include details of discussion with the patient and family members. The importance of Advanced Care Plans (ACP) developed in care homes with individuals and their family.

Community Setting

Difficult to find pertinent records, late recognition of dying phase and limited detail documented regarding discussions with family members.

Mental Health Setting

Care Decisions for Last Days of Life guidance to be used to enable individualised care.

Findings

The bespoke dashboards for NACEL Round 3 containing findings on key themes and the organisation's position against the national average are awaiting publication and the full report was released to the public in July 2022. Following the publication of the dashboards and audit report local improvement activity can begin.



The National Emergency Laparotomy Audit (NELA) was started in 2013 because studies showed this is one of the most risky types of emergency operation, lives could be saved, and quality of life for survivors enhanced by measuring and improving the care delivered.

NELA aims to enable the improvement of the quality of care for patients undergoing emergency laparotomy, through the provision of high quality comparative data from all providers of emergency laparotomy.

The Year 7 report published in November 2021 and highlighted the following key findings for CTMUHB:



Positive findings

- Post-operative critical care was maintained at levels comparable with the national average during this period, which included the peak of the COVID-19 pandemic.
- Risk adjust mortality rates were below the national average for Prince Charles Hospital and Princess of Wales Hospital, and comparable to the national average for Royal Glamorgan Hospital.

Concerns

- Timely administration of antibiotics.
- Lack of perioperative assessment by a consultant geriatrician for patients aged 80 and over or frail patients aged 65 years and over.

Recommendations

- The need for geriatric support in the management of frail and elderly surgical patients was a consistent message from across the acute hospital sites.
- A specialist emergency surgery nurse specialist to manage patients through the perioperative period was deemed necessary (Prince Charles Hospital).
- A lead clinician within the Emergency Department to support the initial management of emergency laparotomy patients was put forward to enhance care at the Princess of Wales Hospital.
- Electronic booking system for emergency surgery theatre lists also proposed for the Princess of Wales Hospital.

NJR is described as a global exemplar of an implantable medical device registry, which covers England, Wales, Northern Ireland, the Isle of Man and Guernsey continues to be the largest orthopaedic registry in the world, with an international reputation and holds over 3 million procedure records in order to provide timely warnings of issues relating to patient safety.

The registry's purpose is to record patient information and provide data on: the performance and longevity of replacement joint implants: the surgical outcomes for the hospitals where these operations are carried out; and on the performance outcomes of the surgeons who conduct the procedures.

Data Quality Award

Dr. Dom Hurford, Medical Director praised members of the Clinical Audit Team for their diligence and dedication to data quality, when the National Joint Registry awarded Cwm Taf Morgannwg UHB the Quality Data Provider status award for 2021/22 in August.

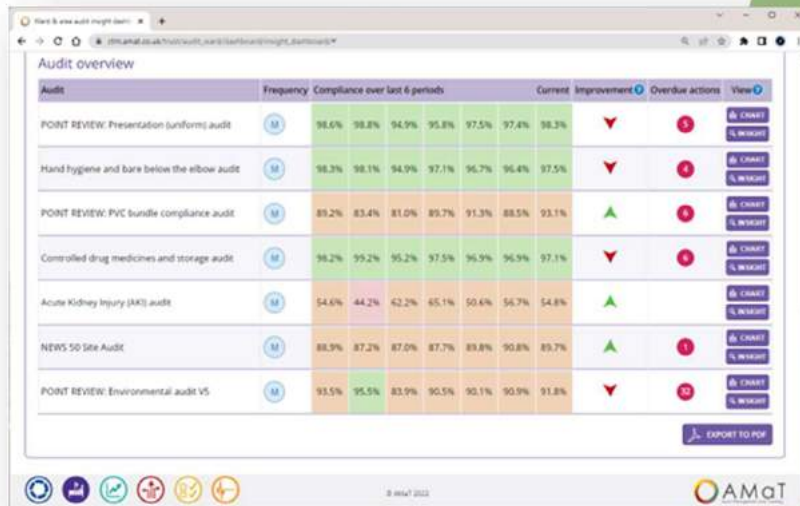
"I know that achieving compliance in order to win this award is no mean feat and is testament to the departmental effort of you all."

The award offers public recognition for achieving excellence in supporting the promotion of patient safety standards through their compliance with the mandatory National Joint Registry (NJR) data submission.



Ward & Community Team real-time clinical audits

AMaT
Insight
Clinical
Dashboard



The screenshot displays the AMaT Clinical Dashboard with an 'Audit overview' table. The table lists various clinical audits with columns for Frequency, Compliance over the last 6 periods, Current status, Improvement, and Overdue actions. Each row includes a 'View' button and a 'Chart' button.

Audit	Frequency	Compliance over last 6 periods	Current	Improvement	Overdue actions	View
POINT REVIEW: Presentation (uniform) audit	M	98.6% 98.8% 94.9% 95.8% 97.5% 97.4% 98.3%	▼	5	5	View Chart
Hand hygiene and bare below the elbow audit	M	98.3% 98.1% 94.9% 97.1% 96.7% 96.4% 97.5%	▼	4	4	View Chart
POINT REVIEW: PVC bundle compliance audit	M	89.2% 83.4% 81.0% 89.7% 91.3% 88.5% 93.1%	▲	0	0	View Chart
Controlled drug medicines and storage audit	M	98.2% 99.2% 95.2% 97.5% 96.9% 96.9% 97.1%	▼	0	0	View Chart
Acute Kidney Injury (AKI) audit	M	54.6% 44.2% 42.2% 45.1% 50.4% 56.7% 54.8%	▲	0	0	View Chart
NEWS 50 Site Audit	M	88.9% 87.2% 87.0% 87.7% 88.8% 90.8% 89.7%	▲	1	1	View Chart
POINT REVIEW: Environmental audit VS	M	93.5% 95.5% 83.9% 90.5% 90.1% 90.9% 91.8%	▼	20	20	View Chart

In April 2020 the ward and area audit module of the AMaT system was first deployed into the Maternity Unit at CTMUHB.

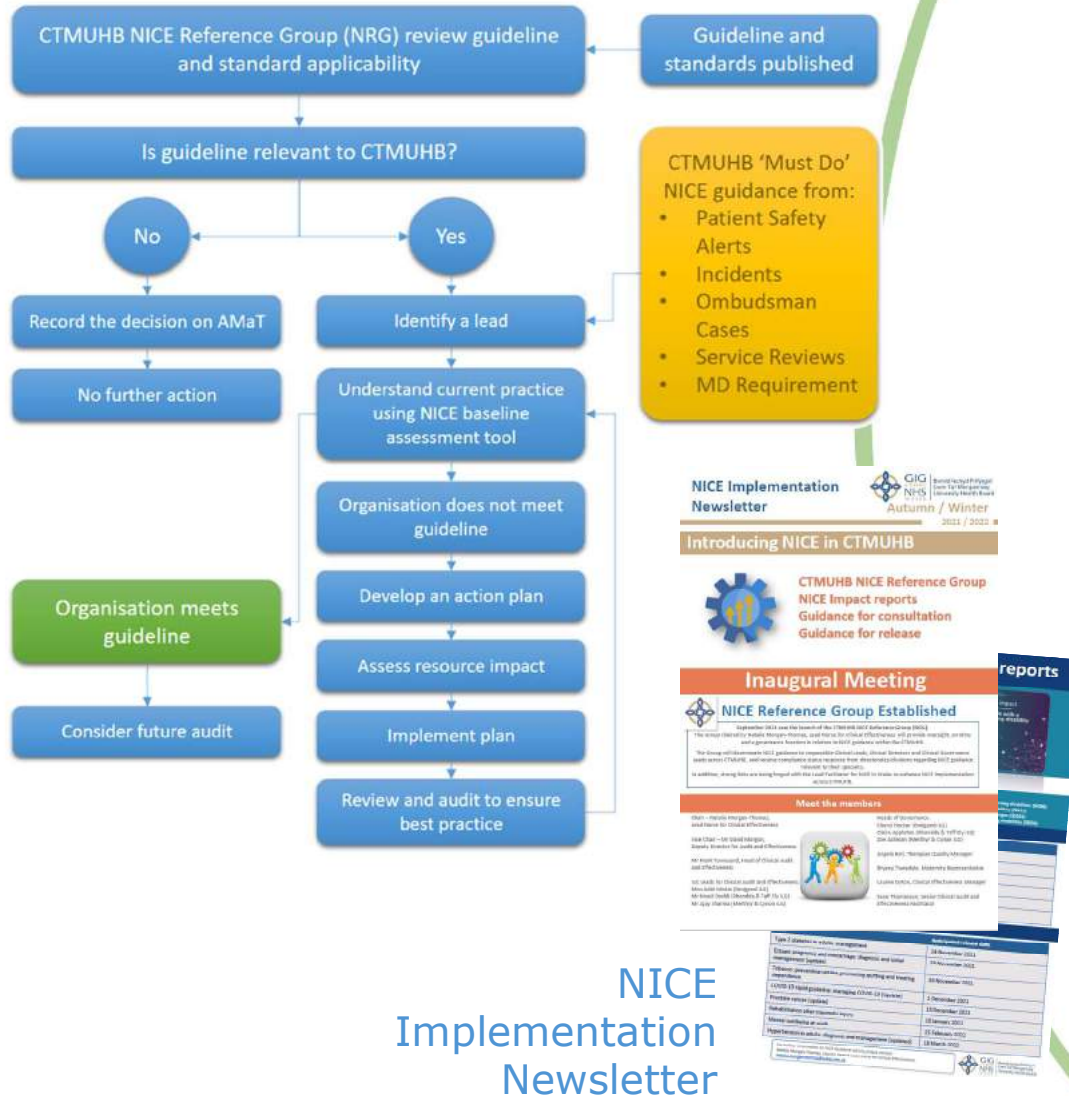
Following the success of the implementation within maternity a decision was made in April 2021 to extend the system rollout Health Board wide with a primary focus on 25b Nurse Staffing Act wards.

The rollout was completed as planned during 2021-22 and has provided significant assurance to the nursing unit around a number of key care metrics.

Some of the key metrics feed into the Health Board bi-monthly Quality Dashboard Report to the Quality and Safety Committee.



NICE Implementation Process Model



In 2021 the organisation set out to develop and deliver an exemplar model to manage all NICE guidance and quality standards.

The following has been achieved in 2021-22:

- Appointed a Lead Nurse for Clinical Effectiveness (who has since qualified as a NICE Scholar)
- Established a NICE Reference Group to review and manage and monitor NICE compliance across the organisation
- Secure a system AMaT to enable the online recording of compliance against NICE guidelines and standards
- Appointed a NICE clinical lead in each of the 3 Integrated locality Groups
- Developed a NICE Newsletter to share best practice
- Working collaboratively across Wales with the NICE Implementation Facilitator for Wales through regular meetings and by helping to lead sub groups of the Welsh NICE Health Network
- Developed a pathway for the implementation of NICE guidelines and standards

Learning from Mortality Reviews

The introduction of Medical Examiners across NHS Wales has provided an opportunity to look at how mortality reviews can be conducted to identify themes and trends, maximise learning, prevent future harm and improve the experience of patients, families and NHS staff.

The Mortality Review Framework for Wales aims to provide a co-ordinated and systematic all Wales approach to the mortality review process to enable local and national implementation of learning, targeted clinical audit and quality improvement work.

Every stage of the mortality review process provides an opportunity for learning and recognizing notable practice. The learning captured is shared via a quarterly newsletter. Immediate make safe cases are instantly communicated to the directors of the ILG's and Directors of nursing if required. Going forward the mortality review module within DATIX will assist us with capturing this information in a more systematic way and each learning point will have an action plan assigned to it.



In 2021-22 CTMUHB
has led on:

The redevelopment of the Once for Wales (DATIX) Mortality Review Model and implementation of the module.



Quarterly Learning from MR Newsletters that identify key themes and trends, MR process performance and identified learning

Monthly Mortality Review (MR) training is undertaken by the Lead Nurse for Clinical Effectiveness and Medical Examiner. The aim to update clinicians on the new MR process nationally and locally within CTMUHB. In addition the training aims to provide clinicians with the knowledge on how to undertake a Hospital mortality review.

MR Learning Events planned
for 2022-23



Clinical Audit and Effectiveness
Annual Report 2021-22



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Agenda Item 3.1

ACTION LOG – AUDIT & RISK COMMITTEE					
Minute Reference	Date of Meeting Action Originated	Issue	Lead Officer	Timescale for Action to be completed	Status of Action (as at date papers were circulated)
18/099	8/10/2018	Endoscopy JAG Accreditation Closure report to be presented to a future meeting.	Interim Chief Operating Officer	January 2019 Revised to: October 2020 Ongoing - Action being led by Director of Operations. This matter is linked to JAG accreditation and updates will be provided to the Committee through the action log at each meeting Now October 2021 Now February 2023	In progress Given the on-going issues and the update provided at the last meeting, we have added to the forward work programme for the committee to receive a formal (written) update on progress and associated risk mitigation at the February 2023 meeting
5.3.5	23/06/2022	Regular updates to be included in the Chief Operating Officers report to Quality & Safety Committee on the work being undertaken to address the issues highlighted within the Internal Audit Follow Up Review – Patient Pathway Appointment Management Process report.	Chief Operating Officer	July 2022 Now September 2022 Now November 2022	In progress Update not included in the September report to the Quality & Safety Committee. Steps would be taken to ensure an update was provided from November onwards.

Agenda Item 3.1

Minute Reference	Date of Meeting Action Originated	Issue	Lead Officer	Timescale for Action to be completed	Status of Action (as at date papers where circulated)
5.4.5	22/08/2022	Internal Audit Review Medical & Dental Rostering - Discussion to be held with the Medical Director outside the meeting in relation to the concerns raised by Members regarding the management response provided.	Director for People	October 2022	In progress A verbal update will be provided at the meeting Update 24.10.2022 - Director for People to provide an update via email outside of the meeting.
5.2	24/10/2022	Audit Recommendations Tracker - Director of Corporate Governance to liaise with Audit Wales on the closure of the recommendations captured in the Clinical Coding Follow Up Review 03 audit.	Director of Corporate Governance	December 2022 Now February 2023	In Progress Assistant Director of Corporate Governance & Risk to revisit this action in the absence of the Director of Governance and agree the way forward in conjunction with Audit Wales.



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Minute Reference	Date of Meeting Action Originated	Issue	Lead Officer	Timescale for Action to be completed	Status of Action (as at date papers where circulated)
5.3.2	24/10/2022	Internal Audit Review – Digital Operating Model. Committee referral to the Digital and Data Committee to provide the scrutiny on the management responses to ensure that they provide the assurance that the actions agreed will address the issues which have been identified.	Director of Digital	February 2023	In Progress Report being presented to the December Digital & Data Committee for discussion
5.3.3	24/10/2022	Internal Audit Review – Medical Records Management. Committee referral to the Digital and Data Committee to provide the scrutiny on the management responses to ensure that they provide the assurance that the actions agreed will address the issues which have been identified.	Director of Digital	February 2023	In Progress Report being presented to the December Digital & Data Committee for discussion



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Agenda Item 3.1

Completed Actions					
Minute Reference	Date of Meeting Action Originated	Issue	Lead Officer	Timescale for Action to be completed	Status of Action (as at date papers where circulated)
4.3	28/04/2022	End of Year Post Payment Verification Report to be developed and presented to a future meeting of the Committee.	All Wales Post Payment Verification Manager	October 2022	Completed On Agenda 24.10.2022
5.1	23/06/2022	Committee members to reflect as to whether they feel the level of detail contained within the final column of the tracker helpful or distracting.	Committee Members	August 2022	Completed Members welcomed the updated tracker format.
5.1	23/06/2022	Consideration to be given to holding a separate workshop with Executive Directors to discuss the older recommendations contained within the Tracker.	Committee Members	September 2022 Now October 2022	Completed Workshop held on 6 October 2022
5.2	22/08/2022	Organisational Risk Register - Response to be provided to I Wells outside the meeting in relation to the queries raised regarding Risks 3267, 3638 and 3337.	Assistant Director of Governance & Risk	October 2022	Completed Response shared with Members by email on 9 September 2022

Agenda Item 3.1

5.4.1	22/08/2022	Internal Audit Progress Report - Consideration to be given to the suggestion made to separate out the Prince Charles Hospital audit activity from the core plan.	Head of Internal Audit	October 2022	Completed Response received from the Head of Internal Audit to advise that the information contained within the Business Intelligence appendix was a demonstration and was for information only. Internal Audit would be looking to provide more detailed analytics in the future, with the format to be confirmed.
5.3.4	23/06/2022	Internal Audit Follow Up Review – Medical & Dental Rostering report to be presented back to next meeting with strengthened management response.	Medical Director	August 2022	Completed and Ongoing Report received at the August 2022 – further assurance was requested by Members in relation to the management response outside the meeting (see action log entry 5.4.5)
4.2	22/08/2022	Losses and Special Payments Report - Detail to be shared with the Committee Chair outside the meeting regarding the cash write off contained on page 7 of the report.	Director of Finance	October 2022	Completed This information was included in the Losses and Special Payments Report presented to the August 2022 Audit & Risk Committee
5.3.2	24/10/2022	Internal Audit Review – Digital Operating Model. Director of Digital to consider the escalation of a risk relating to	Director of Digital	February 2023	Completed Risk Register has been updated to reflect the significant gap between



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		ICT Kit to the Organisational Risk Register.			funding available and funding required for ICT kit. A planning process is underway (as part of the wider IMTP planning process) to prioritise high risk areas of Digital & Data Infrastructure
5.1	24/10/2022	Organisational Risk Register: Updates on risks 4888,4632,4887,4664, 4743 and 4479 to be taken forward outside of the meeting and captured as appropriate in the next iteration of the Organisational Risk Register received by the Committee.	Assistant Director of Governance & Risk	December 2022	Completed Updates on risks 4632, 4887, 4664, 4743 and 4479 are captured in the Organisational Risk Register being received by the Committee at agenda item 5.1. Risk 4888 was previously closed as the target score had been met.



AGENDA ITEM

4.1

AUDIT & RISK COMMITTEE

LOCAL COUNTER FRAUD UPDATE REPORT

Date of meeting

12 December 2022

FOI Status

Open/Public

If closed please indicate reason

Not Applicable - Public Report

Prepared by

Matthew Evans, Head of Local Counter Fraud Services

Presented by

Matthew Evans, Head of Local Counter Fraud Services

Approving Executive Sponsor

Executive Director of Finance & Procurement

Report purpose

FOR DISCUSSION / REVIEW

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

Committee/Group/Individuals

Date

Outcome

(Insert Name)

(DD/MM/YYYY)

Choose an item.

ACRONYMS

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 BY THIS MEETING (ASSESSMENT)

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

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

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

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outlined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If no, please provide reasons why an EIA was not considered to be required in the box below. Not required
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Sustaining Our Future

5. RECOMMENDATION

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



Cwm Taf Morgannwg University Health Board

Audit & Risk Committee – 12 December 2022

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	45	39
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.	125	60
Prevent and Deter		
Discouraging those who may want to commit crimes against the NHS and ensure that such opportunities are minimised.	125	91
Hold to Account		
Detecting and investigating crime, prosecuting those who have committed crimes and seeking redress as a result.	321	200
TOTAL	616	390

4. STRATEGIC GOVERNANCE

The Counter Fraud Team attended an All-Wales Counter Fraud Forum held by Counter Fraud Service Wales in conjunction with NHS Counter Fraud Authority. The Forum covered an update in training around aspects of changes in evidence disclosure, pre charge bail and examination of electronic devices introduced by the Police, Crime, Sentencing and Courts Act 2022. Information was given on plans to develop a new approach to counter fraud intelligence utilising the case management system Clue3 which is to be trialled in NHS Wales. An update from Quality and

Assurance Inspectors was also given with a report to be issued imminently following their inspection visit to NHS Wales in September.

As well as operational updates information was provided of an organisational 'evolution' being undertaken within NHS Counter Fraud Authority. This is essentially a staffing, strategy and organisational review and restructure. There are to be no job losses in this exercise and impact on NHS Wales counter fraud teams will be minimal.

A statistical analysis of performance against key performance indicators has been produced and at Appendix 1 to this report. The analysis measures Health Board performance against an all-Wales benchmark average to provide greater context to the statistical information. The analysis is based on half-year year on year data to allow comparisons to previous performance.

5. INFORM AND INVOLVE

The Counter Fraud Team participated in International Fraud Awareness Week which ran 13-19 November. A series of articles and communications around NHS fraud risk were disseminated throughout the week.

The Counter Fraud Team also conducted site visits to deliver promotional materials and issue a special edition newsletter via Post Rooms.

Given the pressures on Wards at present these were avoided. Some promotional materials have been retained with a view to revisit sites at a more suitable point when pressures subside.

The Counter Fraud Team have disseminated 24 alerts and 16 awareness bulletins to staff in this year. They cover targeted communications to local Departments and Teams around specific fraud risks to their area to all staff communications via SharePoint.

6. PREVENT AND DETER

A proactive exercise has been concluded that examined the Health Board's exposure to continuation of salary payments to temporary staff recruited in response to the Covid-19 pandemic following the expiration of those temporary contracts. This emerged as a potential risk following identification of overpayments of salary to temporary staff members across NHS Wales in a short space of time.

The exercise examined 1240 staff records and established 37 instances of salary overpayment. A full report is at Appendix 2 of this report for information.

7. HOLD TO ACCOUNT

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

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

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

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

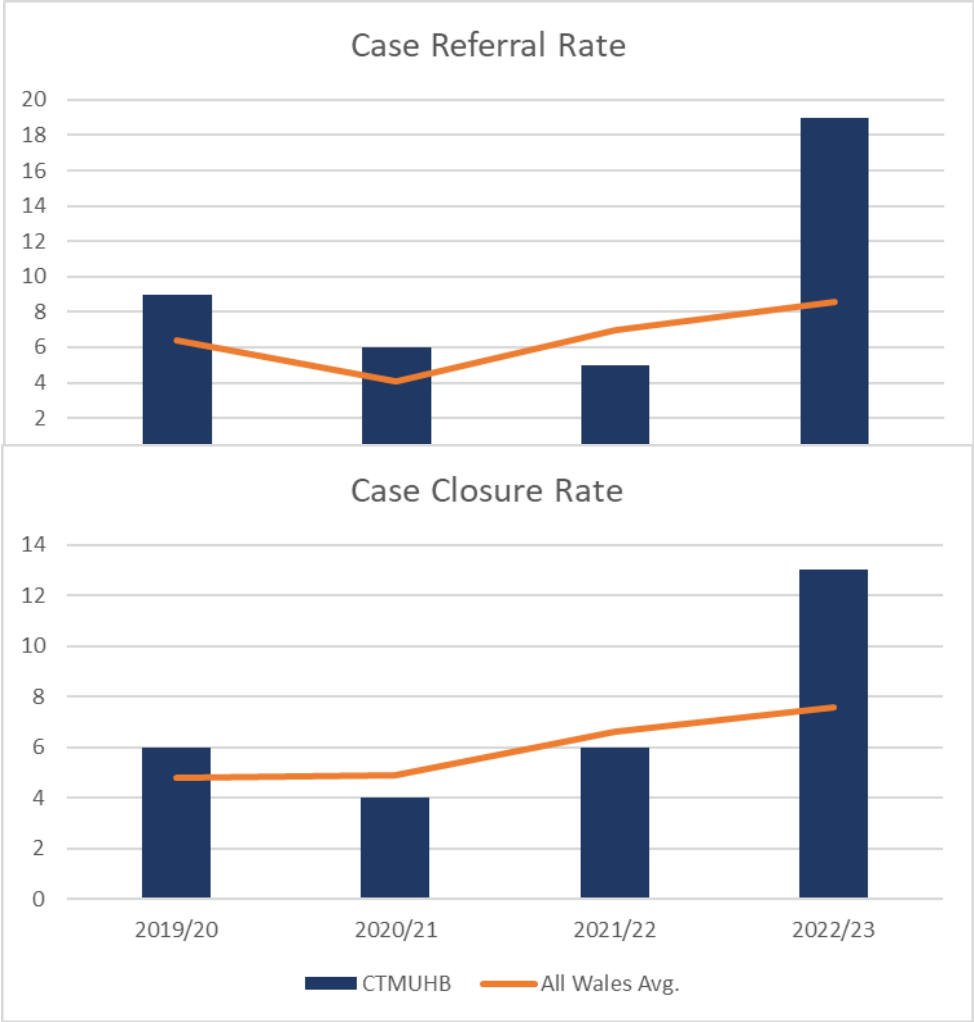


Item 4.1 Appendix 1 - Counter Fraud Half Year Benchmarking Statistics

Counter Fraud Investigation Statistics

Case Referral Rate	2019/20	2020/21	2021/22	2022/23
CTMUHB	9	6	5	19
All Wales Avg.	6.4	4.1	7.0	8.6

Case Closure Rate	2019/20	2020/21	2021/22	2022/23
CTMUHB	6	4	6	13
All Wales Avg.	4.8	4.9	6.6	7.6



Investigation Progression Rate	Cases Open at Start of FY	Referrals Received	Cases Closed	Total Cases Open End

Counter Fraud Investigation Statistics

				of Quarter 2
2019/20	11	9	6	14
2020/21	18	6	4	20
2021/22	13	5	6	12
2022/23	11	19	13	17

Q1 Sanctions	2019/20			2020/21			2021/22			2022/23		
	Criminal	Disp	Civil	Criminal	Disp	Civil	Criminal	Disp	Civil	Criminal	Disp	Civil
CTMUHB	0	1	1	1	4	2	1	1	2	0	0	4
All Wales Avg.	0.6	1.4	1.6	0.3	1.0	1.2	0.3	2.6	1.8	0.3	1.5	2.3
All Wales Total	7	17	19	4	12	14	4	31	22	4	18	27

Counter Fraud Awareness Statistics

Number of Presentations	CTMUHB	All Wales Avg.
2019/20	4	15
2020/21	1	4
2021/22	1	10
2022/23	4	7

Attendance of Presentations as % Staff Headcount	CTMUHB	All Wales Avg.
2019/20	0.5%	5%
2020/21	0.2%	1.9%
2021/22	0.03%	2.3%
2022/23	0.2%	3%

Average Attendance of a Presentation	CTMUHB	All Wales Avg.
2019/20	20	27
2020/21	25	17
2021/22	3	18
2022/23	6	28



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COUNTER FRAUD, BRIBERY & CORRUPTION

Proactive Exercise Temporary Staffing COVID-19 Intake Overpayments of Salary Review

November 2022

Executive Summary

In response to an identified risk the Local Counter Fraud Specialist (LCFS) has undertaken an exercise to explore the procedure around the termination of staff taken on under temporary fixed term contracts due to the Coronavirus Pandemic within the Health Board.

In order to establish compliance with terminating temporary fixed term contracts from the appropriate dates, research was conducted on data provided by the Workforce Information Team.

At the conclusion of the exercise the LCFS found that whilst the majority of staff recruited under temporary fixed term contracts had been terminated from the correct date and in a timely manner, there were a small proportion of staff whose terminations had not been actioned at the time their employment ceased which resulted in them being paid salary for work they had not carried out.

Due to the uniqueness of the Coronavirus Pandemic there were many factors that contributed to late submission of termination forms, the most common being Managers on long term sickness, new Managers coming in to post and the staff themselves moving around different Wards/Departments to support the service where needed.

Introduction and Background

This exercise, led by Local Counter Fraud Services for the Health Board, centred around the risk relating to the late termination of temporary fixed term contracts for staff recruited in response to the Pandemic, and the means for discovering those assignments that were still active when the staff member had ceased working under the temporary fixed term contract.

There appeared to be substantial delays between the staff member leaving their position under the temporary fixed term contract and the termination request being submitted to the Payroll Department which led to payments of salary for work not completed. The LCFS therefore proposed to undertake a proactive exercise to measure termination compliance at conclusion of contracts and identify the most common cause for any late terminations being submitted.

Scope of Exercise

The exercise was undertaken to establish whether staff recruited in response to the Pandemic on a temporary basis were terminated at the appropriate point at conclusion of respective temporary contracts.

In order to measure the compliance of the termination process, the LCFS collated and analysed data supplied by the Workforce Information Team against Health Board systems.

The exercise enabled the LCFS to escalate any anomalies raised during the course of the exercise with Managers to ensure any terminations required were actioned accordingly.

Method

The LCFS requested data from the Workforce Information Team, which detailed staff taken on under temporary fixed term contracts due to the Pandemic response, together with staff that were already registered with the Staff Bank that had taken up temporary fixed term contracts due to the Pandemic response, in order to run the exercise.

The Workforce Information Team provided the LCFS with three separate reports with data relating to staff taken on under temporary fixed term contracts due to the Pandemic response, both clinical and non-clinical as follows:-

- Staff in Post Report as of 17.01.2022.
- NHS Leavers Report between 01.03.2020 and 31.12.2021.
- Bank to COVID-19 Report between 01.03.2020 and 31.12.2021 (staff that were already registered with Staff Bank for the Health Board that took up a temporary fixed term contract).

The Staff in Post report was filtered to show only staff recorded as being on fixed term temporary positions. This data was then reviewed and showed there to be 288 matches.

The NHS Leavers report was reviewed and showed there to be 522 matches.

The Bank to COVID-19 report, which related to staff who were already registered with the Staff Bank for the Health Board, before taking up a temporary fixed term contract was reviewed and showed there to be 430 matches.

Verification checks were carried out on the data provided within the three reports against the information held on the ESR system and the E-roster system.

The LCFS contacted the managers recorded on the reports received from the Workforce Information Team, in respect of any staff not recorded on the E-roster system to ensure they were either still in post under the temporary fixed term contract or had been terminated from the correct date.

Findings

Staff in Post Report

From the data collated by Local Counter Fraud Services the following findings have been documented with regards to the report supplied for Staff in Post as of 17.01.2022:

- 269 matches had no issues with terminations made at appropriate times.
- 10 Matches flagged as possible overpayments.
- 9 matches flagged as having payments suspended pending Payroll Department receiving a termination form.

Further enquiries were carried out with the Payroll Department who were able to confirm the following.

Out of the 10 matches flagged as possible overpayments:-

- 2 had overpayments which were not referred to the Local Counter Fraud Team as they did not fit the criteria for referral.
- 4 had overpayments, however there was a record of the employee having made contact with the Health Board to notify of the overpayment.
- 3 had overpayments and are currently with the Local Counter Fraud Team.
- 1 was with the Payroll Department to determine the position with the overpayment.

Out of the 9 matches flagged as showing payments having been suspended, the Payroll Department were awaiting termination forms. Suspend pay status is used by payroll staff if they have become aware that there is an issue with a particular assignment, this status can be set "With Pay" or "Without Pay".

NHS Leavers Report

From the data collated by Local Counter Fraud Services the following findings have been documented with regards to the report supplied for NHS Leavers between 01.03.2020 and 31.12.2021:-

- 482 matches had no issues with terminations made at appropriate times.
- 5 matches had already been referred to the Local Counter Fraud Team.
- 22 matches were flagged for possible overpayments of under 3 months.
- 8 matches were flagged for possible overpayments of over 3 months.
- 5 matches were flagged as having their payments suspended.

Out of the 5 matches already referred to the Counter Fraud Team, all had been referred back to the Payroll Department for recovery action to commence due to enquiries having established the staff members had already made contact with the Health Board to notify they were being overpaid.

Further enquiries were carried out with the Payroll Department who were able to confirm the following.

Out of the 22 matches flagged for possible overpayment of under 3 months:-

- 7 were terminated from the correct date.
- 9 had overpayments, however there was a record of the employee having made contact with the Health Board to notify of the overpayment.
- 6 had small overpayments which were not referred to the Local Counter Fraud Team as they did not fit the criteria for referral.

Out of the 8 matches flagged for possible overpayments of over 3 months:-

- 5 had overpayments, however there was a record of the employee having made contact with the Health Board to notify of the overpayment.
- 1 had a small overpayment of less than 3 months, which did not fit the criteria for referral to the Counter Fraud Team.
- 1 had an overpayment just over 3 months, which did not fit the criteria for referral to the Local Counter Fraud Team.
- 1 had been terminated from the correct date.

Bank to COVID-19 Report

From the data collated by Local Counter Fraud Services with regards to the Bank to COVID-19 Report, it was established that the 430 matches on the report included some of the matches already reported on via the Staff in Post Report and the NHS Leavers Report. The balance of the matches on this report were shown to have no issues with terminations made at appropriate times.

Conclusion

Following completion of the field work relating to this report the total matches reviewed were **1240**, out of these matches **37** overpayments of salary were identified.

Of the 37 overpayments of salary identified, 12 cases were reviewed by Counter Fraud Services with a total net value of £116,500. The remaining 25 instances of overpayment were referred back to Payroll for recovery action, as these did not meet the criteria for Counter Fraud review.

9 of the cases reviewed by the Counter Fraud Services were referred back to the Payroll Department for recovery action to commence.

3 of the 12 cases were take forward for investigation by the Local Counter Fraud Services with a net value of £31,000 and are currently ongoing.

The majority of termination forms for staff taken on under temporary fixed term contracts due to the Pandemic were completed at conclusion of the respective temporary contracts. However, the exercise identified there were factors that contributed to the small number of cases that were not compliant. The most common factors identified were:

- Staff moving around departments to provide support to the service resulting in managers not being clear as to who was responsible for carrying out the required terminations and staff unsure of who to contact to report overpayments of salary, thus delaying the termination being actioned.
- Staff covering departments due to sickness with less managerial experience being unclear of their responsibility for the staff on temporary fixed term contracts.
- Delays in budget reports being reviewed resulting in any anomalies in the department budgets not being uncovered in a timely manner.
- Staff with temporary fixed term contracts being set up on the Payroll System without automatic end dates, resulting in staff being paid wages for work not carried out due to late termination request being submitted.

The exercise centred on review of a time when Health Board focus was on battling a pandemic, which significantly disrupted normal business. The small number of instances of overpayment have resulted in relatively large value overpayments of salary, but assurance can be taken that the vast majority of temporary contracts were managed in line with expectations. Recovery actions are underway in relation to identified overpayments and criminal investigation proceeding in appropriate cases.



Item 4.1 – Appendix 3

Counter Fraud Investigations Update Report

12 December 2022

Summary

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

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

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

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

Case Status		
Cases Under Investigation	Cases Pending 3rd Party Outcome	Cases Closed 2022/23
15	1	13
Case Rates		
Referrals Received 2022/03	Cases Under Investigation for Over 12 Months	
20	2	
Sanctions/Outcomes		
Criminal Sanctions	Civil Sanctions (Inc. Financial Recovery)	Disciplinary Sanctions
0	4 £38,496	0

Open Cases			
Reference Number	Date Opened	Allegation	Status
WARO/20/00032	24/01/2020	Alleged theft of petty cash/False representation of employment history and qualifications	A full committal file has been submitted to CPS for consideration for prosecution. Based on assessment of evidence charges are anticipated. A first review of prosecution file has been completed by CPS Prosecutor, an action plan was set and returned the same week. Further review is being undertaken by CPS. The subject resigned their Health Board position whilst disciplinary proceedings were underway. NMC are investigating potential criminal fraud offences committed against that organisation and assessing professional registration concerns.
INV/21/00041	12/04/2021	Overpayment of Salary	After termination date was entered incorrectly by inputting 2020 instead of 2019 resulting in error in inputting termination information on the system. The subject continued to be paid for 12 months as a result with overpayment totalling Net £8336.70. Subject has failed to attend interview. Subject has denied receiving payments and has given bank mandate authority for Financial Investigator to access account information to assess. This has caused issues however with Bank not releasing information. Transaction data will be gathered Health Board side and included in a submission file to CPS.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/22/00563	19/05/2022	Overpayment of Salary	The subject has been overpaid in error for an extensive period following their employment on a temporary contract on the CTM UHB Covid vaccination program. Information collated suggests 2 posts were being paid for the same role, 1 fixed term contract and 1 bank. An interview has been undertaken and account gained from subject. A case file is being prepared for CPS submission.
INV/22/00706	21/06/2022	Timesheet Fraud	Timesheets submitted for payment containing signature of a Manager on sick leave from role. Investigation sought to corroborate work completed via Computer Network logs. This proved to be unreliable with data gained unsuitable for use in investigation. The subject's Outlook account was examined but again this is only an indication of work completed and unsuitable for use as primary evidence. Witnesses have been approached and have given account of no concerns relating to work completed by subject. The investigation is inconclusive and has established no evidence of overclaim but equally no evidence giving assurance that work was completed. No reasonable lines of enquiry remain and investigation will conclude on that basis.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/22/00707	21/06/2022	Leave Fraud	False information given in order to gain Special Leave. Investigation have established evidence corroborating allegation. This was shared with managers and parallel disciplinary and fraud investigations ongoing. An interview is being planned to gain account from subject. Given the low level of criminal fraud and the swift advancement of the disciplinary case that process is taking precedence at this time.
INV/22/00842	08/07/2022	Amendment of Fitness for Work Certificate	A genuine Med3 Fitness for Work Certificate was presented by staff member which appears to have been altered to state condition of long covid. Investigation has corroborated that Med3 certificate have been altered to include long covid but that the other condition mentioned on the Med3 is genuine. It would be difficult to establish financial loss in this case due to the genuine sickness. Information has been shared with WOD and management for consideration of disciplinary in this case.
INV/22/01137	18/08/2022	Patient selling prescribed medication	Joint investigation being undertaken with South Wales Police. Reported by member of public known to subject. Intelligence established that there is a long running dispute between the parties. Enquiries seeking to corroborate information.
INV/22/01138	18/08/2022	Non-completion of contracted hours and leave fraud	Evidence has been established of working patterns via digital and locally held records these are being assessed against timesheets and leave records.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/22/01232	06/09/2022	Overpayment of salary	Enquiries have established an overpayment with gross value of £7628.47 following leaving Health Board employment. An interview has been arranged to gain account from subject.
INV/22/01233	06/09/2022	Overpayment of salary	Enquires have established that subject had a fixed term contract related to Covid recruitment. This should have ended and subject continued to work for Bank. Enquiries have established an overpayment with gross value of £7766.33. An interview has been arranged to gain account from subject.
INV/22/01512	18/10/2022	Falsification of qualifications amongst care home staff	Anonymous allegation received via the NHS fraud and corruption reporting line. Enquiries have established that the care home in allegation has closed down. Information has been sought from Health Board regarding potential impact on any NHS funded services. Information has also been shared with RCT Council for their consideration.
INV/22/01513	18/10/2022	Timesheet Fraud	Allegation that staff have been accessing their work rosters to add in additional hours. Enquiries ongoing to establish evidence to review.
INV/22/01528	20/10/2022	Recruitment Fraud	Employment reference from another Health Board is alleged to have been falsified or amended. The reference is for an agency worker and was supplied by the recruitment agency. Enquiries are ongoing to establish the legitimacy of the reference and the party who potentially amended this.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/22/01535	21/10/2022	Timesheet Fraud	Allegation received via the NHS fraud and corruption reporting line. Staff member alleged to using SPA time to complete additional shifts. Investigation ongoing.
INV/22/01582	01/11/2022	Sickness Fraud	Submission of 3 different self-certification notes with differing dates covering absence from Bank Post. Investigation has established that subject submitted a self-certification note in error and was advised this was incorrect. A further note was produced which was believed to be incorrect again upon submission prompting a further note. It transpired no note was ever required as no shifts were booked. No fraud has been established.

Pending Closure			
Reference Number	Date Opened	Allegation	Status
INV/22/00664	10/06/2022	Overpayment of Salary	The subject has been over paid in error for an extensive period following their termination from employment; value of concern £27k. Incident has been referred to Financial Investigators who are supporting investigation. It has been established that the subject has funds in bank account. Civil recovery is underway and no criminal action required in this instance.

Closed Cases			
Reference Number	Date Opened	Allegation	Outcome
INV/21/00449	23/12/2021	Computer Misuse	Allegation that a staff member has downloaded TOR software onto Health Board laptop. TOR is used to access 'dark web' sites. Cyber Security have dealt with immediate risk. Investigation centred around Computer Misuse Act offences. An invite to interview letter was hand delivered to the subject and arrangements made to undertake interview. However, interview did not go ahead and concerns raised around fitness for interview after disclosure that subject is self-medicating. Evidence established that subject was in court for a separate drugs offence matter and failed to appear. Information was shared with Health Board which resulted in dismissal.
INV/22/00840	08/07/2022	Private Work in NHS Time	Relates to abuse of agile/homeworking by working for own business during NHS hours along with potential dual working with overlapping substantive and bank shifts. Investigation established no evidence of working elsewhere whilst working from home. Analysis of bank shifts against substantive shifts established a cross over of one bank shift which amounted to 3 hours. It would be disproportionate to pursue this low level potential offence criminally and information was therefore shared with management. It transpired that management had knowledge of this working

			arrangement. Advice was provide to management around tightening of time recording.
INV/22/00841	08/07/2022	Prescription Fraud	Health Board employee alleged to have amended genuine prescription in attempt to obtain an additional quantity of controlled drugs. Joint investigation being undertaken to ensure safeguarding of individual. Initial enquiries have established no NHS financial loss with items not dispensed. This will be addressed without formal disciplinary proceedings via subject's management.
INV/22/00843	08/07/2022	Timesheet Fraud - Agency	The subject submitted claims for four consecutive overlapping 12 hour shifts at different locations in the Health Board during a 48 hour period. No evidence could be established that shifts hadn't been completed although risks arising from this case are clear. Possible weakness in shift booking processes being explored in local proactive exercise and risk assessment work being taken forward separately from investigation.
INV/22/01135	18/08/2022	Agency worker sent family member to cover shift	Enquiries have established that shift was not undertaken as identity challenged at ward upon arrival. Both family members were registered with agency. Subject's have provided account to agency that originally booked worker had covid so could not attend. No financial loss to HB. Both persons removed from HB approved agency staff list. Both persons subsequently removed from agency. A local proactive exercise is underway to assess risk around this incident.

INV/22/01317	16/09/2022	Inappropriate allocation of contracts	Allegation received regarding possible collusion or malpractice on the allocation of NHS contracts to a firm linked to a family member. Enquiries established that named subject had no influence in the procurement of services from the business in question which is part of an All-Wales contract. Further management had knowledge of the link between staff member and contractor. No fraud or corruption was established.



AGENDA ITEM

4.2

AUDIT & RISK COMMITTEE

NFI Self-Appraisal Checklist

Date of meeting

12 December 2022

FOI Status

Open/Public

If closed please indicate reason

Not Applicable - Public Report

Prepared by

Matthew Evans, Head of Local Counter Fraud Services

Presented by

Matthew Evans, Head of Local Counter Fraud Services

Approving Executive Sponsor

Executive Director of Finance & Procurement

Report purpose

FOR DISCUSSION / REVIEW

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

Committee/Group/Individuals

Date

Outcome

(Insert Name)

(DD/MM/YYYY)

Choose an item.

ACRONYMS

NFI

National Fraud Initiative

1. SITUATION/BACKGROUND

- 1.1 The Health Board is a mandatory NFI participant in a Cabinet Office led exercise amongst public sector bodies. The NFI is a data matching exercise amongst public sector organisations intended to identify fraud and error amongst a variety of risk areas.

The checklist has been produced by Audit Wales as a mechanism for organisations to seek assurance around their approach to completion of NFI.

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

- 2.1 The checklist provides review of approach to NFI and raises actions to improve work undertaken in relation to matched data sets.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

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

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outlined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If no, please provide reasons why an EIA was not considered to be required in the box below. Not required
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Sustaining Our Future

5. RECOMMENDATION

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



Item 4.2

NFI Self-Appraisal Checklist

Introduction

The National Fraud Initiative (NFI) is a data matching exercise conducted by the Cabinet Office to assist in the prevention and detection of fraud.

Data for the NFI is provided by some 1,200 participating organisations from the public and private sectors including government departments. The NFI works with public audit agencies in all parts of the UK.

Data matching involves comparing sets of data electronically, such as the payroll or benefit records of a body, against other records held by the same or another body to see how far they match. The data is usually personal information. The data matching allows potentially fraudulent claims and payments to be identified. Where a match is found it may indicate that there is an inconsistency that requires further investigation.

No assumption can be made as to whether there is fraud, error or other explanation until an investigation is carried out.

All bodies participating in the Cabinet Office's data matching exercises receive a report of matches that they should investigate, so as to detect instances of fraud, over- or under-payments, and other errors, to take remedial action and update their records accordingly.

Part A: For those charged with governance	Yes/No/Partly	Is action required?	Who by and when?
Leadership, commitment and communication			
1. Are we aware of emerging fraud risks, eg due to COVID-19, and have we taken appropriate preventative and detective action?	Yes	The Counter Fraud Team, in line with NHS Fraud Standards, maintain a programme of risk assessment to identify and respond to emerging risks.	
2. Are we committed to the NFI? Have the council/board, audit committee and senior management expressed support for the exercise and has this been communicated to relevant staff?	Partly	Cwm Taf Morgannwg University Health Board is a mandatory participant of the NFI and the NFI is a key resource for the management of Fraud in NHS Wales. Results will be reported through to Audit Committee and senior management. The UHB's commitment to the NFI will be communicated to relevant staff.	
3. Is the NFI an integral part of our corporate policies and strategies for preventing and detecting fraud and error?	Yes	Cwm Taf Morgannwg University Health Board is a mandatory participant of the NFI and the NFI is a key resource for the management of Fraud in NHS Wales, as per the NHS Wales Fighting Fraud Strategy 2019.	

Part A: For those charged with governance	Yes/No/Partly	Is action required?	Who by and when?
Leadership, commitment and communication			
4. Have we considered using the point of application data matching service offered by the NFI team, to enhance assurances over internal controls and improve our approach to risk management?	Yes	Other existing options are available to verify data and are utilised. Point of application data matching service is viewed as a further available option.	
5. Are NFI progress and outcomes reported regularly to senior management and elected/board members (eg, the audit committee or equivalent)?	Partly	Updates are given as part of regular meetings between Director of Finance and Counter Fraud Specialist. Results will be reported to Audit Committee by the LCFS in June 2023, in the first Counter Fraud report following release of new data on 26 January 2023.	LCFS June 2023 (first report following release of new data on 26 January 2023)
6. Where we have not submitted data or used the matches returned to us, eg council tax single person discounts, are we satisfied that alternative fraud detection arrangements are in place and that we know how successful they are?	Yes	Existing auditing systems and controls are considered as part of all NFI work to inform a risk based approach.	

Part A: For those charged with governance	Yes/No/Partly	Is action required?	Who by and when?
Leadership, commitment and communication			
7. Does internal audit, or equivalent, monitor our approach to NFI and our main outcomes, ensuring that any weaknesses are addressed in relevant cases?	Partly	Not explicitly monitored but any identified system weaknesses arising from NFI work is shared with key stakeholders. The LCFS meets with the Head of IA to share details on identified risk, including instances where data mining or sampling has highlighted outliers or concerns.	
8. Do we review how instances of fraud and error arose and use this information to improve our internal controls?	Yes	Creditors matched data from across NHS Wales is being assessed centrally by NWSSP Accounts Payable and Counter Fraud Specialist with view to improving approach and outcomes. This has been ongoing since October 2021.	
9. Do we publish, as a deterrent, internally and externally the achievements of our fraud investigators (eg, successful prosecutions)?	Yes	Publication of achievements from counter fraud work is actively promoted. No successful prosecutions	

Part B: For NFI SROs and Key Contacts	Yes/No/Partly	Is action required?	Who by and when?
Planning and preparation			
1. Are we aware of emerging fraud risks, eg due to COVID-19, and have we taken appropriate preventative and detective action?	Yes	The Counter Fraud Team, in line with NHS Fraud Standards, maintain a programme of risk assessment to identify and respond to emerging risks.	
2. Are we investing sufficient resources in the NFI exercise?	Yes	The Health Board's Counter Fraud Team pick up work around Payroll matches and Creditors matches are picked up by Finance Dept. Accounts Payable staff.	
3. Do we plan properly for NFI exercises, both before submitting data and prior to matches becoming available? This includes considering the quality of data.	Yes	Data submission is organised on an All Wales basis and is promptly submitted. Key stakeholders are kept up to date and informed of timetable.	

Part B: For NFI SROs and Key Contacts	Yes/No/Partly	Is action required?	Who by and when?
Planning and preparation			
4. Is our NFI Key Contact (KC) the appropriate officer for that role and do they oversee the exercise properly?	Yes	The Key Contact is Head of Counter Fraud Services.	
5. Do KCs have the time to devote to the exercise and sufficient authority to seek action across the organisation?	Yes	NFI work is built into the Annual Counter Fraud Workplan. Work is reviewed and backed by the Director of Finance.	
6. Where NFI outcomes have been low in the past, do we recognise that this may not be the case the next time, that NFI can deter fraud and that there is value in the assurances that we can take from low outcomes?	Yes	The approach to NFI is proportionate to the risk outlined within matched reports and the risk relative to outcomes achieved in previous NFI work.	

Part B: For NFI SROs and Key Contacts	Yes/No/Partly	Is action required?	Who by and when?
Planning and preparation			
7. Do we confirm promptly (using the online facility on the secure website) that we have met the fair processing notice requirements?	Yes	Fair Processing and Privacy Notices are issued in line with NFI timetable guidance. This is confirmed in the secure website upon completion.	
Leadership, commitment and communication			
8. Do we plan to provide all NFI data on time using the secure data file upload facility properly?	Yes	Uploads are managed centrally via NWSSP Accounts payable for creditors data and directly from ESR for Payroll data.	

Part B: For NFI SROs and Key Contacts	Yes/No/Partly	Is action required?	Who by and when?
9. Have we considered using the point of application data matching service offered by the NFI team to enhance assurances over internal controls and improve our approach to risk management?	Yes	Other existing options are available to verify data and are utilised. Point of application data matching service is viewed as a further available option.	
Effective follow-up of matches			
10. Do all departments involved in NFI start the follow-up of matches promptly after they become available?	Partly	Work on Payroll matches is commenced upon first availability. Work on Creditors matches is undertaken when resource is available; this is a reflection of the work being viewed as a systems audit given the systems and controls in place within Accounts Payable centred on the same risks arising from NFI creditors matched data. Request that NWSSP ensure prompt follow up on creditors matches.	Director of Finance January 2023
11. Do we give priority to following up high-risk matches, those that become quickly out of date and those that could cause reputational damage if a fraud is not stopped quickly?	Yes	A Risk based approach is used to complete work on NFI matches.	

Part B: For NFI SROs and Key Contacts	Yes/No/Partly	Is action required?	Who by and when?
Effective follow-up of matches			
12. Are we investigating the circumstances of matches adequately before reaching a 'no issue' outcome, in particular?	Yes	Matches are thoroughly reviewed in line with NFI guidance on completing matches before outcomes reached.	
13. (In health bodies) Are we drawing appropriately on the help and expertise available from NHS Counter Fraud Service Wales?	Yes	NHS Counter Fraud Service Wales have a commitment to become involved in cases of identified complex fraud. No such fraud has been identified to engage CFS Wales however.	
14. Are we taking appropriate action in cases where fraud is alleged (whether disciplinary action, penalties/cautions or reporting to the Police or NHS Counter Fraud Service Wales)? Are we recovering funds effectively?	Yes	Investigations (disciplinary/criminal) have commenced in relation to identified concerns arising from Payroll matches.	

Part B: For NFI SROs and Key Contacts	Yes/No/Partly	Is action required?	Who by and when?
Effective follow-up of matches			
15. Do we avoid deploying excessive resources on match reports where early work (eg, on high-risk matches) has not found any fraud or error?	Yes	Risk based approach is utilised taking account of existing systems and controls that cover the same risks. In particular Creditors matches are seen as a systems audit as there is duplication between risk management systems in use and the matches NFI produces.	
16. Where the number of high-risk matches is very low, are we adequately considering the medium and low-risk matches before we cease our follow-up work?	Yes	Matches are assessed in light of existing systems and controls for risk beyond the risk profile attributed by the NFI system.	
17. Overall, are we deploying appropriate resources on managing the NFI exercise?	Yes	The level of resource deployed is proportionate to risk presented by NFI matched data and the level of previous outcomes achieved from NFI work.	

Part B: For NFI SROs and Key Contacts	Yes/No/Partly	Is action required?	Who by and when?
Recording and reporting			
18. Are we recording outcomes properly in the secure website and keeping it up to date?	Yes	All NFI work is recorded within the secure website.	
19. Do staff use the online training modules and guidance on the secure website, and do they consult the NFI team if they are unsure about how to record outcomes (to be encouraged)?	Yes	Guidance and training modules are utilised.	
20. If, out of preference, we record some or all outcomes outside the secure website, have we made arrangements to inform the NFI team about these outcomes?	No	All NFI work is recorded within the secure website.	

The National Fraud Initiative in Wales 2020-21: Management Response

Recommendation	Management response	Completion date	Responsible officer
Recommendation 1 All participants in the NFI exercise should ensure that they maximise the benefits of their participation. They should consider whether it is possible to work more efficiently on the NFI matches by reviewing the guidance section within the NFI secure web application.	The available guidance within the NFI is considered at the outset of work on NFI matches. The available guidance is utilised as a reference point throughout the exercise to ensure efficient and accurate completion. Additionally, NWSSP are undertaking a review of Creditors matched data across NHS Wales NFI data reports with intent to maximise value from work around reviewing these match types.		
Recommendation 3 Audit committees, or equivalent, and officers leading the NFI should review the NFI self-appraisal checklist. This will ensure they are fully informed of their organisation's planning and progress in the 2022-23 NFI exercise.	The NFI self-appraisal checklist has been completed and received as part of the agenda of the Health Board's Audit & Risk Committee. Completion of the self-appraisal checklist resulted in identification of actions relating to progress reporting and operational completion of the 2022-23 NFI exercise.		

The National Fraud Initiative in Wales 2020-21

Report of the Auditor General for Wales

This is an interactive pdf

To navigate through the document please
use the buttons on the left side of the page
and the links marked with underlined text





Key messages

Key messages



Outcomes



Results



Process



Since we last reported on the National Fraud Initiative (NFI) in Wales in October 2020, outcomes valued at £6.5 million have been recorded. The cumulative total of outcomes from the NFI in Wales since NFI started in 1996 are now £49.4 million. Across the UK, the cumulative total of NFI outcomes is now £2.37 billion.

NFI outcomes in Wales decreased by £1.5 million to £6.5 million in the 2020-21 exercise. This was primarily because fewer ineligible claims for Council Tax Single Persons Discount and Housing Benefit claims were detected, reflecting the fact that some local authorities started review of NFI matches later than normal due to Covid-19 pressures.

Data sharing enables matches to be made between bodies and across national borders. Data submitted by Welsh bodies for the 2020-21 NFI exercise helped organisations in other parts of the UK to identify 153 cases of fraud and error with outcomes of £183,045.

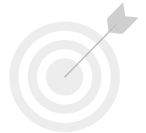
While the majority of Welsh NFI participants display a strong commitment to counter fraud, 13 of the 22 Welsh local authorities identified 95% of the fraud and error outcomes achieved by the sector. This suggests that some local authorities have either failed to recognise the importance of the exercise or are unwilling to allocate adequate, skilled counter-fraud resources to investigate the NFI matches.

One Welsh local authority, Cardiff Council, agreed to participate in an exercise designed to identify fraud and error in applications for COVID-19 business support grants by verifying applicant bank details and trading status. These checks helped to identify outcomes of just under £0.6 million relating to 41 fraudulent or erroneous applications.

Key messages



Outcomes



Results



Process



Recommendations

▶ All participants in the NFI exercise should ensure that they maximise the benefits of their participation. They should consider whether it is possible to work more efficiently on the NFI matches by reviewing the guidance section within the NFI secure web application.

▶ Where local auditors recommend improving the timeliness and rigour with which NFI matches are reviewed, NFI participants should take appropriate action.

▶ Audit committees, or equivalent, and officers leading the NFI should review the NFI self-appraisal checklist. This will ensure they are fully informed of their organisation's planning and progress in the 2022-23 NFI exercise.

Outcomes

Key messages



Outcomes



Results



Process



NFI outcomes

NFI is a counter-fraud exercise across the UK public sector which aims to prevent and detect fraud. NFI uses data sharing and matching to help confirm that services are provided to the correct people.

An NFI outcome describes the overall amounts for fraud, overpayments and error that are detected by the NFI exercise and an estimate of future losses that it prevents.

The NFI recorded outcomes of £6.5 million in 2020-21.

£ NFI outcomes cumulatively in the UK since 1996-97	£ NFI outcomes cumulatively in Wales since 1996-97	£ NFI outcomes across the UK from the 2020-21 exercise	£ NFI outcomes in Wales from the 2020-21 exercise
£2.37 billion	£49.4 million	£443 million	£6.5 million

Key messages



Outcomes



Results



Process



Trends in outcomes

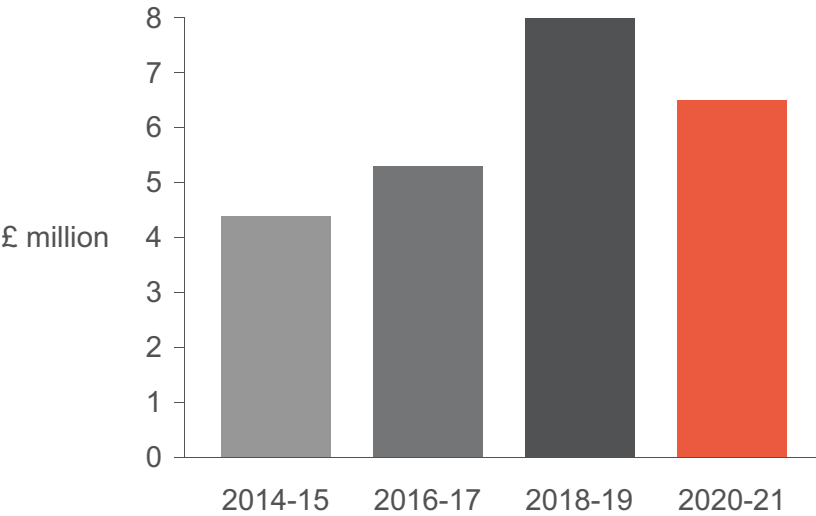
Outcomes in Wales have decreased by £1.5 million to £6.5 million in the 2020-21 exercise. Reasons for the decrease in outcomes include:

- the number of fraudulent or erroneous claims for Council Tax Single Persons Discount detected fell from 3,939 in the 2018-19 exercise to 1,987 in the 2020-21 exercise, resulting in outcomes in this area reducing by £2 million; and
- the number of fraudulent or erroneous claims for Housing Benefit detected fell from 179 in the 2018-19 exercise to 82 cases in the 2020-21 exercise, resulting in outcomes in this area reducing by £0.6 million.

The above fall in outcomes was offset in part by:

- an increase in the number of fraudulent or erroneous applications for social housing detected from 74 in the 2018-19 exercise to 237 in the 2020-21 exercise, resulting in increased outcomes of £0.6 million; and
- the detection of 43 fraudulent or erroneous claims for COVID-19 business support grants resulting in cumulative outcomes of £0.6 million.

Outcomes of £6.5 million were identified in the 2020-21 exercise



While overall outcomes have fallen, this is in part because many NFI participants started review of NFI matches later than normal due to work pressures arising from the COVID-19 pandemic.

The only UK nation which saw an increase in 2020-21 NFI outcomes was England. This increase was due to a significant increase in pension outcomes from matching UK-wide pension scheme data.

Late savings arising from NFI 2020-21 will be reported as part of the NFI 2022-23 exercise.

Key messages



Outcomes



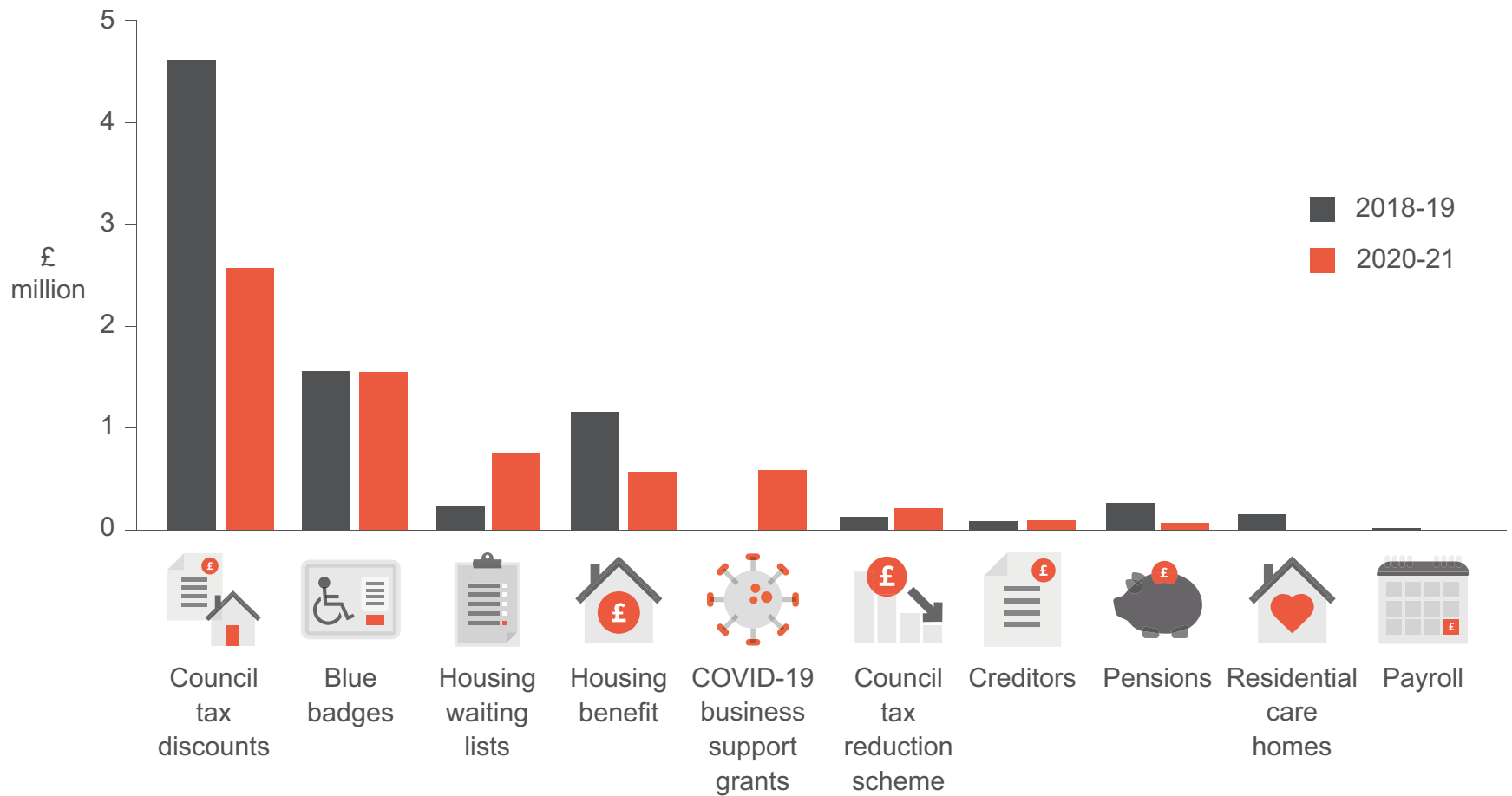
Results



Process



How the latest outcomes compare to the last exercise



Key messages



Outcomes



Results



Process



Seven areas generated almost 98% of outcomes

The areas which generated the most outcomes from the current exercise are as follows:

Category	£	Cases
Council tax discounts	£2.6m	1,987
Blue badges	£1.4m	2,717
Housing waiting lists	£0.8m	237
Housing benefit	£0.6m	84
COVID-19 business support grants	£0.6m	43
Council tax reduction scheme	£0.2m	214
Creditor payments	£0.1m	9

Once overpayments have been identified, public bodies can take appropriate action to recover the money. As at 31 March 2022, 81% of overpayments had been recovered or were in the process of being recovered.

Results



Council tax discounts

Key messages



Outcomes



Results



Process



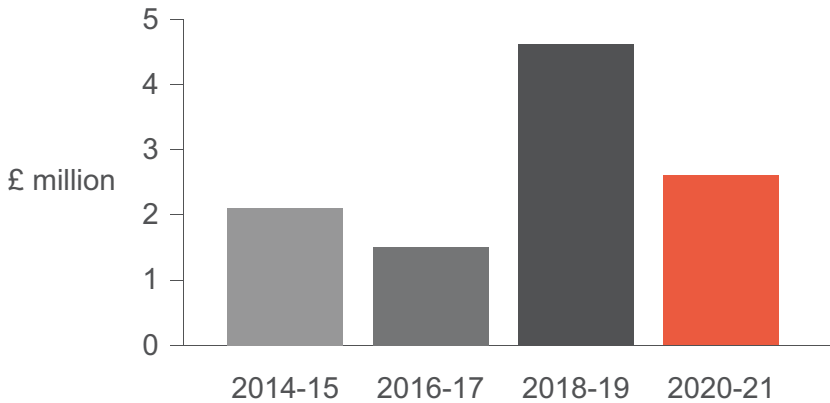
People living on their own, or with no countable adults in the same household, are eligible for a 25% single person discount (SPD) on their annual council tax bill.

Council tax SPD data is matched to electoral register data to help find where people are receiving the discount, but are not the only countable adult at their residence.

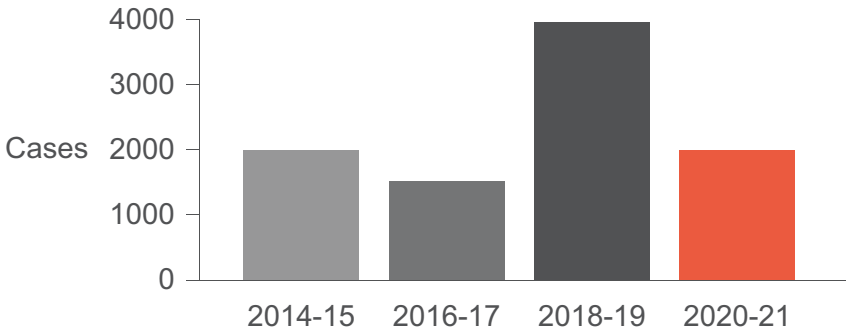
The 2020-21 NFI exercise found that the total council tax discount incorrectly awarded across Welsh local authorities totalled £2.6 million. This is an average outcome of £1,305 for each case (£1,003 per case in the 2018-19 NFI). Review of the NFI matches led to the cancellation of 1,987 SPD claims.

While the number of fraudulent or erroneous SPD claims detected fell from 3,939 to 1,987 in the current exercise, this is partly due to investigation of the matches being delayed due to the COVID-19 pandemic. Many claims have been cancelled since the cut-off date for reporting the NFI 2020-21 exercise and these 'late results' will be reported within NFI 2022-23.

Outcomes of **£2.6 million** in 2020-21



1,987 cases in 2020-21





Key messages



Outcomes



Results



Process



Pensions

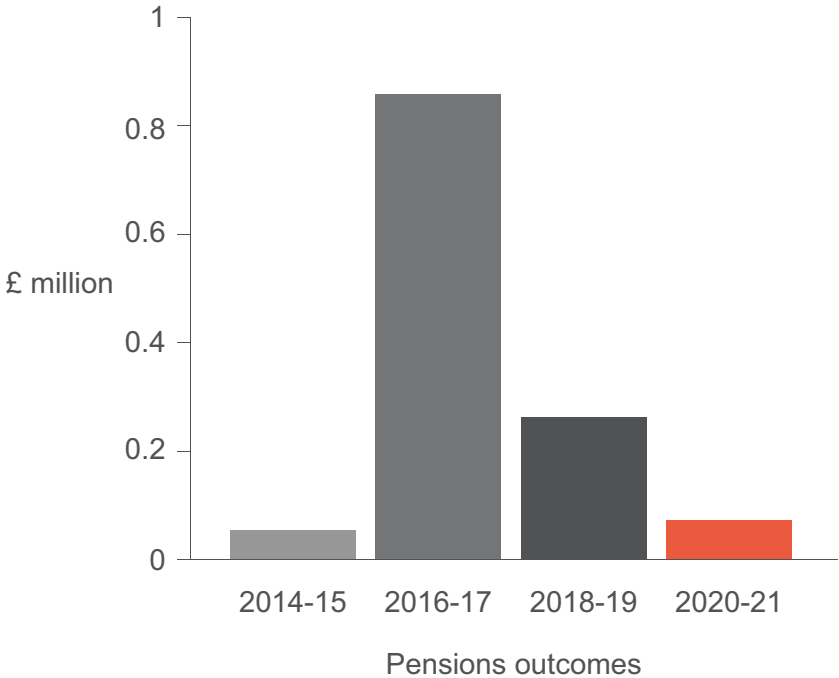
The NFI provides local authorities that administer pensions with an efficient and effective way of checking that they are only paying people who are alive.

The exercise found nine instances where pensions had remained in payment after pensioners had died compared to ten cases in NFI 2018-19.

In total, pensions outcomes for the 2020-21 NFI exercise are £0.073 million.

This is a reduction of £0.26 million from the 2018-19 NFI exercise, and reflects the continuing impact of the ‘tell us once’ reporting process which is ensuring that local authorities become aware of the decease of pensioners earlier. While the number of cases detected by NFI has remained almost unchanged from NFI 2018-19, the average value of each case has fallen from £26,396 to £8,160, because the period of time pensions remained in payment after pensioners’ death was shorter.

Outcomes of £0.073 million in 2020-21





Key messages



Outcomes



Results



Process



Housing benefit

The NFI provides local authorities and the Department for Work and Pensions (DWP) with the opportunity to identify a wide range of benefit frauds and errors.

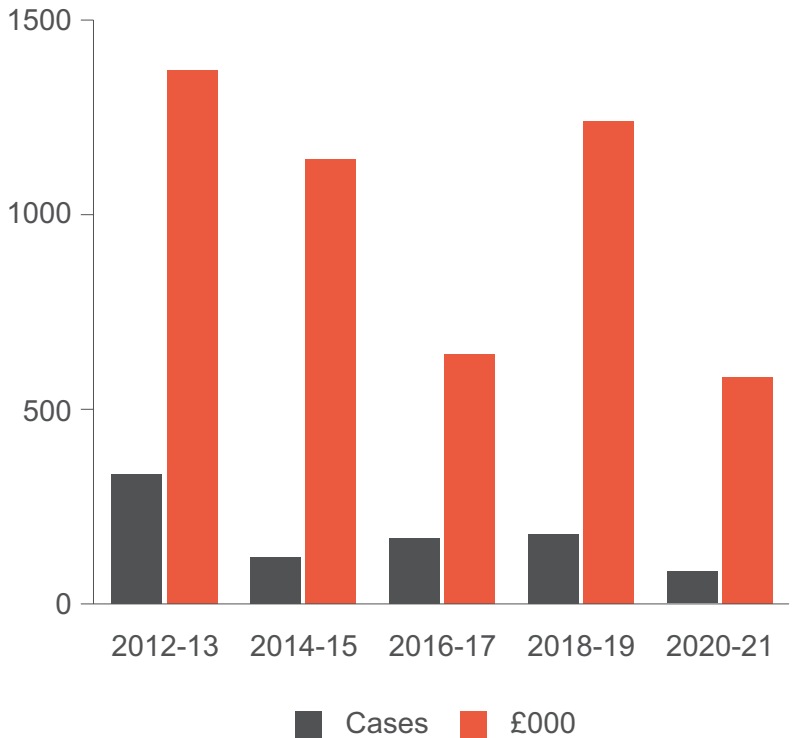
Housing benefit data is matched to student loans, payroll, pensions, housing benefit, housing tenants, licences, deceased person and Amberhill* data to help identify ineligible claims.

The value and number of housing benefit cases recorded with overpayments has reduced from £1.2 million (179 cases) in the 2018-19 exercise to £0.6 million (82 cases) in the 2020-21 exercise.

The fall in housing benefit cases outcomes is mainly due to matches between housing benefit and payroll and pension payments not being included in the 2020-21 exercise. These matches historically identified significant outcomes. These matches were not included as similar data matching is undertaken by the DWP's Verify Earnings and Pensions (VEP) Alerts service which identifies discrepancies between payroll and pension details held by HM Revenue & Customs and council benefits services. Alerts from VEP are sent to local authorities to investigate discrepancies.

*Amberhill is a system used by the Metropolitan Police to authenticate documents presented for identity.

Outcomes of £0.6 million in 2020-21



The majority of fraudulent and erroneous claims for housing benefit detected by local authorities in the 2020-21 exercise related to students who were in receipt of housing benefit when not entitled.

Key messages



Outcomes



Results



Process



Case Study: Housing benefit

Carmarthenshire County Council

The Council continues to recognise the value of NFI in protecting the public purse against the threat of fraud risks and considers NFI as being invaluable in the detection and prevention of fraud. The NFI 2020-21 exercise identified 33 housing benefit to student loan matches and of these 13 were high risk matches. Historically the Council has achieved significant results from this specific report and, as in previous exercises, extended the checking process to all matches. Review of the report identified fraud in 30% of the matches, where it was established that benefit customers had failed to declare they were in receipt of student finance/loans. These ten investigations identified overpayments of benefits in excess of £33,000. The Council has recovered the overpayments or remains in the process of full recovery.

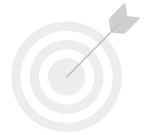




Key messages



Outcomes



Results



Process



Blue badges

The blue badge parking scheme allows people with mobility problems to park for free at on-street parking meters, in pay and display bays, in designated blue badge spaces, and on single or double yellow lines in certain circumstances.

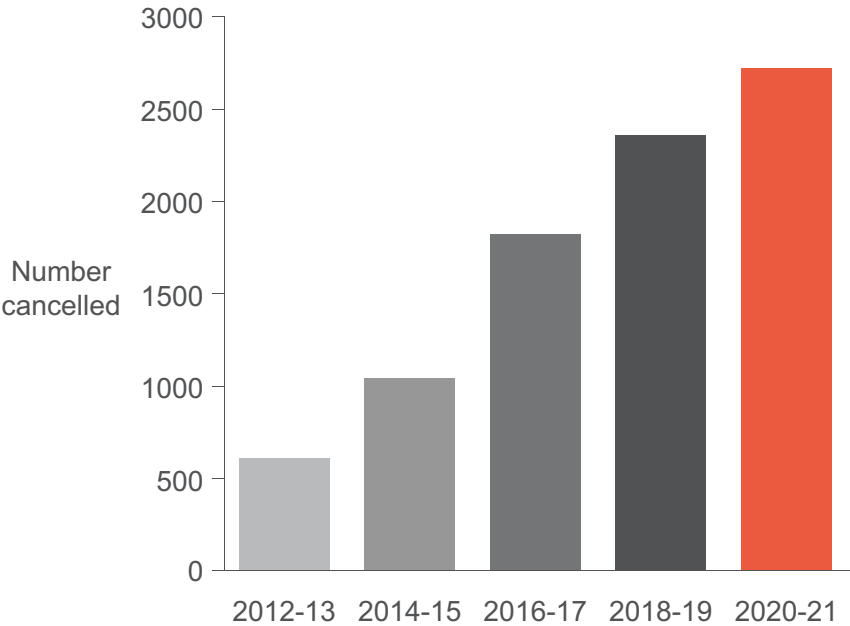
Blue badge data is matched to deceased persons and Amberhill data.

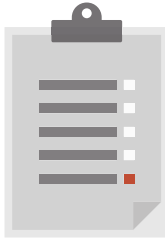
Badges are sometimes used or renewed improperly by people after the badge holder has died. It is an offence for an unauthorised person to use a blue badge.

NFI 2020-21 resulted in the cancellation of 2,717 blue badges in Wales. The number of badges cancelled has increased in each NFI exercise since NFI 2012-13. The estimated value of these cases is £1.4 million based on a calculation of the annual estimated cost of lost parking revenue and the likelihood of these blue badges being misused.

The increase in outcomes is due to a growing recognition of the need to prevent misuse of blue badges. Not only does such misuse reduce parking revenues, it also limits the parking facilities available to genuine blue badge holders.

2,717 outcomes in NFI 2020-21

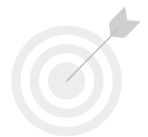




Key messages



Outcomes



Results



Process



Housing waiting lists

NFI uses housing waiting list data to identify possible cases of waiting list fraud. This happens when an individual has registered on the waiting list but there are possible undisclosed changes in circumstances or false information has been provided. This was a new data set for the 2016-17 NFI exercise.

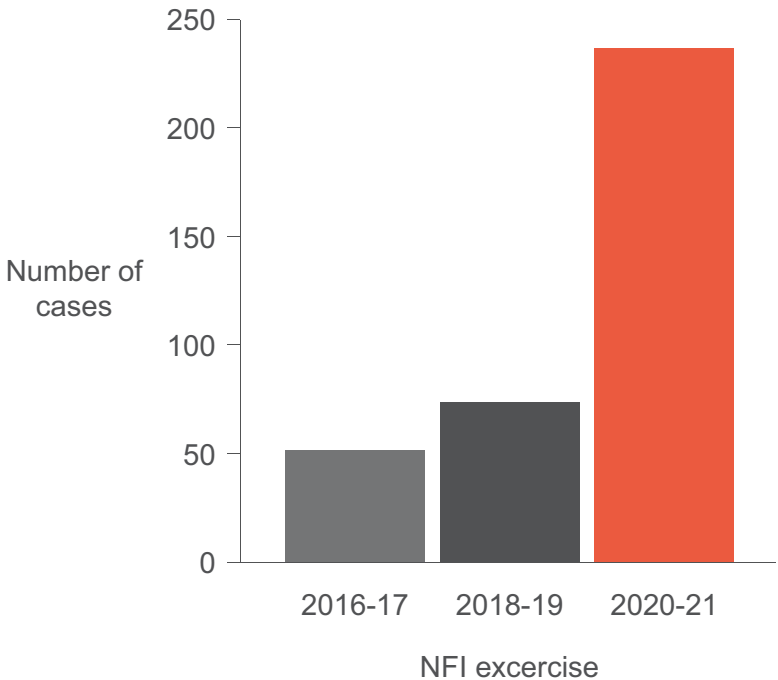
Housing waiting list data is matched to waiting list, housing benefit, housing tenants, deceased persons and Amberhill data.

Local authorities identified 237 cases where applicants were removed from waiting lists compared to 74 cases in 2018-19.

The estimated value of these cases is just under £0.8 million based on a calculation of the annual estimated cost of housing a family in temporary accommodation and the likelihood a waiting list applicant would be provided with a property.

The increase in the number of applications cancelled is due to increased efforts by local authorities to review the NFI matches thereby helping ensure that social housing is only provided to eligible persons.

Number of applicants removed from housing waiting lists



Key messages



Outcomes



Results



Process



Creditor payments



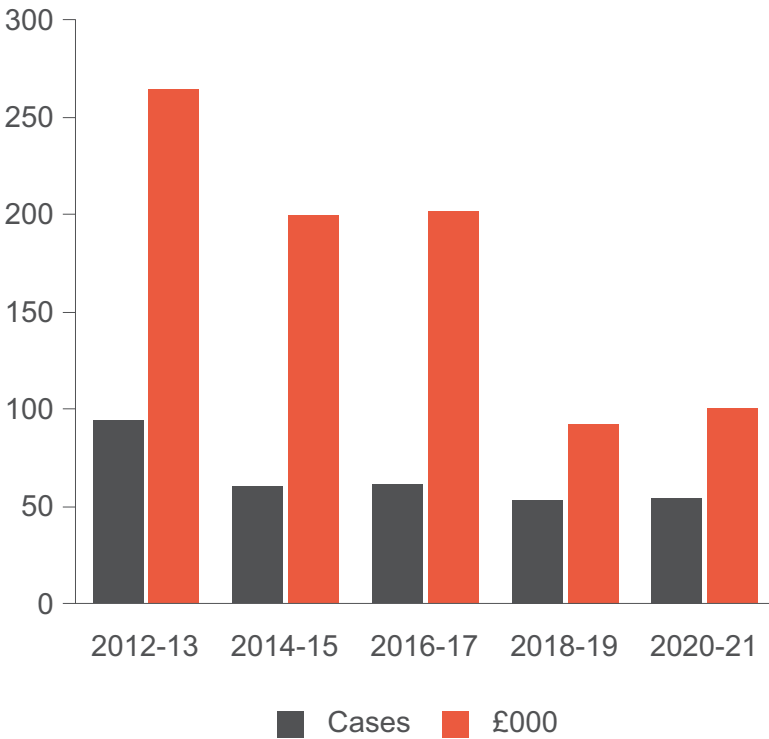
The NFI provides an efficient way to check for duplicate payments and that payments are only made to appropriate creditors.

Creditor payment data is also matched to payroll and Companies House data to help identify undisclosed staff interests in suppliers.

NFI 2020-21 resulted in 54 creditor payment outcomes totalling just over £0.1 million compared to 53 outcomes totalling just under £0.1 million in NFI 2018-19. Recovery action has already taken place or is in process for all of these overpayments.

Creditor payment outcomes have reduced over NFI exercises as participating bodies have improved their internal control systems.

Outcomes of £0.1 million in 2020-21

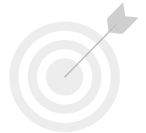




Key messages



Outcomes



Results



Process



Council tax reduction

Council tax reduction helps those on low incomes to pay their council tax bills.

The NFI provides local authorities with the opportunity to identify a range of council tax reduction frauds and errors.

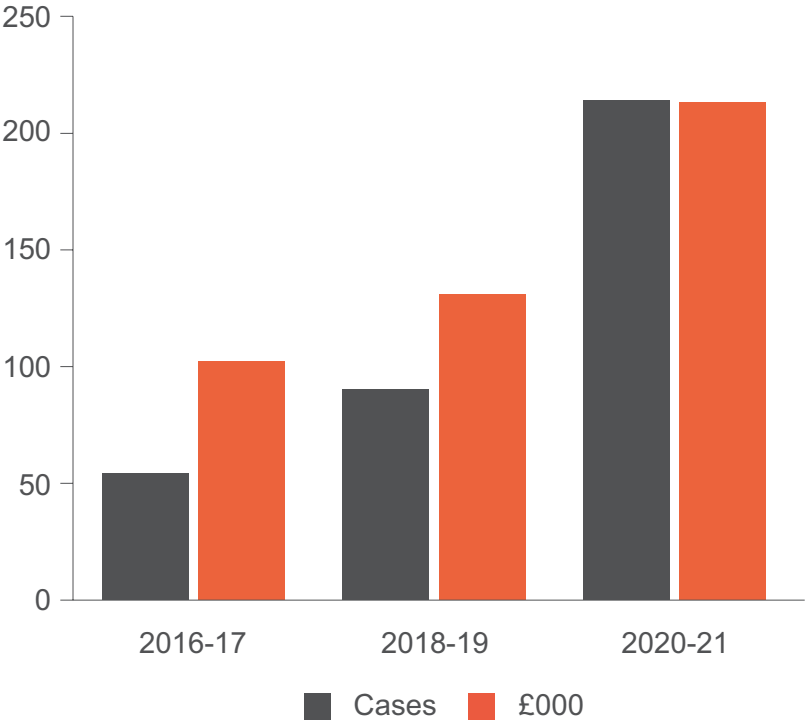
Council tax reduction data is matched to council tax reduction, payroll, pensions payroll, housing benefits, housing tenants, licences, deceased persons and Amberhill data.

The 2016-17 NFI was the first time council tax reduction data sets were included within the NFI.

Outcomes of £0.21 million were identified in the 2020-21 NFI and claims for council tax reduction were amended or cancelled in 214 cases.

The average value of each case was £1,015 compared to £1,457 in NFI 2018-19 suggesting that fraud and error is being identified earlier.

Outcomes of £0.21 million in 2020-21



Key messages



Outcomes



Results



Process



Case study: Vale of Glamorgan Council

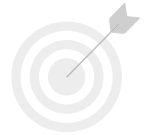
The Council has a proactive and comprehensive approach to reviewing all NFI matches. All council tax reduction matches are reviewed by the Investigation Officer against the Council's internal systems to try and establish the current household status of claimants. One such match appeared to show the claimant had not declared an occupational pension that had been in payment since 2018. The Investigation Officer advised the Benefits Team that further investigation was required. The Benefits Team liaised with the Revenues Team and found there was another person residing at the address who was also in receipt of an undeclared occupational pension and who had received a substantial lump sum pension payment in 2018. Despite numerous attempts to verify the current situation with the claimant, the claimant failed to respond. The Council has cancelled the claim and the claimant has agreed to repay an overclaim of £4,775 in monthly instalments.



Key messages



Outcomes



Results



Process



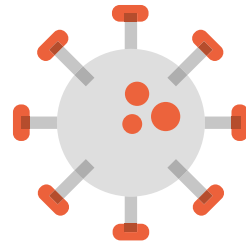
Use of HMRC Data in NFI

In NFI 2020-21, for the first time, Welsh NFI matches were enriched by HMRC data provided under the provisions of the Digital Economy Act 2017. The HMRC data is proving highly effective in helping to identify applicants who have claimed means-tested benefits and discounts but have not declared income that should have been declared on their applications.



Case Study: Denbighshire County Council

The Council proactively reviewed matches between Council Tax Reduction Scheme (CTRS) and HMRC's household composition. One match suggested there was an undeclared non-dependant in the household from 2017, so benefit payments were suspended. The Benefits Team had previously been notified that the person had left the household in March 2017. On investigation, the customer confirmed the failure to declare the non-dependant since May 2017. The NFI match showed the earnings of the non-dependant to be around the threshold at which the highest deduction to the claimant's benefits would apply, so in the absence of further evidence of the non-dependant's income, the is highest deduction was applied. This resulted in an overclaim totalling £20,782. The Council is in the process of recovering the overclaim.



COVID-19 business support grants

Key messages



Outcomes



Results



Process



In response to the COVID-19 pandemic, the Welsh Government put in place a package of measures to support businesses through the crisis. One of these measures included providing grant funding through Welsh local authorities to some retail, hospitality and leisure businesses and to businesses classified as small businesses for business rate purposes. NFI matched these grants to ensure that businesses were not inappropriately claiming multiple grants and that grants were not being awarded to known fraudsters. These checks only identified two cases of fraud and error amounting to £20,000, providing assurance that these practices were not common.

NFI also made optional tools available to local authorities to confirm that grant applicants were actively trading before the COVID-19 pandemic, and that bank account details provided by applicants related to legitimate business accounts. One Welsh local authority, Cardiff Council, used these tools in conjunction with other internal controls to identify 41 cases of fraud and error with a value of £575,000.

Case Study: Cardiff Council

Following the use of various upfront application and payment controls, the Council used a multi-layered approach to post payment verification and assurance processes for COVID-19 business support grants. NFI provided a useful source of intelligence as part of these post payment checks. The Corporate Fraud Investigation Team and colleagues in Business Rates used a range of investigative techniques and identified £575,000 of payments for recovery. For example, one NFI match indicated that a company had ceased trading, online enquiries suggested the business had closed and a Companies House check showed the company had dissolved prior to the grant eligibility date. The company had not notified the Council that they had ceased trading and were not eligible for the grant. The Council has recovered, or is seeking to recover the overclaims wherever there is a realistic chance of doing so.

Key messages



Outcomes



Results



Process



Payments to residential care homes



In previous NFI exercises, NFI has matched residential care home data to deceased persons to identify cases where a care home resident has died, but the local authority has not been notified and so has continued to make payments to the care home.

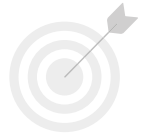
In NFI 2018-19, 11 cases of overpayments were identified where Welsh local authorities were continuing to pay care homes for residents who had died. The average value of these cases was £14,545.

Due to the unintended consequence of a change to legislation affecting Wales, Scotland and England, it was not possible to undertake matching in this area as part of NFI 2020-21. The Auditor General is working with the Cabinet Office and Audit Scotland to find a legislative solution that will allow this matching to be undertaken in future NFI exercises.

Key messages



Outcomes



Results



Process



Matches benefiting other public bodies

One key benefit of a UK-wide data matching exercise is that it enables matches to be made between bodies and across national borders. Data provided by Welsh participants for the 2020-21 NFI exercise helped other public bodies outside Wales identify outcomes worth just over £183,000.

Sector of source data	£	Number of outcomes
Local authorities	162,776	135
NHS	15,811	17
Fire	4,458	1
Total	183,045	153

Most of these outcomes relate to housing benefits, housing waiting lists, and council tax reductions. For example, payroll data from a health board may allow a local authority to identify a housing benefit overpayment.

For those public bodies taking part in the NFI which may not always identify significant outcomes from their own matches, it is important to appreciate that providing their data can help other bodies and sectors identify frauds and overpayments.

Process

Key messages



Outcomes



Results



Process

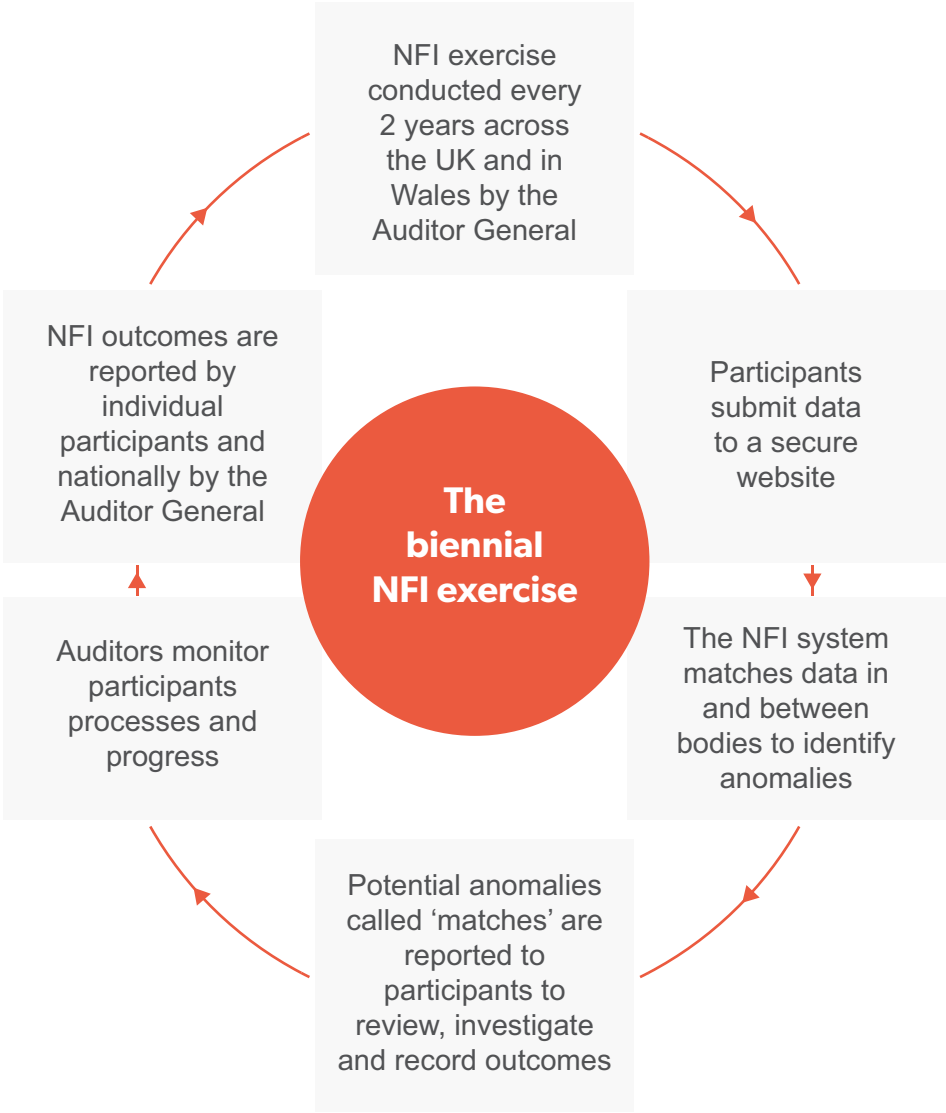


The NFI is a counter-fraud exercise across the UK public sector which aims to prevent and detect fraud. The Auditor General, Cabinet Office, Audit Scotland, and the Northern Ireland Audit Office lead the exercise in Wales, England, Scotland, and Northern Ireland, respectively. The NFI takes place biennially and enables public bodies to use computer data matching techniques to detect fraud and error.

The main purpose of the NFI is to ensure funds and services are provided to the correct people, but the NFI can also identify individuals entitled to additional services or payments eg housing benefit matches may identify customers entitled to council tax discount or reduction.

We carry out the NFI process under powers in the Public Audit (Wales) Act 2004. It is important for all parties involved that this exercise is properly controlled and data handled in accordance with the law. The Auditor General’s [Code of Data Matching Practice](#) summarises the key legislation, and controls governing the NFI data matching exercise.

In Wales, the Auditor General has mandated unitary local authorities and NHS bodies to participate in the NFI. The Welsh Government, some Welsh Government Sponsored Bodies, and Audit Wales participate on a voluntary basis.



Key messages



Outcomes



Results



Process



How bodies work with the NFI

The success of the NFI is dependent on the proactivity and effectiveness of participant bodies in investigating the data matches.

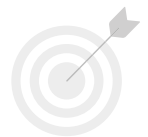
Most participating Welsh public bodies managed their roles in the 2020-21 NFI exercise well.

However, some bodies could be far more pro-active in their approach to the NFI. In particular, some local authorities reviewed very few of the matches they received, and as a consequence did not do sufficient work to address potential frauds. This was due to some participants failing to recognise the importance of the exercise and/or an unwillingness to allocate adequate, skilled counter-fraud resources to investigate the NFI matches.

Key messages



Outcomes



Results



Process



Future developments

- The Auditor General is considering how to further develop the scope of NFI in Wales and areas of potential data-matching currently being explored include, housing tenancies, GP patient registration, business rates.
- The 2022-23 NFI is now underway. Data sets have been reviewed following a period of consultation and NFI participants are starting to submit data for matching.
- The Auditor General continues to work with the Welsh Government to promote and enhance participation in the NFI across Wales.

The Auditor General is independent of the Senedd and government. He examines and certifies the accounts of the Welsh Government and its sponsored and related public bodies, including NHS bodies. He also has the power to report to the Senedd on the economy, efficiency and effectiveness with which those organisations have used, and may improve the use of, their resources in discharging their functions.

The Auditor General also audits local government bodies in Wales, conducts local government value for money studies and inspects for compliance with the requirements of the Local Government (Wales) Measure 2009.

The Auditor General undertakes the National Fraud Initiative in Wales under Part 3A of the Public Audit (Wales) Act 2004 which empowers him to conduct data matching exercises for the purpose of assisting in the prevention and detection of fraud in or with respect to Wales and to publish the results of any such exercise.

The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.



Audit Wales

24 Cathedral Road

Cardiff, CF11 9LJ

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

We welcome telephone calls in
Welsh and English.

E-mail: info@audit.wales

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AGENDA ITEM

4.3

AUDIT & RISK COMMITTEE

PROCUREMENT & SCHEME OF DELEGATION REPORT

Date of meeting

12/12/2022

FOI Status

Open/Public

If closed please indicate reason

Not Applicable - Public Report

Prepared by

Owen James, Head of Corporate Finance

Presented by

Sally May, Executive Director Finance & Procurement

Approving Executive Sponsor

Executive Director of Finance & Procurement

Report purpose

ENDORSE FOR BOARD APPROVAL

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

Committee/Group/Individuals

Date

Outcome

Choose an item.

ACRONYMS

OJEU

Official Journal of the European Union

FCPs

Financial Control Procedures

SoD

Scheme of Delegation

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)

This report provides details of any such transactions within the period 01.10.22 to 30.11.22.

1.2 Purchase to Pay

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 2022-23.

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 BY THIS MEETING (ASSESSMENT)

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 01.10.22 to 30.11.22.

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

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

The Scheme of Delegation allows the Director of Finance and Procurement to approve a waiver of the requirement for competitive tenders up to OJEU or other exceptions to tender rules. **Table A** below provides details of such actions during the period 01.10.22 to 30.11.22

Table A – Single Tender Actions 01.10.22 to 30.11.22

STA	Revenue/Capital	Division	Contract description	Supplier	Contract Value Exc. VAT	Reason for approval	Date Returned
1615	Revenue	Engagement and Communication	Primary Care Campaign	Lloyd RP	£25,380	d)	07/11/22
1618	Revenue	ICT	Imosphere Clinical Software Support and Maint	Imosphere	£31.158	c)	22/11/22
1628	Cap	Capital Estates	Sound Proofed Room at KHHP	IAC Acoustics	£61.883	d)	23/11/22

Reasons for approval:

a) service/work is follow-up, supplier has already undertaken initial work in same area (work undertaken via open competition)

b) Compatibility issue

c) Genuine 1 provider

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

STA 1615 - Primary Care Campaign

Lloyd PR has worked with CTM previously when commissioned by Welsh Government to support the COVID-19 pandemic response.

Lloyd PR is familiar with our content, materials, campaigns, approaches, systems and processes, and this work builds on all of the previous work they have done for CTM. The experience and credentials of Lloyd PR provides reassurance of the quality and calibre of the support provided for this campaign work.

STA 1628 Sound Proofed Room at KHHP

IAC Acoustics previously decommissioned the booths and are being used to re-install to ensure maximum efficiency and value. The booth is manufactured by IAC Acoustics who have the most in-depth knowledge of their product fitting.

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

None

2.2 Purchase to Pay (P2P)

The PSPP figures are reported to 31 October 2022.

The Health Board has not met its 95% target of paying non-NHS invoices within 30 days to Month 7 2022-23 achieving only 93.89% (value 93.81%). This compares to 94.8% (value 94.0%) to Month 7 2021-22.

For the month of October only 88.41% was achieved. This was due to the failure of 1,189 Nurse Agency invoices which accounted for 7%. While the new self-billing process commenced during October, there is a transition phase between paper to electronic timesheets and these are being progressed. It is anticipated that there will be an improvement from November onwards.

	0 - 30 Days		Total		%	
	Number	Value	Number	Value	Number	Value
Apr-22	20,667	46,929,829	21,611	49,682,932	95.63%	94.46%
May-22	19,217	43,766,897	19,796	46,596,405	97.08%	93.93%
Jun-22	25,864	43,490,528	26,670	45,686,653	96.98%	95.19
Jul-22	17,617	36,630,680	18,805	39,207,371	93.68%	93.43%
Aug-22	25,176	40,169,264	26,188	41,979,225	96.14%	95.69%
Sept-22	15,971	40,186,028	18,535	43,957,740	86.17%	91.42%
Oct-22	15,379	38,744,175	17,396	41,928,025	88.41%	92.41%
YTD	139,891	289,917,401	149,001	309,038,351	93.89%	93.81%

The NHS invoice position shows that 85.63% (number) and 97.09% (value) of invoices were paid within 30 days to month 7 2022-23. (80% (number) and 96.5% (value) for the same period in 2021-22).

Scheme of Delegation and Financial Control Procedures

The Scheme of Delegation doesn't currently clarify the position of the Chief Operating Officer on the approval limits tiers. Approval is requested to update the Scheme of Delegation to clarify that the Chief Operating Officer has an approval limit of up to £250,000. This isn't a change to current limits, just a clarification of the approvals to avoid any ambiguity.

¹ All Financial Limits shown below are **inclusive** of VAT

ORACLE REQUISITIONS	Authority Delegated to
Below £1,500	Tier 7 – Nominated Budget holder for specific cost centers
£1,500 to £5,000	Tier 6 - Head of Department or equivalent
Up to £25,000	Tier 5 - Clinical Service Group Manager (or equivalent)
Up to £50,000	Tier 4 - Acute Services General Manager (or equivalent)
Up to £100,000	Tier 3 – Care Group Director, Deputy COO, Director of Governance, Director of Digital
Up to £250,000	Tier 2 - Executive Director <u>and Chief Operating Officer</u>
Up to £500,000	Tier 1 – Director of Finance
Over £500,000	Chief Executive

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

- 3.1 Risk that if the Nurse Agency invoices payment times do not improve, the attainment of the PSPP target may not be achieved.

4. IMPACT ASSESSMENT

5.

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outlined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:



Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below)
	If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not required
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Sustaining Our Future

6. RECOMMENDATION

The Audit & Risk Committee is asked to:

- a) **NOTE** the position on procurement matters for the period 01.10.22 to 30.11.22;
- b) **NOTE** the update regarding Purchase to Pay and achievement of PSPP target.
- c) **ENDORSE FOR APPROVAL** the update to the Scheme of Delegation



AGENDA ITEM

4.4

AUDIT & RISK COMMITTEE

LOSSES AND SPECIAL PAYMENTS 01.07.22 TO 30.09.22

Date of meeting

12/12/2022

FOI Status

Open/Public

If closed please indicate reason

Not Applicable - Public Report

Prepared by

Daxa Varsani – Financial Accountant

Presented by

Sally May - Executive Director of Finance & Procurement

Approving Executive Sponsor

Executive Director of Finance

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

Stephanie Muir, CTMUHB
Assistant Director Claims & Concerns

On-going

NOTED

Georgina Galletly – Director of Corporate Governance

ACRONYMS

WRP

Welsh Risk Pool

NWSSP

NHS Wales Shared Services Partnership

VER

Voluntary Early Release

DEL

Departmental Expenditure Limit



L&R	Legal & Risk
PTR	Putting Things Right
CMRs	Claims Management Reports
LFERs	Learning From Events Reports
ILG	Integrated Locality Group
CSG	Clinical Service Group
SOP	Standard Operating Procedure
GMPI	General Medical Practice Indemnity
HSE	Health and Safety Executive

1. SITUATION/BACKGROUND

- 1.1 This report advises the Audit & Risk Committee on the losses and special payments made by the University Health Board (UHB) for the three month period from 1 July 2022 to 30 September 2022, as required in Standing Financial Instructions.
- 1.2 The Health Board is liable for the first £25k of any Personal Injury or Medical Negligence claim (not including Redress cases), with amounts over this being borne by the Welsh Risk Pool (WRP) managed by the NHS Wales Shared Services Partnership (NWSSP). For any "other" cases such as Employment Matters or Voluntary Early Release (VER) for example, the full cost of the loss is borne by the UHB. Where the WRP would be liable for a reimbursement to the UHB then there will be timing differences between payments being made and any reclaim from the Risk Pool. There is a strict protocol in place for reclaiming from the WRP.
- 1.3 General Medical Practice Indemnity Scheme (GMPI) was introduced in recent years by the Welsh Government as a state-backed scheme within NHS Wales. Legal and Risk Services and WRP operates this scheme and cases settled under the scheme are presented to WRP for reimbursement.
 - Scrutiny of the Learning from Events Report is conducted in the same manner as cases settled under NHS Indemnity or as part of the redress scheme.
 - Payments in relation to claims managed under GMPI are made by the defendant Health Board, and reimbursement by the WRP is made to the Health Board.
 - No excess in relation to reimbursement of cases settled under the GMPI will apply to the Health Board and all costs incurred are fully reimbursed.
- 1.4 In accounting for losses on claims, liability is recognised when legal advice states that there is a probability in excess of 50% of the Health Board having to settle. The quantum of the claim, and associated plaintiff costs are therefore recognised as "expenditure" at this point, with the risk pool recovery element also being recognised. Other losses are recognised as and when they arise.

- 1.5 There is therefore a significant timing issue (which can be several years) between expenditure being recognised within the Health Board's accounts and cash payments being made. Write-off approval action is only required for cash payments. This report highlights:
- a) Amounts that have been charged to expenditure for which payments are yet to be made. These amounts are held within the balance sheet as future amounts owing (or owed by the WRP) at the appropriate Balance Sheet date;
 - b) Amounts charged to expenditure during the current year (together with income from the WRP), and which therefore has a budgetary impact against the Health Board's Revenue Resource Limit; and
 - c) Cash payments made during the period for which write-off action is required, with details being provided within the appendices.

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

- 2.1 Standing Financial Instructions require all losses to be reported to the Audit & Risk Committee. This report is therefore a key element of the governance process around losses and special payments.
- 2.2 The number of claims, both Medical Negligence and Personal Injury, continues to result in significant levels of expenditure. These levels of expenditure are determined case by case and are based on information supplied by Welsh Legal Services.
- 2.3 Section a, b and c below provide details in regards to amounts that have been charged to expenditure for which payments are yet to be made, budgetary impact against the Health Board's Revenue Resource Limit and the cash payments made during this reporting period.

a) Provision and Creditors as at 30 September 2022

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

Table 1

	30.09.22	30.06.22	31.03.22	31.03.21	31.03.20
	£000	£000	£000	£000	£000
	Cumulative	Cumulative	Cumulative	Cumulative	Cumulative
Medical Negligence claims/costs	65,994	64,967	65,127	86,029	85,516
Redress Medical Negligence claims/costs	538	436	235	269	382
Personal Injury claims/costs	618	605	611	436	680
Recoverable from Welsh Risk Pool	(84,441)	(87,279)	(93,074)	(114,863)	(115,161)
Net claim provision (Note 1)	(17,291)	(21,271)	(27,101)	(28,129)	(28,583)
Permanent Injury Benefit	6,018	6,086	6,201	6,320	6,252
Net Provision	(11,273)	(15,185)	(20,900)	(21,809)	(22,331)
Number of live cases on losses system (LaSPaR)					
	30.09.22	30.06.22	31.03.22	31.03.21	31.03.20
Medical Negligence claims (Note 2)	326	316	299	309	279
Redress Medical Negligence claims (Note 2)	243	245	213	168	202
GP Indemnity claims	7	7	7	0	0
Personal Injury claims	129	120	113	110	113

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

Note 1: The decrease in net claim provision for this period reflects the successful reimbursement claims from WRP as detailed in the Table 3. Please note further update on this matter within section B below.

Note 2: There is an overall increase in Medical Negligence and Redress open cases during the first two quarters of the year as noted in the table above. However, a systems reconciliation process is being completed currently and an updated number of open cases will be provided to the next Audit & Risk Committee.

b) Expenditure incurred for the year to 30 September 2022

This is shown in table 2 below, together with equivalent figures for the last three complete financial years and last reporting period to the Audit & Risk Committee (22.08.2022).

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

Table 2

	Year to	Year to	Year to	Year ended	Year ended
	30.09.22	30.06.22	31.03.22	31.03.21	31.03.20
	£000	£000	£000	£000	£000
Medical Negligence claims/costs	3,749	1,374	1,945	13,110	18,455
Redress Medical Negligence claims/costs	431	289	170	305	367
GP Indemnity	0	0	1	0	0
Personal Injury claims/costs	262	42	772	316	557
Recoverable from Welsh Risk Pool	(3,782)	(1,414)	(1,210)	(12,449)	(18,225)
Net claim expenditure (Note 3)	660	291	1,678	1,282	1,154
Permanent Injury Benefit	(80)	(115)	286	470	2,075
Other (Note 4)	1,210	165	570	609	407
Total expenditure	1,790	341	2,534	2,361	3,636

Note 3: The annual budget for net claim expenditure for 2022-23 is £1,785k (year to date £893k), there is therefore an underspend of £233k.

Note 4: As reported to the Audit & Risk Committee previously regarding the Health & Safety Executive (HSE) Fine, the actual payment of £861k has now been made during September 2022.

c) Cash Write-Offs made for the period 1 July 2022 to the 30 September 2022

Table 3 shows the cash impact to 30 September 2022 of the current financial year. More detail is provided within the Appendices for the current reporting period.

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

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

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

Table 3
Cash write-offs made during 22/23

	01.07.22 - 30.09.22 £000	Previously Reported £000	Total 2022-23 £000
Medical Negligence (Appendix 1)			
Claims	547	715	1,262
Costs	694	730	1,424
Defence Fees	106	88	194
Medical Negligence Totals	1,347	1,533	2,880
Redress Medical Negligence (Appendix 2)			
Claims	28	67	95
Costs	6	14	20
Defence Fees	7	8	15
Redress Medical Negligence Totals	41	89	130
GP Indemnity (Appendix 3)			
Defence Fees	0	0	0
GP Indemnity Totals		0	
Personal Injury (Appendix 4)			
Claims	87	24	111
Costs	53	10	63
Defence Fees	67	13	80
Personal Injury Totals	207	47	254
Permanent Injury Benefit (Appendix 5)	103	0	103
Permanent Injury Benefit Totals	103	0	103
Other (Appendix 6)			
Ex-Gratia	28	33	61
Debt Write Off		0	
Loss of Cash	861	0	861
Ombudsman	2	1	3
Employment Matter	153	132	285

Other Totals	1,044	166	1,210
Total	2,742	1,835	4,577
Recovered from Welsh Risk Pool	(5,206)	(7,208)	(12,414)
Net Cash Write-Off	(2,464)	(5,373)	(7,837)

WRP Risk Sharing Agreement

- 2.4 The Audit & Risk Committee will be aware that any overspend incurred by the Welsh Risk Pool will need to be shared amongst NHS organisations, and is therefore an additional financial risk to those organisations.
- 2.5 WRP have confirmed an overspend of £25.3m will need to be shared between the Health Boards in 2022-23 and similar values in the subsequent 3 years. The board have made provision for the increase of the extra £1.1m in the financial plan for 2022/23.

Welsh Risk Pool charge on late submission of reimbursement claims

- 2.6 As reported previously to the Audit & Risk Committee, the Health Board continues to work closely with the colleagues from WRP in resolving the matter relating to the timely submission of the Case Management Reports (CMRs) and Learning from Event Reports (LFERs) for the reimbursement of outstanding monies from WRP.
- 2.7 Following the review of procedures for the management of claims, redress cases and coronial investigations by WRP. An improvement plan was jointly developed by CTM and WRP. Good progress has been made in achieving actions detailed within the plan. However, there are still challenges in respect of timely submission of LFERs. This has been recognised and changes are being made with the responsibility for the facilitation of LFERs being realigned as part of the proposed changes to the new operating model in respect of quality, safety and governance.
- 2.8 Reports on due dates for CMRs are regularly undertaken and audited monthly to ensure all CMR are on target for submission when due. This process has enabled more effective tracking and monitoring of CMRs, with all CMRs continuing to be submitted on time.
- 2.9 Work continues on the effective production and submission of LFERs, which will be supported when the new operating model for quality, safety and governance is implemented.

Actions taken are as follows:

- LFER How to Guide developed and shared widely
- LFER SOP developed
- Weekly reports run and disseminated on LFER status
- Spreadsheet compiled for the red/amber deferred cases which are problematic to track on Datix Cymru
- Request submitted to the Once for Wales Datix team to make amendments to the system allowing easier tracking of red/amber deferred cases
- Integrated Locality Group (ILG) Governance teams now provided access to Datix Cymru, allowing real time review of LFER status
- Ad hoc meetings with service areas in respect of LFERs status and barriers to providing evidence.
- Escalation of any barriers to relevant Executives
- LFER status captured and reported at weekly Executive Patient Safety meeting
- Where learning has been delayed due to the pandemic, any LFERs overdue, which have not yet been submitted, have been submitted partially completed, allowing a 6-month extension.
- Changes requested and made to the new Datix Cymru to allow for more effective tracking of Red/Amber Deferred and overdue LFERs

2.10 In June 2022, CTM were notified of 38 LFERs which were overdue their 6 month extension and were at risk of permanent deferral. A significant amount of work was undertaken with all LFERs being submitted.

2.11 Submissions are reviewed by WRP and either deferred or approved at panel and final approval for reimbursement give at WRP Committee. The following has been achieved:

WRP Committees

July –	£5,208,271.63
September -	£2,901,634.75
November -	£4,336,763.64

Circa £12.4 million

In addition £890,534 has recently been approved at Amber Panel for reimbursement.

- 2.12 Training on Datix Cymru enforces the need to complete the Datix system comprehensively, including action points and uploading evidence of actions taken. This should assist with LFER completion at a later date when Redress or a Claim is triggered.
- 2.13 RCA training includes the importance of the completion of LFERs in a timely manner, with the financial implications highlighted to staff.

Status

- 2.14 There are currently 84 Red/Amber deferred cases recorded on Datix Cymru, of those 9 have gone over the 6 months extension deadline date and can be at risk of permanent deferral.
- 2.15 We continue to submit a high number of blank LFERs in order to gain a 6 month extension. Deferred cases will not reduce until LFERs are submitted in a timely manner.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

- 3.1 There continues to be a risk of permanent deferrals and associated financial penalties due to the high number of blank LFERs being submitted. It is felt that sustainable improvements will be made in this area, when the new operating model in respect of quality, safety and governance is implemented and embedded.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	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
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:



Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	Yes
	If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below.
	If no, please provide reasons why an EIA was not considered to be required in the box below.
	Completed as part of the Financial Control Procedures for Losses & Special Payments (FP 15)
Legal implications / impact	Yes (Include further detail below)
	Losses provided for are informed by legal advice where appropriate based on probability of a successful claim
Resource (Capital/Revenue £/Workforce) implications / Impact	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.
Link to Strategic Goals	Sustaining Our Future

5. RECOMMENDATION

5.1 The Audit & Risk Committee is requested to:

- **NOTE** the losses and special payments made for the period 1 July 2022 to 30 September 2022.
- **NOTE** the update in respect of the matter relating to the late submission of the WRP reimbursement claims.

Medical Negligence Payments 01/07/2022 - 30/09/2022						Appendix 1	
Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimbursement £000	Total £000	Previous Write Offs £000	Cumulative £000
05RVEMN0022	185	2	0	0	187	276	463
10RYLMN0014	36	0	0	0	36	9	45
12RYLMN0004	0	1	0	0	1	50	51
12RYLMN0037	0	0	0	-4,009	-4,009	4,239	230
13RYLMN0005	0	4	0	0	4	19	22
13RYLMN0050	15	0	0	0	15	2	17
14RYLMN0200	0	3	0	0	3	3,571	3,575
15RYLMN0049	0	4	0	0	4	236	240
15RYLMN0136	0	-1	0	1	0	25	25
15RYLMN0203	10	0	0	0	10	56	66
16RYLMN0002	0	0	0	-236	-236	261	25
16RYLMN0073	-11	1	0	0	-10	463	453
16RYLMN0205	81	2	0	0	83	1,273	1,356
17RYLMN0081	0	5	0	0	5	0	5
17RYLMN0122	0	2	0	0	2	39	41
17RYLMN0157	-5	5	0	0	1	432	433
18RYLMN0031	0	0	0	-248	-248	273	25
18RYLMN0033	0	0	0	-257	-257	282	25
18RYLMN0064	40	8	0	0	48	882	930
18RYLMN0085	85	3	15	0	103	26	128
18RYLMN0106	0	2	0	0	2	5	7
18RYLMN0114	0	0	0	0	0	2	2
18RYLMN0137	9	0	0	0	9	42	50
19RYLMN0024	0	0	0	0	0	43	43
19RYLMN0047	0	0	0	0	0	25	25
19RYLMN0061	0	0	3	0	3	18	20
19RYLMN0081	0	0	0	-143	-143	168	25
19RYLMN0083	23	0	25	0	48	12	59
20RYLMN0005	35	4	290	0	329	25	354
20RYLMN0009	20	2	50	0	72	14	85
20RYLMN0027	0	-0	0	0	-0	14	14
20RYLMN0033	0	4	0	0	4	6	9
20RYLMN0035	0	1	9	0	10	2,772	2,781
20RYLMN0112	0	1	0	0	1	2	3
20RYLMN0119	12	0	3	0	15	0	15
20RYLMN0129	0	3	0	0	3	191	194
20RYLMN0164	0	3	0	0	3	4	7
20RYLMN0165	14	4	0	0	17	119	136
20RYLMN0166	16	0	0	0	16	16	32
20RYLMN0171	0	0	73	0	73	3	76
20RYLMN0197	0	0	7	0	7	3	9
20RYLMN0201	0	1	0	0	1	44	45
21RYLMN0019	40	3	0	0	43	399	442
21RYLMN0020	0	0	0	0	0	48	48
21RYLMN0023	0	1	0	0	1	5	6
21RYLMN0030	-4	1	0	0	-3	162	159
21RYLMN0032	0	0	45	0	45	1	46

Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimbursement £000	Total £000	Previous Write Offs £000	Cumulative £000
21RYLMN0065	17	0	0	0	17	23	40
21RYLMN0077	0	1	0	0	1	1	1
21RYLMN0079	0	1	0	0	1	3	4
21RYLMN0090	7	0	0	0	7	10	17
21RYLMN0098	0	5	0	0	5	4	9
21RYLMN0099	0	1	0	0	1	73	74
21RYLMN0117	15	0	0	0	15	3	18
21RYLMN0118	55	0	30	0	85	1	86
21RYLMN0119	0	2	0	0	2	1	3
21RYLMN0133	0	0	0	-72	-72	97	25
21RYLMN0148	0	1	0	0	1	7	8
21RYLMN0158	0	3	0	0	3	0	3
21RYLMN0160	0	0	0	0	0	3	3
22RYLMN0012	0	0	0	0	0	2	2
22RYLMN0027	0	1	0	0	1	0	1
22RYLMN0036	0	5	0	0	5	2	6
22RYLMN0073	0	4	0	0	4	0	4
22RYLMN0154	0	0	0	0	0	0	0
22RYLMN0157	0	3	0	0	3	0	3
22RYLMN0158	0	3	0	0	3	0	3
22RYLMN0164	0	2	0	0	2	0	2
22RYLMN0165	0	1	0	0	1	4	5
22RYLMN0166	0	3	0	0	3	0	3
22RYLMN0169	0	2	0	0	2	0	2
22RYLMN0183	0	1	0	0	1	0	1
23RYLMN0105	0	0	0	0	0	0	0
Total 01/07/2022 - 30/09/2022	694	106	547	4,964	3,617		
Total						16,788	13,171

Redress Payments 01/07/2022 - 30/09/2022						Appendix 2	
Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimbursement £000	Total £000	Previous Write Offs £000	Cumulative £000
16RYLMN0156	0	0	0	-20	-20	22	2
18RYLMN0050	2	0	0	0	2	23	25
19RYLMN0007	0	0	0	-3	-3	5	2
19RYLMN0072	0	0	0	-14	-14	16	2
19RYLMN0109	0	1	0	0	1	5	6
19RYLMN0111	0	0	0	0	0	4	4
19RYLMN0122	0	0	0	-6	-6	8	2
19RYLMN0124	0	0	15	0	15	9	24
20RYLMN0025	2	0	0	0	2	6	7
20RYLMN0161	0	1	0	0	1	0	1
20RYLMN0187	0	1	0	0	1	0	1
21RYLMN0048	0	0	0	0	0	9	9
21RYLMN0053	0	1	0	0	1	0	1
21RYLMN0092	0	0	0	-19	-19	19	0
21RYLMN0108	0	0	0	-5	-5	6	1
21RYLMN0124	0	0	0	-2	-2	4	2
21RYLMN0142	2	0	-0	0	2	2	4
22RYLMN0023	0	0	-0	0	-0	0	0
22RYLMN0087	2	0	0	0	2	5	6
22RYLMN0134	0	0	11	0	11	0	11
22RYLMN0151	0	0	0	-1	-1	1	0
22RYLMN0179	0	0	0	0	0	0	0
22RYLMN0184	0	3	0	0	3	0	3
23RYLMN0018	0	0	1	0	1	0	1
23RYLMN0055	0	0	0	0	0	0	0
23RYLMN0081	0	0	1	0	1	0	1
23RYLMN0091	0	0	1	0	1	0	1
23RYLMN0110	0	0	0	0	0	0	0
Total 01/07/2022 - 30/09/2022	6	7	28	-70	-29		
Total						143	113

GP Indemnity Payments 01/07/2022 - 30/09/2022						Appendix 3	
Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimbursement £000	Total £000	Previous Write Offs £000	Cumulative £000
Total 01/07/2022 - 30/09/2022	0	0	0	0	0		
Total						0	0

Personal Injury Payments 01/07/2022 - 30/09/2022						Appendix 4	
Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimbursement £000	Total £000	Previous Write Offs £000	Cumulative £000
16RYLPI0004	0	20	0	-83	-63	108	45
18RYLPI0007	0	-0	0	-86	-87	112	25
18RYLPI0020	0	5	55	0	60	9	69
18RYLPI0031	0	0	11	0	11	0	11
18RYLPI0034	0	0	0	-2	-2	27	25
18RYLPI0042	0	5	0	0	5	0	5
19RYLPI0004	0	0	0	-1	-1	26	25
19RYLPI0017	2	0	2	0	4	1	5
19RYLPI0030	0	1	0	0	1	0	1
20RYLPI0015	0	2	0	0	2	10	12
20RYLPI0021	3	0	3	0	6	0	6
20RYLPI0022	0	1	0	0	1	0	1
20RYLPI0024	11	1	10	0	22	0	22
20RYLPI0050	0	0	0	0	0	0	0
20RYLPI0061	0	1	0	0	1	0	1
21RYLPI0007	0	2	0	0	2	2	4
21RYLPI0009	0	0	0	0	0	9	9
21RYLPI0011	22	0	0	0	22	8	30
21RYLPI0021	2	0	1	0	3	0	3
21RYLPI0028	7	0	0	0	7	9	16
21RYLPI0029	0	1	0	0	1	1	2
21RYLPI0031	0	1	0	0	1	0	1
21RYLPI0032	0	0	0	0	0	11	11
21RYLPI0034	0	1	0	0	1	5	6
21RYLPI0041	0	0	0	0	0	1	2
22RYLPI0001	0	0	0	0	0	1	1
22RYLPI0002	0	0	0	0	0	1	1
22RYLPI0003	0	1	0	0	1	3	3
22RYLPI0004	5	1	5	0	11	1	12
22RYLPI0007	0	0	0	0	0	1	1
22RYLPI0017	0	0	0	0	0	0	1
22RYLPI0019	0	0	0	0	0	1	1
22RYLPI0022	0	0	0	0	0	0	1
22RYLPI0025	0	0	0	0	0	0	1
22RYLPI0028	0	0	0	0	0	0	1
22RYLPI0029	0	0	0	0	0	0	1
22RYLPI0030	0	1	0	0	1	0	1
22RYLPI0031	0	0	0	0	0	0	1
22RYLPI0033	0	0	0	0	0	3	3
22RYLPI0035	1	3	0	0	4	1	5
22RYLPI0036	0	1	0	0	1	0	1
22RYLPI0037	0	0	0	0	0	0	0
22RYLPI0038	0	0	0	0	0	0	0
22RYLPI0040	0	0	0	0	0	0	0
22RYLPI0041	0	1	0	0	1	0	1
22RYLPI0042	0	0	0	0	0	0	0
22RYLPI0043	0	0	0	0	0	0	0

22RYLPI0044	0	0	0	0	0	0	0
23RYLPI0001	0	0	0	0	0	0	0
23RYLPI0003	0	0	0	0	0	0	0
23RYLPI0004	0	0	0	0	0	0	0
23RYLPI0007	0	0	0	0	0	0	0
23RYLPI0008	0	0	0	0	0	0	0
23RYLPI0010	0	0	0	0	0	0	0
23RYLPI0011	0	0	0	0	0	0	0
23RYLPI0012	0	0	0	0	0	0	0
23RYLPI0013	0	0	0	0	0	0	0
23RYLPI0023	0	12	0	0	12	0	12
Total 01/07/2022 - 30/09/2022	53	67	87	-172	35		
Total						351	386

Permanent Injury Benefit 01/07/2022 - 30/09/2022			
Appendix 5			
Laspar Number	In period Payments £000	Previous Write- Offs £000	Cumulative £000
01RRSPI0020	4	231	234
02RVEPI0001	2	62	64
02RVEPI0003	3	169	171
02RVEPI0004	2	116	117
03RRSPI0020	12	826	838
03RVEPI0028	3	255	258
04RRSPI0009	4	223	227
04RRSPI0024	3	153	157
05RRSPI0020	1	76	77
05RRSPI0021	3	184	187
05RVEPI0033	5	282	287
05RVEPI0034	1	83	84
08RVEPI0009	3	182	185
10RYLPI0070	2	103	105
11RYLPI0065	5	233	238
12RYLPI0059	2	70	71
13RYLPI0020	1	36	37
13RYLPI0050	3	136	139
98RVEPI0005	0	7	7
19RYLPI0022	11	285	296
20RYLPI0032	3	32	34
20RYLPI0033	1	13	15
20RYLPI0034	2	21	23
20RYLPI0035	5	63	69
20RYLPI0036	4	44	47
20RYLPI0037	1	15	16
20RYLPI0038	3	35	39
20RYLPI0039	2	27	29
20RYLPI0040	6	66	72
20RYLPI0041	4	44	48
20RYLPI0042	2	21	23
Total 01/07/2022 - 30/09/2022	103		
Total		4,093	4,196

Other Payments 01/07/2022 - 30/09/2022			Appendix 6
Case Reference	Type	Details	Amount £000
23RYLEM0005	Employment Matter	Employment Matter	18.00
23RYLEM0006	Employment Matter	Employment Matter	17.50
23RYLEM0007	Employment Matter	Employment Matter	20.00
23RYLEM0008	Employment Matter	Employment Matter	97.36
23RYLLC0001	Loss of Cash	HSE Fine	861.00
23RYLMN0081	Ombudsman	Damages	0.60
23RYLMN0091	Ombudsman	Damages	1.20
23RYLMN0110	Ombudsman	Damages	0.10
23RYLEG0099	Ex-Gratia	Loss of Personal Effects	1.10
23RYLEG0124	Ex-Gratia	Loss of Personal Effects	0.90
23RYLEG0125	Ex-Gratia	Loss of Personal Effects	0.29
23RYLEG0152	Ex-Gratia	Loss of Personal Effects	0.08
23RYLEG0153	Ex-Gratia	Loss of Personal Effects	2.57
23RYLEG0154	Ex-Gratia	Loss of Personal Effects	0.25
23RYLEG0155	Ex-Gratia	Damage Compensation	0.27
23RYLEG0126	Ex-Gratia	Retirement Gratuity	0.12
23RYLEG0100	Ex-Gratia	Retirement Gratuity	0.41
23RYLEG0101	Ex-Gratia	Retirement Gratuity	0.40
23RYLEG0102	Ex-Gratia	Retirement Gratuity	0.31
23RYLEG0103	Ex-Gratia	Retirement Gratuity	0.32
23RYLEG0104	Ex-Gratia	Retirement Gratuity	0.26
23RYLEG0105	Ex-Gratia	Retirement Gratuity	0.29
23RYLEG0106	Ex-Gratia	Retirement Gratuity	0.20
23RYLEG0107	Ex-Gratia	Retirement Gratuity	0.26
23RYLEG0108	Ex-Gratia	Retirement Gratuity	0.42
23RYLEG0109	Ex-Gratia	Retirement Gratuity	0.36
23RYLEG0110	Ex-Gratia	Retirement Gratuity	0.21
23RYLEG0111	Ex-Gratia	Retirement Gratuity	0.21
23RYLEG0112	Ex-Gratia	Retirement Gratuity	0.22
23RYLEG0113	Ex-Gratia	Retirement Gratuity	0.42
23RYLEG0114	Ex-Gratia	Retirement Gratuity	0.35
23RYLEG0115	Ex-Gratia	Retirement Gratuity	0.27
23RYLEG0116	Ex-Gratia	Retirement Gratuity	0.47
23RYLEG0117	Ex-Gratia	Retirement Gratuity	0.28
23RYLEG0118	Ex-Gratia	Retirement Gratuity	0.20
23RYLEG0119	Ex-Gratia	Retirement Gratuity	0.35
23RYLEG0120	Ex-Gratia	Retirement Gratuity	0.34
23RYLEG0121	Ex-Gratia	Retirement Gratuity	0.35
23RYLEG0122	Ex-Gratia	Retirement Gratuity	0.20
23RYLEG0123	Ex-Gratia	Retirement Gratuity	0.40
23RYLEG0127	Ex-Gratia	Retirement Gratuity	0.12
23RYLEG0128	Ex-Gratia	Retirement Gratuity	0.30
23RYLEG0129	Ex-Gratia	Retirement Gratuity	0.21
23RYLEG0130	Ex-Gratia	Retirement Gratuity	0.38
23RYLEG0131	Ex-Gratia	Retirement Gratuity	0.23
23RYLEG0132	Ex-Gratia	Retirement Gratuity	0.21
23RYLEG0133	Ex-Gratia	Retirement Gratuity	0.22

23RYLEG0134	Ex-Gratia	Retirement Gratuity	0.39
23RYLEG0135	Ex-Gratia	Retirement Gratuity	0.28
23RYLEG0136	Ex-Gratia	Retirement Gratuity	0.36
23RYLEG0137	Ex-Gratia	Retirement Gratuity	0.31
23RYLEG0138	Ex-Gratia	Retirement Gratuity	0.21
23RYLEG0139	Ex-Gratia	Retirement Gratuity	0.21
23RYLEG0140	Ex-Gratia	Retirement Gratuity	0.33
23RYLEG0141	Ex-Gratia	Retirement Gratuity	0.33
23RYLEG0142	Ex-Gratia	Retirement Gratuity	0.32
23RYLEG0143	Ex-Gratia	Retirement Gratuity	0.33
23RYLEG0144	Ex-Gratia	Retirement Gratuity	0.40
23RYLEG0145	Ex-Gratia	Retirement Gratuity	0.33
23RYLEG0146	Ex-Gratia	Retirement Gratuity	0.32
23RYLEG0147	Ex-Gratia	Retirement Gratuity	0.20
23RYLEG0148	Ex-Gratia	Retirement Gratuity	0.37
23RYLEG0149	Ex-Gratia	Retirement Gratuity	0.21
23RYLEG0150	Ex-Gratia	Retirement Gratuity	0.38
23RYLEG0151	Ex-Gratia	Retirement Gratuity	0.34
23RYLEG0038	Ex-Gratia	Retirement Gratuity	-0.23
23RYLEG0156	Ex-Gratia	Retirement Gratuity	0.31
23RYLEG0157	Ex-Gratia	Retirement Gratuity	0.32
23RYLEG0158	Ex-Gratia	Retirement Gratuity	0.34
23RYLEG0159	Ex-Gratia	Retirement Gratuity	0.22
23RYLEG0160	Ex-Gratia	Retirement Gratuity	0.31
23RYLEG0161	Ex-Gratia	Retirement Gratuity	0.32
23RYLEG0162	Ex-Gratia	Retirement Gratuity	0.31
23RYLEG0163	Ex-Gratia	Retirement Gratuity	0.27
23RYLEG0164	Ex-Gratia	Retirement Gratuity	0.20
23RYLEG0165	Ex-Gratia	Retirement Gratuity	0.40
23RYLEG0166	Ex-Gratia	Retirement Gratuity	0.48
23RYLEG0167	Ex-Gratia	Retirement Gratuity	0.40
23RYLEG0168	Ex-Gratia	Retirement Gratuity	0.40
23RYLEG0169	Ex-Gratia	Retirement Gratuity	0.41
23RYLEG0170	Ex-Gratia	Retirement Gratuity	0.40
23RYLEG0171	Ex-Gratia	Retirement Gratuity	0.34
23RYLEG0172	Ex-Gratia	Retirement Gratuity	0.35
23RYLEG0173	Ex-Gratia	Retirement Gratuity	0.30
23RYLEG0174	Ex-Gratia	Retirement Gratuity	0.42
23RYLEG0175	Ex-Gratia	Retirement Gratuity	0.34
23RYLEG0175	Ex-Gratia	Retirement Gratuity	0.03
23RYLEG0176	Ex-Gratia	Retirement Gratuity	0.27
23RYLEG0177	Ex-Gratia	Retirement Gratuity	0.33
23RYLEG0178	Ex-Gratia	Retirement Gratuity	0.36
23RYLEG0179	Ex-Gratia	Retirement Gratuity	0.25
23RYLEG0180	Ex-Gratia	Retirement Gratuity	0.28
Total 01/07/2022 - 30/09/2022			1044.26



AGENDA ITEM

4.5

AUDIT & RISK COMMITTEE

CONSULTANT JOB PLANNING

Date of meeting	12 December 2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Dr Nerys Conway Assistant Medical Director for Medical Workforce
Presented by	Dr Nerys Conway, Assistant Medical Director, Medical Workforce
Approving Executive Sponsor	Executive Medical Director
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	Date	Outcome
		Choose an item.

ACRONYMS	
ABUHB	Aneurin Bevan University Health Board
ADH	Additional duty hours



AMD	Assistant Medical Director
BMA	British Medical Association
CAVUHB	Cardiff and the Vale University Health Board
CTM	Cwm Taf Morgannwg
DCC	Direct Clinical Care
ILG	Integrated Locality Group
LNC	Local Negotiating Committee
NWSSP	NHS Wales Shared Services Partnership
PTHB	Powys Teaching Health Board
SAS	Specialty & Associate Specialist
SPA	Supporting Professional Activities
UHB	University Health Board

1. **SITUATION/BACKGROUND**

The purpose of this paper is to provide the Audit & Risk Committee with an update on the progress around job planning.

2. **SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING – INTERNAL AUDIT REPORT FINDINGS 1-7**

2.1 Job plan completion and sign-off

- Job planning is a contractual requirement that need to be completed and signed off by Consultant and SAS Doctors.
- Signed-off job plans currently stand at 33% for consultants and SAS doctors.
- During the pandemic, job planning dropped significantly and this figure has increased steadily since the height of the pandemic in 2020-21.
- There have been two management reconfigurations within CTM (ILG and the Care Groups) which has left some confusion amongst the Consultant and SAS workforce regarding who should be responsible for their job planning process. Some Directorates have opted to delay job planning at present until the Care Group structure is embedded. Now the Care Groups have been established the Care Group Medical Directors have a



responsibility to allocate and ensure that the job planning process is being completed appropriately within their Care Group.

- An eJob Planning User guide clearly sets out the responsibilities and process that allows for effective job planning. There is also an SPA document in its final stages of completion to support Consultants through their job planning process.
- One of the work streams for the Medical Workforce Productivity Programme is focused on job planning. This work stream is led by the AMD for Medical Workforce.
- Two job planning workshops have been planned for the New Year, one for CTM Consultants (26th January 2023) and another for CTM SAS Doctors (16th January 2023). These will be led by the AMD for Medical Workforce in collaboration with Christopher Saunders from the BMA. The aim of these will be to engage the workforce around the process of job planning including the benefits to them as individuals and their specialties. It will also be an opportunity to ask the Medical Workforce team specific issues related to job planning

2.2 Weekly number of sessions, activities and outcomes

- Development of a SPA policy document was required to standardise the approach across the UHB for SPA and DCC split, to ensure fairness and equity.
- The final submission has taken place and it is expected to be approved for distribution to the Medical Consultant workforce following the LNC meeting in December 2022.

2.3 Clear personal outcomes within the job plan

- As part of the job planning training, clear personal outcomes will be factored into the process and are now recorded in new job plans. The training that has been rolled out across the UHB has covered this area. The job plans have clear outcomes regarding the site where the activity is to be undertaken, the type and duration of activity, and clarity around whether the activity constitutes a DCC or a SPA.
- However, further work is needed to quantify the specific amount of the clinical activity that is expected from the specified duration of the DCC.
- The new SPA document deals with ways of seeking objective evidence of the activity undertaken as an SPA.

2.4 Additional Duty Hours (ADH)

- The "Patchwork" Medic bank was launched in October 2021 initially in the former Bridgend ILG without a rate card, but with the software solution Patchwork in place to manage the ADH booking and approvals.
- All areas across CTM have now adopted the use of Patchwork and it is used for all ADH payments.
- What this provides the Health Board with is the ability to see in real time what rates are being paid for ADHs in every area.
- There is work currently taking place looking at a regional rate card in collaboration with CTM, ABUHB, CAVUHB, HDUHB, and PTHB. This work is

being led by NWSSP. Of note there has been a recent rate card released by the BMA in Wales and England.

- One of the work streams for the Medical Workforce Productivity Programmes is also focusing on ADH rates.
- Analysis of the Patchwork data is not as clear as initially hoped. In certain contentious areas we have set the specialty across all 3 sites (along with former ILG directors) to agree a specialty agreed rate (that is fair but also affordable by the Health Board). This is based upon Patchwork data.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 None.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Correct and current job plans allows for better planning around staff levels and DCC sessions. This has a direct impact on quality, safety and experience.
Related Health and Care standard(s)	Staff and Resources
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below)
	If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not required
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Committee are requested to **NOTE** the report and the update provided.



AGENDA ITEM

4.6

AUDIT & RISK COMMITTEE

MEDICAL ROSTERING

Date of meeting

12/12/2022

FOI Status

Open/Public

If closed please indicate reason

Not Applicable - Public Report

Prepared by

Paul Harrison, Head of Workforce Productivity and eSystems.

Presented by

Dr Nerys Conway, Assistant Medical Director, Medical Workforce

Approving Executive Sponsor

Executive Medical Director

Report purpose

FOR NOTING

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

Committee/Group/Individuals

Date

Outcome

(Insert Name)

(DD/MM/YYYY)

Choose an item.

ACRONYMS

AMD	Assistant Medical Director
BMA	British Medical Association
ED	Emergency Department
MD	Medical Director
MWSG	Medical Workforce Sustainability Group

1. SITUATION/BACKGROUND

- 1.1 The purpose of this paper is to give the committee an update on the progress achieved in relation to the audit report on Medical Rostering.

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

2.1 Recommendation 1.1

Responsible person: Assistant Medical Director (AMD) for Workforce

"The Health Board should determine its long-term objective in the use of Health Roster for Medical and Dental staff to generate rosters and achieve the potential efficiencies the system will generate.

If there is to be roll out of the rostering module, work should be carried out to determine those areas that are already expressing an interest in using this module. A new project plan should be developed with achievable timeframes and appropriate resources to support the roll out."

Update - Complete

All areas using Health Roster have been through a programme of training, with a recorded attendance, showcasing the system capabilities and how to use it. This does not include the areas in ACT and ED.

2.2 Recommendation 3.1

Responsible person: AMD for Workforce

"The draft Medics Rostering Policy should be further reviewed to remove any legacy references to the Nursing Rostering Policy. Feedback should then be sought from the appropriate groups and approval obtained from the appropriate committee ahead of making the policy available to all relevant staff."

Update – In progress

The Medical Workforce Sustainability Group (MWSG) has not met since the policy was completed. The MWSG has now been disbanded as a formal group, which was the agreed route for medical policies to follow for ratification.

The policy will now go through the Policy Review Group, and then progress to the Local Negotiating Committee (LNC) for noting.

2.3 Recommendation 3.2

Responsible person: Anaesthetics & Emergency Department (ED) roster managers

"For areas where the full roll out of Health Roster is not imminent, separate 'how to' guides on the local system used should be considered. The guides should include the step-by-step process for creating the rosters and also guides for users of the system, allowing consistency during unexpected periods of absence."

Update – In progress

How to guides are yet to be developed or shared by Anaesthetics or Emergency Department (ED) colleagues.

2.4 Recommendation 4.1

Responsible person: Executive Medical Director (MD)

"Management should ensure that the Study Leave policy is approved and circulated within the Health Board."

Update – In progress

The MD is in active talks with the BMA to come to solution to the differences in study leave entitlements.

The former Cwm Taf policy and the Swansea Bay policy have some fundamental differences that ideally need to be harmonised across the whole of Cwm Taf Morgannwg University Health Board.

This is not in the gift of the Health Board to do unilaterally, it needs to be agreed in partnership.

2.5 Recommendation 5.1

Responsible person: Integrated Locality Group Directors

"As the Health Board makes progress in increasing the job planning compliance rates, management need to ensure that rosters align to the updated job plans, including ensuring SPA and DCC sessions align to the agreed job plans."

Update - Complete

Training has been offered to all areas on job planning and relating it to activity on rosters. A general guide for job planning has also been issued and is available to all staff to access.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

- 3.1 There is a risk the BMA will not accept any changes to the Study leave policy for former Swansea Bay employees, if it is detrimental to offer in comparison to the current policy.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care	Staff and Resources



standard(s)	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below)
	If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below.
	If no, please provide reasons why an EIA was not considered to be required in the box below.
Legal implications / impact	Not a policy
	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	
	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

- 5.1 The Committee are requested to **NOTE** the report and the update provided.



AGENDA ITEM

5.1

AUDIT & RISK COMMITTEE

ORGANISATIONAL RISK REGISTER

Date of meeting

12th December 2022

FOI Status

Open

If closed please indicate reason

Not applicable – Public Meeting

Prepared by

Cally Hamblyn, Assistant Director of Governance & Risk

Presented by

Cally Hamblyn, Assistant Director of Governance & Risk

Approving Executive Sponsor

Chief Executive

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

October 2022

RISKS REVIEWED

Executive Leadership Group

7th November 2022

RISKS REVIEWED AND MANAGEMENT SIGN OFF RECEIVED

Quality & Safety Committee (Assigned risks only)

15th November 2022

RISKS REVIEWED

ACRONYMS

1. SITUATION/BACKGROUND

- 1.1 The purpose of this report is for the Audit & Risk Committee to review and discuss the organisational risk register and consider whether the risks escalated to the Organisational Risk Register are in accordance with the Risk Management Strategy.

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

- 2.1 The risk updates for this period has been impacted by the implementation of the new Care Group Model. The Executive Leadership Group supported "Guiding Principles: Quality Governance & Accountability during the Operating Model Transition" where the following transitional arrangements have been agreed:

- **Organisational Risk Register:** Workshop approach to realign risks on the Organisational Risk Register led by Nurse Directors. Timeframe: Workshop Sept/Oct 22. Realignment to complete by 31.1.2023.
- Central Quality Governance Team to provide a report to Care Groups which will contain all **Datix Legacy Information** for Risk, Incidents, Claims, Complaints etc. The Nurse Directors to then undertake an exercise to align activity/data to Care Group Model – Timeframe for alignment 31.1.2023.

The Assistant Director of Governance & Risk, along with the Chief Operating Officer and/or Deputy Chief Operating Officers, has started to meet with Care Groups during October and November to review risks in terms of alignment to the new Care Group Model. The Organisational Risk Register will continue to be updated to reflect the changes being made as a result of this activity.

- 2.2 The following progress has been made since the last report:
- Monthly Risk Management Awareness Sessions (Virtually via Teams). The monthly sessions are set in the calendar until the end of 2022 and will continue beyond that date if required. 344 members of staff trained to date.
 - Risks on the organisational risk register have been updated as indicated in **red**.

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 NEW RISKS

Quality Governance: Concerns and Claims

- Datix ID 5254 – Failure to manage redress cases efficiently and effectively in respect of the Duty of Candour. Risk scored as a 20.

Patient, Care and Safety Function - Nursing

- Datix ID 5267 - There is a risk to the delivery of quality patient care due to difficulty recruiting & retaining sufficient numbers of nurses. Risk scored as 16.

Digital & Data

- Datix ID 5276 - Failure to deliver replacement Laboratory Information Management System, LINC Programme, by summer 2025. Risk rated as a 20.

3.2 CHANGES TO RISKS

a) Risks where the risk rating INCREASED during the period

Health, Safety & Fire

- Datix ID 4780 – Patient Handling Training Risk Score increased from a 16 to a 20.

Quality Governance (Compliance)

- Datix ID 4922 – Covid-19 Inquiry Preparedness - Information Management, Risk Score increased from a 16 to a 20.

b) Risks where the risk rating DECREASED during the period

Health, Safety & Fire

- Datix ID 4356 – Overdue Fire Risk Assessments. Risk Score decreased from a 20 to a 16.

3.3 CLOSED RISKS FROM THE ORGANISATIONAL RISK REGISTER

Patient, Care and Safety Function - Nursing

- Datix ID 4106 - Increasing dependency on agency staff cover which impacts on continuity of care, patient safety.
- Datix ID 4157 - There is a risk to the delivery of high quality patient care due to the difficulty in recruiting and retaining sufficient numbers of registered nurses and midwives.

Rationale for closure and/or removal from the Risk Register is captured in Appendix 1.

3.4 DISCUSSION POINTS

3.4.1 Emerging Risks

The Assistant Director of Governance & Risk has been made aware of the following emerging risks in the service that are likely to be escalated to a future Organisational Risk Register return:

Central Support Functions:

- **Population Health** - Permanency of service critical staff to support the Covid-19 Vaccination Programme
- **Medical Directorate** - Escalation of a risk relating to Clinical Policies.
- **Digital & Data** - MS Sustainability, Unsupported server operating systems, Safe transition from paper to digital record.

Care Groups

- **Unscheduled Care Group:**
 - Lack of funding for priority winter schemes within 2022-23 winter plan
 - Non-resilient NIV Pathway
 - Lack of acute frailty assessment services/pathways
 - Lack of resilience of vascular pathway
 - Absence of D2RA Model and pathways.
- **Diagnostics, Therapies and Specialties**
 - A review of the current overarching Pathology risk as well as other emerging risks in this area including significant concerns around mortuary capacity.
 - Radiology risks.
- **Primary Care and Community** - GMS Sustainability

3.4.2 Updates Received since the Executibe Leadership Group

Since the Executive Leadership Group reviewed the Organisational Risk Register at its meeting on the 7th November 2022, updates have been received from the Digital & Data Function which have been captured in this update.

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

Consequence	5			4253 3337 4768 4772 2987 3993	5254 4080 3826 4664 4887 5214	
	4				4149 4458 4148 4337 3008 4743 4798 4906 4908 4809 5014 4722 4753 4356	4152 3585 3133 2787 1133 4752 4679 4922 4479 4940 4315 4417 5267
						4491 4632 4071 4721 4103 4841 4827 5153 5154 5036 4907 4780 4922 5276
	3					3638 4691 4732 4920 5207 4971
						4672 4671 4512 4590 4691 2808



						4699	5040 4217
	2						
	1						
CxL	1	2	3	4	5	Likelihood	

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Governance, Leadership and Accountability If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If no, please provide reasons why an EIA was not considered to be required in the box below. Not applicable for the Risk Register item.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

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.

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
5276	Director of Digital	Central Function - Digital and Data	Assistant director of therapies and health science	Sustaining Our Future	Business Objectives - Operational Patient safety Digital Healthcare Wales interdependencies	Failure to deliver replacement Laboratory Information Management System, LINC Programme, by summer 2025,	IF: LINC Programme fails to deliver replacement Laboratory Information Management System (LIMS) by summer 2025 THEN: CTM would be without a supported Pathology LIMS system RESULTING IN: Without the implementation of the new LIMS system the pathology service may fail to produce accurate, timely patient results for diagnosis, monitoring and screening of patients which would impact treatment, patient flow and waiting times.	Currently LINC Programme reports progress against timeline to LINC Programme Board and Chief Executive Group.	As the NHS Wales Health Collaborative becomes part of the NHS Executive it has been agreed that the LINC Programme will move to Digital Health Care Wales	Digital & Data Committee Quality & Safety Committee	20	C4xL5	8 (C4xL2)	New Risk Escalated October 2022	26.10.2022	26.10.2022	26.11.2022
5254	Director of Corporate Governance	Centre Support Function - Quality Governance - Concerns and Claims	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Failure to manage Redress cases efficiently and effectively in respect of Duty of Candour	IF: The Health Board is unable to meet the increased work demand in respect of the implementation of Duty of Candour Then: the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. Resulting in: Risk to quality and safety of patient care, resulting from poor management of cases. Financial impact to the Health Board from Redress cases which have been poorly managed and consequently proceed to claim.	Controls are in place and include: * New incident framework developed * Engagement with the All Wales Duty of Candour Network to discuss implementation of the Duty * Reports run on predicted case numbers * Request to the All Wales Duty of Candour Network that an impact assessment is undertaken	October 2022: Invest to save bid has been developed and submitted, which requests 2 Redress Handlers, this should give some capacity, however focus will be on addressing the current backlog. Some resource has been identified through the operating model, which should give some capacity within the current legal service. Impact assessment being undertaken to assess resources needed to manage expected workload when Duty is introduced. Board Development session being arranged to raise awareness of accountabilities of Board in compliance with the Duty of Candour and Duty of Quality (Oct 2022) where local implications will be shared.	Quality & Safety Committee	20	C4xL5	8 (C4xL2)	New Risk Escalated October 2022	07.10.2022	07.10.2022	07.12.2022
4922	Director of Corporate Governance	Central Support Function - Quality Governance (Compliance)	Assistant Director of Governance & Risk	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Covid-19 Inquiry Preparedness - Information Management	IF: The Health Board doesn't prepare appropriately for the Covid-19 enquiry THEN: the organisation will not be able to respond to any requests for info RESULTING IN: poor outcomes in relation to lessons learnt; supporting staff-wellbeing and reputational issues.	The Covid-19 Inquiry Working Group are monitoring a number of preparedness risks such as: - Retention and Storage of information, emails and communication - Capturing reflections of key decision makers prior to any departure from the Health Board - Organisational Member. The Health Board has a Covid-19 Inquiry CTM Preparedness Plan which is monitored via the Covid-19 Inquiry Working Group. The Board and Quality & Safety Committee received a detailed update on the preparedness progress at their respective meetings in March 2022 and September 2022.	Establish a Timeline for CTMUHB - the timeline will have a few elements and uses and will continue to evolve as information is archived. This Timeline does not include the Health Board Information as this requires the archiving of documents in order to populate it. Archiving Information against the Timeline is yet to commence as the current Covid-19 Information Manager resigned from the role and left the Health Board at the end of August. Recruitment for a successor to the role was unsuccessful and therefore the pace of progress in developing the Health Boards Timeline and gathering key documentation centrally is being significantly impacted which could be detrimental to the Health Board being able to efficiently and effectively respond to requests from the Inquiry. The AD for Governance & Risk is exploring other options for resourcing this role including project management support. Following a briefing meeting with Legal Counsel it was clear that the Health Boards focus should be on the timeline and documentary evidence at this stage which has heightened the risk in terms of the resource afforded to the preparedness for the inquiry. Legal Counsel advised the Health Board to pause the introduction of the All Wales Reflection document at this stage of the Inquiry. At the Covid-19 Pandemic Inquiry Working Group on the 11th October the likelihood of this risk was increased from a 4 to a 5 based on the above risk factors.	Quality & Safety Committee	20 ↑ 16	C4xL5	8 (C4xL2)	↑ Increased from a 16 to a 20 in October 2022	23.11.2021	11.10.2022	30.11.2022
4780	Executive Director for People	Central Support Function -Health, Safety & Fire	Head of Health, Safety & Fire	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm & Statutory Duty / Legislation	Patient Handling Training	If there are no Trainers available to provide patient handling training Then all new starters need to be on restricted duties. Organisational compliance is affected. Training response to Incidents such as W156305 cannot be achieved. Manual Handling Training staff resource is not sufficient for new HB. Current establishment of two Trainers to approx. 7000 patient handling staff makes compliance with regulatory requirements unachievable. Resulting in breach of Health & Safety Law, particularly MHOR 1992, LOLER 1998, PUWER 1998, H&S at Work Act. Non-compliance with Organisational mandatory training requirements. Enforcement action from the HSE.	Two Band 3 Training Assistants continue to deliver Inanimate Load Handling Training so staff groups such as Admin & Clerical are not at risk. The current Training Post for Bridgend is vacant, new Trainer commencing employment 31st August 2021. Trainer in post at Tonteg is on LTS (Long Covid). Manual Handling Advisor picking up training where possible which is impacting on their ability to function within their role.	Mitigating action is to increase the establishment within the Manual Handling Team by at least one extra Trainer, one extra Assistant and another Risk and Safety Officer. As at 03/05/2002. - Currently the Health Board does not have additional monies to support these posts. To review later in the year to see if improvements in the financial forecast have improved. Review position: 31.8.2022. Update August 2022 - Following recent discussions with the Director for People, an updated business case will be submitted to the Strategic Leadership Group to address additional resources. Review set for the 30.09.2022. Update October 2022 - Risk score escalated in October due to the increased training required by new starters, bank staff and overseas nurses.	Health Safety & Fire Sub Committee	20 ↑ 16	C4 x L5	4 C2xL2	↑ Increased from a 16 to a 20 in October 2022	06.08.2021	29.09.2022	30.11.2022
5214	Executive Medical Director / Chief Operating Officer	Planned Care Group	Care Group Medical Director	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Critical Care Medical Cover	IF: Depleted Consultant Intensivist numbers at Princes Of Wales (POW) continue as a result of medical reasons, retirement and unable to recruit to vacant posts. No Middle Grade medical tier at POW. Consultant intensivist delivered service. Then: Without Middle Grade tier positions the ability to attract and recruit Consultants will be limited. Resulting in: the Health Board being unable to deliver safe patient care with gaps in rota. Potential for days and nights to not be consultant covered. No medical team to manage patients.	Daily management of the rota. Use of agency to cover gaps. CTM internal cover (limited options). Development of CTM strategy for Critical Care.	Workforce business proposal to fund Middle Grade tier to ELG. Digital solution to provide safe cross site Consultant cover for RGH and POW, requires IT solution across POW and RGH. Develop workforce modelling for next 2 years and 10 years. Appoint Critical Care lead across CTM to establish one department - 3 sites approach (Care Group organisational change).	Quality & Safety Committee People & Culture Committee	20	C5xL4	10 (C5xL2)	↔	19.8.2022	19.8.2022	20.09.2022
4887	Director for Digital	Central Support - Digital & Data Function	Medical Records Manager	Improving Care	Service / Business Interruption		IF: The Medical Records Filing library at Princess of Wales is full to capacity making it very difficult for staff to retrieve and or file case notes. THEN: Risk of unable to manoeuvre mobile racking, therefore unable to access case notes Risk of fire as case notes close to source of ignition Risk of Fire Service or HSE closing access department Very High risk of upper limb injury Risk of notes falling from height causing injury (some case notes are in excess 8.3kg) Risk of Fire Service or HSE closing access to department RESULTING IN: If we could not retrieve any case notes, Consultants would be unable to make clinical decisions impacting on patient care. If the whole library was affected, this would impact 100 of thousands of patients care. Admissions/Outpatients would have to be cancelled staff refusing to continue to work in unsafe environment. Multiple and serious injuries to staff, possibly death.	(The case notes are very tightly packed on shelves. Mobile racking is falling due to age, lack of maintenance, and weight Case notes are being stored inappropriately on floors under desks, and insecurely at height. The working environment is congested, with no dedicated storage space for large ladders. Significant force is required to retrieve each file (123.N - this is 3 times higher than what is considered to be high force).) Broken Racking at Bridgend Offsite Stores - Repairs have been carried out with damaged racking in Bridgend North Rd Offsite stores. Temporary use of container deployed on site. Broken Racking at POW - On each occasion the racking has failed, the engineer has been able to repair it (£500 + VAT) but it continues to fail. Please see progress notes for more information. Access to this specific racking is permitted to Supervisors only, who only access it once a day. The Filing Library is closed to non-Medical Records staff, aside from the Porters who require access for emergency OOH admissions. Task and Finish group establish to address the above risks. Capacity has been identified at Glanrhyd and noticed served to SBUHB to vacate. It is hoped that we will be able to relocate notes to this area in mid-July, which will address the immediate H&S issues. Currently waiting for procurement process to be completed.	Relocation of Case Notes from POW/Bridgend Off-site Store to Glanrhyd Site. Timeframe 19.8.2022 Replace racking and review office environment of POW filing Library. Timeframe 30.01.2023 Creating additional long term storage space. Update 31.10.2022 - Approx. 30,000 records have already been redistributed across POW, North Road Offsite Store and Glanrhyd Library, to improve conditions at POW. Work is still ongoing at POW to redistribute records safely. Original broken rack mostly vacated but other racks holding notes have similar issues. Glanrhyd partly vacated by SBUHB but not fully available for use yet. The Medical Records Department plan to relocate 10 Registration Medical Records staff to the Library Offices in this space. Proposal put forward by an Operational Services Manager to relocate additional 17 Appointment Booking Centre staff into these same offices and also the Library area. This Library space is already identified for boxed records, compromising room for future growth and safer storage; this will affect the ongoing position at POW and North Road. Risk to be reviewed in 6/52, when SBUHB should have fully vacated and a decision made as to who/what will occupy remaining space at Glanrhyd Library.	Digital & Data Committee & Quality & Safety Committee	20	C5xL4	10 C5xL2	↔	27.10.2021	31.10.2022	12.12.2022

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4827	Executive Director for People	Central Support - Health, Safety & Fire Safety Function	Head of Health, Safety & Fire	Improving Care	Patient / Staff /Public Safety	Lack of Lead for Face Fit Training along with Face Fit Trainers	If the organisation fails to appoint and provide a fully qualified face fit testing lead and suitable number of Face Fit Testers. Then there is a potential for staff to be exposed to airborne viruses eg Covid, flu, etc; Resulting in lack of assurance that the risk is being adequately managed at a local and Board level further resulting in a high risk of prosecution by the Health and Safety Executive.	Departmental Trainers have been trained but not in the numbers required by the organisation. Many of those trained during the first phase has now returned to substantive posts and are unable to undertake this role. Also may now be out of compliance for annual review of practice. Single H&S Coordinator is taking up this role on a part-time basis but this is inadequate for the requirements due to the commitments of his substantive post and the demands/size of the organisation. Departmental trainers are in post across the organisation but not all are able to fulfil this role either due to returning to busy substantive roles or being out of compliance of their annual review. Despite posts being added to Trac, it has become apparent that there is no funding available in the UHB to support this work. Discussions are underway between the Director for People and the Deputy Director of Nursing. No clear plan available to address this risk currently.	SBAR completed outlining the requirements regarding Fit Testing. As at 3.5.2022 it has been confirmed that there is no funding available and it has been added to the Health Board's priority list. Further update is awaited from the Strategic Leadership Team. Update June 2022 - 23/06/2022 - No further update from the Senior Leadership Team and this risk is now increasing due to the current risk in the UK from Monkeypox. Update August 2022- : Discussions to take place between the Director for People and Deputy Director of Nursing due to the continued requests for this training. Meeting to be arranged ASAP. Review date 30.09.2022. Update October 2022: Meeting took place in September 2022 with Deputy Director of Nursing and ILG Nurse Directors to review the possibility of staff being nominated to undertake qualitative (bitter/sweet) fit testing in each ILG area. H&S Team have committed to providing courses to ensure these fit testers are competent. Further meeting to be arranged to confirm arrangements. Review 30.11.2022.	Health Safety & Fire Sub Committee	20	C4xL5	9 C3xL3	↔	01.02.2021	1.11.2022	30.11.2022
4491	Chief Operating Officer	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety	Failure to meet the demand for patient care at all points of the patient journey	IF: The Health Board is unable to meet the demand upon its services at all stages of the patient journey. Then: the Health Board's ability to provide high quality care will be reduced. Resulting in: Potential avoidable harm to patients	Controls are in place and include: • Technical list management processes as follows: - Speciality specific plans are in place to ensure patients requiring clinical review are assessed. - All patients identified will be clinically reviewed which will include an assessment of avoidable harm which will be reported and acted upon accordingly. - A process has been implemented to ensure no new sub specialty codes can be added to an unreported list, this will be refined over the coming months. - All unreported lists that appear to require reporting have been added to the RTT reported lists - All unreported lists that are to remain unreported (as they do not form part of the RTT criteria) are being reviewed and will be visible and monitored going forward. • Patients prioritised on clinical need using nationally defined categories • Demand and Capacity Planning being refined in the UHB to assist with longer term planning. • Outsourcing is a fundamental part of the Health Board's plan going forward. • The Health Board will continue to work towards improved capacity for Day Surgery and 23:59 case load. • A Harm Review process is being piloted within Ophthalmology – it will be rolled out to other areas. • The Health Board has taken advice from outside agencies especially the DU when the potential for improvement is found. • Appropriate monitoring at ILG and Health Board levels via scheduled and formal performance meetings with additional audits undertaken when areas of concern are identified Planned Care board established. The Health Board is exploring working with neighbouring HBs in order to utilise their estate for operating.	The Health Board has established a Planned Care Board, with a full programme of work to address FUNB, demand and capacity and a recovery programme which will include cancer patients; The plans have timescales – which are being monitored, however it is likely that it will take time to reduce waiting times to acceptable levels in the post-covid-19 environment. The PCH Improvement Programme has significantly accelerated a number of mitigating actions designed to improve flow, reduce risk and improve the quality of care in the unscheduled care pathway. Updates on this are provided through the Quality & Safety Committee including specific actions and measures. There is also a PCH Improvement Board that meets monthly with the COO as the SRO. The Health Board is centralising the operational management and decision making around all elective services with the clear aim of increasing and protecting elective activity as we deal with the pressures of the Covid-19 pandemic and winter. This process commenced in late October 2021 and greater clarity will be provided in the next review. The IMTP process will drive the development and prioritisation of these plans ahead of implementation in 2022-2023.Additionally as part of the IMTP Process we will be able to complete robust capacity and demand planning for all surgical specialities for the first time, this will allow us to fully understand our likely trajectory for recovery during 2022-2023 and beyond. Update July 2022 - Risk scoring unchanged. Revised Improvement trajectories for each specialty now in place updated via the Planned Care Recovery Programme Board. The Health Board is working with Cardiff and Vale University Health Board and Swansea Bay University Health Board to support recovery actions in high risk specialities. Update September 2022 - Continue delivery of the Planned Care Recovery Actions. Reconfiguration orthopaedic inpatient operation. Commissioning the insourcing of the workforce to deliver to Theatres. Amalgamation of Health Board wide capacity plans. Significant work ongoing in relation to FUNB which is being captured in the performance reports. Update October 2022 – Procurement exercise commenced 20 Oct 22 re the insourcing of the workforce to deliver to Theatres. Recruitment to theatres transformation role from 28 Oct 22. Amalgamation of Health Board wide capacity plans. Significant work continuing in relation to FUNB which is being captured in the performance reports.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4xL5	12 C4 x L3	↔	11.01.2021	28.10.2022	30.11.2022
5153	Executive Director of Finance & Procurement	Central Support Function - Finance	Deputy Director of Finance	Sustaining Our Future	Financial Stability Risk	Failure to achieve financial balance in 2022/23.	IF: The Health Board is not able to plan and deliver changes which enable current run rates of expenditure to align with the available funding for 2022/23 (including funding for Covid response costs and Exceptional Items) . Then: The Health Board will not be able to deliver a break-even financial position for 2022/23. Resulting in: Potential deficit in 2022/23 leading to potential short term unsustainable cost reductions with associated risks, qualification of the accounts and potential Welsh Government regulatory action. The context is that the draft financial plan for 22/23, submitted to WG at the end of April, has three elements : A core plan which has a planned deficit of £26.5m, excluding Ongoing Covid response costs of £32.3m and Exceptional Items of £19.0m. Assumed non-recurring funding for the Covid and Exceptional costs has yet to be confirmed by WG. Delivery of the Core plan is also predicated on a the delivery of efficiency savings of £17.3m which is a significant step up in savings compared to recent years.	Developing the Health Board's understanding and use of Value Based Healthcare principles to drive service planning and improvement going forward. Developing a more project and programmatic approach to planning and delivery of efficiency savings schemes, with focus on pipeline schemes as well as schemes in delivery. Including the development and implementation of the CTM Improvement Plans. Developing the Value & Efficiency Programme with a focus on 'Enabling schemes' to support savings identification and delivery. Routine monitoring arrangements in place. Regular reporting to Management Board and Planning, Performance & Finance Committee and Board.	Further discussions needed with Welsh Government to understand the likely funding position for 22/23. Update September 2022 Further discussions needed with Welsh Government to understand the likely funding position for 22/23 in relation to the Core plan deficit, Exceptional items and ongoing Covid response costs. Update 24.10.2022 - Position remains as reported for September 2022. No change to risk score.	Planning, Performance & Finance Committee	20	C4 x L5	12 C4 x L3	↔	8.7.22	24.10.2022	30.11.2022
5154	Executive Director of Finance & Procurement	Central Support Function - Finance	Deputy Director of Finance	Sustaining Our Future	Financial Stability Risk	Failure to reduce the planned recurrent deficit of £28.0m at the end of 2022/23.	IF: The Health Board is not able to plan changes which enable current run rates of expenditure to align with the expected available funding for 2023/24. Then: The Health Board will not be able to develop a break-even financial plan for 2023/24 and deliver it . Resulting in: Potential deficit in 2023/24 leading to potential short term unsustainable cost reductions with associated risks, qualification of the accounts and potential Welsh Government regulatory action.	Developing the Health Board's understanding and use of Value Based Healthcare principles to drive service planning and improvement going forward. Developing a more project and programmatic approach to planning and delivery of efficiency savings schemes, with focus on pipeline schemes as well as schemes in delivery. Including the development and implementation of the CTM Improvement Plans. Developing the Value & Efficiency Programme with a focus on 'Enabling schemes' to support savings identification and delivery. Routine monitoring arrangements in place. Regular reporting to Management Board and Planning, Performance & Finance Committee and Board.	Update October 2022 - The M6 YTD position is a £14.6m deficit. This represents a £1.4m adverse variance compared to 6/12th of the £26.5m Core plan deficit. The M6 Savings position is forecasting £17.5m of Savings in 22/23 but only £10.4m on a Recurrent basis. (Savings target for 22/23 = £17.3m). The forecast underlying recurrent deficit at 31/3/23 is now £34.9m. This position represents a £6.9m deterioration from the planned recurrent deficit of £28.0m and is due to the forecast shortfall in recurrent savings delivery in 22/23. Further develop the savings planning processes via the Value and Efficiency programme. Further discussions needed with Welsh Government to understand the likely funding position for 22/23 in relation to the Core plan deficit, Exceptional items and ongoing Covid response costs.	Planning, Performance & Finance Committee	20	C4 x L5	12 C4 x L3	↔	8.7.22	24.10.2022	30.11.2022
4071	Chief Operating Officer All Integrated Locality Groups Linked to RTE 5039 / 4513	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety	Failure to sustain services as currently configured to meet cancer targets.	IF: The Health Board fails to sustain services as currently configured to meet cancer targets. Then: The Health Boards ability to provide safe high quality care will be reduced. Resulting in: Compromised safety of patients, potential avoidable harm due to waiting time delays for treatment.	• Tight management processes to manage individual cases on the cancer Pathway. • Regular reviews of patients who are paused on the pathway as a result of diagnostics or treatment not being available. To ensure patients receive care as soon as it becomes available. • Regular Quality impact assessments with the MDTs, to understand areas of challenge and risk • Harm review process to identify patients with waits of over 104 days and potential pathway improvements. • Initiatives to protect surgical capacity at the Vale hospital for ASA 1+2 level patients until alternatives become available. • All three ILGs are working to maximising access to ASA level 3+4 surgery on the acute sites. • HB working to ensure haematological SACT delivery capacity is maintained. • Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies. • Considerable work around recommencing endoscopy and other diagnostic services whilst also finding suitable alternatives for impacted diagnostics. • Alternative arrangements for MDT and clinics, utilising Virtual options Cancer performance is monitored through the more rigorous monthly performance review process. each ILG now reports actions against an agreed improvement trajectory. Weekly monitoring led by the Chief Operating Officer to monitor progress. Pathology backlog clearance plan funded and in delivery.	Continue close monitoring of each patient on the pathway to ensure rapid flow of patients through the pathway. Active management of the diagnostic backlog (including endoscopy) and exploration of all options to reduce this. Comprehensive planning for repatriation of theatre and haematology services for when private provision is lost. This also needs to consider options for continuation during a potential second surge. These actions are ongoing and assigned to the EDO, DPC&MH and Medical Director. The Cancer Business Unit remain fully involved in the processes to improve care and that at present they are awaiting feedback from ILGs on their plans for restarting elective and other activity and their demand and capacity assumptions. There was a refocus on this risk post Covid-19 impact and there has been a consistently improving position from February to July. During July there was a slight deterioration which is being addressed and actioned. Each ILG has returned a Cancer Recovery Plan to facilitate monitoring by the COO. This remains ongoing with individual issues addressed as they arise. An Operating Framework has been developed with a tightened Performance Management framework which will be monitored by the COO. Update March 2022, the enhanced monitoring process continues with progress being made in all specialities. There is a lag between the increase in activity which is being evidenced and the impact on the Suspected Cancer Pathway (SCP) which results in overall performance still being depressed. Improvement activity in outpatients and diagnostics is in place and being closely monitored. There is an unmitigated risk within the breast cancer specialty where are RTE ILG continue to develop an improvement plan, however, it is worth highlighting the constrained nature of breast cancer capacity across Wales. Update June 2022 - Score unchanged. Recovery trajectories and associated actions in place for each tumour site to address long waiting times and to improve overall performance against the 62 day standard. In addition there is weekly monitoring led by the Chief Operating Officer to monitor progress. Pathology backlog clearance plan funded and in delivery. Update September 2022 - Score remains unchanged. Recovery actions continue with focus on Urology and Lower GI. Improvements are being recognised in Gynae and Breast Surgery which are currently ahead of plan. Cancer treatments remain higher than pre-Covid levels. Update October 2022 - Score remains unchanged. New Cancer Assurance cycle from November 2022. Recovery actions continue with focus on Urology, Lower GI and Dermatology. Improvements are being recognised in Gynae and Breast Surgery which remain in line with plan. Cancer treatments continue to be higher than pre-Covid levels.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4 x L5	12 (C4 x L3)	↔	01/04/2014	28.10.2022	30.11.2022

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
4080	Executive Medical Director Executive Director of People	Central Support Function - Medical Directorate & People Directorate	Assistant Medical Director	Improving Care	Patient / Staff /Public Safety	Failure to recruit sufficient medical and dental staff	If: the CTMUHB fails to recruit sufficient medical and dental staff. Then: the CTMUHB's ability to provide high quality care may be reduced. Resulting in: a reliance on agency staff, disrupting the continuity of care for patients and potentially affecting team communication. This may effect patient safety and patient experience. It also can impact on staff wellbeing and staff experience.	- Associate Medical Director for workforce appointed July 2020 - Recruitment strategy for CTMUHB being drafted - Explore substantive appointments of staff undertaking locum work in CTMUHB - Feedback poor performance and concerns to agencies - Development of 'medical bank' - Developing and supporting other roles including physicians' associates, ANPs	The response to Covid-19 has impacted the original timeframes for these actions due to the requirement to focus on clinical operational service delivery during the pandemic. Revised dates have been included below: 1. AMD and workforce to develop recruitment strategy - 31.3.2021 Update October 2021: The Health Board is in the process of introducing patchwork across Merthyr & Cynon ILG on 6th October and Rhondda Taf Ely on 20th October. This will give an indication of the gaps and the spend, allowing the ILG's to establish a medical recruitment strategy. 2. AMD and DMD to develop retention and engagement strategy - 31.3.2021 – Revised Date February 2022. 3. Reduce agency spend throughout CTMUHB – Update January 2022 - Patchwork rolled out across CTM. Data gathering currently. When sufficient data will have the discussions with HR and clinicians on a fair and appropriate rate card. Update July 2022: Patchwork has been introduced and the data is being used to identify gaps which will support the basis of a business case for additional recruitment aligned to the medical productivity work. 4) Task and Finish group to look into conversion of ADHs into permanent posts. 5) Task and Finish group Retire and return (emphasis on recruit new consultants (and therefore join on call) than R&R approach, use R&R on 1 year contracts and re-advertise posts on yearly cycle.	Quality & Safety Committee People & Culture Committee	20	C5 x L4	15 (C5xL3)	↔	01.08.2013	14.07.2022	31.08.2022
4103	Chief Operating Officer	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety	Sustainability of a safe and effective Ophthalmology service	If: The Health Board fails to sustain a safe and effective ophthalmology service. Then: The Health Boards ability to provide safe high quality care will be reduced. Resulting in: Sustainability of a safe and effective Ophthalmology service	- Measure and ODTc DU reviews nationally. - Clinical staffing structure stabilised and absence reduced (new consultant, nurse injectors, ODTc's, weekend clinics). - On going monitoring in place with regards RTT impact of Ophthalmology. - In line with other services, to meet the RTT requirement services are being outsourced - maintaining this level of performance will be challenging going forward. - Additional funding for follow up appointments provided and significant outsourcing undertaken (6,500 cases) with harm review piloting to assess all potential harms. - Additional services to be provided in Community settings through ODTc (January 2020 start date). - Intravitreal injection room x2 established with nurse injectors trained. - Follow up appointments not booked being closely monitored and outsourcing enacted. - Regular updates re follow up appointments not booked being monitored by Management Board / Q&SR (patient safety issues) and Finance, Performance and Workforce Committee (performance issues). - Reviewing UHB Action Plan in light of more recent WAO follow up review of progress. - Primary and Secondary Care working Groups in place. - Ophthalmology Planned care recovery group established overseeing a number of service developments: WLI clinics, outsourcing of Cataract patients, development of an ODTc in Maesteg Hospital, implementation of Glaucoma shared care pathway, implementation of Diabetic Retinopathy shared care pathway, regional work streams, trial of new Glaucoma procedure (IMS), streamlining pathways. - Quality and Performance Improvement Manager post created to provide dedicated focus, detailed demand and capacity analysis being undertaken. - All patients graded according to the WG risk stratification R1, R2, R3. Additionally, several specific waiting lists are further risk stratified to ensure that the highest risk patients are prioritised.	Update October 2022: Legacy patients: Temporary funding has been secured for a Senior Lead Nurse until March 2023 to review and complete Clinical Harm Reviews. A paper is being presented to the Executive Director of Nursing in November 2022 to consider governance support. R1: The clinical lead has carried out a sample exercise to review the R1 status. A large proportion of those patients do not meet the R1 criteria. A large proportion of these cases have been downgraded to R2 status. Additional capacity: Plans are being developed for additional weekend sessions between now and 31st December 2022 to reduce the longest waits requiring follow up. Additional capacity: A plan for a see and treat one stop for long waiting cataracts is awaiting approval. In addition a community follow up scheme takes 200 glaucoma patients we are asking additional 150 new slots to clear the 104 week waits by 31st December 2022. Core capacity: has been reviewed to meet pre pandemic levels with the exception of one clinic. Follows Up a validation has been undertaken by a clinical team member and a number of anomalies have been identified from potential discharges and duplicate pathways. Further clinical validation is required, however, current job plans do not cover this at least an additional 6 sessions would be required to review all patients over 12 months. Open Pathways: circa 13,000, 1400 of these were removed following discovery of an IT issue, further validation is required but a dedicated validation team would be required to undertake this. Improvement Programmes: Funding for a Band 6 Service Pathway co-ordinator is awaiting approval. Wet AMD Referral Service will commence in December 2022.	Quality & Safety Committee	20	C4 x L5	12 (C4 x L3)	↔	01/04/2014	28.10.2022	30.11.2022
4632	Executive Director of Therapies and Health Sciences.	Unscheduled Care Group	Head of Strategic Planning and Commissioning	Improving Care	Patient / Staff /Public Safety	Provision of an effective and comprehensive stroke service across CTM (encompassing prevention, early intervention, acute care and rehabilitation)	If: changes are not made to improve and align stroke prevention initiatives, early intervention campaigns, and acute and rehabilitation stroke care pathways across CTM THEN: avoidable strokes may not be prevented, patients who suffer a stroke may miss the time-window for specialist treatments (thrombolysis, thrombectomy), and patients may not receive timely, high-quality, evidence-based stroke care RESULTING In: higher than necessary demand for stroke services, poorer patient outcomes/increased disability, increased length of stay, and poor patient/carer experience. Impact will extend to the need for increased packages of care, increased demand for community health services, and increased carer burden when discharged to the community.	- Executive-led Stroke Strategy Group in place, with targeted task and finish under development. - ToR and membership of Strategy Group updated. - Close working amongst executive team to escalate and address operational and clinical issues in relation to stroke pathway - Regional and National Stroke Programme Boards established - Unified, evidence-based pathway developed for thrombectomy - Bristol thrombectomy service becoming 24/7 in Autumn - Oversight of performance via regular SSNAP audit results, Performance Dashboard updates and Quality and Safety Committee reports - Full engagement from clinical teams in HIW review of flow of stroke patients in May 22. National report due in Spring 2023.	Update 1st November 2022: • Recruitment process underway as part of CTM Consultant Recruitment Drive. CSG working with medical staffing agencies seeking a Locum Consultant for PCH following a resignation. • A more stable rota for on-call stroke consultant rota being developed through joint working between PCH and POW consultants. Continued dialogue with Cardiff and Vale UHB to look at long term solutions to rota, feeding into the South Wales Central Regional Programme Board. • Regional developments with Cardiff and Vale UHB continue to progress to plan, with second meeting of the South Central Regional Programme Board on 25/10/22 and joint CTM/C&V UHB Stakeholder Event 26/10/22. Continued engagement with NHS Collaborative re: timelines for national programme. • Fortnightly Stroke Pathway Task and Finish Group. Review of priorities, progress and risks undertaken. Nominated leads identified and priority actions being progressed at pace. Work underway to review demand/capacity and therapies workforce gaps, exploring potential improvements to data streams and review of pathways for TIA across CTM. • Action taken forward from Stroke and Bed Management Task and Finish Groups to re-start ring fencing stroke capacity on a daily basis. Daily plan to create a ring fenced bed for stroke in PCH and POW to be confirmed through daily flow calls. Confirmation of stroke demand on all three sites (PCH, RGH and POW) communicated through daily flow calls. • Stroke patients needing transfer from RGH to PCH to be prioritised, with POW being explored as an option if significant system pressures. Comms poster to be circulated. • Continued implementation of VBHC stroke prevention programme: optimal management and targeted case finding of atrial fibrillation and hypertension in primary care. GP with Special Interest recruited and other key posts underway. • FAST programme being rolled out nationally. • Analysis underway to understand delayed seeking of help within Merthyr locality. Plan to be developed once reasons better understood. • Changes being planned to rehab pathway. • Unified criteria for thrombolysis agreed across both acute stroke sites. • Unified acute stroke management pathway across both sites under development. • Additional resource proposals included in the 2022/23 IMTP – funding was not available this year (7 day working, ESD, additional rehab beds). Alternative options being actively explored, with ESD provision for Bridgend as a priority	Quality & Safety Committee	20	C4 x L5	12 (C4 x L3)	↔	05.07.2021	1.11.2022	31.12.2022
4664 removed from publication due to business sensitive information in relation to Ransomware Attacks																	
4743	Chief Operating Officer	All Care Groups	Deputy COO (Acute Services)	Improving Care	Patient / Staff /Public Safety	Failure of appropriate security measures / Safety Fencing	If: there is a failure in security measures. Then: there is an increased likelihood of patients having unrestricted and inappropriate access on the site. Resulting In: absconding events and possible harm to the patient or members of the public	- The risk of absconding, and self harm/ suicidal ideation for Mental Health and CAMHS patients is risk assessed on admission and reviewed regularly thereafter. - Works programme to review and renew physical barriers such as door locks and restricted window access to limit unauthorised ingress and egress from Mental Health and CAMHS units are in situ. - High risk patients are escorted when outside the units - Absconding patient policy in place - Some fencing is in place in the areas concerned, however, it is aged and fails to provide an adequate barrier.	Funding Bid for approx. £385K has been submitted by Estates Update April 2022: The Car Park Security Fencing in the Bridgend Locality is now largely complete with minor 'snagging issues' to close off. Door systems in 1y Llidard CAMHS have been upgraded to include an alarm system on the Mag-lock doors. If the Mag-lock does not engage within a set time frame, then an alarm will sound. Multi storey Car Park at Princess of Wales Hospital has had anti-climb security fencing fitted. This was a WG Capital scheme and is awaiting final project sign-off to complete the works. The only outstanding area is the stairwell which will require more detailed technical design work to identify a solution. That work has commenced and once complete the works can be tendered. This will require further funding in 22/23 Capital & Estates Update September 2022 - solution to the fencing of the stairwells has been found and funding uplift approved in August ACMG. This work should commence in the early autumn completing within the financial year. Update October 2022 - Deputy COO Acute Services to review this risk from a pan Health Board perspective and identify actions per Care Group as appropriate. Timescale 31.12.2022.	Quality & Safety Committee	20	C5 x L4	15 (C5xL3)	↔	05.07.2021	1.11.2022	31.12.2022

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5036 Link to RTE 5155	Chief Operating Officer	Diagnostics, Therapies and Specialities Care Group	Service Director - Diagnostics, Therapies and Specialities Care Group	Improving Care	Patient / Staff /Public Safety	Pathology services unable to meet current workload demands.	IF: Pathology services cannot meet current service demands. THEN: - there will be service failure - there will be continued delays in reporting of Cellular Pathology results - failure to provide OOH services required for acute care - inadequate support and accommodation for Clinical Haematology cancer patients - increased turnaround times for provision of results including timely autopsies - increased pressure on existing staff - inadequate training provision throughout - inability to repatriate services from Bridgend. RESULTING IN: 1. Failure to meet cancer targets and national cancer standards 2. Anxiety for patients waiting for delayed results 3. Unsuspected cancer cases being missed in the backlog potentially leading to patient harm. 4. Delays in the reporting of critical results and issue of blood products OOH leading to patient harm 5. Failure to meet the standards required for provision of autopsy reports for the ME service 6. Clinical incidents due to errors and poor training. 7. Poor compliance with legislation and UKAS standards (that are mandated by the HB and Welsh Government). 8. Reputational damage and adverse publicity for the HB. 9. Continued inequity of services provided to CTM patient population.	1. Triaging of patient samples (into urgent & routine) as they arrive into Cellular Pathology. 2. Outsourcing of routine Cellular Pathology backlog to an external laboratory (LDPATH) 3. Expansion of Cellular Pathology into POCT training room. 4. Capital bids being progressed for ageing equipment. 5. All Wales LINC programme for implementation of Pathology LIMS and downstream systems. 6. Use of locums throughout all departments. 7. Advertisement and recruitment for vacant posts 8. Use of overtime to cover OOH services. 9. Business case to increase capacity of CNS support for Clinical Haematology patients. A Cellular Pathology Recovery Plan paper has been submitted to the Executive team for review - end of May 2022	Blood Bank Capacity Plan 31/05/2022 Demand & capacity review 30/06/2022 Workforce redesign 30/06/2022 Dedicated Pathology IT resource 30/06/2022 Accommodation review 30/06/2022 Novation of Equipment to the Managed Service Contract 30/09/2022 Update June 2022 - Review scheduled for the end of September 2022 to consider the improvements as a result of the mitigating actions undertaken. Update September 2022 - the Health Board continues to outsource samples and is increasing the volume of outsourcing. Regional working underway to explore longer term solutions for Pathology Services.	Quality & Safety Committee	20	C4 x L5	6 (C3xL2)	↔	02.03.2022	07.09.2022	31.10.2022
3826 Linked to 4839 and 4841 in Bridgend Linked to 4462	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director - Unscheduled Care.	Improving Care	Patient / Staff /Public Safety	Emergency Department (ED) Overcrowding	IF: As a result of exit block due to hospital capacity and process issues patients spend excess amounts of time within the Emergency Department. This is manifested by, but not limited, to significant 12 hour breaches currently in excess of 400 per month. There are also large numbers of patients spending longer than 24hrs and 48hrs within the ED (please see attached information). Then: patients are therefore placed in non-clinical areas. Resulting In: Poor patient experience, compromising dignity, confidentiality and quality of care. The ability for timely ambulance handover with extensive delays for patients requiring assessment and treatment. Filling assessment spaces compromised the ability to provide timely rapid assessment of majors cases; ambulance arrivals and self presenters. Filling the last resus space compromises the ability to manage an immediate life threatening emergency. Clinicians taking increasing personal risk in management of clinical cases. Environmental issues e.g. limited toilet facilities, limited paediatric space and lack of dedicated space to assess mental health patients. Some of the resulting impact such as limited space has been exacerbated by the impact of the Covid-19 pandemic and the need to ensure appropriate social distancing.	1. Triaging of patient samples (into urgent & routine) as they arrive into Cellular Pathology. 2. Outsourcing of routine Cellular Pathology backlog to an external laboratory (LDPATH) 3. Expansion of Cellular Pathology into POCT training room. 4. Capital bids being progressed for ageing equipment. 5. All Wales LINC programme for implementation of Pathology LIMS and downstream systems. 6. Use of locums throughout all departments. 7. Advertisement and recruitment for vacant posts 8. Use of overtime to cover OOH services. 9. Business case to increase capacity of CNS support for Clinical Haematology patients. A Cellular Pathology Recovery Plan paper has been submitted to the Executive team for review - end of May 2022	Continue to implement actions identified in the control measures. Action plans are in the process of being reviewed so a timescale will follow once the review has been undertaken by the lead. Update September 2022 – Risk reviewed by Nurse Director for Unscheduled Care, risk to be closed owing to multiple changes to structures and reporting systems since original risk was opened. Risks to be reviewed and understood against new frame work outlined by the Six Goals Board local governance, quality and safety feedback mechanisms and unscheduled care quality and performance reporting mechanisms. Risk will be closed once the detail has been agreed and new risk superseding this current risk. Update 3.11.2022 – mitigations to improve flow and discharge at POW now being addressed through workstreams 2, 3 and 4 of the UEC 6 goals programme, with rapid focus on reducing lost bed days due to discharge delays, formal launch of D2RA model and pathways Dec 22, along with launch of e-whiteboards/discharge referral forms	Quality & Safety Committee	20	C5 x L4	15 (C5xL3)	↔	24.09.2019	03.11.2022	31.12.2022
4907	Director of Corporate Governance	Central Support Function - Quality Governance (Concerns & Claims)	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety	Failure to manage Redress cases efficiently and effectively	IF: The Health Board is unable to meet the demand for the predicted influx of Covid19 related, FUNB Ophthalmology Redress/Claim cases Then: the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. Resulting In: Risk to quality and safety of patient care, resulting from poor management of cases. Financial impact to the Health Board from Redress cases which have been poorly managed and consequently proceed to claim.	Controls are in place and include: • Regular reports run on all Redress cases, with monitoring by the Head of Legal Services & Legal Services Manager • Covid-19 monies secured for one Band 5 Redress Handler to take forward the Covid-19 related cases. A Redress panels have been established where required and meetings with ILGs undertaken when required to ensure legal aspects have been reviewed and validated.	The Health Board have developed an action plan in response to Welsh Risk Pool review, which is in the process of being delivered. Recommendation from the review are being monitored by the Audit & Risk Committee. All actions due to be completed by the end of March 2023. The Health Board has secured Covid funding in respect of the recruitment Covid19 specific Redress Handlers. Update September 2022: The Health Board are starting to realise the risk with evidence of redress cases being moved into claims due to delays, which are being settled for less than £25k, which is non reimbursable through WRP procedures for a claim, however can be reclaimed under redress. An invest to save bid has been developed to address the redress backlog. Update October 2022: Invest to save bid has been developed and submitted. Some resource has been identified through the proposed Quality Governance Operating Model, which should provide some capacity within the service.	Quality & Safety Committee	20	C4xL5	8 (C4xL2)	↔	02.11.2021	30.09.2022	30.11.2022
5267 (Capturing risks 4106 and 4157 which are now closed)	Executive Director of Nursing & Quality	Centre Support Function - Patient Care & Safety - Nursing	Deputy Executive Director of Nursing	Improving Care	Patient / Staff /Public Safety	There is a risk to the delivery of quality patient care due to difficulty recruiting & retaining sufficient numbers of nurses	IF: the Health Board fails to recruit and retain a sufficient number of registered nurses and midwives due to a national shortage & Health Care Support workers (HCSW's) Then: The Health Board's ability to provide high quality care may be impacted as there would be an overreliance on bank and agency staff. Resulting in: The potential for disruption to the continuity and of patient care and risk of suboptimum team communication due Potential to impact on patient safety and staff wellbeing. Financial implications of continue high use of agency cover (includes registered nurses and HCSW's) Please note - this risk is an amalgamation of two previous risks i.e., 4106 and 4157, these have been closed with a narrative to state this combined new risk has been created.	Proactive engagement with HEIW Scheduled, continuous recruitment activity overseen by WOD. Overseas RN project continues. • Close work with university partners to maximise routes into nursing • Retire and return strategy to maintain skills and expertise • Dependency and acuity audits completed at least once in 24 hrs on all ward areas covered by Section 25B of the Nurse Staffing Act; this has now been rolled out to all wards within CTMUHB. • Reporting compliance with the Nurse Staffing Levels (Wales) Act regularly to Board • Regular review by Birth Rate Plus, overseen by maternity Improvement Board • Implementation of the Quality & Patient Safety Governance Framework including triangulating and reporting related to themes and trends • Targeted approach to areas of specific concern reported via finance, workforce and performance committee Nurse Rostering Policy - Now approved with a launch date of December 2022. Automated nursing agency invoicing system implemented within the Health Board by the Bank office team - rosters must be locked down daily to enable the system to work- provides more rigor to roster management at ward/ department level.	NURSE ROSTERING Nurse Rostering Policy to be launched in December 2022. Nursing Productivity Group actions continue to progress well through this forum. Registered Nurse Off contract agency forms have been revised to enable a higher level of scrutiny and sign off by Nurse Directors (in hours) and Exec on call out of hours. The HCSW agency shift requests will follow the same type of forms and sign off from December 2022. Workforce and finance teams are working together to provide joint metrics and monitoring of agency useage and cost progress monitored via Nursing Productivity group who report into the Value & Effectiveness portfolio group. SAFER CARE Roll out in POW site due to be completed by end of November 2022 with plans to roll out to other sites later in 2022. ENHANCED SUPERVISION Corporate nursing team are currently undertaking focused work within POW in the areas of high usage of agency HCSW's, update will be provided in December 2022	Quality & Safety Committee	16	C4xL4	C4xL3	New Risk Escalated October 2022	25.10.2022	25.10.2022	01.12.2022
4356	Executive Director for People Health, Safety & Fire Function	Central Support - Health, Safety & Fire Safety Function	Head of Health, Safety & Fire	Improving Care	Legal / Regulatory	Overdue/Out of date fire risk assessments due to resource issues and the amount required to be undertaken	IF: Fire Risk Assessments are not completed and reviewed in a timely manner. Then: Significant findings on the FRA may have changed which could compromise the safety of patients, staff, visitors/contractors and building fabric. Resulting In: Increased risk of fire/harm, enforcement action by Enforcing Authority i.e. Notification of Deficiencies (IN01) which will further escalate to Enforcement Notices (EN01) if no remedial action is taken.	There are FRA's in place however a substantial number have not been reviewed by the review date. Fire safety advisors are reviewing FRA's in areas where it is safe to do so (Covid restrictions are in place in many areas). A concentrated effort will be necessary to reduce the number of overdue FRA's. Despite the appointment of an additional fire officer in 2021, this risk is likely to increase in the first part of 2022 due to the retirement and loss of 2 other fire officers (Specifically in Merthyr Cynon ILG area) To try and mitigate this risk, fire officer property allocations have been reassigned and only high risk FRA (patient sleeping areas) will be the main focus of the Team until the 2 fire officer vacancies are appointed. Following targeted work by the Fire Team, all FRAs are approximately at 95% compliance. With the reduction in the fire team resource this risk may increase in due course.	It is recommended that additional fire safety resources are provided to support the work of the fire officers to undertake FRA reviews. As referred to in Risk ID:4315, 2 x Band 5 additional fire safety trainers to be appointed. Update July 2021 - Recruitment to Fire Officer post underway and pending a successful shortlisting exercise interviews are planned for circa mid July. Update May 2022: Posts have been added to Trac and approved ny the Head of Health, Safety and Fire. Due to lack of funding in the Health, Safety and Fire Budget these posts remain on hold. The 2 Fire Officer posts are subject to a Vacancy Control Panel to determine whether they can be advertised. Without these posts the UHB will be unable to manage this risk going forward. Update June 2022 - One fire officer post has been approved on TRAC and has been appointed to. The second post has been withheld due to budget constraints. This will increase this risk in time as the limited fire resource is now smaller. August 2022 Update - Risk reviewed and position as reported at June 2022 remains. Review date remains at 30.09.2022. October 2022 - Following targeted work by the Fire Team, all FRAs are approximately at 95% compliance. With the reduction in the fire team resource this risk may increase in due course.	Health, Safety & Fire Safety Sub Committee of the Quality & Safety Committee	16 ↓ 20	C4xL4	6 (C2xL3)	↔	26.10.2020	29.09.2022	31.12.2022

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4149	Chief Operating Officer	Mental Health Care Group	Clinical Service Group Manager - CAMHS.	Improving Care	Patient / Staff /Public Safety	Failure to sustain Child and Adolescent Mental Health Services	If: The Health Board continues to face challenges in the CAMHS Service (covering locality CAMHS in CTM and Swansea Bay as well as specialist CAMHS services commissioned by WHSSC - Inpatient Unit at Ty Llidard and FACTs service) Then: there could be an impact in maintaining a quality service Resulting in: recruitment and retention challenges and detrimental impact on wellbeing of existing workforce, long waiting times; inability to implement new models of care required to meet increasing demand; supporting patient pathways via services and standards of care planning required by the All Wales Mental Health Measure. If the specialist WHSSC commissioned services are not sustained the impact would be far reaching given the population they serve (inpatient - South Wales, FACTs - whole of Wales) and would result in more complex patients not being supported and treated in Wales. Difficulties remain with waiting times for specialist CAMHS; recruitment of key staff and ability to implement new model of care and the new neurodevelopmental service remains challenging.	o Reported local and Network pressures across the CAMHS Network with variable problems dependent on the area of the network. o Updates provided to Management Board on developing service model to address reported issues and additional investment secured to increase capacity within the service and to address service pressures. Waiting list initiatives in place whilst staff recruitment is being progressed. o Service Model developed around Core CAMHS in Cwm Taf Morgannwg which includes agreement with General Paediatrics to take the lead on Neurodevelopmental Services and shared care protocols with Primary Care. o New investment impact being routinely monitored internally via the SMT and via monitoring meetings with the ILG Monthly commissioning meeting discussions taking place across the Network in relation to service pressures and funding. Additional funding received for investment in services • Implementation of the Choice and Partnership Approach (CAPA) with a new service model introduced ensuring the service aligns itself with All Wales Mental Health Measure. All referrals accepted to CAMHS will now receive a Part 1 Mental Health Assessment to determine the level of support required. Performance is being reported and monitored via monthly performance meetings • A number of service reviews in relation to Ty Llidard undertaken and monitored via Q,S&R Committee. Additional nursing leadership implemented and progress on required action plans and proposed staffing model. Business case being drafted for additional investment to support staffing model in March 22. Workshops scheduled with WHSSC to review service specification and gap analysis. First workshop took place on 15th Feb 22. Staff and stakeholder consultation event took place in April. Improvement Board set up and improved reporting to WHSSC on actions taken and progress being made. Survey undertaken with colleagues demonstrating improvement. • Community CAMHS in both CTM UHB and Swansea Bay UHB are carrying out WLI via the planned care recovery (PCR) scheme. The additional clinics and dedicated team for assessment and single point of access have helped to reduce waiting times in CTM UHB to approx 4 weeks. Number of patients on CTM waiting list has reduced from 365 to just over 200 patients. The waiting times in Swansea Bay UHB have reduced significantly(from 32 weeks+ to 1.9 weeks). Capacity and demand work has been undertaken with clear improvement trajectories and the implementation of a new service model to aim to meet demand. Planned care recovery schemes in place to address the backlog. • There has been progress with being able to recruit to vacancies with a number of new	Risk reviewed and updated the controls Ongoing improvement in community CAMHS performance in relation to waiting list - Swansea Bay waiting list reduced down from 462 to 90 in September. CTM waiting list reduced from 365 in May 2022 to 200 in September. Work ongoing to improve compliance with part 1a and 1b. New SIF MH bids funding received and in progress of recruitment. Further work required for community CAMHS performance on part 2, improvement plans in both areas. Continued improvements being made in the escalation plan for Ty Llid via the Improvement Board. values and behaviour leadership survey undertaken which demonstrates good feedback from colleagues on improvement but also helps identifies areas for improvement. FACTs service - consultant interviews taking place on 1st November. Progressing recruitment plan to address vacancies	Planning, Performance & Finance Committee & Quality & Safety Committee	16	C4xL4	8 C4xL2	↔	01/01/2015	07.10.2022	30.11.2022
4479	Executive Director of Nursing & Midwifery	Central Support Function - Infection, Prevention and Control	Deputy Lead Infection Prevention Control Nurse & Decontamination Officer,	Improving Care	Patient / Staff /Public Safety	No Centralised decontamination facility in Princess of Wales Hospital (POWH)	If: there is no centralised decontamination facility in POWH Then: there are a number of areas undertaking their own decontamination via automated/manual systems. Resulting In: possible mismanagement of the decontamination processes/near misses/increased risk of infection/litigation risks and non compliance with national guidance/best practice documents. The hospital site is at risk of losing their JAG accreditation in Endoscopy if plans to centralise decontamination is not progressed. There is no dirty - clean flow for procedure room 2 in endoscopy. There is some decontamination equipment in HSDU that needs replacement. The decontamination equipment in Urology is at the end of it's life and there are regular service disruptions due to failed weekly water testing results.	Monthly audits undertaken in all decontamination facilities in POWH by the lead endoscopy decontamination officer and results shared at local decontamination meetings. AP(D)support available on site. Monthly ILG decontamination meetings take place where all concerns are escalated to the HB Decontamination Committee meeting. SOPs in place Water testing carried out as per WHTM guidance Maintenance programme in place for decontamination equipment 07/10/2021 - In view of aging Urology washer disinfectors, urology service managers to liaise with APDs to initiate/ agree a service contract for maintenance and servicing of equipment with an external. August 2022 Update: Lead IPC Nurse and Deputy Executive Nurse Director reviewed the Controls in Place with no updates reported for August	Centralised Decontamination Facility at POWH - 02/08/21 - SOC approved by WG and design team appointed. Project team group and working group to be set up - Timeframe 30.09.2021. Each area that decontaminates scopes/intra cavity probes(outside CSSD)has developed SOPs detailing the decontamination process. Evidence of SOPs to be shared at decontamination meeting in POWH. Lead IPCN to ask Operational Lead for Decontamination to action. 02/08/21 - Operational lead for Decontamination has requested assurance from the lead endoscopy decontamination officer in POW. Timeframe 30.11.2021. 15.12.2021 - risk peer reviewed and agreed that the risk remains as a 20. Development of a business case to create a single centralised decontamination facility on the POWH site has commenced with Welsh Government Funding support. Business case expected to be completed by Spring 2022. Availability of WG funding to create the unit remains a risk. Update June 2022 - Risk reviewed at Infection Prevention Control committee 28/06/2022 and update provided - JAG have agreed to extend accreditation in Princess of Wales for a further 6 months and have requested a progress report on plans for central decontamination. Update: Lead IPC Nurse and Deputy Executive Nurse Director reviewed the Action Plan with no updates reported for August. 17/08/22 - contingency plan being developed with key service users. Central decontamination facility at detailed design stage and business case should be ready for submission by end of January 2023	Quality & Safety Committee	16	C4xL4	2 C1xL1	↔	30.12.2020	1.11.2022	30.11.2022
1133	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety	Long term sustainability and staffing of the Emergency Department (ED) at the Royal Glamorgan Hospital. (RGH).	If: the Clinical Service Group (CSG) is unable to deliver a sustainable staffing model for the Emergency Department at the RGH; Then: the Health Board will be unable to deliver safe, high quality services for the local population; Resulting in: compromised safety of the patients and staff and possible harm.	ED sustainable workforce plan developed and being implemented (May 2021). Option 1 funded so risks around sustainability remain particularly in respect of the consultant workforce. Financial position remains a challenge as locum and agency staff still used. No agreed plan to align staffing to benchmarking standards and the staffing levels on other sites within CTM. Boundary change and challenges across CTM continue to have a significant impact on the RGH site. September 2022 Review by Nurse Director for Unscheduled Care: Currently 6.3 wte ANPs in post with 3 new trainees commencing. Advert for locum Consultant in progress Ad-hoc locum for middle grade to cover for absences and planned leave	ED sustainable workforce plan developed and being implemented (May 2021). Reviewed no change as at 7th September 2021. Reviewed 21.09.2021 - remains working progress. Update September 2022 - Nurse Director Review 7/9/22: Unscheduled care group to review immediate workforce resource across all three acute sites by end of October 2022. Actions to then be decided in terms of immediate measures for distribution of staff, governance lines to be agreed (nursing, AHP and Medical) and immediate plan for winter months to be agreed and acted upon. Medium term and substantive plans for workforce requirements and innovations to be worked through as part of six goals board and advanced practice board.	Quality & Safety Committee. People & Culture Committee - Workforce aspect	16	C4 x L4	12 (C4xL3)	↔	20.02.2014	07.09.2022	31.10.2022
2787	Executive Director for People	Central Support Function - Health, Safety & Fire	Head of Health, Safety & Fire	Improving Care	Patient / Staff /Public Safety	Absence of a robust Health Surveillance Programme for employees.	If: there is no monitoring in place for staff who work in areas of the organisation where known health risks could develop e.g. Hand, Arm Vibration (HAVs), noise, skin conditions such as contact dermatitis, respiratory etc. Then: then this means that the organisation may not be able to identify the areas and departments within the organisation that require Health Surveillance intervention. Should a reportable incident occur CTMUHB will be liable to criminal repercussions by the HSE. Resulting in: it not being possible to develop a robust HS programme for the organisation without this baseline intervention as required by the Health & Safety Executive (HSE). Criminal Actions by the HSE.	OH linking with H&S to re-establish the skin surveillance programme. Plan to submit a briefing to execs in relation to the associated risks due to the absence of a health surveillance programme.	Plan to submit a briefing to execs in relation to the associated risks due to the absence of a health surveillance programme. August 2022 Update: Health & Safety Coordinator from the H&S Team is to link with the Head of Service from Occupational Health to agree a plan to undertake workplace assessments and referrals to Occupational Health. Review date set as the 30.09.2022. Update October 2022: Scoping Exercise for Health Surveillance remains ongoing. Review date set for 31.12.2022.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	16	C4 x L4	8 C4xL2	↔	26.06.2017	29.09.2022	31.12.2022
3008	Chief Operating Officer	Children and Families Care Group	Raised by Obstetrics in PCH.	Improving Care	Patient / Staff /Public Safety	Risk of injury due unavailability of opportunities to train and maintain compliance with Manual handling training.	If: There is a lack of manual handling training there is the risk of potential injury to a member of staff or injury to the patient. Then: There are a number of clinicians who have not had the opportunity to meet the requirements for manual handling training. Resulting In: Potential harm being caused to both staff and patients.	1. Staff are aware of the risks associated with manual handling. 2. All staff have been informed to consider the ergonomics of the environment that this activity is being undertaken. 3.Appropriate equipment is available in the clinical areas or on request from the MH team e.g. pat slides, slide sheets, hoists. 4. Manual Handling risk assessments are incorporated into the admission bundles 5. The training group are planning training for clinical staff with the manual handling department - current position that this can not be supported 7. Ask other HB's their MH requirements SBUHB online training package to be shared. 8. Directorate will Seek out any opportunities for online updating to support current practice 9. E-learning module has been sourced for all staff to complete on line update for manual handling.	Organisational plan for compliance training. Update August 2022 - mitigating actions two registered nurses to undertake train the trainer and initially cascade to community midwifery staff commencing Sept 22. Care group will seek out any opportunities for online updating to support current practice. Review date 01/11/22. Based on the improvement since the re-start of face to face training this risk is being reviewed for de-escalation. Update October 2022 - Head of Health, Safety & Fire - mitigating actions monthly module B training to facilitate improvement in knowledge and skills to be rolled out by Lead . Next review date 30/11/22.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	16	C4 x L4	12 (C4xL3)	↔	01.05.2017	30.08.2022	01.11.2022

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
3133	Chief Operating Officer	Central Support Function -Facilities	Governance and compliance manager, Facilities	Improving Care	Patient / Staff /Public Safety	Due to capacity issues to deal with Covid-19 staff not attending medical gas safety training and courses being rescheduled.	If: Staff are not able to attend Medical Gas Safety training or courses are being continuously rescheduled. Then: Staff are not being trained in safe storage and flow of cylinders (e.g. oxygen). Resulting In: Failure to adequately and safely obtain and continue flow of cylinders (e.g. oxygen), potentially causing harm to patients.	PSN041 Patient Safety Notice and local safety alert disseminated to all staff. Posters developed and displayed in areas to encourage attendance. New staff trained at induction. TNA has been undertaken. Refresher training is undertaken, however current attendance levels by clinical staff for Medical Gas Safety training is poor, hence the current risk score. Medical Gas Cylinder Policy developed with training section completed by Medical Device Trainer, referencing the mandatory requirement for training by all users. Completed To make it a key requirement that staff can be released to attend training to re-enforce safety and operating guidelines of medical gas cylinders. Completed. Medical Device Trainer has put in place a B4 role who is undertaking a rolling programme for Medical Gas Training, with two sessions, twice a month, at each ILG every month. However, although training has been undertaken for Porters and graduate nurses, nursing staff currently in post are still not attending and attendance continues to be poor due to current circumstances with Covid-19 and due to not being able to be released for the 2 hours of training. Medical Device Trainer and Assistant Director of Facilities to request again for the Executive Director of Nursing Midwifery and Patient Care to review nursing attendance and make the necessary arrangements to allow nursing staff to attend training and also to look at the possibility of introducing a 'training day' that will allow nursing staff to be released to attend those courses that are struggling with attendance levels. Meeting held and COO has requested for Facilities to work on a monthly Medical Device Training Compliance report template that can be presented to both COO and ILG Director leads to inform current compliance position and actions to improve attendance and compliance for all courses including Medical Gas Training. Medical Device Trainer has stated that the current report template needs to be reconfigured to account for the change of wards and Directorates for the new ILG structure and to deal with the pandemic, this will take time to complete, hence the change in action implementation date to account for this.	Update: September 2022. Action: Use reporting template to monitor attendance. Timescale: 31/03/2022 - Complete. Quarterly reports in place for all med device training sent to Corporate Services for dissemination to ILG management, places offered, places attended/competency assessments etc. Medical gas training compliance is 33% in April 2022 report, 8.85% in July 2022 report (DW WG 31/08/2022). No change to mitigation at this time until a sufficient level of compliance for Medical Gas Training is being consistently achieved. Review Date: 30/11/2022	Quality & Safety Committee.	16	C4 x L4	8 (C4xL2)	↔	01/05/2018	21.10.2022	30.11.2022
3585	Chief Operating Officer.	Unscheduled Care Group	Care Group Service Director - Unscheduled Care.	Improving Care	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Princess of Wales Emergency Department Hygiene Facilities	If: the toilet and shower facilities are not increased within the Emergency Department. Then: at times of increased exit block the facilities are insufficient for the needs of the patients in the department. Resulting In: Poor patient experience, complaints and further concerns raised from the Community Health Council have repeatedly flagged this issue on visits to the department.	There are additional toilet facilities in the radiology department that mobile patients can be directed to however staff do whatever they can within the constraints that they have. Additional facilities being explored as part of departmental capital works.	Additional facilities being explored as part of departmental capital works. There is a capital plan for improvement works in ED. The improvements will be – 1. NIV cubicle, 2. Creation of a second patient toilet, 3. Improvement to HDU area, 4. Relocation of Plaster Room, 5. Creation of 2 paediatric bays with adjoining paediatric waiting room, 6. Redesign of waiting room and reception desk. Prior to the Covid pandemic, improvements 2-6 were planned, but the creation of an NIV cubicle has taken priority. The plans are in the process of being signed off for all areas but there is no confirmed start date yet. There was / is potential for delays in sourcing materials by contractors and we need to consider the need to keep contractors as safe as possible from any Covid contact. Patient numbers are now increasing daily but we are restricting visitors and relatives attending with patients (unless required as carers etc). We have also developed a remote waiting room for patients who can safely wait in their cars. This will help to mitigate the footfall in the department when the capital work commences. June 21 Update - Capital works for NIV room still ongoing and therefore no progress yet with the rest of the capital build. NIV room to be handed back mid June and patient toilet will be the next priority for completion. Update August 2021 - No Change.RCEM audit undertaken. Staffing remains ongoing issues- plans in place and frequently reviewed. ASCU staffing plan agreed at ILG level and ongoing. Surge trolleys in place to cope with additional capacity requirements. Building works progressing and some phases complete. X references to ID4458 & ID3826.Update: Awaiting update from Capital team to confirm start date for next phase of works. Patient toilet is the next priority. Update from Capital Team 6.5.2022: The ILG have been requested to provide availability for a prioritisation meeting for the 22/23 limited discretionary funding that is available - this will need to be discussed alongside their outstanding risks and prioritised for funding. Update June 2022 - Additional toilet works not yet commenced. Agreement from Capital / Estates teams to undertake the work. No start date yet. Update 3.11.2022 - WG funding secured to have works undertaken. CTM capital team progressing ASAP.	Quality & Safety Committee	16	C4 x L4	1	↔	31.05.2019	3.11.2022	30.12.2022
4148	Executive Director of Nursing & Midwifery	Central Support Function - Quality Governance (Quality & Patient Safety)	Assistant Director Quality, Safety & Safeguarding	Improving Care	Patient / Staff /Public Safety	Non-compliance with Deprivation of Liberty Safeguards (DoLS)legislation and resulting authorisation breaches	If: the Health Board fails to adequately resource the DoLS Team to address the backlog of authorisations and adequately manage a timely and effective response to new authorisations. Then: the Health Board will be unlawfully depriving patients of their liberties and failing to comply with the DoLS legislation Resulting In: the rights, legal protection and best interests of patients who lack capacity potentially being compromised. Potential reputational damage and financial loss as a result of any challenge by the ombudsman or litigation.	During February 2022 review of this risk the control measures have been revisited and streamlined. - Prioritisation assessment is being undertaken on the urgent authorisations. - Hybrid approach to the management of authorisations which includes the ability to offer a virtual format if necessary, although face to face is the preferred mechanism. - As at February 2022, the DoLS Team have now returned to full establishment which will support the resilience within the function. - A temporary Best Interests Assessor has now commenced with the Health Board whose role will be to focus on reducing the backlog. This post have been extended for a further year following CTMUHB being granted further WG funding to address the backlog. - A temporary Practice Educator has also been appointed whose role will be to prepare the Health Board for the Liberty Protection Safeguards and ensure that all staff are trained in the Mental Capacity Act. This post has been extended for a year following CTMUHB being granted further WG funding. - From February 2022, the DoLS Training has been revised and is running virtually on a monthly basis. - Audits are undertaken by the DoLS Team to look at compliance across the Locality Groups with the support of AMaT. - Capacity issues are also being supported by addition resources sourced through CTM Staff Bank. August 2022 Update: As a result of enhanced WG funding MCA training has been reviewed an delivered virtually and face to face across sites within CTMUHB. Both YCC and YCR staff have received bespoke training in response to concerns raised by the DU. In addition, training has been agreed and planned to be delivered to service groups within all three ILG. Compliance is being monitored through the Safeguarding Executive Group. Quarter 1 had the highest recorded number of referrals in a quarter, this coincides with the additional training. It is reassuring that the referrals are correctly identifying those people who need urgent and standard DoLS.	The Health Board has received confirmation that the Welsh Government will be offering funding to address backlogs in authorisations, to provide training in the MCA and prepare the implementation of the Liberty Protection Safeguards. This will be offered in three stages. CTMUHB have already succeeded in securing a £123,000, this has been used to extend the Best Interest Assessor and the Practice Facilitator roles. There will also be a three day Best Interest Assessor post going out to audit in May 22. It is anticipated that the Health Board will need to apply for further funding throughout the year to address any backlog and plan to implement the LPS. - The implementation of the change in legislation with regards the Liberty Protection Safeguards will improve the Health Boards compliance however the date of implementation is still awaited. The Code of Practice is currently out for consultation. - The DoLS Team are meeting with leads within the Locality Groups to work with CSGs to progress the action plan in order to enhance the awareness of the MCA, the risks associated with DoLS authorisations and timely review required and reporting compliance. This work has commenced within YCC and YCR. There are plans to extend this work throughout CTMUHB. Update July 2022 - funding of £90K received to facilitate continued improvement in MCA awareness and training. Training sessions being delivered. to targeted areas in the UHB to improve awareness and therefore quality of care and safety. A Learning Event is planned to highlight the issues in respect of capacity, the MCA and planned changes as a result of new legislation. No further steer on the implementation of LPS. Awaiting feedback in relation to the consultation on the code of practice. Update August 2022 - CTMUHB have received further WG funding of £184K. A further four BIA posts have recently gone out to advert. Two further Mental Capacity Practitioners will be advertised in September 2022. It is anticipated that the substantial increase in the teams resources will enable the BIA to address the current backlog and respond to the increase in DoLS requests. The appointment of two further MCA Practitioners will allow for increased capacity to deliver MCA training and prepare for further LPS training throughout CTMUHB. Sessions to highlight the issues in respect of capacity, the MCA and planned changes as a result of new legislation have commenced. Comments in respect of the proposed code of conduct have been submitted to WG by CTMUHB. Once all vacancies have been filled it is anticipated that the backlog of outstanding authorisations can be significantly reduced and the risk reviewed.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	01/10/2014	25.08.2022	21.10.2022
4152	Chief Operating Officer	Diagnostics, Therapies and Specialties Care Group	Care Group Service Director.	Improving Care	Patient / Staff /Public Safety	Back log for Imaging in all modalities / areas and reduced capacity	If: there is a backlog of imaging and reduced capacity Then: waiting lists will continue to increase. Resulting in delay and diagnosis and treatment. Due to the Covid-19 outbreak, all routine imaging has stopped and there is reduced capacity for imaging of USC sand Urgent patients.	Additional clinics, locum appointments, clinical validation of waiting lists, outsourcing and alternative contracting arrangements and the use of additional mobile scanners. The constraining factor in all of these measures is the availability of a suitably skilled workforce. The ending of double-time enhanced rate payments in early May 2022 presents an additional challenge. All patients requiring Radiology diagnostics as part of the Single Cancer Pathway are closely tracked and not waiting beyond 20 days.	Increased capacity required for current referrals to address backlog, particularly in CT/MRI /Ultrasound. Require funding and procurement of mobile scanners in the longer term. Actions: Staffing Resource, Capacity and Demand Planning and business case. No change to risk score or mitigation.	Quality & Safety Committee	16	C4 x L4	4	↔	01/06/2020	04.05.2022	30.06.2022
4315	Executive Director for People	Central Support Function - Health, Safety & Fire	Head of Health, Safety & Fire	Improving Care	Patient / Staff /Public Safety	Non Compliance of Fire Training - Provision	Insufficient staff (Fire Officers) available to provide mandatory face to face fire training. IF Limited number of places available due to the restrictions posed by social distancing so the amount of staff that can be trained at one time has been significantly reduced. Learning & Development is currently working with the Health Board Fire Officers to reinstate the fire element of Corporate Orientation, so progress is being made to address those who have had no CTMUHB fire training at all. THEN Risk of injury or loss of life from smoke inhalation, burns. Prosecution from the Fire Authority for not meeting the requirements of current legislation(RRF50. RESULTING IN Legal action by an individual against the UHB should an incident occur and staff not suitably trained.	Fire Officers are trying to provide training when they and suitable rooms are available. The training is based on a risk based approach and follows the approved Training Needs Analysis. However due to the restrictions posed by social distancing the amount that can be trained at one time has been significantly reduced. 19/04/2022 - Due to financial constraints on the Health, Safety and Fire budget these 2 posts are on hold and will not be released until financial stability is achieved. Linked to risk 4356. Overdue/Out of date fire risk assessments due to resource issues and the amount required to be undertaken Update June 2022 - Due to financial constraints unfortunately one of the Fire Officer posts has been sacrificed to achieve financial balance. This will impact on training provision and conducting Fire Risk Assessments going forward and this risk is likely to increase over time. August 2022 Update: No change so risk as was reported in June 2022. Review set for end of October 2022. Update 1.11.2022 - No change to risk since last report	Health Safety & Fire Sub Committee	16	C4 x L4	8 C4xL2	↔	05.10.2020	01.11.2022	31.12.2022	

	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
4337	Executive Lead: Director for Digital.	Central Support Function - Digital & Data	Chief Information Officer	Creating Health	Operational: - Core Business - Business Objectives - Environmental / Estates Impact - Projects Including systems and processes, Service /business interruption	Integrated IT Systems	If: The Health board does not have a unified electronic health and care record and systems which are integrated across the organisation and with our primary and social care providers Then: The Health board will be unable to deliver safe, high quality, clinically and cost effective care to patients Resulting In: Compromised safety of patients needing treatment that are reliant on clinical test results and information being available to clinicians to plan and deliver the treatment plan and the requirement for sub-optimal manual processes	Key Controls - SBUHB Service Level Agreement - Bridgend disaggregation and the one-CTM aggregation plan - NHS Wales Control Agreement and data sharing agreements - Numerous national service management boards and Technical oversight groups providing strategic, tactical and operation governance. - National ePR programme and systems Gaps in Control The full business case for the Bridgend / old-CT integration remains unfunded. There are currently a number of CTM systems that are not compatible with Bridgend systems. SBUHB have no process in place to incorporate the needs of Bridgend users in their developments. There is insufficient discretionary capital funding available to support delivery of the aggregation plan There is no data item integration with GP systems Numerous delays in NHS Wales progressing open architectural approach. Strategic approach to becoming an anchor organisation to encourage SMEs not developed, resulting in challenges in proceeding with small agile developments Discipline of organisation in keeping to the supported application platforms is being challenged - in particular staff are keen to exploit the opportunities presented by the MS365 platform however there are no resources available to support, train or integrate this platform within the EPR architecture	Update August 2022 - Regarding the Bridgend/CT aggregation: Programme as set out in IMTP progressing to plan. Discretionary capital programme has made provision to support priority areas of the plan. Business case for all Wales PAS development which incorporates Bridgend / CT aggregation has been funded for the next 3 years(recd 24/8/22). All Wales programme for opening up the architecture starting to develop via National Data Resource however there are numerous challenges and delays faced in getting system and service changes and improvements being put in place. UPDATE 28/10 ICT Risk meeting: Regarding the Bridgend/CT aggregation: Programme as set out in IMTP progressing to plan with posts funded by WG being recruited to. Tactical approach to data sharing with primary care yet to be agreed, and funded, noting NDR programme has recently offered a non recurrent financial contribution . All Wales API for 5 data systems expected January 2023 as first step in truly opening up the architecture. UHB has approached DHCW to make a joint appointment to develop and maintain APIs to the Myrdin PAS, which will support the clinical services in managing patient flows within the UHB. Although funding for staff has been allocated, the market for skills of this nature is sparse and this provides challenges in recruiting and retaining staff.	Digital & Data Committee	16	C4 x L4	8 (C4xL2)	↔	14.10.2020	22.10.2022	01.12.2022
4458	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director - Unscheduled Care.	Improving Care	Patient / Staff /Public Safety	Failure to Deliver Emergency Department Metrics (including 15 minute Handover and 4 and 12 hour breaches.)	If: the Health Board fails to deliver against the Emergency Department Metrics Then: The Health Boards ability to provide safe high quality care will be reduced. Patients will be waiting in the ambulance rather than being transferred to the Emergency Department. Resulting In: A poor environment and experience to care for the patient. Delaying the release of an emergency ambulance to attend further emergency calls. Compromised safety of patients, potential avoidable harm due to waiting time delays. Potential of harm to patients in delays waiting for treatment.	Senior Decision makers available in the Emergency Department. Regular assessments including fundamentals of care in line with National Policy. Additional Capacity opened when safe staffing to do so. Senior presence at Health Board Capacity Meeting to identify risk sharing. Winter Protections Schemes Implemented within ILG's. 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 Unscheduled Care Improvement Board will monitor progress on the programme on a monthly basis. Given the decrease in compliance for 12 and 4 hour waits, it is impossible to outline progress at this point. It is anticipated that the work of the Urgent Care Improvement Group will be able to report some improvement in the coming months. Update September 2022 Update - UEC Six Goals Improvement Programme now commenced – workstream 2 (integrated front door) – rapid mobilisation of other elements of the front door (SDEC, Acute frailty assessment, Hot/rapid access clinics) to facilitate ED de-crowding and timely ambulance offload. Update 3.11.2022 - now being addressed via UEC 6 goals programme, workstreams 2, 3 and 4. Aim to improve whole hospital/system flow, implementing D2RA model and pathways Dec 22, implementing enabling processes to improve flow and discharge - including e-whiteboards/e-discharge referrals, discharge hub, additional components of integrated front door (including acute frailty ax, hot clinics, SDEC), discharge lounges on each site.	Quality & Safety Committee Planning, Performance & Finance Committee	16	C4 x L4	12 (C4 x L3)	↔	04/12/2020	3.11.2022	31.12.2022
4679	Executive Director for People (Executive Lead for Occupational Health)	Central Support Function - Occupational Health	Head of Service - Employee Health Wellbeing Service (Occupational Health)	Improving Care	Patient / Staff /Public Safety	Absence of a TB vaccination programme for staff	If: the Health Board is not providing TB vaccination to staff Then: Staff and patients are at risk of contracting TB Resulting in: Failure to comply with the Department of Health and Social Care guidance and lack of confidence in the service	The 'fitness letter' issued by Occupational Health to the appointing line manager following an employee health clearance highlights vaccination status. Screening for latent TB for new entrants and offering T spot testing to assess positive or negative.	Update May 2022 - Training to be provided to the CTM OH nurses from the CAV OH nurses via a 'train the trainer' approach. Dates being arranged for May 2022. All necessary paperwork in place. Update June 2022 - Training Ongoing. Risk reviewed and remains same. Update August 2022: training has been delayed due to staffing issues within OH department. New dates have been identified in September. New recruits continue to be risk assessed for active TB symptoms and where appropriate new staff from areas of high risk of TB are screened for latent TB. Update October 2022 - Risk reviewed and remains same. Trainer has been identified no date confirmed as yet to commence training the OH Nurses.	Quality & Safety Committee People & Culture Committee	16	C4xL4	8 C4xL2	↔	09.06.2021	31.10.2022	31.12.2022
4798	Executive Director of Therapies & Health Sciences Therapies hosted by Merthyr & Cynon Integrated Locality Group	Diagnostics, Therapies and Specialities Care Group	Clinical Director of Allied Health Professionals - Therapies	Improving Care	Patient / Staff /Public Safety	Unsafe therapy staffing levels for critical care services at Prince Charles Hospital, Royal Glamorgan Hospital and Princess of Wales Hospital.	If the therapy services (physiotherapy, speech and language therapy, dietetics, occupational therapy) continue to not be at the recommended staffing levels according to national level requirements (GPICs), Then: the critical service will be unable to meet the need of patients requiring therapy, Resulting in: significant negative impact on patient outcomes, ability to recover from critical illness and length of stay in critical care unit and consequently in hospital longer than needed.	Currently staff stretch to cover and prioritise patient need as much as possible. During winter pressures have tried in the past to recruit locums but availability still remains an issue for some services and not sustainable. Sighted within HB Critical Care Board as significant gap and within peer review response. Update 16-9-21 Continuing with therapy business case as actions below. No other updates	Completed comprehensive business case detailing recommendations for staffing, gaps, impact and consequences of gaps Next steps require consideration for prioritising of funding for gaps in therapy posts in critical care within ILGs to decrease risk RTE critical care short-term planning business case, identified RGH therapies workforce requirement, however these would need to be recruited to recurrently, as unable to recruit to fixed term tenure. Update: The Therapy workforce model has been completed for three bespoke staffing options for a Tier 1 unit with 4-8 PACU beds as part of the reconfiguration work. Update July 2022: no change to mitigations; Emerging discussions are taking place in relation to critical care which are likely to impact this risk; Further updates will be provided in 2 months' time Update August 2022 - risk reviewed and no change. Further review added 29.09.2022. No funding has been allocated to enable recruitment of AHP workforce to meet GPIC standards. Options appraisal for the existing AHP critical care workforce will be undertaken, which will include consideration of consolidation onto a single site for some of AHP professions with minimal staffing. AHP Clinical Director to review the options and propose a plan by October 2022. Update 31/10/22 - Current Situation Full engagement by AHP Leads with all Critical Care meetings and submission of all required therapy workforce info in line with GPICs standards but no confirmed investment in therapies for Critical Care across CTM. SLT and Dietetics are the most affected, with no cover in PoW and very limited cover in RGH and PCH. Recent Datix for PoW when team became aware that the 'emergency' enteral feeding regime was 10 years old, not written by a dietitian, and recommending a feed no longer stocked in PoW. Actions: Actions continue to try to improve safety at PoW, led by Head of Nutrition & Dietetics. Ongoing Therapy & ITU discussions with PoW and RGH regarding repurposing monies to fund SLT sessions. CD for AHPs met with PCH intensivist w/c 24/10/22. Meeting to be planned for upcoming weeks to review the AHP situation across CTM. Intensivist is engaging the Critical Care Network to seek support and advice. Risk remains high across all 3 sites.	Quality & Safety Committee	16	C4xL4	8 C4xL2	↔	20.08.2021	28.10.2022	30.12.2022
4809	Executive Director for People	Central Support Function - Health, Safety & Fire	Head of Health, Safety & Fire	Improving Care	Patient / Staff /Public Safety	Non Compliance with Mandatory Violence and Aggression Training	training review was undertaken to identify HB violence and aggression training requirements. Following review the HB is unable to achieve full compliance on any training module. This is due to lack of training resource within the Health Safety and Fire Team. If the training is not delivered, then the organisation will not be compliant with mandatory Violence and Aggression Training. Restraint training is mandatory for inpatient acute services for Mental Health and CAMHS. Training is delivered by inpatient staff and the Health Safety and Fire Personal Safety Advisor. If there is insufficient training resource available then the organisation will be unable to maintain compliance on annual refreshers. If the PSA is unable to deliver key aspects of their role due to the high demand for violence and aggression training delivery then advice to clinical areas is greatly reduced. Resulting in non compliance of mandatory training and a risk of injuries to both staff and patients and possible claims.	Personal Safety Advisor delivers training modules with some support from part time trainers within Mental Health and CAMHS. However there is insufficient resource to ensure compliance within the entire organisation. Trained tutors available from clinical areas. The PSA regularly has to support training due to ward based trainers unable to be released to deliver. This role is not currently included in their job description which has resulted in some trainers resigning from delivering, hence compounding the lack of training resource. The availability of the PSA to offer personal advice to clinical areas is greatly reduced due to the excessive training requirement.	Module D PMVA Training Provision / Programme Delivery - Meeting to be arranged with Senior Managers within Mental Health to review the management, coordination and delivery of PMVA training. in late March when revised PMVA report completed. Meeting has taken place and Mental Health colleagues are reviewing how best this training provision can be supported by them. Further meeting scheduled for late April 2022. Senior Managers have devised an audit to all specialist clinical areas identifying their violence and aggression mandatory requirements. The PSA has been provided with some audit but this work is incomplete. A further meeting is yet to be arranged. Module D PMVA Training Provision / Programme Delivery - Meeting to be arranged with Senior Managers within Mental Health to review the management, coordination and delivery of PMVA training. in late March when revised PMVA report completed. An Audit has been devised and disseminated to Senior Managers to complete to determine the mandatory violence and aggression training requirements. To date 17/06/2022 6 completed audits received. Contact via email to RGH 13/06/22 for their audits. Once received all audits a report will be drafted. Meeting has taken place and Mental Health colleagues are reviewing how best this training provision can be supported by them. Further meeting scheduled for late April 2022. Senior Managers have devised an audit to all specialist clinical areas identifying their violence and aggression mandatory requirements. The PSA has been provided with some audit but this work is incomplete. A further meeting is yet to be arranged. 31/05/22 Still awaiting mandatory training audits to complete the report and rearrange the meeting. Timeframe: 26.8.2022 Update August 2022 - Further meetings arranged with Mental Health Team to confirm training standards and provision going forward. Review date set 31.12.2022. Update October 2022 - No Change as reported in August 2022. Review date set for 31.12.2022.	Health Safety & Fire Sub Committee	16	C4 x L4	9 C3xL3	↔	31.08.2021	17.08.2022	31.12.2022

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
4906	Director of Corporate Governance	Central Support Function - Quality Governance (Concerns & Claims)	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety	Impact on the safety – Physical and/or Psychological harm	Failure to provide evidence of learning from events (Incidents and Complaints) If: The Health Board is unable to produce evidence of learning from events. Then: the Health Board will be unable to recoup any costs from Welsh Risk Pool for personal injury or clinical negligence claims made against the Health Board. Resulting in: Risk to quality and patient safety with potential for further claims as learning and improvement will not have taken place. Financial impact to the Health Board	Controls are in place and include: * Monitored and reported through the weekly Executive Quality & Safety meeting. * Regular engagement and meetings with the Executive team to assist in gathering of learning. * Improvement plan implemented by WRP with monthly targets to submit the backlog. * Learning From Event Report (LFER) Standard Operating Procedure devised and disseminated * LFER 'How to Guide' devised and disseminated * Ad-hoc training available on request. * Internal targeted monitoring in place.	The Health Board are developing a Learning Framework to ensure Learning is captured and shared across the organisation. Currently at consultation stage. The Health Board have developed an action plan in response to Welsh Risk Pool review, which is in the process of being delivered. Recommendation from the review are being monitored by the Audit & Risk Committee. All actions due to be completed by the end of March 2023 Welsh Risk Pool have implemented a targeted improvement plan. Initial target was marginally missed, however, work continues to meet the overall deadline for 1st June. Update September 2022: Work continues in this area, however this is still proving a challenging area of work. The new operational model has ensured that this area of work is included as part the Care Group Governance Team. Update October 2022: A data reconciliation with WRP has demonstrated that the data held by CTM and WRP now correlate. This has been achieved through updating data and an in depth data validation. This will be invaluable going forward as service areas will have a clear position in relation to LFERs. The Governance teams continue to support service areas with the completion of LFERs. Guiding principles for the governance and accountability for quality and safety have been developed to support service areas through the transitional process to the new operating model.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	02.11.2021	30.09.2022	30.11.2022
4908	Director of Corporate Governance	Central Support Function - Quality Governance (Concerns & Claims)	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety	Impact on the safety – Physical and/or Psychological harm	Failure to manage Legal cases efficiently and effectively If: The Health Board was unable to sustain ongoing funding for the two temporary Legal Services Officers Then: the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. Resulting in: Risk to quality and safety of patient care, resulting from lack of capacity to management cases in a efficient and effective manner, which could result in failure to comply with the WRP procedures resulting in financial penalties	Controls are in place and include: * Regular reports run on all Redress cases, with monitoring by the Head of Legal Services & Legal Services Manager Some funding secured in respect of one Band 5 Redress Handler, however there still remains a Redress backlog and there has been an influx of inquests. A Redress panels have been established where required and meetings with ILGs undertaken when required to ensure legal aspects have been reviewed and validated.	The Health Board have developed an action plan in response to Welsh Risk Pool review, which is in the process of being delivered. Recommendation from the review are being monitored by the Audit & Risk Committee. All actions due to be completed by the end of March 2023. Update September 2022 - Benchmarking exercise completed, which demonstrates low staffing to workload capacity with counterparts across Wales. Invest to save bid has been drafted with a hope to recruit 2 Redress Handlers. In addition opportunities are being explored to realign resources from the changes to quality and safety within the Operating Model review and workshop is being held in Sept 2022 to review skill mix in the claims handling team. Update October 2022 - Invest to save bid has been completed and submitted for consideration, with a hope to recruit 2 Redress Handlers. In addition opportunities are being explored to realign resources from the changes to quality and safety within the Operating Model review. A workshop has been held with the Legal Services team to review ways of working moving forward into the new operating model.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	02.11.2021	30.09.2022	30.11.2022
4940	Executive Director of Nursing	Central Support Function - Quality Governance (Patient Experience)	Assistant Director of Nursing & People Experience.	Improving Care	Quality, Complaints & Audit	Delay to full automated Implementation of Civica	If: the Information team are not be able to complete the necessary data extraction requirements Then: there will be a delay to the roll out of the automated survey process within the Civica system. Resulting in: a lack of service user feedback and opportunity to areas of improvement as well a good practice.	The Health Board launched the electronic ""Have your Say"" and Generic Patient Experience Survey on the 13.02.22. Posters containing QR codes are displayed on notice boards in our hospital sites, KHPH and Dewi Sant. In addition links are available on our internal and external webpages, along promotion on available social media channels. A small card (like a business card) containing a QR code has been developed which will displayed in main thoroughfares such as Emergency Departments, Outpatients and community settings. Their will be made available to staff that are providing services in patients' homes. Exploration is taking place as to how the posters/cards can be promoted within he wider non-health board community settings. August 2022 Update: Value Based Health Care are working together with patient safety and quality to ensure the Health Board can align patient/peoples engagement / feedback. There is an objective in the new WG transformation strategy where we all have to work together and embed proms and premis. There is currently only one member of staff working on the Civica system (PT)and therefore resource is currently a major factor for the implementation and maintenance of the system. No change to the challenges relating to the full automation of Civica which remains an issue. Due to this CTM response rate to patient feedback is considerably lower when compared to other Health Boards e.g SBUHBB, HDUHHB, ABUHHB, BCJHHB. Volunteers within POW are now actively engaging with patients in regards to the Have your say/ patient experience survey	Implementation of the Civica System. Information Team has completed provision of all data feeds (August 2022) Whilst the overall consequence and likelihood of the risk is not extremely high, the SMS component remains high as currently there is no target date for full implementation of the automated element of Civica which would increase real time response rates. Reactive feedback continues be received and reported on via complaints, claims and compliments. August 2022 Update - SMS component remains high as currently there is no target date for full implementation of the automated element of Civica which would increase real time response rates. CIVICA system piloted in PoW in August using volunteers to capture feedback using the CIVICA system via IPADS.	Quality & Safety Committee	16	C4 x L4	12 (C4xL3)	↔	09.12.2021	25.08.2022	21.10.2022
4417 (Linked to Risk IDs 4706 and 4703)	Chief Operating Officer	All Care Groups	Deputy COO (Acute Services & Primary, Community & Mental Health)	Improving Care	Patient / Staff /Public Safety	Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Management of Security Doors in All Hospital Settings Following several serious incidents following patients absconding from clinical areas, the HSE have issue an Improvement Notice on Bridgend Integrated Locality Group (see Documents) outlining the following actions: In consultation with employees and involving competent persons: 1. Identify the units, wards and premises where in-patients may be at risk from wandering, absconding or escaping. 2. For each of these, undertake a suitable and sufficient risk assessment of physical and procedural measures to prevent in-patients from wandering, absconding or escaping. 3. Identify the measures needed to protect patients at risk 4. Record the significant findings. Any lessons learned from the above should be formally shared with the other 2 Integrated Locality Groups for action. IF: the Health Board do not comply with the notice. THEN: the Health Board may be subject to prosecution by the HSE RESULTING IN: Large Fines and poor publicity.	Clinical areas across the Health Board should have in place local arrangements/procedures to prevent patients from absconding.	Identify the units, wards and premises where in-patients may be at risk from wandering, absconding or escaping in RTE Locality. 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. Identify the measures needed to protect patients at risk. Record the significant findings. Led by Leads in the relevant ILG Sections. Timeframe 31.5.2022. Health Board Learning: Learning has been shared via H&S groups. Local action to be taken by managers. Bridgend Review requested in April 22 Health Safety and Fire Group to ensure action plans are active and risks have been re reviewed. Timeframe July 2022. Update June 2022: - BILG - 21/06/22 Version 7 of the Risk Assessment document updated and circulated to the Director of Operations and colleagues within the BILG to highlight progress made and areas outstanding. Night shift planned for 25.6.22 and a further update will be provided. Revised review date due to outstanding remedial work required and change of ward occupancy, resulting in a further review and ongoing monitoring. Timeframe 30.09.2022. - RTE - Locality Director of Operations currently reviewing all other areas in the ILG. Timeframe 30.09.2022. Update August 2022 - position as reported in June with a review date of the 30.09.2022. Update October 2022 - Deputy COO Acute Services and Deputy COO for Mental Health, Community and Primary Care to review this risk from a pan Health Board perspective and identify actions per Care Group as appropriate. Timescale 31.12.2022.	Health Safety & Fire Sub Committee	16	C4 x L4	8 C4xL2	↔	30.09.2020	1.11.2022	31.12.2022
5014	Chief Operating Officer	Children and Families Care Group	Children and Families Care Group Service Director and Clinical Services Group Manager	Improving Care	Patient / Staff /Public Safety	Impact on the safety – Physical and/or Psychological harm	Care of Obstetric & Gynaecology patients in the ED at the Royal Glamorgan Hospital IF patients continue to present at the ED at the RGH with obstetric and gynaecology related issues and if boundary changes and diverts at times of high demand lead to increased risks for this patient cohort . THEN they will need to transfer to the ED at PCH where the appropriate services are in place. RESULTING IN a delay in the provision of appropriate care and treatment and this could lead to in-utero death, neonatal injury or disability, death of a pregnant lady due to blood loss and a loss of reproductive ability.	Pathways in place and subject to regular review. WAST is aware of the patient pathway and the need for O&G patients to go straight to PCH. Patients self presenting at the RGH ED would be prioritised for transfer to PHC Emergency cases would receive immediate general surgical care from non O&G specialists	Update October 2022 - the Assistant Director of Governance & Risk met with the Care Group Director and the Clinical Services Group Manager for the Children and Families Care Group regarding this risk and agreed that a review will be undertaken by the end of December to consider if the implementation of the On Call rota has mitigated this risk sufficiently to reduce the risk score. This will include engagement with the Executive Medical Director. Review by 31.12.2022	Quality & Safety Committee	16	C4 x L4	9 (C3xL3)	↔	15.02.2022	01.11.2022	31.12.2022

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4722	Chief Operating Officer	Mental Health Care Group	Service Director - Mental Health and Learning Disability Care Group	Improving Care	Patient / Staff /Public Safety	Senior Medical Workforce Shortfall	If the gaps in the senior medical workforce in RTE are not addressed (2wte vacancy OP, 1wte LTS, 1wte Non clinical duties plus paternity leave and isolation) Then routine work such as clinics will be cancelled, clinical decision making will be delayed and emergency escalation compromised along with the ability of the service to discharge the powers of the Mental Health Act. It is also possible that the training of junior doctors will be negatively affected. Resulting in poor quality and unsafe patient care, increasing concerns, risk of litigation, compromise of the UHB's reputation and removal of UHB from Psychiatry training programme.	Regular meetings with interim CSGD and Consultants to plan cover arrangements and support on weekly basis. Medical model change to functional inpatient at the RGH MHU covered by 3 Locum Inpatient consultants (22 sessions - 12/6/6) to cover 2 x Treatment Wards (28 beds) and 1 x PICU (6 beds). Recruitment - Vacancies out to advert for locum and substantive contracts. Exploring options for overseas recruitment. All staff being offered additional hours. In-patient team has been bolstered by an additional Registrar and 2 x SHOs ANP's covering appropriate PCMHSS AND CMHT clinics.	Update 06/06/22 - Vacant post in Rhondda Adult MH and been notified that Locum for Taff Ely who also covers in patient wards 1 day a week will be leaving the end of this week. This leaves 2 vacancies in sectors for adult and an inpatient day short fall. Update Sept-22 - All adverts agreed to go in BMJ as part of wider recruitment drive. JDs have been reviewed and refreshed. Update November 2022 - Locum cover secured to mitigate partial risk pending substantive appointments. Recruitment exercise underway an interest has been received. Medical Director appointed into the Mental Health and Learning Disability Care Group to provide oversight and leadership on sustainable medical workforce activity.	People & Culture Committee Quality & Safety Committee	16	C4xL4	6 (C2xL3)	↔	28/06/2021	01.11.2022	31.12.2022
2987	Executive Director of Finance	Central Support Function - Estates Improvement Project	Central Support Function - Estates Improvement Project	Improving Care	Patient / Staff /Public Safety	Fire enforcement order is in place for the ground and first floor PCH due to inadequate fire compartments to prevent spread of fire, smoke and noxious gasses	If: The Health Board fails to meet fire standards required in this area. Then: the safety of patients, staff, contractors/visitors etc. and the protection of the buildings could be compromised. Resulting in: potential harm, risk of fire. Possible further enforcement in the form of prosecution.	Fire Enforcement Order. An action plan and target dates for the 1st and ground floor areas at PCH is available and is subject to available finance for completion. Phase 1b of the wider programme has been completed and the UHB has now achieved remediation for physical fire issues identified in the FEN in the majority of the new Pharmacy, Dining Room and Kitchen areas at PCH which opened in January 2021. This has tackled the higher risk for fire areas of the old kitchens and improved the fire stopping below ITU as well as reducing the overall volume of area remaining in the FEN to be remediated (remediated c2000m2 of c18000m2). In addition the UHB secured Welsh Government approval in October 2020 for the Phase 2 FBC, in the sum of £220m, which will see progressive improvement of the majority of the remaining G&FF areas to be remediated for fire over the next 5 and a half years. As a reminder these works are progressive due to the need to balance them against maintaining service delivery as best as we are able and are intended to be supplemented (to run concurrently with final years of the Phase 2) by a final Phase 3 business case intended to address the final physical accommodation areas included within the FEN. Ongoing maintenance of fire systems. Increased knowledge on site of the fire issues, fire training, initial works carried out on areas as part of the scheme already.	Ground and first floor major project approved by WG to address the fire notification on PCH. In progress with completion due 2026 / 27. Annual reviews as to remediation progress are held with SWF&RS and the Health Board is required to evidence continued progression in the shortest timescale. If satisfied SWF&RS issue an annual extension letter against the FEN. The current extension runs to the 31/07/22. The Phase 2 programme has now reached a point where an additional c 3500m2 of FEN accommodation has been handed to the contractor (End of Jan 2022) as the next section to be remediated, having now decanted these areas to alternate fire compliant accommodation. An extension of a further 12 months has been granted by the Fire Service and will now expire on 31/07/2022. Update June 2022 - Phase 2 Update - The need for capital investment is recognised and is recognised on the Health Board list of schemes. The plans have been drawn up so the project can be progressed when the funding becomes available. The capital funding challenges, in NHS Wales, however, are recognised and so in the meantime to ensure safe respiratory and non respiratory pathways fracture clinic has been moved to Ysbyty Cwm Cynon to allow the PCH ED to move into the vacated space. The impact of this change has been to reduce the risk and we continue to actively manage the risk. There has been a slight reduction in the likelihood of unsafe overcrowding (3) but the net consequence of overcrowding in an ED is significant when it happens (5) Current risk score relating to environment is 15. Update August 2022 - Risk has been reviewed by Head of Health, Safety and Fire as has wider organisational implications for fire safety management. Risk remains unchanged.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	15	C5xL3	6	↔	29.11.2017	28.07.2022	30.11.2022
2808	Chief Operating Officer	Children and Families Care Group	Clinical Service Group Manager	Improving Care	Patient / Staff /Public Safety	Waiting Times/Performance: ND Team	If: The Neurodevelopment service does not have capacity to achieve the WG assessment target (80% of assessments to commence within 26 weeks of referral) and to follow up patients in a timely way, due to demand exceeding capacity Then: Patients will wait excessive periods to reach a diagnosis and children on medication that require titration and monitoring may not be able to be seen within the appropriate timeframes Resulting in: Delays in appropriate treatments being commenced, delays in accessing support e.g. in school following a diagnosis, delay in being effectively titrated, risks associated with delays in medication monitoring	The service is operating as efficiently as possible e.g. enhanced roles for SLT/CNS/Pharmacist. Pathways have been reviewed e.g. ADOS's limited to only those cases where clinically necessary. Clinical Lead role created to support this (as below). Non-recurrent investment of the below posts have been given for 12 months, but Clinical Service Group has highlighted the requirement for these posts to be made permanent. *1.0 wte Psychiatrist (clinical lead role) *Uplift from 8a to 8b 0.6 wte Pharmacist *1.0 wte Band 3 admin *0.6 wte Band 3 HCsw Additional clinics are currently being held on weekends to address longest waiters. (WLI has been carried out in the service since 6 months of the service being set up) Meetings with National Lead for Values Based and Prudent Health Care arranged to look at modelling of the service. Bids have been submitted through successive IMTPs and previously against new WG funding sources for the ND service. Within Bridgend the Directorate is reviewing the feasibility of repatriating the SLA from Swansea Bay so that a local service can be developed	Seeking confirmation that non-recurrent funding is made permanent for fixed term posts - timeframe 31.3.2022. Consideration required for further investment in the service to allow us to meet the demands on the service and reach the Welsh Government target of 80% of assessments being seen within 26 weeks. This will also reduce the need for WLI every year. Further investment in the service following D&C review - Timeframe - 31.03.2022. September 2022 Update - it was agreed at the August PCR Board meeting that funding would be made available to support an additional Consultant, uplift to for a member of the Pharmacy staff, the appointment of an Administrative Assistant and a Health Care Support Worker. In addition, Welsh Government has announced that there will be funding for ND services across Wales over the next few years. The funding will be allocated to Regional Partnership Boards for distribution in-line with Regional Integration Fund aligned to the six national models of care with emphasis on taking a whole system approach with education, social care, health and 3rd sector working to deliver new models of care. October 2022: Risk remains unchanged however, review underway with Clinicians. Next review 31.12.2022.	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	14.07.2017	02.11.2022	31.12.2022
3638	Executive Medical Director	Diagnostics, Therapies and Specialties Care Group	Chief Pharmacist	Inspiring People	Patient / Staff /Public Safety	Pharmacy & Medicines Management - Training & Development Infrastructure	If: the planned HEIW led changes to the education and training of pharmacists and pharmacy technicians with increased numbers of trainees across both primary and acute care are fully implemented Then: the there will be insufficient capacity within the medicines management team to provide the required training, supervision and management of the planned trainees. Resulting in: a lack of appropriately qualified pharmacy professionals to meet future service demands in all sectors and particularly in hard to recruit to ILGs such as Merthyr where we have established a "grow our own" model. This can impact the primary care sustainability MDT model. Also a reduction in reputation of a HB that has a very high level of % qualifying and a reduction in future applicants. Current capacity is overstretched and a robust education, training and development infrastructure is needed to meet these demands for specialist & advanced practitioners in primary and secondary care.	SBAR submitted to CBM in March 18 to increase training capacity in order to meet the demand. Included in IMTP and prioritised as number one priority. A bid was included as part of the primary care pacesetter for education and development in primary care academic hubs and was successful. This element of the ed/tr will be implemented in 2018 for 3 years with evaluation. The secondary care elements were not supported in the IMTP prioritisation process and so this still leaves significant risks. SBAR needed to describe the impact of the new technicians training qualification. Funding approved for primary care lead pharmacist - commenced in post April 2019. Included a new case in 2019/20 IMTP as high priority. SBAR for Nov CBM on new technician training requirements. Progress and evaluate primary care pacesetter plan to increase training infrastructure to inform business case to continue funding and scale up.	Update June 2021: HEIW have agreed training support grants for trainers to support pre-registration foundation posts which mitigates the risk for this group of staff. However this funding is only temporary and not guaranteed beyond 2022-23, which presents a potential risk around recruitment of suitable staff. The post-registration foundation programme has been deferred until 2022 which buys some time for health boards to explore solution to the significant financial shortfall that will arise form the lack of on going funding for these posts. Update July 2021 - No further update to that recorded in June 2021. Review 30.09.2021. Update November 2021 - as reported to the Quality & Safety Committee: Discussion with HEIW have resulted in a delay to the financial changes until 2024, which will allow the service related impact to be better transitioned into the planning cycle. Update February 2022 - Risk remains as funding for the posts will be significantly reduced from 2023 onwards as HEIW will reduce from 50% to 20% funding. The shortfall in funding between establishment and post costs remains the risk. The funding resource is being captured in the IMTP submission for 22-23 in preparedness for the impact in 2023-4. Funding gap is approximately £90k pa. This equates to 2 posts. Decision of funding is required by March 2022 to allow for recruitment process in 2023. Update August 2022 - Bid submitted to CTMUHB IMTP prioritisation panel. Bid not successful. Reduced student numbers submitted to HEIW, will only be able to take on 3 acute sector trainees in 2023, reduced from 6. This will have implications for clinical service delivery and staff recruitment & retention.	People & Culture Committee	15	C3 x L5	6 (C3xL2)	↔	02.01.2018	08.09.2022	30.12.2022
3993	Executive Director of Strategy & Transformation	Central Function - Planning Project Risk	Head of Capital, Strategic and Operational Planning	Improving Care	Patient / Staff /Public Safety	Fire Enforcement Notice - POW Theatres.	If: The Health Board fails to meet fire standards required in this area. Then: the safety of patients, staff, contractors/visitors etc. and the protection of the buildings could be compromised. Resulting in: potential harm, risk of fire. Possible further enforcement in the form of prosecution.	Storage room obtained on ward 16 to store theatre equipment to ensure evacuation corridor is kept free for evacuation. Staff training on lift evacuation. Closed storage cupboards purchased for safe storage of equipment. "safe" areas identified with Senior Fire officer for storage of equipment in corridors. Weekly meetings to discuss and plan building work necessary to meet requirements of the enforcement notice. Enforcement notice has been extended to December 2021. Need to plan for drop in theatres to mitigate work commencing	Need building work to be undertaken to ensure safety. Operating theatres will need to close for this to occur. Fire enforcement notice has been extended to December 2023 by South Wales Fire and Rescue Service, work is ongoing with the construction supply chain partner to complete detailed design, obtain planning permission, a costed programme and submit a business case to Welsh Government by Spring 2022. WG have requested an options review be urgently undertaken on this as the preferred decant option is indicatively costed at £50M. The ILG are confirming availability for a management review of alternative options for delivery prior to a stakeholder session. Post this a report will need to be prepared for and discussed with WG to determine the way forward in terms of business case processes and timings. Update September 2022 from Capital & Estates - initial meeting with WG indicated that further work required to follow up on alternative options to the 6 theatre modular build so follow up WG meeting being arranged for late October / early November. Supply Chain partner reengaged to undertake more detailed engineering and design works. Update November 2022 - Risk remains unchanged as the options work is ongoing and meeting with WG is likely to be at the end of November with an outcome to the options review being discussed at that meeting. It is expected that this meeting will confirm the preferred way forward.	Quality & Safety Committee Health, Safety & Fire Committee	15	C5xL3	8	↔	31.01.2020	17.10.222	31.12.2022

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4512	Chief Operating Officer	Mental Health Care Group	Deputy COO - Primary, Community and Mental Health	Improving Care	Patient / Staff /Public Safety	Care of patients with mental health needs on the acute wards.	If: there is a consistent number of patients with mental health needs who are being cared for on the acute wards without RMN support or there are delays in discharge an appropriate EMI setting; Then: patients who have been sectioned and / or are under medication review may remain on wards where specialist mental health therapy and input is not possible; Resulting in: incidents of staff and patients assaults may occur; poor patient experience; increased supervision needed.	MHL team contacted for each patient who required support; 1:1 patient supervision where required; Ward manager and senior nurse undertake regular patient reviews; Regular meetings with the mental health CSG in place. , number of working groups established and working well.	Regular meetings with the mental health CSG in place, number of working groups established and working well. No change to mitigation or risk score. Update September 2022 - update requested from the Deputy COO - Primary Care, Community and Mental Health. Update October 2022 - Deputy COO - Primary Care, Community and Mental Health and Interim Clinical Service Group Manager, Mental Health are reviewing this risk and consider that the risk score will be reduced in the next update of the Organisational Risk Register. Timeframe assigned: 31.12.2022.	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	30/12/2020	02.11.2022	31.12.2022
4590	Executive Medical Director	Diagnostics, Therapies and Specialities Care Group	Chief Pharmacist	Improving Care	Patient / Staff /Public Safety	Critical Care Pharmacist Resource	If: additional resource is not identified to increase the critical care clinical pharmacy service Then: there is a risk that insufficient support can be provided to meet national standards and there would be lack of capacity to support future surges in demand, such as Covid. Resulting In: an increasing risk to patient safety, increased workload for critical care nursing and medical staff and lack of appropriate support for digital developments such as e-prescribing	SBAR included in Medicines management and advised to include in ACT directorate IMTPs. Meetings to discuss potential funding arranged with ACT leads. Baseline level of service (0.2wte) pharmacist time per site. A small pool of CC trained pharmacists are providing clinical services to acute wards which would be impacted if they are redeployed to support ITU, resulting in risk to patient safety and flow on acute wards.	June 21: Current situation included in planning review of CTMUHB ICU services Aim is to secure funding for 1WTE 8a specialist pharmacist for each critical care in RGH, POW and PCH and also supporting technician resources Update November 2021 as reported to the Quality & Safety Committee: Discussions are ongoing with ILGs so that pharmacy resource costs are included in any new business cases e.g. PACU and progress can be made to meeting the standards. Update February 2022: Discussion are ongoing with ILG's and submission for funding was made in Medicines Management in IMTP Feb 2022. Update August 2022 - Currently 40% gap in staff in post vs standards (1.5 wte) across all acute sites. Funding agreed for RGH and staff recruited into post. Currently non-recurrent. Funding request submitted within IMTP.	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	05.04.2021	08.09.2022	08.10.2022
4671 removed from publication due to business sensitive information																	
4672	Executive Lead: Director for Digital.	Central Support Function - Digital & Data	Chief Information Officer	Creating Health	Operational: - Core Business - Business Objectives - Environmental / Estates Impact - Projects Including systems and processes, Service /business interruption	Access to a complete, integrated, and coded medical record.	If: The Health Board is not able to record information accurately and reliably, with complete and up to date information Then: the data informing the clinical, regional and organisational decisions we and our partners (including WG) make, will be inaccurate, out of date or incomplete Resulting in: Degradation in our delivery of the quadruple aim and strategic objectives and damage to our reputational standing with our population and partners. Further we will be prevented from driving forward our ambitions to become a digital organisation, an exemplar for R&D and Value etc.	Operational controls: Coding key performance indicators covering productivity, demand and backlog robustly monitored Digitised Patient Notes programme board monitors scanning times, adherence of contractor to terms and quality of staff in maintaining a record DHCW annual coding quality audit. Coding Improvement and transformation plan established incorporating additional trained coding capacity, coding at source, use of data captured in other systems and e-forms implemented. Natural language programming resource deployed and outputs of programme being validated. Tactical - EPR programme with deployment of snomed-CT 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 (NDR /CDR & Sharing arrangements) Coding transformation programme Gaps in controls Scanning time of outpatient activity to digitise the record is at 51 days cf maximum clinically safe time of 24-48 hours Quality of paper record and its filing is very poor with audits identifying over 70% of paper records are not maintained to acceptable standards Digital solutions not yet using snomed-CT/ structurally coded data Information and Technical Standards not being followed with national body favouring document rather than data exchange Vast amounts of clinical information stored in disparate spreadsheets not visible to central medical record or available to patients or system leaders (including value based healthcare) Digital transcription programme unsupported & unsupported from march 23	Update August 2022 - Consideration being given to Cessation of creating scanned records for any more new patients enabling scanning capacity to be put towards address backlog of active patients who already have a record in the scanning system - Development of a Health Board coding strategy for the development of the profession developed and being taken forward - Natural Language Programming (NLP) and data linkage being used to autocode targeted spells, improving levels of coding completion, based on Snomed-CT - Adoption of data level standards based architecture, - Coding transformation plan - Opportunity for bi-directional real time integration between primary and secondary care available - National Data Resource (NDR), Clinical Data Repository (CDR) and integration programme Update October 2022 - Consideration being given to Cessation of creating scanned records for any more new patients enabling scanning capacity to be put towards address backlog of active patients who already have a record in the scanning system - Development of a Health Board coding strategy for the development of the profession developed and being taken forward, which underpins the coding transformation plan - Natural Language Programming (NLP) and data linkage being used to autocode targeted spells, improving levels of coding completion, based on Snomed-CT identified as increasingly successful and cost effective - Adoption of data level standards based architecture, - Opportunity for bi-directional real time integration between primary and secondary care available but requires tactical decision by UHB Board - National Data Resource (NDR), Clinical Data Repository (CDR) and integration programme UPDATE 28/10 ICT Risk meeting - no further update	Digital & Data Committee	15	C3 x L5	9 (C3xL3)	↔	05.06.2021	22.10.2022	01.12.2022
4732	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety	Lack of orthogeriatrician as NICE guidance and KPI1 NHFD	If: If we do not have this specialist service THEN: our patients will receive suboptimal care than others in the UK and across Wales with potential for non achievement of KPIs set by the Welsh Government, increased length of stay, increased complications such as delirium and pressure ulcers and increased mortality. RESULTING IN: The inability to achieve good outcomes and care appropriately for our patients has a detrimental effect on staff wellbeing too.	The already stretched on call medical team are contacted for ad hoc advice. There is no COTE service and no specialist advice available	Recommendation: Employ a frailty team at each site to care for this complex group of patients. This may have cost benefits such as reduced length of stay, reduced complications and reduced complaints. Timeframe: 31.01.2022 Update June 2022: Funding for Consultant Orthogeriatrician identified and two COTE elderly posts in place. Update September 2022 - COTE and Orthogeriatrician service model being finalised for PCH. Timescale within next 3 months.	Quality & Safety Committee	15	C3 x L5	4 (C2 x L2)	↔	30.06.2021	07.09.2022	03.10.2022

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4772	Chief Operating Officer	Central Support Function - Facilities	Governance and compliance manager, Facilities	Improving Care	Operational: - Core Business - Business Objectives - Environmental / Estates Impact - Projects Including systems and processes, Service /business interruption	Replacement of press software on the 13 & 10 stage CBW presses	If: The 10 & 13 stage Lavatec presses have old software control systems, and are both vulnerable to failure. Following a fault developing and a recent maintenance call out it was identified that the 10 stage press is working intermittently caused by a software problem. Then: If the 10 Stage press control system fails the consequence of not purchasing the software replacement would result in the laundry service being unable to produce to full capacity and reduced to around 55%. If the Stage 10 press control system software fails then it could also impact on the Stage 13 press. The consequence of both presses failing and not purchasing the software replacement would result in the laundry service being unable to process any laundry which will result in all CTMUHB laundry being outsourced to commercial laundries. The costs will be significantly higher than those incurred in-house. Resulting In: - Potential of service failure due to existing system. - Potential of CTM sites being without bedding and linen at existing volumes and turnaround times. - Potential increased costs resulting from having to outsource laundry processing to commercial laundries in the event of equipment failure.	The All - Wales Laundry review continues, and at the current time, it is likely that services will be provided from CTM laundry until at least 2024. After this time, the equipment could be moved and rehoused elsewhere to continue to support CTM and the All-Wales Laundry agenda. Previous IMTP submissions have included as a priority £375K for a replacement automated sorting and roll cage washer/dryer system at the laundry. The software that controls system for the CBW forms an integral part of the current press. Benefits of equipment being replaced: - Reduced risk of service failure and therefore improved confidence in continued production. - Easier to diagnose and put right any mechanical defects. The Laundry is being monitored remotely by the system supplying company. This ensures that we are able to run the system and any problems quickly rectified on the 13 stage CBW. The 10 stage new software has now been installed and updated and all snagging completed. We were in the process of arranging a date for the 13 stage CBW software to be updated when the bolts on the 10 stage sheared, this will be repaired Monday 4th July 2022 we will then arrange for the new software to be updated on the 13 stage. There is a robust contingency plan in place we are able to continue with a normal service until these issues are resolved. We also have the ability to call upon the other L4 region production units. The contingency plan provides for a 5 day full service with ability to call on the other L4 within the All Wales Laundry agreement to produce our linen if needed.	Update September 2022 SON to be submitted and if successful replacement software purchased and installed. Timescale: 30/11/2022. SON approved and funding provided, awaiting installation. Update from Deputy Linen Services Manager that order has been raised to replace. 10 stage press received completed software upgrade. However, since the last review of this risk on the washer the bolts sheared off the press reducing production by 50%. A contractor has been to site to try and carry out repairs but so far have not been able to due to the severity of the problem. The contractor has now gone back to the manufacture on the next steps. Dependent on what the manufacture suggests, it's also lead time and down time of this machine, we are looking at the machine out of service for the next few months leaving the laundry only operating at 50% capacity and limited resilience if the other stage washer fails. Until there is a response received from the contractor, there are no definite answers on parts, costs or timescales. All departments, including Facilities, Estates and NWSSP have been informed of the issue. As a contingency the 13 stage press is being monitored and will be upgraded after the 06/09/2022. Based on this update the risk remains as a high risk and will be reviewed in 3 months time or once the repairs have been undertaken and software has been installed. No Change to mitigation at this time. Review Date: 30/11/2022	Quality & Safety Committee Planning, Performance & Finance Committee	15	15 (C5xL3)	5 (C5xL1)	↔	27.07.2021	21.10.2022	30.11.2022
4920	Executive Director of Therapies & Health Sciences	Diagnostics, Therapies and Specialities Care Group	Deputy Head of Occupational Therapist	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Capacity within the ED/ Medical/ Rehabilitation and Orthopaedic Inpatient Occupational Therapy Service within Princess of Wales	If: clinical capacity remains significantly reduced due to staff sickness and vacancies Then: clinical service delivery will be negatively compromised. Resulting in: Increased length of stay, potential clinical incidents, poor clinical outcomes for patients, and increase in complaints. It will impact on staff wellbeing within the team and increase incidence of staff sickness.	Regular team meetings to support prioritisation and wellbeing. Updating AHP lead in Bridgend ILG on potential impact.	Recruitment of locum. Additional hours offered, resulting in part- time staff working additional hours. Redeployment of staff according to clinical priority, utilising a therapies version of daily "safe to start" with AHP Clinical Director, where staffing is monitored daily Update September 2022 - Last review 30.8.22 next rv 31.10.22. No change to mitigations, recruitment in progress, and improvement in staffing is expected by November. Update October 2022 - No change to mitigations, recruitment still in progress.	Quality & Safety Committee	15	C3 x L5	12 (C3xL4)	↔	27.11.2021	21.10.2022	30.12.2022
4971	Chief Operating Officer	Primary & Community Care Group	Assistant Director for Primary Care	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Adult Special Care Dentistry	If: the Community Dental Service is unable to recruit a special care dentist, then there will be no dedicated specialist to undertake the appropriate assessment and dental treatment under GA for vulnerable adults in a timely manner, resulting in more patients waiting, longer waiting times, patients being in pain and some having to access secondary care dental services as an urgent or emergency care.	Patients can be seen within the CDS for advice and treatment under local anaesthesia where this can be tolerated by the patient. A Consultant advert has been placed 3 times alongside a Specialist level post to widen the opportunity for recruitment. No applications received. If either post is recruited in to the risk will be mitigated. Although it will take some time to clear the current waiting list. Patients will be contacted regularly as part of safety netting to check that their condition is not deteriorating and no one is left in pain.	All the patients on the list are being reviewed and contacted regularly to assess if their dental condition has deteriorated or if they are in pain . Consideration is being given as to whether treatment can be undertaken in a local routine dental practice as opposed to the community dental service (CDS). This is very much on an individual basis. Discussions are taking place with Medical Staffing, HEIW and Cardiff Dental School with regard to the possibility of recruiting from abroad. Especially in view this is a national recruitment problem and other Health Boards are in a similar position. September 2022 Update – Risk position discussed within Primary Care and rating being reviewed and will be updated once considered via the Primary Care processes. Update October 2022 - Recruitment stage to re-commence with interviews likely to take place in January with two potential candidates expressing an interest with continued dialogue and engagement with them.	Quality & Safety Committee	15	C3xL5	3 C1xL3	↔	04.01.2022	31.10.2022	31.12.2022
5040	Executive Lead: Director of Digital	Central Support Function - Digital & Data	Chief Information Officer	Creating Health	Operational: - Core Business - Business Objectives - Projects Including systems and processes, Service /business interruption	Digital Healthcare Wales (DHCW interdependencies	If: The Health Board can not integrate new applications into its digital architecture in a timely fashion Then: there could be a detriment to patient care, inefficiencies in care provision and loss in confidence by Health Board staff in the technology provided to them leading to them using alternative software and bespoke systems (including paper based systems) to carry out their duties which are not integrated and major strategic priorities for the organisation (e.g. Bridgend aggregation and the deployment of the new Emergency Department system) not being delivered Resulting in: delays in clinical decisions and consequently treatment which may affect clinical outcomes, reduced levels of productivity and thus poorer access to services, staff appetite to work digitally and in accordance with the digital standards required to realise the full strategic benefits of an integrated record and repository not being realised. Other consequences include: 1. Loss of information integrity and accessibility as multiple copies of clinical records. 2. Failure and delay of digital system deployments (e.g. WEDS) 3. Possible breaches to the GDPR, safeguarding and information governance risks. 4. Mistrust by staff of the ICT systems and services they are using 5. Money being wasted	A 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 fulfilty has been exposed by demand pushing the waiting times for developments to start (not complete) to over 12 months Gaps in controls: WG have agreed some funding for the PAS element, however the DHCW IMTP continues to be a top down decision process rather than one being based on HB (user / customer) needs - driven in part by demand overwhelming their capacity (much of which is either Covid born or results from the significant overrun in establishing a minimum viable product to replace CanISC) and numerous critical constraints not continuing to be observed in the system whilst the architecture remains closed. HB carrying vacancies in critical areas with no capacity to cover the work from within. As a consequence programme to digitise the Emergency Department processes and records has been suspended. Data acquisition from DHCW products is a curates egg, some new APIs are being made available to standards, however latest PAS offering is via csv download, presenting challenges to adoption of standards within certain areas. UHB still awaiting availability of access to key HB data such as radiology and tests results.	National Data Resource Programme has accelerated plan to open up the architecture, with API management procured for all of Wales. National Funding received from WG for PAS integration work to create a second team supporting data migration. CTMUHB appointment process has commenced. WG funding for £7m awarded to support PAS integration 24/8/22 UPDATE 28/10 ICT Risk meeting - no further update October 22 - National Data Resource Programme has accelerated plan to open up the architecture, with API management procured for all of Wales & implementation data set for Jan 23 - will be limited in nature. National Funding received from WG for PAS integration work to create a second team supporting data migration. CTMUHB & DHCW appointment process has commenced. Included within this is a post for PAS integration developer.	Digital & Data Committee	15	C3xL5	9 C3xL3	↔	07.02.2022	22.10.2022	02.12.2022
3337 Linked to RTE Risk 4813 and M&C 4817.	Chief Operating Officer Director of Primary Care and Mental Health Services	Central Support Function: Digital & Data Mental Health Care Group	Lead Infrastructure Architect Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Use of Welsh Community Care Information System (WCCIS) in Mental Health Services	If: Mental Health Services do not have a single integrated clinical information system that captures all patients details. Then: Clinical staff may make a decision based on limited patient information available that could cause harm Resulting In: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace.	1. Process in place for clinical teams to access information via local authority and health board teams. 2. Clinical teams will only use historical information as part of their current risk assessment and if this is not available they will judge the risk accordingly. 3. WCCIS Programme Board establishment for CTM will be finalised by the 30th June 2021, Merthyr and Cynon CGS Lead will Chair this group. The Chair of this group will report to the Senior Responsible Officer. The Task and Finish Groups established and aligned to this Programme board. 4. Local Authority have recently developed reports for Mental Health which identifies practitioner caseloads, admissions and discharges and care plan for compliance. 5. Deployment order in place for all existing WCCIS mental health staff users 6. Community Drug and Alcohol Team in Bridgend have now moved over to WCCIS, early implementation learning continues to take place. 7. WCCIS Regional Working Group now has a representative from the Health Board to maintain pace of delivery for WCCIS mental health rollout. 8. CTM have set up a Project Board in partnership to prepare for implementation of WCCIS 9. Project manager has been recruited. This role is leading on the development and implementation plan. 10. Business Case identifying additional ICT resource to progress the disaggregation process developed and awaiting approval. Workforce capacity impacts on programme deliverables. Patient Safety Controls: - CSG's have undertaken initial review and rationalised staff access to all information systems to understand the presenting need for access. - CSG's have introduced mechanisms to monitor and control access to FACE/WCCIS/W Drive to ensure prudent access to patient information. - Each clinical team has at least one staff member with resources and training to access information in line with agreed permissions to ensure ease of access to available information from all systems. - RTE lead nurse will lead pan CTM MDT working group to develop consistent approach to clinical record keeping and monitor ongoing IG process/ workstreams (Meeting date in November to be confirmed).	1. A Business Case has been developed which identifies additional staff resource required to progress the disaggregation process to bring all CTMUHB staff who currently use WCCIS via local authority over to CTMUHB WCCIS platform. Requires Programme Board approval. Business Case pending approval. 2. Director of Digital, CTMUHB undertaking a review to understand if WCCIS remains the best solution to progress for CTMUHB in general and for Mental Health specifically. WCCIS "go-live" at ABUHB in August 2022. Lessons learnt group is attended by CTUHB Project Manager. 3. Options Appraisal completed with plans to present to the ELG on the 7th November 2022 with a view to progress to full Business Case. A service improvement and learning team is being established and the role of this team will be to develop robust oversight and mitigations in relation to record keeping until such time and integrated system is available.	Quality & Safety Committee	15	C5xL3	6	↔	07/11/2018	28.10.2022	31.12.2022

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
4691 Linked to RTE Risks 4803, 4799, 3273 and 3019.	Chief Operating Officer Director of Primary Care and Mental Health Services Rhondda Taf Ely Locality	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. SRU/ Pinewood – anti-ligature work has been completed. RTE CSG - RTE specific environmental risk mitigation plan in place and under regular review. RGH MHU are currently in the process of extensive anti-ligature upgrades as part of a capital work scheme, including all doors and ensuite on ward admissions/21/22 and PICU being upgraded. PICU is now complete and contractors are currently working on Ward 21. Following this work will proceed to admissions and 22 in turn. Update 28.10.2022 - 28.10.22 Ward 21– Completed Ward 22– Scheduled Completion and handover back to us 25th October 2022 PICU – Scheduled Completion and handover back to us 28th October 2022 Admissions – Due to commence work 31st October 2022, estimated completion date 15th December 2022 M&C CSG - SRU/Pinewood – ligature work has been completed.	The mitigating environment and staffing measures put in place last year are still in place. Anecdotally it is reported that the ward feels safer by night, the challenge for the ward team is to now use QI methodology to make a case for continuing with these staffing levels after the capital work is complete. No incidents involving suspended ligatures have been reported since these measures were implemented. This is reflected in Bridgend CSG risk register. Annual revisiting of all patient ligature risks progress Statement of Needs via capital process for any ligature risks assessed as needing resolution. SRU/ Pinewood – anti-ligature work has been completed. RTE CSG - RTE specific environmental risk mitigation plan in place and under regular review. RGH MHU are currently in the process of extensive anti-ligature upgrades as part of a capital work scheme, including all doors and ensuite on ward admissions/21/22 and PICU being upgraded. PICU is now complete and contractors are currently working on Ward 21. Following this work will proceed to admissions and 22 in turn. Update 28.10.2022 - 28.10.22 Ward 21– Completed Ward 22– Scheduled Completion and handover back to us 25th October 2022 PICU – Scheduled Completion and handover back to us 28th October 2022 Admissions – Due to commence work 31st October 2022, estimated completion date 15th December 2022 M&C CSG - SRU/Pinewood – ligature work has been completed.	1. Discussions to commence with Welsh Government in relation to the inpatient environment. 2. A strategic case to be prepared and submitted to Welsh Government -COMPLETE Strategic Outline Document submitted and agreement to commence a Strategic Outline Business Case received. 3. If the strategic case conversation is supported by Welsh Government, develop a strategic outline business case. Timescale March 22 4. If the strategic outline business case is accepted, progress to the development of a full business case. 5. Full Business Case paused due to pandemic. Resource to be identified to progress full Business Case. A Quality Improvement Programme in relation to inpatient care is being developed and a workstream in relation to therapeutic environments is being established with the aim of optimising the patient experience. Inaugural workshop scheduled for the 20th December 2022. Interviews pending for the Assistant Director of Strategic Transformation and this role will lead a range of strategic programmes including recommencing a new capital business case for a new Mental Health Unit. Update - 28.10.22 with no change to risk rating	Quality & Safety Committee	15	15 (C3xL5)	6 (C3xL2)	↔	15.06.2021	28.10.2022	31.12.2022
4253	Chief Operating Officer	Mental Health Care Group	Service Director – Mental Health and Learning Disability Care Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Ligature Points - Inpatient Services	IF: the Health Board fails to minimise ligature points as far as possible across identified sites. Then: the risk of patients using their surroundings as ligature points is increased. Resulting In: Potential harm to patients which could result in severe disability or death.	Bridgend Locality: The anti-ligature works has not yet been completed and signed off. There are snagging issues on ward 14 and remedial decoration. On PICU the bathrooms have not been started. All works have been chased by Senior Nurse to project lead for updates on completion. Actions identified for escalation if no update received regarding completion dates. The risk score remains unchanged at present. o Increased Staff observations in areas where risks have been identified. o Any areas of the unit not being occupied by patients are to be kept locked to minimise risks o The use of safe and supportive observations o Risk assessment process for patients and environment is in situ o Some anti-ligature work has been completed in some bedrooms which are used for patients assessed as being at higher risk.	Bridgend Locality: o action plan developed with support from the head of nursing within the ILG. o Health Board has approved additional staffing by night and to fund the outstanding capital anti ligature works. guidance issued to all staff on the implementation of local procedural guidelines. o Use of therapeutic activities to keep patients occupied Update 25.5.2022 - Major Works complete and official handover undertaken on the 25th May 2022 with contractor. Risk scoring reduced from a 20 to a 15. The Target Score has not been met as there are still works to complete internally with Estates. Bridgend 28.10.22 All anti-ligature works in PICU, Ward 14, Angleton have been completed and areas handed over subject to completion of a few outstanding snags by the contractors. Work is awaiting final sign-off. Review end of December 2022 with a review of revisiting the risk score.	Quality & Safety Committee Health, Safety & Fire Committee	15	C5xL3	10 C5xL2	↔	17/08/2020	01.11.2022	31.12.2022
5207	Executive Director of Strategy & Transformation	Primary & Community Care Group or Central Function?	Deputy Director of Strategy and Partnerships	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Care Home Capacity	IF: the rising costs of delivering care in private facilities drives a number of providers to cease trading. Then: there will be a loss of capacity within the system. Resulting In: exacerbated delays in hospital flow, an impact on wait times and increased admission to hospital for displaced patients. Patient experience will be impacted due to increased hospital stays. There will also be a longer term impact on residential care opportunities.	Multi Agency Operational Group established that effectively risk assesses the homes and manages any emergent contractual/ provider/ safeguarding issues, we wonder if this is forward looking enough in the current context. Local Authorities have regular contact with Care Homes to assess any challenges that they are facing and will intervene as appropriate based on risk and circumstances.	Via the Regional Partnership Board and other partnership meetings questions will continued to be escalated to seek assurance. Reports on specific incidents will be taken to Planning, Performance & Finance Committee. Care Providers will continue to engage with Welsh Government to escalate their concerns around the current position.	Quality & Safety Committee Planning, Performance & Finance Committee	15	C5xL3	10 C5xL2	↔	19.8.2022	26.10.2022	30.11.2022
4699	Executive Lead: Director of Digital	Central Support Function – Digital & Data (Information Governance)	Chief Information Officer	Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Failure to deliver a robust and sustainable Information Governance Function	IF: The Health Board is not able to legally share the business and patient sensitive information for which it is a data controller and which it is required to shared for the delivery of care Then: There will be a loss of trust and confidence in the Health Board from its patients, population, staff and 'care providing partners' and thus will not have the information required to provide safe, high quality and effective care and to make informed evidenced based decisions. Resulting in: Poor outcomes for our population, a loss of reputation for our organisation, substantial delays in improving services, inability to collaborate regionally or deliver integrated care services.	Key Controls: - Adoption and implementation of All Wales IG and Data protection policies. - Continual improvement and progress made in mitigating non delivery of legislation (CLDC, DPA etc) - Mandatory training in Information Governance with auditing functionality (such as NIIAS) built in to monitor compliance. - Accessible but robust data protection process for new and existing data sharing arrangements (DPIA procedures) - Joint data controllership arrangements with DHCW + WASPI -Professional (clinical) training and approach to maintain an accurate and timely medical record Gaps in Controls: 1. Shortfall in trained IG professionals 2. Inability to legally stipulated timescales for Freedom of Information and Subject Access Requests	Cyber and Data Protection Improvement Plans being taken forward. - Timeframe: Quarterly updates Response to ICO audit recommendations being managed on a prioritised and smart basis (aligned to other improvement areas) Benchmarking training with other organisations in Wales undertaken. (SB have 9wte, CTM 2.5wte funded, 1.5 wte now --> 0.5wte by end of Sept.) Procedures and requirement to initiate all programmes being enhanced to meet legal requirement of privacy by design Update August 2022 - Further attempt to recruit to two vacated positions in progress Re-allocation of coding staff to IG function on very short term basis to provide some continuity and cover. UPDATE 28/10 ICT Risk meeting - No further update October 22 - Actioning of Cyber and Data Protection Improvement Plans decelerated due to staffing. - Timeframe: Quarterly updates Response to ICO audit recommendations being managed on a prioritised and smart basis (aligned to other improvement areas) Benchmarking with other organisations in Wales undertaken. Procedures and requirement to initiate all programmes being enhanced to meet legal requirement of privacy by design Re-allocation of 1 coding staff to IG function and appointment of agency head of IG for 3 month period made, to sure up IG function. Recruitment process underway for Head of IG. IG Officer post currently delayed via the recruitment process.	Digital & Data Committee	15	C3xL5	12 C3xL4	↔	18.06.2021	22.10.2022	02.12.2022
4217	Executive Director of Nursing & Midwifery Infection Control	Central Support Function – Infection, Prevention and Control	Lead Infection, Prevention and Control Nurse	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	No IPC resource for primary care	If there is no dedicated IPC resource for primary care. Then: the IPC team is unable to provide an integrated whole system approach for infection prevention and control. Resulting In: non compliance with the reduction expectations set by WG. A significant proportion of gram negative bacteraemia, S.aureus bacteraemia and C.Difficile infections are classified as community acquired infections.	Liaise with specialist services in primary care e.g., bowel and bladder service IPC team investigate all preventable community acquired S.aureus and gram negative bacteraemia and share any learning with the IPC huddles arranged in primary care to look at community acquired. Update August 2021: the IPC team is working collaboratively with the bowel and bladder service to investigate all preventable urinary catheter associated bacteraemia. Any learning points/ actions is being shared with community teams. Work in progress to start/reintroduce RCAs/IPC huddles for community acquired C.Difficile cases.	A business case for additional resources for an IPC team for primary care to be developed. Due Date: 31.08.2021 07/10/2021 - Lead IPC Nurse is a member of an All Wales task and finish group looking at the IPC workforce across Wales. Report to IPCC once national work complete - Due to complete in December 2021. August 2022 Update: Risk score amended based on control measures in place. No additional measures implemented. Lead IPC Nurse to scope primary care services in next 4 weeks. reviewed by Lead IPC Nurse and Deputy Executive Nurse Director 06/09/2022, risk reduced from 20 (4x5) to 15 (3x5). Consequence score amended and reduced to 3 (from 4). Update 11/10/22 - scoping work delayed but plans to start in next 4 weeks.	Quality & Safety Committee	15	C3xL5	6 C3xL2	↔	16/07/2020	06.09.2022	21.10.2022
4721	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	Shift of the boundary for attendances at the ED.	IF: the current boundary change to redirect emergency cases from the lower Cynon Valley to the Royal Glamorgan Hospital is not reviewed: THEN: patients will continue to be admitted to a hospital further from their home RESULTING IN: increased pressure on the medical teams to manage an increased patient cohort, lack on continuity of care with follow up arrangements closer to home	Boundary change currently subject to review to understand the impact across CTM.	Boundary change currently subject to review to understand the impact across CTM. Update April 2022 - Meeting to be convened between M&C and RTE clinicians to agree way forward. For discussion at Execs 25th April. Review 30.06.2022. No change to mitigation or risk score. Update September 2022 - Following review of this risk scoring by the COO the consequence score has been reassessed as a 3. This risk remains under constant review.	Quality & Safety Committee	15	C3xL5	12 (C3xL4)	↔	28/06/2021	11.10.2022	30.11.2022

De-escalated Risks from the Organisational Risk Register - November 2022											
Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	De-escalation Rationale

Nil this period

Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan
4106	Executive Director of Nursing and Midwifery	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Increasing dependency on agency staff cover which impacts on continuity of care, patient safety	IF: The Health Board increasingly depends on agency staff cover Then: the Health Board's ability to provide stability and consistency in relation to high quality care could be impacted. Resulting in: disruption to the continuity, stability of care and team communication. Potential to impact on patient safety and staff wellbeing. There are also financial implications of continued use of agency cover.	Recurring advertisements of posts in and nursing continue with targeted proactive recruitment employed in areas of high agency/locum use. Provision of induction packs for agency staff Agency nursing staff are paid via an All wales contract agreement, any off framework agency requests must be authorised by an Executive Director prior to booking (system of audit trail in place). Fixed Term Contracts being offered to all existing HCSW and RN currently on the Nurse Bank. Redesign services wherever possible to embrace a healthier Wales and therefore impact upon the workforce required to deliver services. Updated August 2022. As of July 2021 - the overseas recruitment campaign has ceased pending further scoping exercises by Workforce and Organisational Development. Bi-Annual Nursing Staffing Levels Wales Act - Acuity Audit to be undertaken in June 2021 to report to Board in October 2021. Completed: This has been completed and received by the Board. Nursing & Midwifery Strategic Workforce Group re-established and has met. The Nursing Productivity Outputs will feed into this group along with monitoring roster KPIs and overall nurse recruitment including overseas. (Control Measure).	Deputy Exec DON is currently reviewing the nurse rostering policy in conjunction with the workforce team in order to put in place (in conjunction with workforce team) clear roster monitoring KPI's and Bank usage/recruitment KPI's . Established a new nursing workforce taskforce. Consultation with Local Partnership Forum undertaken and amendments to the policy have been made as appropriate, the policy will be seeking approval at the Quality & Safety Committee in May 2021- Timescale 31.5.2021. Update November 2021: The Revised policy which was based on SBUHB's current policy (in terms of content / KPI's etc. was taken to Local Partnership forum where it was identified further amendments were requested, these were made in terms of making the clear distinction between the current break times in some areas of POW and that of the rest of CTMUHB. The policy is currently with an ILG Nurse Director who has kindly offered to make the policy more "user friendly" Timescale: 31st December 2021 August 2022 Update: Overseas Nurse recruitment recommenced in June 2022 as part of the All Wales Overseas Nurse Recruitment programme. A total of 91 overseas Nurses will be recruited by December 2022 (noting that these will not be qualified RN's). A newly developed retention task & finish group has been established with it's first meeting having been held in August. A gap analysis of the NHS England 7 Steps is underway. Nurse Roster policy back with DEDoN for comments. Risk ID 4106 and 4157 will be amalgamated - timeframe 30.09.2022.
4157	Executive Director of Nursing and Midwifery	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	There is a risk to the delivery of high quality patient care due to the difficulty in recruiting and retaining sufficient numbers of registered nurses and midwives	IF: the Health Board fails to recruit and retain a sufficient number of registered nurses and midwives due to a national shortage Then: the Health Board's ability to provide high quality care may be impacted as there would be an overreliance on bank and agency staff. Resulting in: Disruption to the continuity and stability of care and team communication Potential to impact on patient safety and staff wellbeing. There are also financial implications of continued use of agency cover.	- Proactive engagement with HEIW continues. - Scheduled, continuous recruitment activity overseen by WOD. Overseas RN project continues. - Targeted approach to areas of specific concern reported via finance, workforce and performance committee - Close work with university partners to maximise routes into nursing - Block booking of bank and agency staff to pre-empt and address shortfalls - dependency and acuity audits completed at least once in 24 hrs on all ward areas covered by Section 25B of the Nurse Staffing Act. - Deputy Exec DON is currently reviewing the nurse rostering policy in order to put in place (in conjunction with workforce team) clear roster monitoring KPI's and Bank usage/recruitment KPI's - Reporting compliance with the Nurse Staffing Levels (Wales) Act regularly to Board - Regular review by Birth Rate Plus compliant, overseen by maternity Improvement Board - Implementation of the Quality & Patient Safety Governance Framework including triangulating and reporting related to themes and trends. - successful overseas RN recruitment. - There is an operational Nursing Act Group that reconvened from April 2021. - Impact assessment signed off from a Mental Health Nursing perspective in relation to an extension to the Nurse Staffing Act 2016.	Established recruitment campaign - which is monitored at the Nursing Workforce Strategic Group - group due to meet/recommence in April 2021.The Nursing and Midwifery Strategic Workforce Group did not meet in April 2021 as planned due to the need to revise membership in line with ILG structure, however, bi-monthly nursing workforce operational task force meetings have been held chaired by the Deputy Director of Nursing since February 2021. the Strategic workforce group is scheduled to meet on the 11th May 2021. This action has been overtaken by the Nursing Productivity Programme. Revised nurse rostering policy currently being taken through the relevant approval process - Timescale 31.3.2021.Consultation with Local Partnership Forum undertaken and amendments to the policy have been made as appropriate, the policy will be seeking approval at the Quality & Safety Committee in May 2021- Timescale 31.5.2021Complete and currently with WF&OD to finalise through to Approval. Await review of Birth Rate Plus Compliant Tool by WG - Timescale - WG led so await WG timescales - No further update at this time. Remains the same as at February 2022. Impact assessment relating to Health Visiting provision with regards to compliance of the draft principles of the Nurse Staffing Act 2016 to be completed by the end of March 2022. Ward Assurance Pilot Tool tested within PCH and to be rolled out across the other two Acute Hospitals by the end of April 2022. August 2022 Update: The Health Board receives a draft birth rate and compliance report which the Director of Maternity reviews the completes the outputs. A full data set of compliance is completed and sent to WG by the Director of Midwifery. An initial point review audit has been completed on all Wards in CTM using the Ward Assurance template populated through AMaT (Audit Management and Tracking system). An updated paper is being presented to the November 2022 Quality & Safety Committee. Risk ID 4106 and 4157 will be amalgamated - timeframe 30.09.2022.



AGENDA ITEM

5.2

AUDIT & RISK COMMITTEE

AUDIT RECOMMENDATIONS TRACKER UPDATE REPORT

Date of meeting	12/12/2022	
FOI Status	Open/Public	
If closed please indicate reason	Not Applicable - Public Report	
Prepared by	Emma Walters, Corporate Governance Officer	
Presented by	Cally Hamblyn, Assistant Director of Governance & Risk	
Approving Executive Sponsor	Chief Executive	
Report purpose	FOR NOTING	
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	Date	Outcome
ACRONYMS		

1. SITUATION/BACKGROUND

- 1.1 The main purpose of this report is to present an update to the Audit & Risk Committee on reported progress of Audit report recommendations in the revised format.

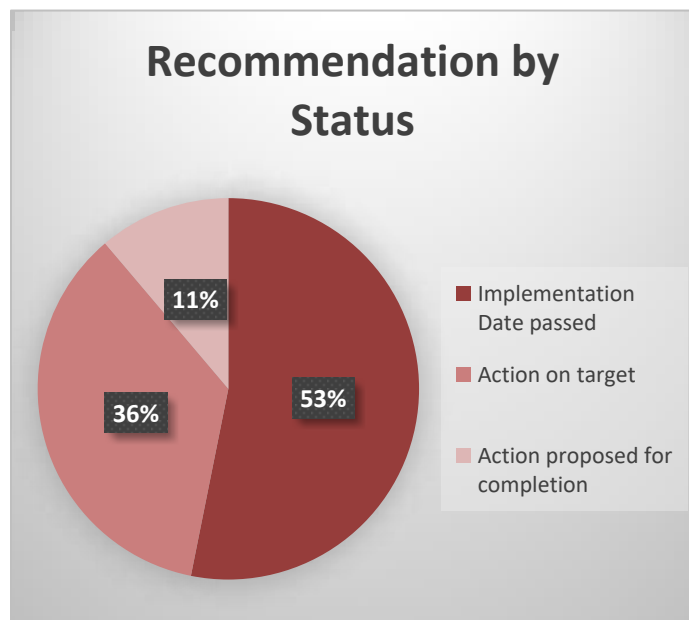
- 1.2 This report relates to both internal and external audit review recommendations.

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

- 2.1 Steps have been taken to seek updates from Management leads in relation to outstanding internal and external audit recommendations which are classed as high/medium/low priority. Members will note that 17 internal audit recommendations have been completed/closed and are proposed for removal from the tracker, together with 10 external audit recommendations, some of which are historical and have been superseded and explanations have been included where relevant on the tracker.

Internal Audit

- 2.2 The tables below provide a summary of the current position in relation to Internal Audit Recommendations, noting that the proportion of red status recommendations has deteriorated to 53% compared to the October position which was at 35%.





Recommendations by Priority & Status				
Priority	TOTAL	Implementation Date passed	Action on target	Actions Completed
High	33	16	14	3
Medium	96	48	36	12
Low	14	11	1	2

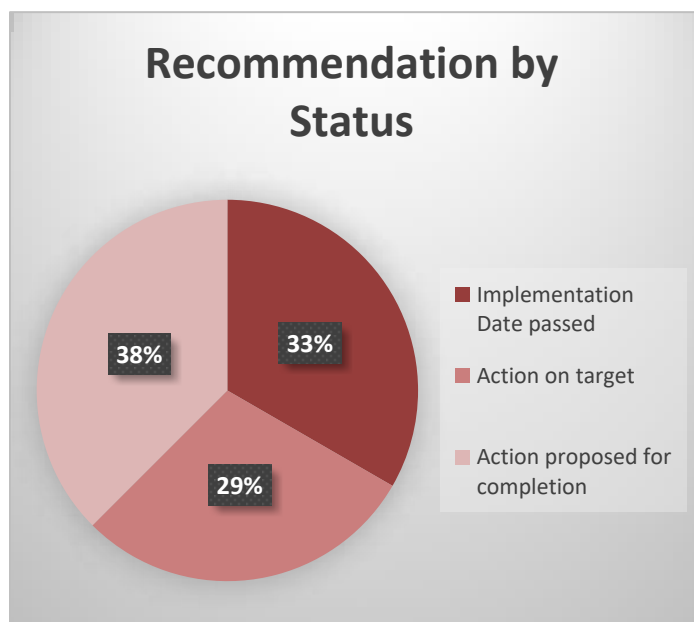
Recommendations by Executive Lead & Status				
Executive Lead	Total	Implementation Date passed	Action on target	Actions Completed
Director of Corporate Governance	3	1	2	0
Director of Finance	29	23	4	2
Chief Operating Officer	19	15	3	1
Director of Nursing	25	7	18	0
Director of Digital	24	4	10	10
Director for People	20	6	14	0
Director of Strategy & Transformation	15	15	0	0
Medical Director	8	4	0	4

Implementation Date Extended by					
Priority	TOTAL	More than 24 Months	18-24 Months	12-18 Months	6-12 Months
High	19	3	2	2	12
Medium	37	4	7	11	15
Low	4	0	1	2	1



External Audit (Audit Wales)

- 2.3 The tables below provide a summary of the current position in relation to External Audit Recommendations. You will note that the percentage of recommendations whereby the implementation date has now passed remains at 33%.



Recommendations by Priority & Status				
Priority	TOTAL	Implementation Date passed	Action on target	Actions Completed
High/Medium/Low	31	8	13	10

Recommendations by Executive Lead & Status				
Executive Lead	Total	Implementation Date passed	Action on target	Actions Completed
Director of Corporate Governance	2	2	0	0
Chief Operating Officer	2	1	0	1
Director of Finance	6	0	5	1



Director of Digital	1	0	1	0
Director of Nursing	14	4	5	5
Director for People	5	1	1	3
Medical Director	1	0	1	0

Implementation Date Extended by					
Priority	TOTAL	More Than 24 Months	18-24 Months	12 - 18 Months	6 -12 Months
High/Medium/Low	14	4	4	4	2

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

- 3.1 As outlined in section 2, the audit tracker will continue to be updated.
- 3.2 The revised format will continue to be further refined over time, but aims to provide a more thorough tracker and audit tool for the Audit Committee.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Robust internal processes aligned with a strong governance framework is essential to ensuring patients experience the greatest possible levels of safety and quality.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:



Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below)
	If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below.
	If no, please provide reasons why an EIA was not considered to be required in the box below.
Legal implications / impact	Not required
	Yes (Include further detail below)
	There may be an adverse effect on the organisation if the UHB does not fully implement learning and improvements identified as part of Audit arrangements.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

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

Red	Red -
Orange	Orange -
Yellow	Yellow - Action
Green	Green - Action
Blue	Blue - Action

Ref	Date added	Assurance rating	Recommendation	Priority	Management Action Agreed	Responsible Executive Lead/Management Lead	Responsible Management Lead	Original Agreed Implementation Date	Revised Implementation Date	Status	Progress	Updates during this period/Latest Update	Previous Updates
CAMHS Management Arrangements 05	Feb-21	Limited	1. We agree with the planned approach to identify CAMHS related policies in existence and to review them to ensure consistency across the localities. This work should also ensure relevance and alignment to current legislation and expected working practices. 2. Once updated, the policies should be made accessible to relevant staff and have dates for future review and individuals / post holders named who are responsible for such reviews.	High	CAMHS Policy Group newly established, with ToR being developed. All CAMHS policies to be identified, reviewed and standardised to ensure consistency across localities, and to ensure relevance and alignment to current legislation and expected working practices. Action plan will be devised. Policies will be made accessible to relevant staff and have dates for future review and individuals / post holders named who are responsible for such reviews.	Chief Operating Officer	Head of Nursing	Mar-21	01/05/2021 August 2021 Now December 2021 Now September 2022 01/12/2022 to support Sharepoint development		In progress	December 2022 Update - CAMHS policy page has been added to the CTM UHB Sharepoint page to hold relevant specific CAMHS policies for all staff to access and enables a system for review when required. In addition to the age appropriate bed policy highlighted last month a transition policy has been developed and will be signed off by the MH Care Group. Local management teams are currently pulling together the list of other local standard operating policies and ensuring there is central index for staff to access and system for review.	March 2021 Update - Update will be available in May 2021. CAMHS Policy Group newly established, with ToR developed. All CAMHS policies to be identified, reviewed and standardised to ensure consistency across localities, and to ensure relevance and alignment to current legislation and expected working practices. Action plan will be devised. Policies will be made accessible to relevant staff and have dates for future review and individuals / post holders named who are responsible for such reviews. Work delayed due to key staff redeployment due to Covid & HB restructure. Confirmation on the action taken will be confirmed in August 2021. July 2021 Update - CAMHS Policy Group newly established, with ToR developed. All CAMHS policies identified, to be reviewed and standardised to new format to ensure consistency across localities, and to ensure relevance and alignment to current legislation and expected working practices. Action plan devised to ensure rolling programme. Policies will be made accessible to relevant staff and have dates for future review and individuals / post holders named who are responsible for such reviews. Work delayed due to key staff redeployment due to Covid & HB restructure. Confirmation on the action taken will be confirmed in August 2021. September 2021. Work on the policy reviews continues, the target date remains December 2021. November 2021 Update - nothing further this month. There has been a change in management arrangements and an update on the work that remains ongoing will be ready for the next meeting. February 2022 Update - no permanent CSG Manager in post. Update will be available for the next meeting. April 2022 – Due to changes in nursing structure and gap in CSG Manager the progress on this action has been delayed. Head of Nursing and CSG Manager will meet in April 2022 to review actions outstanding and make a plan to address the review and publication of policies. June 2022 Update - CSG and Head of Nursing have met and discussed approach. Each LMT has been requested to update current policies and database established. Progress has been made with documents drafted. This will be discussed at Senior Nurse meeting on 14th June with an outline of timescales. August 2022 - This was discussed in the QPSE meeting with the senior nursing team and a number of policies and SOP were brought for review and sign off. Agreement to review which are relevant to go through the HB policy group. October 2022 Update - Local SOPs have been reviewed, one around the use of the age appropriate bed in CTM is being developed with Adult Mental Health and will go through the appropriate HB forums for policy sign off. Plans are being developed HB wide and via the Mental Health care group to develop a sharepoint to hold local SOP and policies.
Concerns 1.2	Feb-22	Limited	A comprehensive set of Standard Operating Procedures should be developed setting out the process to follow from the point a concern or complaint is received through to the provision of a response. The SOP should include concerns from all sources such as those received via the dedicated email accounts, those made in person or issues raised via local MPs or MSs. The responsibilities of the Corporate Concerns Team and the ILGs should be clearly set out.	High	Review the PTR Guidance alongside the CTM structures to identify what Standard Operating Procedures are required and develop and implement to support the new process.	Director of Nursing	Interim Head of Concerns, Redress & Legal	Jun-22	Now September 2022 Now January 2023		In progress	December 2022 update - Complaints Manager and Head of Concerns & Business Intelligence now in post, reviews have now started, however, changes to the operating model will need to be finalised before any changes are made. These should be updated and in place in line with the operating model in January 2023.	April 2022 Update - On hold until changes to the operating model. June 2022 - Central triage complaints resource identified as part of operating model changes. Once new model is in place. Policies and SOPs will be reviewed and amended in line with the new model. August 2022 Update Work continues on the new Operational model, this incorporates 2 complaints triage posts which will assist with managing complaints more effectively, promoting early resolutions where possible and appropriate. The centralisation of Quality & Safety (including complaints), will ensure a consistent approach to complaints management across the Health Board, with current capacity constraints will be addressed following the implementation of the new operating model. The Complaints Manager post has been out to advert and will be recruited into imminently. This will be supported by a staff member returning from secondment. These are scheduled to take place in August. A key priority will be the review of policies and procedures once the new operational model has been implemented. October 2022 update - Complaints Manager and Head of Concerns & Business Intelligence now in post, reviews have now started, however, changes to the operating model will need to be finalised before any changes are made. These should be updated and in place in line with the operating model in January 2023.
Concerns 3.1	Feb-22	Limited	3.1a A training programme should be developed and rolled out across the Health Board to ensure that staff are suitably trained for the roles they are performing in relation to the Concerns process. 3.1b A training needs analysis should be undertaken in each ILG and for corporate teams to identify the staff that fall into the three levels of training outlined in the Concerns Training Plan. The PADR process could be used in the future to help identify training needs.	High	3.1a CTM Concerns Management training programme to be developed encompassing Putting Things Right, the Once for Wales Concerns Management System and Welsh Risk Pool procedures, more specifically Learning from Events Reports. 3.1b Training Needs Analysis Template to be developed following development of Concerns Management training programme. To be shared with the ILGs for completion and identification of all staff who should receive the training.	Director of Nursing	3.1a Interim Head of Concerns, Redress & Legal 3.1b Interim Head of Concerns, Redress & Legal/ILG Heads of Quality & Safety	3.1a April 2022 3.1b June 2022	Now January 2023		In progress	December 2022 Update 3.1a - The launch of the new Incident Management Framework and the training which is in place to support this covers a number of elements including family support, psychological safety, staff support, investigation, breach of duty, causation, redress, claims and learning from events reports, sharing of learning. Complaints policies/procedures will be updated in due course in line with the new operating model and changes to PTR following implementation of Duty of Candour. 3.1b - Training Needs analysis will be undertaken on completion of prospectus with the newly formed care groups. Progress has been slow due to lack of complaints staff in central roles.	3.1a April 2022 Update - Partially completed in respect of LFERs and Once for Wales CMS. PTR to be completed. 3.1b April 2022 Update - To be developed once training package has been completed. June 2022 3.1a New PTR Training package in process of being developed, in conjunction with the new Incident framework. Elements of training have already been undertaken in respect of LFERs and Once for Wales CMS. Weekly LFER drop in training sessions have been underway for the past 6 weeks, which will assist staff with completion of LFERs. 3.1b Training Needs analysis will be undertaken on completion of prospectus with the newly formed care groups. August 2022 Update 3.1a - The launch of the new Incident Management Framework and the training which is in place to support this covers a number of elements including family support, psychological safety, staff support, investigation, breach of duty, causation, redress, claims and learning from events reports, sharing of learning. 3.1b - Training Needs analysis will be undertaken on completion of prospectus with the newly formed care groups. October 2022 3.1a - The launch of the new Incident Management Framework and the training which is in place to support this covers a number of elements including family support, psychological safety, staff support, investigation, breach of duty, causation, redress, claims and learning from events reports, sharing of learning. Complaints policies/procedures will be updated in due course in line with the new operating model and changes to PTR following implementation of Duty of Candour.
Concerns 6.1	Feb-22	Limited	6.1a A SOP should be developed that documents the quality assurance processes underpinning the end stages of the investigation that lead to the issue of the PTR Concerns Response Letters. The SOP should include who is responsible for quality checking and how quality checks should be documented, including, if deemed necessary, the use of the checklist contained in the policy. Training on the required quality assurance process documented in the SOP should be carried out with relevant staff. 6.1b The Quality Assurance Checklist contained in Appendix 4 of the Concerns Policy should be reviewed and a decision made regarding the expectation for it to be used.	High	6.1a Standard Operating procedure to be developed as part of a suite of SOPs outlined in 1.2 above 6.1b QA checklist to be reviewed at the same time as the SOP is develop	Director of Nursing	Interim Head of Concerns, Redress & Legal	Apr-22	Now September 2022 Now January 2023		In progress	December 2022 Update 6.1a - Work continues on the new Operational model, which includes complaints triage. And more support for the PALS service. This should assist with managing complaints more effectively, promoting early resolutions where possible and appropriate. The centralisation of Quality & Safety (including complaints), will ensure a consistent approach to complaints management across the Health Board, current capacity constraints will be addressed following the implementation of the new operating model. The Complaints Manager and Head of Concerns & Business Intelligence are now in post and this will be a priority area of work, in line with the implementation of the new operating model. 6.1b - QA document will be reviewed in conjunction with Care Group Governance teams within the new operating model.	6.1a April 2022 Update - On hold until changes to the operating model. 6.1b April 2022 Update - On hold until changes to the operating model. June 2022 6.1a - A review of all Policies and associated SOPs has begun and will incorporate the new operating model. Progress on this action has been slow due to the Complaints Manager not being in post and focus on changes to the operating model. 6.1b - will be reviewed in conjunction with Governance teams within the new operating model. August 2022 Update 6.1a - Work continues on the new Operational model, this incorporates 2 complaints triage posts which will assist with managing complaints more effectively, promoting early resolutions where possible and appropriate. The centralisation of Quality & Safety (including complaints), will ensure a consistent approach to complaints management across the Health Board, with current capacity constraints will be addressed following the implementation of the new operating model. The Complaints Manager post has been out to advert and will be recruited into imminently. This will be supported by a staff member returning from secondment. These are scheduled to take place in August. A key priority will be the review of policies and procedures once the new operational model has been implemented. 6.1b - QA document will be reviewed in conjunction with Care Group Governance teams within the new operating model. October 2022 6.1a - Work continues on the new Operational model, this incorporates a new Early Resolution team, which includes complaints triage. This should assist with managing complaints more effectively, promoting early resolutions where possible and appropriate. The centralisation of Quality & Safety (including complaints), will ensure a consistent approach to complaints management across the Health Board, with current capacity constraints will be addressed following the implementation of the new operating model. The Complaints Manager post has been out to advert and will be recruited into imminently. This will be supported by a staff member returning from secondment. These are scheduled to take place in August. A key priority will be the review of policies and procedures once the new operational model has been implemented.
Concerns 9.1	Feb-22	Limited	9.1a A formalised process should be put in place to ensure there is shared learning from the outcome of concerns, complaints and incidents and also the processes followed when dealing with concerns and complaints. This should include how data will be collected and analysed in or to identify trends and patterns for example across CSGs, ILGs, specialities or by type of concern. Lessons learnt information should then be shared in a consistent way across the Health Board. 9.1b Subsequently, ILGs should ensure they have suitable processes and methods in place for the dissemination of lessons learnt across all of their CSGs.	High	9.1a Regular reports are provided from Datix and monitored via various groups and committees. The quality of information provided will be strengthened with engagement with the RL Datix team. Development of a Learning Framework underway to ensure learning is captured from various avenues and shared across the organisation. 9.1b This will form part of the Learning Framework as per 9.1a and included in the SOPs as per 1.2.	Director of Nursing	9.1a Datix Manager 9.1b AD Nursing & Patient Safety and Interim Head of Concerns, Redress & Legal AD Nursing & Patient Safety and Interim Head of Concerns, Redress & Legal	Jan-22	Now September 2022 Now January 2023		In progress	December 2022 Update 9.1a Various reports are already available and presented at various committees. The Datix team are now producing reports in the new Care Group model whilst maintaining ILG reporting for historic areas. Dashboards are being developed for Care Groups, and training is being rolled out to support key users to be able to run reports and access data "live". The Head of Concerns & Business Intelligence for CTM is co-chair of the All Wales work stream on Data, Business Intelligence and Dashboards. CTM have volunteered to be a pilot site for the Business Intelligence tool within Datix Cymru as part of the Phase 2 roll out. 9.1b The Listening and Learning Framework was launched at a Listening and Learning event in September. As part of this a learning repository is being developed to capture and share learning across the organisation.	The Listening and Learning Framework remains in DRAFT form. A Learning from Events day is planned for July 2022, whereby top themes will be discussed with shared learning from past incidents/complaints. A newsletter is in the process of being devised. 9.1b - this will be reviewed and strengthened and will incorporate the new operating model changes. August 2022 Update

Ref	Date added	Assurance rating	Recommendation	Priority	Management Action Agreed	Responsible Executive Lead/Management Lead	Responsible Management Lead	Original Agreed Implementation Date	Revised Implementation Date	Status	Progress	Updates during this period/ Latest Update	Previous Updates
Fire Safety Management 5.1	Feb-22	Limited	Appropriate systems should be developed to allow the production of basic management information in relation to risk assessments.	High	The Health Board will explore the use of the Risk Module in Datix to support the recording and escalation of risks following a Fire Risk Assessment. A Strategic Leadership Group paper will be produced to provide an options appraisal as to how fire risk assessments can be better captured and monitored.	Director for People	Head of Health, Safety and Fire	31/03/2022 30/04/2022	Now November 2022 Now December 2022		In progress	December 2022 Update - Despite chasing them, no further progress with this from colleagues in Shared Services.	April 2022 Update - NHS Wales Shared Services Partnership: Facilities and Estates are currently reviewing the All Wales software package following concerns raised by all Health Boards and Trusts in Wales. August 2022 Update - whilst work continues within NHS Wales Shared Services Partnership: Facilities and Estates, there are no definitive dates when this work will be completed. CTM is fully involved in this work to help support an all Wales solution to this. Update October 2022 - No further progress with this from colleagues in Shared Services.
Fire Safety Management 9.1	Feb-22	Limited	ILG reporting could be improved by the inclusion of the issues raised at the observation.	High	ILGs will review their Health, Safety and Fire Group Agendas to ensure this recommendation is addressed. The listed fire information will be required from each Clinical Service Group and provided through their regular reports to the Health, Safety and Fire Group.	Director for People	ILG Director of Operations	May-22	Now January 2023		In progress	December 2022 Update - no further update provided against this recommendation as new Care Group Operating model is still not available.	April 2022 Update - Ongoing. Update - This recommendation will have to be reviewed further as a result of changes to the Health Board's Operating Model. October 2022 Update - no further update provided against this recommendation
Patient Pathway Appointment Management Process Follow Up 1.1	Jun-22	Limited	Management should ensure that the correct data detailed within the outcome reports is produced for each of the Clinical Service Groups, especially where services and therefore data was previously the responsibility of a different ILG.	High	Discussion will be held with colleagues in Performance to ensure that this data is correct for each Service Group and fits in with the new operating model.	Chief Operating Officer	ILG Directors of Operations / Head of Information	Aug-22	Now December 2022 Now January 2023		In progress	December 2022 Update - date for completion remains January 2023.	August 2022 Update - No formal feedback received from ILGs. To ensure progress, meeting planned for Thursday 25 August 2022 to discuss this audit. October 2022 Update - Colleagues within the Information Department have commenced work to transition reports to a site based reporting model (away from ILGs) and will be seeking advice on the Service Grouping that the Organisation required to place over Specialty codes. The change in operating model will slow this process - hence the date has changed to January 2023.
Patient Pathway Appointment Management Process Follow Up 1.3	Jun-22	Limited	On receipt of the outcome reports, management within the CSGs should ensure that they analyse the data to identify trends such as those staff or departments that are continually failing to input outcome data or making the errors. Appropriate action should be taken including the provision of additional training on the WPAS.	High	ILGs will ensure that they undertake this action.	Chief Operating Officer	ILG Acute Services General Managers	Aug-22	Now December 2022 Now February 2023		In progress	December 2022 Update - progress slow as a consequence of activity on sites. Meeting in diaries to resolve way ahead.	August 2022 Update - No formal feedback received from ILGs. To ensure progress, meeting planned for Thursday 25 August 2022 to discuss this audit. October 2022 Update - Report generated regularly for former ILG structure. Steps will be taken to ensure that the recommendation of additional action is taken.
Patient Pathway Appointment Management Process Follow Up 1.5	Jun-22	Limited	Given the ongoing problem of outcomes not recorded, management should look to build on the roll out of electronic outcome forms.	High	Consideration will be given by ILGs to roll out electronic outcome forms by September 2022	Chief Operating Officer	ILG Directors of Operations / Head of Information	Sep-22	Now February 2023		In progress	December 2022 Update - progress slow as a consequence of activity on sites. Meeting in diaries to resolve way ahead.	August 2022 Update - Date remains September 2022. October 2022 Update - no further comment, will be picked up as part of re-focus on this audit.
Patient Pathway Appointment Management Process Follow Up 2.1	Jun-22	Limited	Management should ensure that the correct data detailed within the closed pathway reports is produced for each of the Clinical Service Groups, especially where services and therefore data was previously the responsibility of a different ILG.	High	ILGs will work with colleagues in Performance to make sure that this information is available and appropriate.	Chief Operating Officer	ILG Acute Services General Managers / Head of Information	Aug-22	Now December 2022 Now February 2023		In progress	December 2022 Update - progress slow as a consequence of activity on sites. Meeting in diaries to resolve way ahead.	August 2022 Update - No formal feedback received from ILGs. To ensure progress, meeting planned for Thursday 25 August 2022 to discuss this audit. October 2022 Update - These reports have been reinstituted as a submission to DHCW and can be made available. Once recipients have been confirmed, the Information Department can discuss method and provide the report regularly to the required audience.

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Patient Pathway Appointment Management Process Follow Up 2.2	Jun-22	Limited	Management should ensure that closed pathway reports are being sent to the correct staff within each of the Clinical Service Groups to ensure that the patients are put onto an open pathway. In addition, closed pathways reports should be sent on a regular basis to staff within Bridgend ILG, or checks should be made to ensure managers are accessing this data for themselves.	High	ILGs will work with colleagues in Performance to ensure that the appropriate staff are identified.	Chief Operating Officer	ILG Acute Services General Managers / Head of Information	Aug-22	Now December 2022 Now February 2023		In progress	December 2022 Update - progress slow as a consequence of activity on sites. Meeting in diaries to resolve way ahead.	August 2022 Update - No formal feedback received from ILGs. To ensure progress, meeting planned for Thursday 25 August 2022 to discuss this audit. October 2022 Update - no further comment, will be picked up as part of re-focus on this audit.
Patient Pathway Appointment Management Process Follow Up 2.3	Jun-22	Limited	On receipt of the reports, management within the CSGs should ensure that they analyse the data to identify any trends such as those staff or departments that are continually making the errors and closing pathways incorrectly. Appropriate action should be taken including the provision of additional training on the WPAS.	High	ILGs will ensure that they undertake this action	Chief Operating Officer	ILG Acute Services General Managers	Aug-22	Now December 2022 Now February 2023		In progress	December 2022 Update - progress slow as a consequence of activity on sites. Meeting in diaries to resolve way ahead.	August 2022 Update - No formal feedback received from ILGs. To ensure progress, meeting planned for Thursday 25 August 2022 to discuss this audit. October 2022 Update - limited action undertaken in this area. There have been conversations on ADT / Outcomes / FUNB transactions timeliness and correctness in recent weeks that are yielding improvement. Further details will be available at the next meeting.
Patient Pathway Appointment Management Process Follow Up 2.4	Jun-22	Limited	The Acute Services Manager in each ILG should be provided with the reports for their area to enable them to monitor and have oversight of the errors being made.	High	ILGs will work with colleagues in Performance to make sure that this information is available and appropriate.	Chief Operating Officer	ILG Acute Services General Managers / Head of Information	Sep-22	Now February 2023		In progress	December 2022 Update - progress slow as a consequence of activity on sites. Meeting in diaries to resolve way ahead.	August 2022 Update - Date remains September 2022. October 2022 Update - Report generated regularly for former ILG structure. Steps will be taken to ensure that the recommendation of additional action is taken.
POW Theatres Fire Safety Works 1.1	Aug-22	Limited	Management should formulate a Project Board immediately, with appropriate terms of reference and attendance as the accountable body for project delivery (as part of defined project governance).	High	Agreed - This will be put in place to consider the options appraisal. The executive structure and personnel changed across this time. The project involves Health & Safety, Capital, and Strategy & Planning. The role of Senior Responsible Officer was therefore re-allocated. The project is currently being re-appraised. Subsequent to this, and pending the options appraisal to Welsh Government, governance will be further addressed as appropriate for the approved scheme. The CEO has also been in receipt of regular informal briefings from the Project Director.	Director of Strategy & Transformation	Project Director	Immediate	Now November 2022 Now January 2023		In progress	December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place.	October 2022 Update - This has been delayed whilst resolving the WG questions over the options appraisal to determine the best way to deliver the works. It is expected that a Project Board will be fully implemented by November
Digital Operating Model 1.1	Nov-22	Limited	An appropriate steering and ownership governance tier should be established that enables stakeholders to own, steer and oversee the delivery of digital objectives.	High	Accept A new governance and ownership arrangement will be created to align to the Health Board Transformation Change Programme and delivery board created as part of the Care Group Model Implementation.	Director of Digital	Director of Digital	Qtr 3 2022/2023			In progress	December 2022 Update - Executive Leadership Group currently utilised for Digital & Data Prioritisation and Approval. Patient Centre Contact Programme created under the Unified Change Board. Extensive engagement has taken place between the Digital & Data team and the Care Groups during the period. Final Digital & Data Governance Group to be confirmed.	
Digital Operating Model 2.1	Nov-22	Limited	The Digital Clinical leadership structure should be revised and improved. • The CNIO role should be formalised; and • a network of digital clinical leaders should be established that mirrors the Health Board structure to ensure that each area as a defined leader who can act as a conduit and help embed digital.	High	Accept Digital Clinical Leadership will be developed and formally recognised as part of the Strategic Leadership Group within the Digital & Data Directorate. A new set of roles & capabilities will be identified as part of the new Digital & Data Governance arrangements.	Director of Digital	Director of Digital	Qtr 3 2022/2023			In progress	December 2022 Update - As part of the IMTP process, formalisation of a digital clinical group is required. Existing Digital Clinical Leaders are undertaken a benchmarking exercise.	

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Digital Operatin g Model 3.1	Nov-22	Limited	As part of the review of the directorate structure, consideration should be given to ensuring that the structure and resources includes: • appropriate digital leadership within the structure; • ongoing change management support; • digital transformation and project resource; and • Office 365 team and support.	High	Accept A Digital Leadership Change Process will be initiated in the Autumn of 2022. A subsequent review of senior management support and related resources will commence in the first half of 2023.	Director of Digital	Director of Digital	Qtr 3 2022/2023 Qtr 4 2022/2023	Now 31 December 2022		In progress	December 2022 Update - Digital Strategic Leadership consultation period has ended. Work ongoing on finalising the draft Job Descriptions - plan to complete in December 2022	
Digital Operatin g Model 6.1	Nov-22	Limited	The Health Board should ensure that appropriate funding is provided to enable equipment to be kept up to date.	High	Accept Appropriate funding will be identified as part of the IMTP process for a 2023 submission.	Director of Digital	Director of Digital	Qtr 4 2022/2023			In progress	December 2022 Update - IMTP development will propose required capital and revenue funding to support digital requirements	
Concern s 1.1	Feb-22	Limited	The concerns policy should be reviewed and updated to accurately reflect the structure, roles, responsibilities and active involvement of the corporate function and the ILGs in respect of the management, investigation and reporting arrangements relating to concerns and complaints.	Medium	Changes will be made to the Concerns Policy and management process in line with the Concerns Improvement project. This will be undertaken via a collaborative process between Corporate and the ILGs and in light of any changes to the Operating Model following the current review.	Director of Nursing	Interim Head of Concerns, Redress & Legal	Jun-22	Now September 2022 Now January 2023		In progress	December 2022 update - Complaints Manager and Head of Concerns & Business Intelligence now in post, reviews have now started, however, changes to the operating model will need to be finalised before any changes are made, along with consideration of Duty of Candour and the changes to PTR. These should be updated and in place in line with the operating model in January 2023.	April 2022 Update - On hold until changes to the operating model. June 2022 - A review of all Policies and associated SOPs has begun and will incorporate the new operating model. Progress on this action has been slow due to the Complaints Manager not being in post and focus on changes to the operating model. August 2022 Update Work continues on the new Operational model, this incorporates 3 complaints triage posts which will assist with managing complaints more effectively, promoting early resolutions where possible and appropriate. The centralisation of Quality & Safety (including complaints), will ensure a consistent approach to complaints management across the Health Board, with current capacity constraints will be addressed following the implementation of the new operating model. The Complaints Manager post has been out to advert and will be recruited into imminently. This will be supported by a staff member returning from secondment. These are scheduled to take place in August. A key priority will be the review of policies and procedures once the new operational model has been implemented. October 2022 update Complaints Manager and Head of Concerns & Business Intelligence now in post, reviews have now started, however, changes to the operating model will need to be finalised before any changes are made. These should be updated and in place in line with the operating model in January 2023.
Concern s 3.3	Feb-22	Limited	Records of all training attended in relation to both PTR/Concerns training and Datix Once for Wales Training should be retained.	Medium	Undertake scope on training record management and how this is captured within CTM if it is not retained within ESR Discussion with ESR team to ascertain whether training records can be included on ESR for Concerns Management training. Discussion with Organisational Development regarding retention of training records and how this links to PADRs.	Director of Nursing	Interim Head of Concerns, Redress & Legal	Feb-22	Now December 2022		Part Completed	December 2022 Update - ESR have confirmed training can be captured on ESR, however resource to update ESR would have to be considered. Following the centralisation of quality and safety, a review of training which is not captured on ESR will be undertaken and a consistent method implemented.	3.3a April 2022 Update - Discussions ongoing. 3.3b April 2022 Update - Email to ESR team to query whether PTR and 3.3c April 2022 Update - Email to correspondence in respect of PADRs and training. June 2022 There is no unified way of recording training if it isn't on ESR. Various different methods in place. August 2022 Update Consideration for inclusion in PTR training as part of induction. Engagement with ESR team to ascertain whether training can be captured within ESR. Following the centralisation of quality and safety, a review of training which is not captured on ESR will be undertaken and a consistent method implemented. October 2022 Update ESR have confirmed training can be captured on ESR, however resource to update ESR would have to be considered. Following the centralisation of quality and safety, a review of training which is not captured on ESR will be undertaken and a consistent method implemented.
Concern s 4.2	Feb-22	Limited	4.2a Management should understand why RTE has not been re-categorising early resolution concerns that were not resolved in the timeframe and take appropriate action to resolve and accurately record in Datix. 4.2b To ensure consistency, a Standard Operating Procedure (SOP) should be in place outlining the process for re-categorising concerns, including who is responsible for performing this task. Training should be provided where necessary.	Medium	4.2a As 4.1 above 4.2b Standard Operating procedure to be developed as part of a suite of SOPs outlined in 1.2 above.	Director of Nursing	4.2a Complaints Manager 4.2b Interim Head of Concerns, Redress & Legal	Apr-22	Now December 2022 Now January 2023		In progress	December 2022 Update - 4.1b - A review of all Policies and associated SOPs has begun and will incorporate the new operating model and any legislative changes to PTR and Duty of Candour. 4.2a - A review of RTE practice has been undertaken and changes made to ensure consistency across the Health Board, along with benchmarking with NHS Wales colleagues within the Complaints Network. 4.2b - Work continues on the new Operational model, this incorporates complaints triage and more support for PALS, which will assist with managing complaints more effectively, promoting early resolutions where possible and appropriate. The centralisation of Quality & Safety (including complaints), will ensure a consistent approach to complaints management across the Health Board, current capacity constraints will be addressed following the implementation of the new operating model. Key posts have now been filled. A key priority will be the review of policies and procedures once the new operational model has been implemented.	4.2a April 2022 Update - Complaints Manager not in post. 4.2b April 2022 Update - On hold until changes to the operating model. June 2022 4.1a - Audits will be reinstated when Complaints Manager is in post. Further review will be required once the new operating model is in place and established. 4.1b - A review of all Policies and associated SOPs has begun and will incorporate the new operating model. Progress on this action has been slow due to the Complaints Manager not being in post and focus on changes to the operating model. August 2022 Update 4.2a - A review of RTE practice has been undertaken and changes made to ensure consistency across the Health Board. 4.2b - Work continues on the new Operational model, this incorporates 3 complaints triage posts which will assist with managing complaints more effectively, promoting early resolutions where possible and appropriate. The centralisation of Quality & Safety (including complaints), will ensure a consistent approach to complaints management across the Health Board, with current capacity constraints will be addressed following the implementation of the new operating model. The Complaints Manager post has been out to advert and will be recruited into imminently. This will be supported by a staff member returning from secondment. These are scheduled to take place in August. A key priority will be the review of policies and procedures once the new operational model has been implemented. October 2022 Update 4.1b - A review of all Policies and associated SOPs has begun and will incorporate the new operating model. 4.2a - A review of RTE practice has been undertaken and changes made to ensure consistency across the Health Board. 4.2b - Work continues on the new Operational model, this incorporates 3 complaints triage posts which will assist with managing complaints more effectively, promoting early resolutions where possible and appropriate. The centralisation of Quality & Safety April 2022 Update - Partially completed in respect of LFERs and Once for Wales CMS. PTR to be completed. June 2022 A review of all Policies and associated SOPs has begun and will incorporate the new operating model. Progress on this action has been slow due to the Complaints Manager not being in post and focus on changes to the operating model. Training on new policies and SOPs will be included in the training package outlined in 3.1 Audits will be reinstated as outlined in 4.1a when Complaints Manager is in post, this will incorporate any rationale for deviating from policies and SOPs. However, changes to the operating model and centralisation of complaints management should ensure a more unified approach across the organisation. August 2022 Update - The review of Policies and Procedures is due to take place in August and September, taking into account changes to the operating model. Once this is completed a training needs analysis will be undertaken in conjunction with the central care group governance teams and a training plan will be developed and implemented.
Concern s 5.1	Feb-22	Limited	For each concerns investigation undertaken, in the absence of detailed Standing Operating Procedures, the process outlined in the Concerns Policy and Procedure documents should be followed. Comprehensive notes and evidence should be added to Datix in a timely manner to support the process followed, the investigation carried out and the lessons learnt. Where aspects of the policy are not being undertaken at all, it should be established if this is due to staff not being aware of this aspect of the process or if the policy is in fact out of date and in relation to current practices.	Medium	To be included in training programme as per 3.1a and 3.1b above	Director of Nursing	Interim Head of Concerns, Redress & Legal	Apr-22	Now December 2022		Part Completed	December 2022 Update - The review of Policies and Procedures is underway taking into account changes to the operating model. Once this is completed a training needs analysis will be undertaken in conjunction with the central care group governance teams and a training plan will be developed and implemented. Training is already taking place since the launch of the new Incident Management Framework. The supporting training covers a number of elements including family support, psychological safety, staff support, investigation, breach of duty, causation, redress, claims and learning from events reports, sharing of learning. Training continues with the implementation of the new Datix Incident reporting module with the importance of updating Datix reinforced.	However, training is already taking place since the launch of the new Incident Management Framework. The supporting training covers a number of elements including family support, psychological safety, staff support, investigation, breach of duty, causation, redress, claims and learning from events reports, sharing of learning. Training continues with the implementation of the new Datix Incident reporting module with the importance of updating Datix reinforced. October 2022 Update The review of Policies and Procedures is underway taking into account changes to the operating model. Once this is completed a

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Concern s 6.2	Feb-22	Limited	Evidence should be retained of CSG management's contribution to the quality checking process of review and oversight of the investigation's outcomes and the draft PTR Concerns Response letters prior to their submission to an ILG Director for sign-off.	Medium	Standard Operating procedure to be developed as part of a suite of SOPs outlined in 1.2 above	Director of Nursing	Interim Head of Concerns, Redress & Legal	Jun-22	Now October 2022 Now December 2022		In progress	December 2022 Update - The review of Policies and Procedures is underway taking into account changes to the operating model. Once this is completed a training needs analysis will be undertaken in conjunction with the central care group governance teams and a training plan will be developed and implemented. Quality assurance and audit programme is in the process of being developed	April 2022 Update - On hold until changes to the operating model. June 2022 A review of all Policies and associated SOPs has begun and will incorporate the new operating model. Progress on this action has been slow due to the Complaints Manager not being in post and focus on changes to the operating model. August 2022 Update This will be completed by the Complaints Manager, supported by the Senior BI and Complaints Manager during the period of August and September, taking into account changes to the operating model. October 2022 The review of Policies and Procedures is underway taking into account changes to the operating model. Once this is completed a training needs analysis will be undertaken in conjunction with the central care group governance teams and a training plan will be developed and implemented. Quality assurance and audit programme is in the process of being developed
Concern s 6.3	Feb-22	Limited	A process of retrospectively reviewing the quality assurance processes applied in ILG should be introduced at a corporate level to ensure oversight, challenge and facilitate learning.	Medium	To form part of the rolling corporate concerns management audit programme	Director of Nursing	Interim Head of Concerns, Redress & Legal	Apr-22	Now December 2022		In progress	December 2022 Update - This will be included into the Quality Assurance and Audit Programme. There has been some slippage to progress in this area due to shortage of staff within central complaints.	April 2022 Update - Complaints Manager not in post. June 2022 Audits will be reinstated as outlined in 4.1a when Complaints Manager is in post. Changes to the operating model and centralisation of complaints management should ensure a more unified approach across the organisation. August 2022 Update This will be included into the Quality Assurance and Audit Programme. Due to be reviewed and updated in August 2022 and rolled out in September 2022. October 2022 Update This will be included into the Quality Assurance and Audit Programme. Due to be reviewed and updated in November 2022.
Concern s 6.4	Feb-22	Limited	All ILGs should ensure that the content of their PTR Concerns Response Letters are empathetic, showing concern and explaining with clarity the outcomes and lessons learned arising from the reported complaint. Letters should be independently reviewed and signed by an ILG Director in a timely manner.	Medium	This recommendation should be achieved following development of SOPs, Training and the QA process.	Director of Nursing	Interim Head of Concerns, Redress & Legal	End of June 2022	Now September 2022 Now December 2022		In progress	December 2022 Update - A review of complaint response letters has been undertaken in conjunction with the Communications department and the CEO. The review has focussed on the empathy of letters whilst ensuring they are informative and cover the necessary legislative requirements. Regular QA reviews will take place as part of the audit programme. These have been shared with the ILG Governance teams	April 2022 Update - On hold until changes to the operating model. June 2022 Standard templates have been devised and approved in early 2021. Audits will be reinstated as outlined in 4.1a when Complaints Manager is in post, this will incorporate any rationale for deviating from standard template. However, changes to the operating model and centralisation of complaints management should ensure a more unified approach across the organisation. August 2022 Update - A review of complaint response letters has been undertaken in conjunction with the Communications department and the CEO. The review has focussed on the empathy of letters whilst ensuring they are informative and cover the necessary legislative requirements. Regular QA reviews will take place as part of the audit programme. October 2022 Update A review of complaint response letters has been undertaken in conjunction with the Communications department and the CEO. The review has focussed on the empathy of letters whilst ensuring they are informative and cover the necessary legislative requirements. Regular QA reviews will take place as part of the audit programme.
Concern s 7.1	Feb-22	Limited	Clarity should be sought, and information documented with a SOP as to when a case should be closed on Datix and the circumstances for when it can be re-opened. To avoid any confusion, information contained in a SOP and the Concerns Policy should align.	Medium	To be included in the development of SOPs as per 1.2 above	Director of Nursing	Interim Head of Concerns, Redress & Legal	Apr-22	Now September 2022 Now January 2023		In progress	December 2022 Update - The review of Policies and Procedures is underway taking into account changes to the operating model. Once this is completed a training needs analysis will be undertaken in conjunction with the central care group governance teams and a training plan will be developed and implemented.	April 2022 Update - On hold until changes to the operating model. June 2022 A review of all Policies and associated SOPs has begun and will incorporate the new operating model. Progress on this action has been slow due to the Complaints Manager not being in post and focus on changes to the operating model. August 2022 Update - The review of Policies and Procedures is due to take place in August and September, taking into account changes to the operating model. October 2022 Update The review of Policies and Procedures is underway taking into account changes to the operating model. Once this is completed a training needs analysis will be undertaken in conjunction with the central care group governance teams and a training plan will be developed and implemented.
Concern s 7.2	Feb-22	Limited	Prior to closing concerns at early resolution stage, some form of quality assurance process should be followed that ensures all aspects of the concern raised by the complainant have been adequately addressed, thus preventing the case being potentially re-opened at a later date. This process should be documented.	Medium	To be included in the development of SOPs and training as per 1.2, 3.1a and 3.1b above	Director of Nursing	Interim Head of Concerns, Redress & Legal	Jun-22	Now September 2022 Now January 2023		In progress	December 2022 Update - 3.1a - The launch of the new Incident Management Framework and the training which is in place to support this covers a number of elements including family support, psychological safety, staff support, investigation, breach of duty, causation, redress, claims and learning from events reports, sharing of learning. Complaints policies/procedures will be updated in due course in line with the new operating model and changes to PTR following implementation of Duty of Candour. 3.1b - Training Needs analysis will be undertaken on completion of prospectus with the newly formed care groups.	April 2022 Update - On hold until changes to the operating model. June 2022 A review of all Policies and associated SOPs has begun and will incorporate the new operating model. Progress on this action has been slow due to the Complaints Manager not being in post and focus on changes to the operating model. August 2022 Update - The review of Policies and Procedures is due to take place in August and September, taking into account changes to the operating model. October 2022 Update The review of Policies and Procedures is underway taking into account changes to the operating model. Once this is completed a training needs analysis will be undertaken in conjunction with the central care group governance teams and a training plan will be developed and implemented. The way re-opened complaints are recorded within CTM is different and consequently skews data. Once the centralisation of the quality & safety team is implemented, the way complaints are managed will be more consistent in line with new/revised policies and procedures. October 2022 3.1a - The launch of the new Incident Management Framework and the training which is in place to support this covers a number of elements including family support, psychological safety, staff support, investigation, breach of duty, causation, redress, claims and learning from events reports, sharing of learning. Complaints policies/procedures will be updated in due course in line with the new operating model and changes to PTR following implementation of Duty of Candour.
Concern s 8.1	Feb-22	Limited	In relation to aged open concerns, it should be ensured comprehensive Datix records are maintained including recording the reason / justification for why the case has remained open and that relevant management are aware of it remaining open.	Medium	Process already in place which includes dashboards, and is monitored via Patient Safety Executive Meeting. The importance of recording regular updates on Datix will be included as part of 3.1a training programme.	Director of Nursing	Interim Head of Concerns, Redress & Legal	Apr-22	Now December 2022		Part Completed	December 2022 Update - Training is taking place in respect of Datix Cymru and the training which has supported the launch of the Incident Management Framework, both include the importance of using Datix Cymru to record all information and ensuring it is regularly updated. This will also be included within any additional training in respect of the new Complaints Policies and Procedures. Training will be required for Duty of Candour implementation and Datix Cymru will be incorporated.	3.1b - Training Needs analysis will be undertaken on completion of prospectus with the newly formed care groups. June April 2022 Update - Partially completed in respect of LFERs and Once for Wales CMS. PTR to be completed. June 2022 Process already in place which includes dashboards, and is monitored via Patient Safety Executive Meeting. June The importance of recording regular updates on Datix will be included as part of 3.1a training programme. June August 2022 Update - Training is taking place in respect of Datix Cymru and the training which has support the launch of the Incident Management Framework, both include the importance of using Datix Cymru to record all information and ensuring it is regularly updated. This will also be included within any addition training in respect of the new Complaints Policies and Procedures. October 2022 Update Training is taking place in respect of Datix Cymru and the training which has supported the launch of the Incident Management Framework, both include the importance of using Datix Cymru to record all information and ensuring it is regularly updated. This will also be included within any additional training in respect of the new Complaints Policies and Procedures.

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Concerns 8.2	Feb-22	Limited	Where cases remain open beyond 30 days, ongoing progress contact should be maintained with the complainant and evidence of this retained within Datix.	Medium	Will be addressed in the development of the SOPs as per 1.2 and included as part of the training programme as per 3.1a.	Director of Nursing	Interim Head of Concerns, Redress & Legal	Apr-22	Now September 2022		In progress	December 2022 Update - Training is taking place in respect of Datix Cymru and the training which has supported the launch of the Incident Management Framework, both include the importance of using Datix Cymru to record all information and ensuring it is regularly updated. This will also be included within any additional training in respect of the new Complaints Policies and Procedures.	April 2022 Update - On hold until changes to the operating model. June 2022 4A review of all Policies and associated SOPs has begun and will incorporate the new operating model. Progress on this action has been slow due to the Complaints Manager not being in post and focus on changes to the operating model. Completion of Datix will be incorporated into the training package. August 2022 Update - Complaints opened over 30 working days are regularly monitor via the weekly data review meeting and the Executive Patient Safety meeting. Updates to patients/family's will be incorporated into the Quality Assurance and Audit Programme being developed in August. Complaints Policies and Procedures are being reviewed in August and September. The centralisation of the quality and safety function with alignment to care groups should ensure a more consistent approach. Findings of the audits will be shared and acted upon, with current capacity constraints will be addressed following the implementation of the new operating model. October 2022 Update Training is taking place in respect of Datix Cymru and the training which has supported the launch of the Incident Management Framework, both include the importance of using Datix Cymru to record all information and ensuring it is regularly updated. This will also be included within any additional training in respect of the new Complaints Policies and Procedures.
Concerns 10.1	Feb-22	Limited	CSGs and ILGs should be able to demonstrate through meeting minutes or action notes the level of scrutiny that takes place in relation to concerns data to ensure inactivity is challenged, progress is made, and management are fully sighted on the issues in their area of responsibility.	Medium	10.1a Monthly performance meetings with the ILGs and CGS to continue. 10.1b CSG scrutiny panel to continue. 10.1c Weekly assurance meetings with the CSGs to continue. 10.1d Development of a standard agenda template and standard concerns management template with KPI to ensure consistent scrutiny across all ILGs. 10.1e Director of Corporate Governance to attend ILG Performance Meetings for the purpose of seeking assurance on concerns data.	Director of Nursing	ILG Heads of Quality & Safety	Immediately	Now December 2022		Part Completed	December 2022 Update - 10.1/10.b/10.c - Various reports are already available and presented at various committees. The Datix team are now producing reports in the Care Group format in addition to some historic reporting in the ILG format. Dashboards are being developed for Care Groups, and training is being rolled out to support key users to be able to run reports and access data "live". The Head of Concerns & Business Intelligence for CTM is co-chair of the All Wales work stream on Data, Business Intelligence and Dashboards. CTM have volunteered to be a pilot site for the Business Intelligence tool within Datix Cymru as part of the Phase 2 roll out. The centralisation of the quality and safety function should assist in moving forward in a uniform way in respect of quality and safety. 10.1d - Standardisation of Governance process and various care group specific committees/groups will be undertaken when the new operating model is implemented. 10.1e - The Director of Corporate Governance has held various ad hoc meetings with ILGs, in particular in relation to Learning from Events. The Assistant Director of Concerns & Claims attends a weekly data review meeting whereby Complaints monitoring and management is discussed along with 30 wk day compliance, along with LFERs. Lessons are shared across the 3 ILGs	10.1a/10.1b/10.1c April 2022 Update - Performance meetings continue across the ILGs and CSGs. These include review of complaints management, 30 wk day compliance and learning. These may become more standardised when the operational model is reviewed and changed. 10.1d April 2022 Update - This will be developed following review of the Operating model. 10.1e April 2022 Update - The Director of Corporate Governance has held various ad hoc meetings with ILGs, in particular in relation to Learning from Events. The Assistant Director of Concerns & Claims attends a weekly meeting whereby Complaints monitoring and management is discussed along with 30 wk day compliance. Lessons are shared across the 3 ILGs. June 2022 10.1a/10.1b/10.1c - Detailed reports are provided by the Datix team and these are used to monitor performance across ILGs and CSG. Monitoring will have a more uniform approach once changes are made to the operating model. 10.1d - Standardisation of Governance process and various care group specific committees/groups will be undertaken when the new operating model is implemented. 10.1e - The Director of Corporate Governance has held various ad hoc meetings with ILGs, in particular in relation to Learning from Events. The Assistant Director of Concerns & Claims attends a weekly meeting whereby Complaints monitoring and management is discussed along with 30 wk day compliance. Lessons are shared across the 3 ILGs. August 2022 Update - 10.1/10.b/10.c - Various reports are already available and presented at various committees. The Datix team and OFWCMS team will move into the portfolio of the Director of Corporate Governance from 1st August 2022. A review of reports provided by the team will be undertaken in line with the changes to the operating model. Dashboards will be developed where possible to avoid the need to run reports, enabling service areas to view data "live". Engagement with the OFW National Team in respect of the Business Intelligence tool which is due to be rolled out as part of Phase 2 of the OFWCMS (Datix Cymru), will continue to ensure that CTM are abreast of any developments in respect of business intelligence. CTM will volunteer to be part of any pilot work in respect of the new business intelligence tool. The centralisation of the quality and safety function should assist in moving forward in a uniform way in respect of quality and safety. 10.1d - Standardisation of Governance process and various care group specific committees/groups will be undertaken when the new operating model is implemented.
Fire Safety Management 4.1	Feb-22	Limited	Management should develop an appropriate medium-term strategy to demonstrate co-ordination of efforts in managing the fire risk.	Medium	The Health Board will develop a medium term strategy for fire safety across its sites.	Director for People	Head of Health, Safety and Fire Head of Capital and Estates ILG Director of Operations	Mar-23				December 2022 Update - A new Senior Fire Officer has been appointed following the retirement of the previous post holder. The new Senior Fire Officer came in to post on the 7th November 2022 and has been requested to develop this plan over the coming 2 months.	April 2022 Update - Work ongoing. August 2022 Update - no further update provided on this occasion October 2022 - No further update provided on this occasion.
Fire Safety Management 11.1	Feb-22	Limited	Management should confirm an appropriate timeline to update drawings in respect of compartmentation for all sites.	Medium	Capital and Estates Governance Board will action and provide assurances to the Health, Safety and Fire Sub Committee	Director for People	Head of Capital & Estates	Jun-22	Now December 2022 Now September 2023		In progress	December 2022 Update - The former CTMUHB Senior Fire Officer has been reemployed to carry out a review of all Fire Orientation/compartmentation plans across the HB and feed information into the HB CAD operator for updating. Royal Glamorgan Hospital will be completed by Jan 2023. Survey work commenced in Princess of Wales Hospital in November 2022 and will be finalized in March 2023 this will be followed by Prince Charles Hospital which will take a further 4 months to complete. This work will allow the HB to have centralised base line fire plans for all the DGH sites that will be utilised for all Passive and Active fire information such as Damper, cause & effect etc. as well as any other services or operational need. Work to the Community Hospitals will commence on completion of the DGH.	April 2022 Update - Work ongoing by the Capital and Estates Team. August 2022 Update - no further update provided on this occasion. September 2022 - The Estates Team have appointed a fixed term member of staff to complete this activity. Person started in September 2022 and an update will be provide at the next review to identify a compliance date. Work has started and a GAP analysis is being undertaken to identify any gaps, once the field work has been done a better understanding of timescales can be provided.
Fire Safety Management 12.1	Feb-22	Limited	Management should confirm a process of review of local procedures in respect of each high-risk action addressed.	Medium	Capital and Estates Governance Board will action and provide assurances to the Health, Safety and Fire Sub Committee	Director for People	Head of Capital and Estates	Jun-22	Now December 2022 Now June 2023		In progress	December 2022 Update - The former CTMUHB Senior Fire Officer has been reemployed and is currently reviewing the high risks that are on the Estates risk list, this list will be updated during the next reporting period.	April 2022 Update - Work ongoing by the Capital and Estates Team. Current Procedure to be reviewed and revised where necessary. August 2022 Update - no further update provided on this occasion. October 2022 - The Estates Team have appointed a fixed term member of staff to complete this activity. Person started in September 2022 and an update will be provide at the next review to identify a compliance date.
Patient Pathway Appointment Management Process Follow Up 3.1	Jun-22	Limited	Management should establish if staff in the Rhondda Taf Ely and Merthyr Cynon ILGs areas can be provided with the same access to watch lists within WPAS as staff in Bridgend ILG, allowing all staff to be able to view and then monitor each other's watch lists. If this functionality is not available, then our original recommendation should be implemented. A review of the watch list process should be undertaken and following that guidance produced that ensures all Medical Secretaries are using a standard approach that is user friendly and does not restrict access, allowing visibility to other staff members	Medium	This will be addressed by the ILG with colleagues from Performance	Chief Operating Officer	ILG Directors of Operations / Head of Information	Sep-22	Now February 2023		In progress	December 2022 Update - progress slow as a consequence of activity on sites. Meeting in diaries to resolve way ahead.	August 2022 Update - Date remains September 2022. October 2022 Update - no further comment, will be picked up as part of re-focus on this audit.

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POW Theatres Fire Safety Works 1.2	Aug-22	Limited	The Health Board should appropriately define and operate project linkage to the Senior Responsible Officer.	Medium	Agreed - This will be put in place to consider the options appraisal. The executive structure and personnel changed across this time. The project involves Health & Safety, Capital, and Strategy & Planning. The role of Senior Responsible Officer was therefore re-allocated. The project is currently being re-appraised. Subsequent to this, and pending the options appraisal to Welsh Government, governance will be further addressed as appropriate for the approved scheme. The CEO has also been in receipt of regular informal briefings from the Project Director.	Director of Strategy & Transformation	Project Director	Aug-22	Now November 2022 Now January 2023		In progress	December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place.	October 2022 Update - Whilst appointments and structures are confirmed this remains outstanding
POW Theatres Fire Safety Works 3.1	Aug-22	Limited	The Health Board should ensure timely completion of contacts.	Medium	Agreed – though in this case, due to the bespoke nature of the contract – a single phase business case, this did not align with the national framework contract stages - requiring additional edit prior to issue. Covid also impacted timely return.	Director of Strategy & Transformation	Project Director	At future contracts	Now January 2023		In progress	December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place.	October 2022 Update - Until a way forward is agreed with WG this will not be required as no new contracts will be let
POW Theatres Fire Safety Works 4.1	Aug-22	Limited	The Health Board should assess the methodology of awarding direct contracts at design and construction projects.	Medium	Agreed – we will ensure this at future awards. However, in the early stages of this project, we did not want to contractually commit to the full scheme at the outset, until the position had been appraised.	Director of Strategy & Transformation	Project Director	At future contract awards	Now January 2023		In progress	December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place.	October 2022 Update - This is a future recommendation at such a time post business case approval
POW Theatres Fire Safety Works 4.2	Aug-22	Limited	The Health Board should confirm how value for money will be assured at the letting of the construction stage award for a Cost Adviser.	Medium	Agreed	Director of Strategy & Transformation	Project Director	Aug-22	Now 2023 Now January 2023		In progress	December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place.	October 2022 Update - This will be reviewed at the letting of a contract for construction stage post business case approval in 2023
POW Theatres Fire Safety Works 4.3	Aug-22	Limited	The Health Board should ensure appropriate contractual arrangements are in place for the Cost Adviser.	Medium	Agreed	Director of Strategy & Transformation	Project Director	Aug-22	Now 2023 Now January 2023		In progress	December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place.	October 2022 Update - This will be addressed on letting the contract post business case approval in 2023
POW Theatres Fire Safety Works 6.1	Aug-22	Limited	Upon recommencement of the project, management should utilise Key Performance Indicators in accordance with the contract.	Medium	Agreed. These will be applied as required.	Director of Strategy & Transformation	Project Director	Upon re-engagement with the SCP	Now 2023 Now January 2023		In progress	December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place.	October 2022 Update - This will be addressed on letting the contract post business case approval in 2023

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POW Theatres Fire Safety Works 8.1	Aug-22	Limited	Management should ensure appropriate reporting, forecasting and management of project costs, for each project phase, to a project group, accountable for delivery, including overall project reporting of: • contacted sums; • cash flow budgeted to date; • expenditure to date; • forecast out-turn; and • associated variance commentary.	Medium	Agreed. However, profiled costs are provided from the Supply Chain Partner. There is formal cost monitoring in terms of performance against funding to ECMG and monthly reviews of capital costs. Further reporting of the formats suggested will follow as appropriate upon review pending scale of the revised proposal.	Director of Strategy & Transformation	Project Director	Aug-22	Now 2023 Now January 2023		In progress	December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place.	October 2022 Update - This will be addressed on letting the contract post business case approval in 2023
POW Theatres Fire Safety Works 9.1	Aug-22	Limited	Pending the outcome of the options appraisal, in the circumstance that Theatres reprovision remains within preferred option, the Project Board should re-assess procurement options to ensure value for money.	Medium	Agreed. This will be undertaken at the future procurement.	Director of Strategy & Transformation	Project Director	At confirmation of the preferred option	Now 2023 Now January 2023		In progress	December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place.	October 2022 Update - This will be addressed on letting the contract post business case approval in 2023
POW Theatres Fire Safety Works 10.1	Aug-22	Limited	A costed risk register should be regularly maintained and reported, as applicable to the current project phase.	Medium	Agreed	Director of Strategy & Transformation	Project Director	Aug-22	Now November 2022 Now January 2023		In progress	December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place.	October 2022 Update - This will be developed and included at business case stage once a preferred option is identified in November
POW Theatres Fire Safety Works 10.2	Aug-22	Limited	Management should actively monitor and report the value of residual risk v remaining contingency.	Medium	Agreed	Director of Strategy & Transformation	Project Director	Aug-22	Now 2023 Now January 2023		In progress	December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place.	October 2022 Update - This will be addressed on letting the contract post business case approval in 2023
POW Theatres Fire Safety Works 10.3	Aug-22	Limited	Risks should be individually assigned to those best placed to control them, with time parameters for action.	Medium	Agreed	Director of Strategy & Transformation	Project Director	Aug-22	Now November 2022 Now January 2023		In progress	December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place.	October 2022 Update - This will be developed and included at business case stage once a preferred option is identified in November
POW Theatres Fire Safety Works 10.4	Aug-22	Limited	An exception report should be published of targeted risk mitigations not achieved.	Medium	Agreed	Director of Strategy & Transformation	Project Director	Aug-22	Now 2023 Now January 2023		In progress	December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place.	October 2022 Update - This will be addressed on letting the contract post business case approval in 2023

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Digital Operatin g Model 4.1	Nov-22	Limited	The balance between the use of DHCW solutions and development of in house solutions within the operating model should be reviewed to ensure that it matches the needs of the organisation. Consideration should be given to increasing the level of in house development resource in order to provide Health Board specific digital solutions at a pace that suits the Health Board	Medium	Accept Development resources will be considered and proposed as part of subsequent structural reviews. Acknowledgement that any development resource proposal will need to be prioritised against other financial decision points for the Health Board.	Director of Digital	Director of Digital	Qtr 2 2023 / 2024			In progress	December 2022 Update - Digital development resources will be aligned to the requirements of the IMTP from Care Groups	
Digital Operatin g Model 5.1	Nov-22	Limited	The skills required by the Digital Directorate should be fully defined and mapped to those already in place. A structured training & development plan should be defined to meet skills shortages, alongside the use of temporary staff to meet gaps short term.	Medium	Accept Full review of the capacity and capability required will be completed in 2023 as part of a phased approach to the future target operating model for the Digital & Data Directorate.	Director of Digital	Director of Digital	Qtr 2 2023 / 2024			In progress	December 2022 Update - Activity to be undertaken once Strategic Leadership roles are finalised	
Digital Operatin g Model 7.1	Nov-22	Limited	The Health Board should clearly state that minimum digital literacy is a requirement, with provision of training if required.	Medium	Accept Digital literacy to be included within the workforce and organisational development plan as part of the IMTP.	Director of Digital	Director of Digital	Qtr 4 2022/ 2023			In progress	December 2022 Update - Digital Literacy and training initiatives to be outlined within the IMTP	
Digital Operatin g Model 8.1	Nov-22	Limited	The work to restructure support should be finalised, with greater provision of: - fix at first contact; - use of process automation for handling calls; - use of digital champions within services; - a structured SharePoint site; and - how to guides.	Medium	Accept A phased programme of work will be developed alongside the structural review. This programme is likely to run for 12 months.	Director of Digital	Director of Digital	Qtr 3 2023/ 2024			In progress	December 2022 Update - New Digital Service Desk launched in November 2022. Work ongoing to complete how to guides ...	
POW Theatres Fire Safety Works 2.1	Aug-22	Limited	The Health Board should confirm that resource requirements are appropriately assessed utilising a detailed resource schedule at the business case stage.	Low	Agreed. The project has been adequately resourced with two internal officers to date. Formal application for resources would be made at a formal business case, and we will look to make appropriate application at that time.	Director of Strategy & Transformation	Project Director	At the business case	Now 2023 Now January 2023		In progress	December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place.	October 2022 Update - This will be addressed on letting the contract post business case approval in 2023
POW Theatres Fire Safety Works 7.1	Aug-22	Limited	The Health Board should obtain advice from NWSSP; Specialist Estates Services in relation to a performance bond for construction works	Low	Agreed	Director of Strategy & Transformation	Project Director	Aug-22	Now 2023 Now January 2023		In progress	December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place.	October 2022 Update - This will be addressed on letting the contract post business case approval in 2023

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Nurse Agency Usage 01	Apr-20	Reasonable	1. Clarity should be provided as to whether the Staff Bank Policy Induction Checklist (Appendix C) should be completed or the more recently revised 'Ward induction checklist for bank and agency workers'. 2. Ward Managers / the Nurse in Charge should be reminded of the importance to complete the induction checklist to ensure that new agency nurses are appropriately orientated and provided with relevant health and safety overview of the ward they are due to work on.	High	Induction check list to be reviewed and agreed by Heads of Nursing, Ward Managers & Senior Nurses to receive updated check list that must be completed for all new Bank and agency nurses. Updated Bank/Agency Nurse Induction Checklist to be included into the revised Staff Bank policy.	Director for People	Head of Corporate Nursing	March 2020/April 2020/August 2020	February 2021 June 2021 Now September 2021 Now December 2021 Now April 2022 Now July 2022 Now August 2022 Now October 2022 Now December 2022		In progress	December 2022 - The policy has been completed and was sent to the Policy Review Group in November 2022. While the meeting was not quorate the policy has been shared with the group members for final review via comments. Then potential sign off will be achieved on the 15th December, at the next Policy Review Group before progressing through the final governance route.	November 2020 Update - The Bank Policy is being updated during December 2020/January 2021. The updated policy will consist of a review and update of all the bank and agency forms. January 2021 update - Policy has been completed and is awaiting review by policy sub groups. APRIL 2021: Amendments came back via policy infrastructure, which will be incorporated into the policy draft for approval. This will be taken through the Health Board's policy group by Jun-21. Revised implementation date provided. July 2021 Update - Policy development group has been difficult to complete due to the pandemic and poor attendance at meetings to make them quorate. The policy is still under review in conjunction with the union representation, but has been completed. It needs a final review with the group before being sent to the policy group for ratification. The revised date for policy being live will slip to September. Sept 21 update: Due to inability to get interested parties to agree on the final policy, alongside the cancellation of the last 2 meetings for not being quorate, the policy has not progressed further. The policy is awaiting agreement in partnership to progress to policy group. November 2021 Update - Draft Staff Bank Policy scheduled for Policy Review Group on 18th November 2021. January 2022 Update - Policy sent to policy group for ratification. Apr 2022 - The policy was sent through the ratification route. Comments on the content were made post the policy review group meeting. These comments have been taken away and are actively being worked upon by the Deputy Director of Nursing & the Staff Bank Manager. The Policy will then be resubmitted to the policy group in May, if approved this will then progress to the LPF and be signed off for use in the UHB. June 22 update - The policy has been updated and is progressing through the approval process. August 2022 update - The policy is yet to be ratified. The LPF has not sat since the last audit report return as it was cancelled, to allow for
Nurse Agency Usage 02	Apr-20	Reasonable	1. The Bank / Agency Nurse Quality Monitoring Form should be reviewed to ensure it is fit for purpose and provides a suitable means for the routine monitoring of the quality of work provided by agency staff. 2. Ward Managers should be reminded of the need to complete the quality monitoring form and returning it to the Bank office as a means of formally evaluating the performance of agency nurses and aiding and informing any future acceptance or rejection of potential agency nurses in the event of query or concern. 3. The Clinical Incident Reporting for Agency Staff flowchart and the Staff Bank Policy should be reviewed to ensure consistent guidance for managing and monitoring issues relating to the quality of service provided by agency staff. If the flowchart is the Health Boards preferred approach, all Ward Managers should be made aware that in line with the agreed flowchart, incidents are appropriately and consistently recorded on DATIX to allow effective monitoring. 4. Attempts to cross-reference patient experience data	High	Revised Clinical Incident Reporting flowchart to be placed into the Staff Bank Policy. Bank / Agency Nurse Quality Monitoring Form will be reviewed to ensure it is fit for purpose and amendments made for updated policy in August 2020. The cross-referencing of patient experience and agency use data is something that we will look into. In the first instance we will need to see if data in relation to patient experience can be obtained from colleagues in the Health Board and we will look to see if meaningful reports can be produced. In the mean-time we will continue to review specific concerns that have been raised via our routine processes.	Director for People	Head of Corporate Nursing	Aug-20	October 2020 February 2021 June 2021 Now September 2021 Now December 2021 Now April 2022 Now July 2022 Now August 2022 Now October 2022 Now December 2022		In progress	December 2022 - The policy has been completed was sent to the Policy Review Group in November. Unfortunately the meeting was not quorate, however, the policy has been shared with the group members, for final review via comments. Then potential sign off will be achieved on the 15th December, at the next Policy Review Group prior to the final stages of the governance route.	July 2020 Update - The policy will be written in September 2020, which will coincide with the change in recruitment processes for staff bank workers. Roll out and publication of the policy will be completed by end of October 2020. November 2020 Update - The Bank Policy is being updated during December 2020/January 2021. The updated policy will consist of a review and update of all the bank and agency forms. July 2020 Update - Due to outbreak of covid-19 and consequent pressure on staff bank to recruit additional bank workers to support existing and new HB services has meant a delay in starting this policy. January 2021 Update - No further change/update. APRIL 2021: See above for policy amendments. Remaining recommendations delayed due to the pandemic but will be taken forward in the same timeframe as the policy approval. Revised implementation date provided. July 2021 Update - Policy development group has been difficult to complete due to the pandemic and poor attendance at meetings to make them quorate. The policy is still under review in conjunction with the union representation, but has been completed. It needs a final review with the group before being sent to the policy group for ratification. The revised date for policy being live will slip to September. Sept 2021 update: Due to inability to get interested parties to agree on the final policy, alongside the cancellation of the last 2 meetings for not being quorate, the policy has not progressed further. The policy is awaiting agreement in partnership to progress to policy group. November 2021 Update - No further update provided. January 2022 Update - Policy sent to policy group for ratification. Apr 2022 - The policy was sent through the ratification route. Comments on the content were made post the policy review group meeting. These comments have been taken away and are actively being worked upon by the Deputy Director of Nursing & the Staff Bank Manager. The Policy will then be resubmitted to the policy group in May, if approved this will then progress to the LPF and be signed off for use in the UHB. June 22 update - The policy has been updated and is progressing through the approval process. August 2022 update - The policy is yet to be ratified. The LPF has not sat since the last audit report return as it was cancelled, to allow for ratification of the policy through the appropriate route. The policy will be taken to the next LPF in September 2022. October 2022 Update - The policy has been stalled due to changes needed to the asset booking process required by the Nursing Group. Productivity
Director ate Review Acute Medicine & A&E 13	Aug-20	Reasonable	An inventory of non-capital assets should be developed for each department within the directorate, detailing their assets, which fit under the definition of inventory as detailed within the Financial Control Procedure.	High	It is accepted that this area needs attention and this will need to be prioritised by the CSG general managers during 2020-21 once supporting staffing structures are in place.	Chief Operating Officer	General Manager	Apr-21	01/05/2021 August 2021 April 2022 Now September 2022 Now March 2023		In progress	December 2022 Update - position remains the same in RTE area.	RTE ILG January 2021 Update - action has been delayed due to the COVID pandemic and this area will need to be addressed in 2021-22. for focus in the future - further action will be completed asap. May 2021. A check has been made across the old Cwm Taf Directorates and a review has been taken on this issue. This does remain a key risk - and both MC and RTE recognise that it will take time to be complete. The CSG Manager in MC has recently sent out information to staff and anticipates an earlier resolution than RTE but it is recognised in both areas. September 2021 Update. No change to report, the target date remains April 2022. November 2021 Update - Target date is April 2022 - nothing further to report. February 2022 Update - the Directorate at MC has established a link with Procurement colleagues to work on this. In RTE, the pressure of work means that there is no update yet and no further action taken. April 2022 Update - Further improvement in MC - the process has started and the anticipated completion is September 2022. June 2022 Update - target remains September 2022, though this will be difficult given the amount of detailed work that will be required within existing staffing profiles. August 2022 Update. For MC, the completion date remains at September 2022. For RTE, this is still an aspiration but not one that the CSG can support at present. October 2022 Update - the situation remains the same, the view of the Directorate is that there is not at present the capacity to complete this task.
PCH Redevelopment Governance Audit 03	Apr-21	Reasonable	Appropriate arrangements will be made to ensure that vacancies identified within the resource schedule are filled as a matter of priority (O).	High	Agreed. All of the appointments for additional resources are progressing and the Senior Responsible Officer has confirmed that all are permanent positions (Noting that the appointments are for a 5.5 year construction programme and employment rights become permanent due to this duration). Responsibility for the appointments rests with departmental heads to progress these positions with assistance from the Major Projects Unit.	Director of Finance	Deputy Senior Responsible Officer	Mar-21	01/08/2021 Now November 2021 Now May 2022 Now August 2022 Now October 2022 Now March 2023		In progress	December 2022 Update - The most recent post advertisement realised only one candidate being interviewed. However, that candidate proved unsuitable. Discussions have taken place between IPC and Capital and determined that a post of lower grade will be advertised which will enable the Deputy Lead Infection Prevention Control Nurse and Decontamination Officer to be dedicated to the project.	May 2021 Update - One Commissioning Officer in post. 2 Estates posts addressed; Offer made and being processed for Informatics Officer and additional hours granted to part time Officer. 2 Estates post being addressed; applications received with no suitable candidates, being re-advertised. Discussion held with IT about committing resource to project of Contracted member of staff. Discussion held with IPC regarding need to advertise for post. Agreement obtained from NWSSP Audit (E.Jones) that Implementation Date becomes end of July due to new RO in post. July 2021 Update - Arrangements in place to resource the project requirements. October 2021 - Follow up report received which identified that this recommendation was Partially Implemented. Requirements as specified at the Full Business Case for Phase 2 are currently being reviewed for adequacy. A number of posts have been filled with only two posts remaining - having not been filled following advertisement. November 2021 - Of the two posts that remained to be filled, the Estates Officer post has been awarded and is awaiting confirmation of a start date from the appointee. The IPC post has been advertised twice with no applicants showing interest. The grading of the post is being reviewed. February 2022 update - The remaining Estates Officer will be in post by the end of February 2022. The IPC post is currently being re-advertised one more time at Band 7. If there are no suitable applicants, advertising at a Band 6 will be considered to attract a different profile of candidate. April 2022 Update - The Estates Officer appointment is in post. The IPC post has had no applicants when advertised twice. The job description is being revised before being advertised again. In the meantime, the project is being covered by the Deputy Lead Infection Prevention Control Nurse and Decontamination Officer. June 2022 Update - In light of inability to attract interest in the post, dialogue is to be undertaken with Welsh Government to request that the funding be used to appoint Band 3 nurses to release the Senior Infection Prevention Control Nurse to the project. In the meanwhile, the project is being covered by the Deputy Lead Infection Prevention Control Nurse and Decontamination Officer. August 2022 Update - The post remains unfilled despite repeated advertisements. The project continues to be covered by the Deputy Lead Infection Prevention Control Nurse and Decontamination Officer. October 2022 update - The application date for the IPC post closed on 5/10/22 with interviews scheduled for 17/10/22. In the meanwhile, the project continues to be covered by the Deputy Lead Infection Prevention Control Nurse and Decontamination Officer.
Welsh Language Standards Compliance 04	Oct-21	Reasonable	4.1) Management should review and enhance the reporting and monitoring structures which are currently in place and implement a robust system which provides assurance both to senior management but also provides feedback to the departments and ILGs responsible for implementing Standards. In order to implement this management should consider: • Setting up local Welsh Language Standards working groups within the departments and ILGs which are attended by the key leads from those areas and the Welsh Language Manager, thus allowing localised progress to be given on the status of the action plans and relevant support. • These groups could feed into an overall Welsh Language Group, whose membership should consist of relevant staff from Workforce & Organisational Development along with other areas across the Health Board along with representatives from the local working groups and the Welsh Language Manager. Findings and best practice from ward audits should be shared at this group. • Regular updates against the Standards should be provided to Board, via the People and Culture Committee who are responsible for this monitoring compliance.	High	4.1) The Welsh Language Manager will engage with the ILG SMTs, to determine the feasibility and benefits of establishing local ILG Welsh Language Working Groups and how these would be managed and supported by the Welsh Language Manager. Reporting and monitoring of progress will be strengthened by the requirement for regular compliance reporting, from the nominated Senior ILG leads to the Welsh Language Working Group. The reporting will be further enhanced by having a standard agenda item of "sharing examples of good practice" to assist achievement of compliance in other areas. This information will be provided to the nominated senior ILG lead by the network of ward Welsh Language Champions. The People and Culture Committee when developing its cycle of business for 2022 will incorporate Welsh Language Standards Compliance updates, to be presented and report twice yearly, to provide assurance to the Board.	Director for People	Welsh Language Group Manager/Assistant Director of Workforce/ILG Leads	Oct-21	Now December 2021 Now March 2022 Now May 2022 Now August 2022 Now October 2022 Now December 2022 Now January 2023		In progress	December 2022 update - The WL Steering Group has been deferred while some key appointments are still being made within Care Groups. The first meeting will convene in New Year.	November 2021 Update - A new Welsh Language Committee will meet for the first time in December 2021. Senior leadership will be made aware of their responsibilities in this meeting. Action plans will be distributed and returned to the Welsh Language Manager. Highlight reports and good practice will be shared with the Committee. Formal monitoring and reporting will be via the new Welsh Language Committee to the People and Culture Committee. The first report will be submitted by March 2022 which will co-inside with the writing of the Welsh Language Standards Annual Report. Update Jan 2022 - (4.1) The first meeting of Health Board's Welsh Language Committee was unable to meet in December 2021, due to COVID-19 Service and staff pressures. The meeting has been rescheduled for 17 March 2022. 1.1) The WL Manager contacted senior ILG leads in February and met Bridgend ILG 1.2) A new action plan template document has been created will be dated and version controlled to allow progress to be mapped. June 2022 4.1) The Welsh Language Steering Group arranged for the 17 March 2022 was postponed. The meeting is in the process of being rescheduled. The Welsh Language Services Manager has met with 7 service areas with a further 8 scheduled during May and June to set departmental/service level action plans, and has been invited to RTE ILG governance and business meeting and Senior Nurse Professional Forum in June to progress this work further. The Welsh Language Annual Report is currently being developed and will be presented to the People and Culture Committee in August 2022, prior to being published in September 2022. Welsh Language Standards are now built into People and Culture Committee cycle of business. August 2022 Update - The Terms of Reference for the new Welsh Language Steering Group are currently being revised to reflect the Health Boards New Operating Model and Management Structures. It is anticipated the first meeting of the Welsh Language Steering Group will take place during October 2022. Welsh Language Report etc. for endorsement and approval are being presented to the Executive Leadership Group for endorsement and People and Culture Committee for approval. The Welsh Language Annual Report is currently being scrutinised via this route, in preparation for publication in September 2022. October 2022 update - The Terms of Reference for the Welsh Language Steering Group have been reviewed and amended to reflect the new Operating Model. The first meeting of the WL Steering group has been deferred until December 2022, as some of the key Care Group appointments are still outstanding. The Welsh Language Annual report has been published in accordance with the statutory requirement.

Ref	Date added	Assurance rating	Recommendation	Priority	Management Action Agreed	Responsible Executive Lead/Management Lead	Responsible Management Lead	Original Agreed Implementation Date	Revised Implementation Date	Status	Progress	Updates during this period/Latest Update	Previous Updates
CHC and FNC 8.0	Feb-22	Reasonable	formalised reporting structure should be put in place that allows the monitoring and scrutiny of CHC data to take place at varying levels within the Health Board, and to facilitate management in being able to make informed decisions around the delivery of the service and care packages provided.	High	CURRENT REPORTING MECHANISMS • In light of the current review of the Health Board's operating model, it is agreed that CHC reporting and monitoring will be included as part of this review and will incorporate any reporting management tool identified by Welsh Government in the new framework. • Prior to the review of the operating model, CHC / FNC will be a standing agenda item on monthly Community Service Group performance meeting agendas. Reporting to Health Board Quality and Safety Committee and Planning, Performance and Finance Committee will commence.	Chief Operating Officer	Lead Nurse for CHC and NHS Funded Care	May-22	Now July 2022 Now October 2022 Now December 2022		In progress	November 2022 Update - Team continue to work through actions from Quality & Safety Committee to strengthen reporting. Reportable data has been identified and admin are currently reviewing best way to present information concisely. Await new operational model to finalise plans for reporting.	April 2022 Update - No update this month due to sickness of Lead Nurse. Anticipated that there will be more to report at the next meeting. June 2022 Update. This is subject to ongoing development with a pivot table being worked on. Ongoing work to consider how this will be cascaded in new operating model alongside Finance. August 2022 Update - paper to go to Board to progress in September 2022. October 2022 Update - Paper went to Quality & Safety Committee in September 2022. Actions required following Committee. The team are working through these to strengthen reporting across the organisation and the new operational model.
Overtime & Additional Hours 5.0	May-22	Reasonable	The functionality available in Health Roster to monitor compliance with the various Working Time Regulations requirements should be used to ensure staff are not in breach of regulations. For those areas not using Health Roster, managers should routinely monitor the hours and working patterns of staff to ensure they are not in breach of WTRs. To do this effectively, they should be aware which staff have opted out of the WTRs and therefore know the upper limit of hours to be worked in a week.	High	The UHB will turn on the Health Roster functionality to block book bank / agency workers to work any non-WTR compliant shifts. The revised Overtime Policy will set out the line manager's responsibility to routinely monitor the hours and working patterns of their staff, to ensure compliance with WTRs, when Health Roster is not used. The Policy will also require the manager to check whether their staff who regularly work overtime have completed a WTR Opt-Out Form. The Overtime Policy will be cross referenced with the WTR Policy	Director for People	Head of Workforce Productivity and E-Systems Assistant Director of Policy, Governance and Compliance	July 2022 November 2022	Now January 2023		In progress	December 2022 update - Work has commenced on reviewing the policy and will be taken to the January 2023 People Policy Review Group.	August 2022 Update - The Overtime Policy will be reviewed by the Workforce Policy Review Group in September 2022. The review will take into consideration the internal audit recommendations. October updated 2022 - A policy task and finish group has now been established to review this policy. The first meeting of the group will take place in October 2022 and will ensure audit recommendations are incorporated.
Welsh Risk Pool Claims 1.3	Jun-22	Reasonable	To prevent future issues arising, management should ensure all staff are aware of the requirement to capture learning information in Datix at the point of investigation, in order to support the administrative process for reimbursement and to allow appropriate learning to be shared in good time.	High	Staff to be reminded of importance of updating Datix Cymru for all incidents and concerns, using various methods such as management discussions, Datix Cymru training programme, patient safety discussions.	Director of Nursing	Assistant Director of Patient Safety/Assistant Director of Concerns & Claims/Care Group Leaders	Jun-22	Now January 2023		In progress	December 2022 Update - Training is taking place in respect of Datix Cymru and the training which has support the launch of the Incident Management Framework, both include the importance of using Datix Cymru to record all information and ensuring it is regularly updated. This will also be included within any additional training in respect of the new Complaints Policies and Procedures. Capturing learning is a key focus of the new Incident Management Framework and associated training. The Listening and Learning Framework was launched at a Listening and Learning event in September. As part of this a learning repository is being developed to capture and share learning across the organisation.	August 2022 Update Training is taking place in respect of Datix Cymru and the training which has support the launch of the Incident Management Framework, both include the importance of using Datix Cymru to record all information and ensuring it is regularly updated. This will also be included within any addition training in respect of the new Complaints Policies and Procedures. Capturing learning is a key focus of the new Incident Management Framework and associated training. Listening and Learning Framework in draft format, due to be rolled out in September 2022. Inaugural Learning from Events Day to be undertaken in September. October 2022 Update Training is taking place in respect of Datix Cymru and the training which has support the launch of the Incident Management Framework, both include the importance of using Datix Cymru to record all information and ensuring it is regularly updated. This will also be included within any additional training in respect of the new Complaints Policies and Procedures. Capturing learning is a key focus of the new Incident Management Framework and associated training. The Listening and Learning Framework was launched at a Listening and Learning event in September. As part of this a learning repository is being developed to capture and share learning across the organisation.
Financial Systems 8.1	Jun-22	Reasonable	Management should ensure that staff responsible for approving requisitions and processing purchase orders are aware of the correct procurement process as stated in the Requisition of Goods and Services FCPO and the All-Wales No PO No Pay policy.	High	Procurement will increase the training and cascade information relating to the No PO No Pay policy. We will identify the areas of retrospective ordering, implement a plan and ensure bespoke training to these areas.	Director of Finance	Head of Procurement	Jul-22	Now August 2022 Now November 2022 Now January 2023		In progress	December 2022 update : - As part of the Finance Delivery Unit AW P2P group, the No PO policy approach within HBs is being developed as best practice within the HB, and internal communication to Directorates is being strengthened and re-issued by Jan 2023 - All FCPs are being reviewed as part of the new delivery model and update of the SoD. Therefore the FCP will be updated once the new SoD has been approved. CTM systems ensuring training undertaken prior to giving Oracle access to new users, and refresher training being developed. As part of the Finance Delivery Unit AW P2P group,(SRO - DOF Swansea Bay) the No PO policy and exemption list is being reviewed together with a Communications plan through an AW Task & Finish group. Outline paper with planned approach approved by AW P2P group 17th November. CTM already undertaking focused P2P training, Facilities and Estates completed, further lunch and learn sessions being scheduled monthly to target Non compliant areas.	August 2022 Update - All FCPs are being reviewed as part of the new delivery model and update of the SoD. Therefore the FCP will be updated once the new SoD has been approved. As part of the Finance Delivery Unit AW P2P group, the No PO policy approach within HBs is being developed as best practice within the HB, and internal communication to Directorates is being strengthened and re-issued by Oct 2022. October 2022 Update - All FCPs are being reviewed as part of the new delivery model and update of the SoD. Therefore the FCP will be updated once the new SoD has been approved. CTM systems ensuring training undertaken prior to giving Oracle access to new users, and refresher training being developed. As part of the Finance Delivery Unit AW P2P group,(SRO - DOF Swansea Bay) the No PO policy and exemption list is being reviewed together with a Communications plan through an AW Task & Finish group. Outline paper with planned approach going to AW P2P group 17th November. CTM already undertaking focused P2P training, Facilities and Estates completed, further lunch and learn sessions being scheduled monthly to target Non compliant areas.
Medical Records Management 4.1	Nov-22	Reasonable	Datix incidents should be raised for records missing over 30 days as per the procedure guidance.	High	Agreed Datix to be updated.	Director of Digital	Director of Digital	Qtr 3 2022/2023			Completed	December 2022 Update - Datix has been updated by the Medical Records function. Propose to close	
Medical Records Management 4.2	Nov-22	Reasonable	A formal reporting process for health records should be established which includes key performance indicators such as, but not limited to: - Number of records provided - Percentage of records available at point of need - Number untracked / missing records.	High	Agreed Performance report to be created as part of routine service provision.	Director of Digital	Director of Digital	Qtr 3 2022/2023	Now January 2023		In progress	December 2022 Update - Work ongoing. New Head of Clinical Administration commenced role in November 2022 and now developing a suite of metrics for the Medical Records function - to be reported to the Digital & Data Committee from January 2023	

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Medical Records Management 5.1	Nov-22	Reasonable	A project structure for digitisation should be re-established, and led by the executive sponsor. The structure should include monitoring and reporting of progress and issues, with resolution sought for any issues and communication to clinical services.	High	Agreed Programme board to be re-established.	Director of Digital	Director of Digital	Qtr 3 2022/2023			Completed	December 2022 Update - Proposed to close - Programme Board has been re-established. Digital Director is the interim Exec Sponsor in the absence of a Service Sponsor	
Medical Records Management 7.1	Nov-22	Reasonable	The retuned files should be monitored and a record kept of errors in files, and the source of the files. These errors should be reported to the clinical service areas, noting that there is a professional requirement on staff to ensure appropriate record keeping and requesting that all staff ensure that file quality is maintained.	High	Agreed Standard Operating Procedure to be developed for reporting quality issues with the paper record.	Director of Digital	Director of Digital	Qtr 3 2022/2023			In progress	December 2022 Update - As part of Medical Records review in November 2022, SOP for reporting quality issues has been identified and in development	
Medical Records Management 8.1	Nov-22	Reasonable	As part of the project structure referred to above, a work stream for developing e-forms should be established. This should include clinical input. the Health Board should seek to increase the amount of e-form development skills in place by training existing staff and recruiting to the project.	High	Agreed Work stream to be created to oversee the development of a work plan for e-Forms (including Clinical Input).	Director of Digital	Director of Digital	Qtr 3 2022/2023			Completed	December 2022 Update - Propose to close - This is covered as part of the Health Board single digital record group	
Directorate Review Radiology Management Arrangements 02	Jul-19	Reasonable	All Radiology specific policies and procedures should be documented in a central record and assigned an 'owner' responsible for ensuring their assigned policies and procedures are maintained up to date. All directorate specific policies and procedures should be made available to all directorate staff via SharePoint.	Medium	Currently moving forward with a new SharePoint site for Radiology - linking with Karl Carpenter (Digital Services Manager) and maintenance of this will be part of the remit of a Superintendent Radiographer post currently being advertised within the Health Board.	Chief Operating Officer	Directorate Manager	Dec-19	October 2020 - March 2021 - June 2021 - August 2021 - Now - December 2021 - Now - September 2022 - Now - April 2023		In progress	December 2022 Update - The Directorate has started working with Corporate IT on building a new Sharepoint site which will be used as the document repository and regular weekly meetings are taking place to progress. Agreement has been reached for the Policy for 'Management and Authorisation of Policies etc. in Radiology and work is starting to address policies in a logical / clinically prioritised order.	March 2020 Update - Test site created by E-Business team. Awaiting further direction from Directorate. July 2020 Update - Work continues led by Dr Ally Yates, Consultant Radiologist to review all policies and procedures. Radiology has its own 'policy for making policies' based on the Health Board version. As policies are being renewed they are being put in to the new format and agreed although formal governance meetings in Radiology have drifted during Covid. With regard to the Sharepoint site a quick dummy site with some new features was developed but no further progress has been made. January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. An update will be provided in March 2021. March 2021 Update - A test site was set up in March 2020 and the process of reviewing all policies started in June 2020 led by Dr Ally Yates. The appointment of the Head of Radiography post will take place imminently and this will aid implementation. A plan outlining expected completion dates will be worked on by the meeting in June 2021. Covid-19 has meant that this process has lost momentum. May 2021 Update - A test site was set up in March 2020 and the process of reviewing all policies started in June 2020 led by Dr Ally Yates. The appointment of the Head of Radiography post will take place imminently and this will aid implementation - this post is going out for advertisement in July 21. A plan outlining expected completion dates will be worked on by the meeting in June 2021. Covid-19 has meant that this process has lost momentum. July 2021 Update - Process underway to update and amalgamate all policies from two distinctive ones to a whole HB approach, with the potential for some local discretion. Regarding updated policies, yes all updated policies will be available on Sharepoint. In addition POW have developed an app for use by SpRs with all policies and help available on their mobile phones. Pilot in POW due to start with August new intake and expect to roll out for next rotation. September 2021 Update. Nothing further to add - target date remains December 2021. November 2021 Update - as a consequence of staff sickness there will be no update this quarter - it will be available for the next meeting. February 2022 Update - as a consequence of staff sickness there will be no update this quarter - it will be available for the next meeting. April 2022 Update - Nothing further to report for this meeting. Issue will be chased up in the coming month. June 2022 Update - New senior management support in the service. All procedures and policies have been reviewed and in shared folders. Full governance structure and review re-established across CTM from July 2022. Work continues for service usable SharePoint page with the superintendent leading. August 2022 Update. The new Interim CSGM has been asked for a response. It is anticipated that progress will be reported at the next meeting. October 2022 Update - the Directorate is in the process of re-invigorating this recommendation. In addition, it is likely that after a follow up audit, a new Radiology report with a new recommendation about this is about to be produced, superseding this one.

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Medical Equipment and Devices Follow Up 03	Feb-20	Reasonable	While we understand that currently, the department does not have the resources to undertake a reconciliation of equipment that has been loaned to wards, consideration should be given to undertaking periodic checks between the equipment available in the library and the equipment recorded as being on loan on the system.	Medium	1. Band 2 Equipment library Job Description is now matched – to be uploaded and advertised on TRAC to appoint staff. This will then enable periodic checks between the equipment available in the library and the equipment recorded as being on loan on the system to be undertaken. 2. Continued use of partial RF-ID system to be utilised with confirmation that data connection to RAM 5000 can be completed. 3. SON to be submitted to Capital for increased RF-ID system coverage for RGH (£244.8K), early indication from Capital is that a more detailed business case will be required as roll out to other sites is also required.	Chief Operating Officer	Assistant Director of Facilities	Apr-20	September 2020 April 2021 July 2021 Now March 2022 Now September 2022 Now January 2023		Part Completed	December 2022 Update - A meeting with Kinsetu has been arranged for 8th Dec at POW, to initiate the project of the Ktrack 02 software upgrade and data migration. There has been no change to the timescale for the development of the virtual server by ICT, it still remains Jan 23. Clinical Engineering Band 07 - ICT vacancy is ready for TRAC activation. Following changes within the Department, a meeting is set for December 2022 to ensure continuity is maintained	1. April 2020 Update - B2 equipment library post - advertised – undergoing shortlisting. Target Date amended to reflect current circumstances regarding Covid-19 (DW 02/04/2020). 2. April 2020 Update - RF-ID –limited area in use – no further work done - however attempting to obtain further funding through technology funds from Welsh government in meanwhile. Target Date amended to reflect current circumstances regarding Covid-19 (DW 02/04/2020). 3. April 2020 Update - RF-ID –limited area in use – no further work done - however attempting to obtain further funding through technology funds from Welsh government in meanwhile. Target Date amended to reflect current circumstances regarding Covid-19 (DW 02/04/2020). 1. July 2020 Update - Interviews held. Recruitment checks in progress for successful candidate (WG 02/06/2020). Start date confirmed as 20/07/2020 (WG 16/07/2020). 3. July 2020 Update - Business case to be developed for submitting to Capital/Finance to support phased approach to implementation on each site, with request from Finance to be revenue neutral. (WG 09/06/2020). 3rd draft of business case paper to be finalised with various options and costs for funding (WG 16/07/2020). 3. September 2020 Update - SON submitted to Capital and DOF on 30/07/2020, awaiting prioritisation and decision on funding. WG advised that target date has been amended to reflect this update, date amended to 31/03/2021 (DW 28/08/2020). 2. July 2020 Update - Identified costs in IMTP, some work performed by supplier for COVID equipment tracking for mapping sites. Equipment that is tagged will now update 'Last known location' field on RAM each night in background process if within areas with antennae or by using hand held device. Complete (WG 09/06/2020). 1. Role now in place. Complete (WG 28/08/2020) January 2021 Update - Additional hand-held devices have now been ordered and delivered. Further work is in progress by the supplier to implement the site mapping for the devices to be functional on PCH and POW sites. Further purchase orders are to be submitted for additional works and installation, presentation to be provided at next CMAG and ECMG in February 2021 for planning of future phase rollout. Total cost is £654K (WG 25/01/2021). March 2021 Update - 1 & 2. July 2020 Update - B4 Medical Device training co-ordinator in post, now advised of all new medical equipment installations, and overseeing user training prior to issue. Complete (PJ 17/07/2020). 3. January 2021 Update - New B6 medical device trainer now in post, with all new equipment purchases being referred to Rob Matthews prior to installation. Complete (PJ 06/11/2020). 1. April 2020 Update - Capital bid SON process finalised now following CTM transition and being used with all POWH Capital bid SONs now being added to the correct database for the 2020/21 capital year bids and will be used moving forward. Complete (DW 02/04/2020). 2. April 2020 Update - Capital bid SON process finalised now following CTM transition and being used with all POWH Capital bid SONs now being added to the correct database for the 2020/21 capital year bids and will be used moving forward. Complete (DW 02/04/2020). 3. May 2021 Update - For phase 1 equipment has arrived but further work is needed for implementation such as addressing Wi-Fi connectivity issues at POW, addressing new ICT issues with scanning large amounts of equipment in one area via handhelds, mapping locations into the system at PCH, and final installation of oxygen cylinder tracking and bed store equipment at RGH. This work is scheduled to begin in May / June 2021. Due to this the target date has been moved to 31/07/2021. It should be noted that now in place is that any new equipment is now being tagged as part of the RF-ID system and this will continue moving forward. (PJ WG 12/05/2021). 3. July 2021 Update - Wi-Fi connectivity issues at POW are now resolved. ICT issues with scanning via handhelds has been resolved. Mapping locations is no longer viable under current circumstances with ward moves etc. Department lists will be used instead on Version 2 of software. Fixed reader points have been installed at RGH for extended coverage for oxygen cylinder tracking and bed store equipment. Supplier awaiting approval for remote access (to update and set system up to Version 2 of software and database) from ICT. Access issues for the tracking system on Citrix at POW need to be resolved with ICT. Quote received to apply fixed reader points to fully cover RGH site as next phase and will now be submitted to Capital for funding. Lead member from Clinical Engineering has now left the organisation, which has made planning and implementing the above works difficult. Based on the above updates, the target date has been moved to 31/03/2022. (WG DW 20/07/2021). 3. September 2021 Update - Supplier still awaiting approval for remote access (to update and set system up to Version 2 of software and database) from ICT. Access issues for the tracking system on Citrix at POW still being resolved with ICT. Quote received to apply fixed reader points to fully cover RGH site as next phase and submitted to Capital for funding, awaiting decision. (DW WG 20/09/2021). 3. November 2021 Update - CITRIX issue resolved at POW. Remote access issue resolved for supplier to install V2 software for BOC cylinder project.
Nurse Agency Usage 03	Apr-20	Reasonable	1. The Staff Bank Policy should be reviewed and updated as necessary to reflect current practice, process and systems in place within the Health Board. The policy should more explicitly reference the engagement and management of agency nurses as opposed to just focussing on Bank staff. 2. Where other relevant policies exist, such as the Rostering Policy, these should be cross-referenced within the Staff Bank Policy. 3. Where procedures are developed to supplement existing policies, reference should be made to the overarching policy and if necessary, the policy should be updated to reflect the existence of the procedure. 4. Senior Nurse Management across the Health Board should ensure the dissemination and awareness of the recently developed procedure for booking bank and agency nurses for use by Ward Managers and the Thornbury authorisation and approval pro forma.	Medium	The Staff Bank Policy will require updating to include the Collaborative Bank project which is due to commence in April 2020. The updated version will include appropriate references to the UH Rostering Policy. The updated policy will include: ■ The updated 'Booking Bank & Agency Nurses -Procedures for Ward Managers' ■ The new Request for Thornbury Nurses proforma. ■ The updated e-datix reporting algorithm The following documents will be re-circulated to Heads of Nursing. ■ The updated The updated 'Booking Bank & Agency Nurses -Procedures for Ward Managers' ■ The new Request for Thornbury Nurses proforma. ■ The updated e-datix reporting algorithm Heads of Nursing to ensure all the documents listed above are circulated to Ward Managers and Senior Nurses.	Director for People		March 2020/April 2020/August 2020	October 2020 February 2021 June 2021 Now September 2021 Now April 2022 Now July 2022 Now August 2022 Now October 2022 Now December 2022		In progress	December 2022 - The policy has been completed was sent to the Policy Review Group in November. Unfortunately the meeting was not quorate, however, the policy has been shared with the group members, for final review via comments. Then potential sign off will be achieved on the 15th December, at the next Policy Review Group prior to the final stages of the governance route. July 2020 Update - The policy will be written in September 2020, which will coincide with the change in recruitment processes for staff bank workers. Roll out and publication of the policy will be completed by end of October 2020. November 2020 Update - The Bank Policy is being updated during December 2020/January 2021. The updated policy will consist of a review and update of all the bank and agency forms. July 2020 Update - Due to outbreak of covid-19 and consequent pressure on staff bank to recruit additional bank workers to support existing and new HB services has meant a delay in starting this policy. Jan 21 update - Policy has been completed and is awaiting review by policy sub groups. APRIL 2021: See above for policy amendments. Remaining recommendations delayed due to the pandemic but will be taken forward in the same timeframe as the policy approval. Revised implementation date provided. July 2021 Update - Policy development group has been difficult to complete due to the pandemic and poor attendance at meetings to make them quorate. The policy is still under review in conjunction with the union representation, but has been completed. It needs a final review with the group before being sent to the policy group for ratification. The revised date for policy being live will slip to September. Sept 2021 update: Due to inability to get interested parties to agree on the final policy, alongside the cancellation of the last 2 meetings for not being quorate, the policy has not progressed further. The policy is awaiting agreement in partnership to progress to policy group. November 2021 Update - No further update provided. January 2022 Update - Policy sent to policy group for ratification. Apr 2022 – The policy was sent through the ratification route. Comments on the content were made post the policy review group meeting. These comments have been taken away and are actively being worked upon by the Deputy Director of Nursing & the Staff Bank Manager. The Policy will then be resubmitted to the policy group in May, if approved this will then progress to the LPF and be signed off for use in the UHB. June 22 update – The policy has been updated and is progressing through the approval process. August 2022 update – The policy is yet to be ratified. The LPF has not sat since the last audit report return as it was cancelled, to allow for ratification of the policy through the appropriate route. The policy will be taken to the next LPF in September 2022. October 2022 Update - The policy has had to be stalled due to changes needed to the agency booking process required by the Nurse Productivity Programme Board. This renewed process is currently with nursing leadership to approve, which is a part of the bank policy. Once this has been approved, the policy will then progress through the route to ratification.	
Nurse Agency Usage 04	Apr-20	Reasonable	1. A review of the Temporary Nursing & Midwifery Staffing Decision Checklist (Appendix 5) contained within the Roster Policy should take place to ensure all aspects remain relevant. Consideration should be given if the checklist needs to be completed for every shift filled by an agency employee or if one checklist could be completed covering all agency shifts needed on a week's rota. 2. The importance of completing the checklist should be reiterated to the Nurse in Charge as means of supporting and substantiating the decision to use agency nursing.	Medium	Appendix 5 in the Roster Policy will be replaced with the updated 'Booking Bank & Agency Nurses -Procedures for Ward. Heads of Nursing to ensure the checklist is re-circulated to Ward Managers and Senior Nurses emphasising the importance of the completion of the check list for all new bank and agency nurses to the ward areas/department.	Director for People	Head of Corporate Nursing	April 2020/May 2020	August 2020 February 2021 June 2021 Now September 2021 Now December 2021 Now April 2022 Now July 2022 Now August 2022 Now October 2022 Now December 2022		In progress	December 2022 - The policy has been completed was sent to the Policy Review Group in November. Unfortunately the meeting was not quorate, however, the policy has been shared with the group members, for final review via comments. Then potential sign off will be achieved on the 15th December, at the next Policy Review Group prior to the final stages of the governance route. July 2020 Update - Due to outbreak of covid-19 and consequent pressure on staff bank to recruit additional bank workers to support existing and new HB services has meant a delay in starting this policy. Jan 21 update - Policy has been completed and is awaiting review by policy sub groups. APRIL 2021: The Rostering Policy has been updated and is currently in the system for approval. A new Rostering Group has been established with Senior Nurses to ensure appropriate and consistent rostering practice across the Health Board. The Rostering Policy will be approved within the same timeframe as the Bank Policy. A revised implementation date has been provided. July 2021 Update - Policy development group has been difficult to complete due to the pandemic and poor attendance at meetings to make them quorate. The policy is still under review in conjunction with the union representation, but has been completed. It needs a final review with the group before being sent to the policy group for ratification. The revised date for policy being live will slip to September. Sept 2021 update: Due to inability to get interested parties to agree on the final policy, alongside the cancellation of the last 2 meetings for not being quorate, the policy has not progressed further. The policy is awaiting agreement in partnership to progress to policy group. November 2021 Update - No further update provided. Feb 2022 Update - Policy sent to policy group for ratification. Apr 2022 – The rostering policy is being reviewed at the next policy group in April 2022. Comments on the content can be made up to 2 weeks after this meeting. If there are none received, it will progress to the LPF and achieve final sign off for use in the UHB. June 22 update – The Locality Nurse Director RTE has completed the policy and	
Cyber Security Follow Up 05	Jun-20	Reasonable	Original Recommendation - The organisation should provide additional resource for a minimum defined period to allow for the data communications team to improve network security. Updated Recommendation - Work should continue to improve the network security of the Health Board. Following the firewall audit, the firewall rules should be amended to increase the security position.	Medium	Original Management Response - Data communications security will be addressed by the new posts discussed in finding 2. Updated Management Response - The firewall audit has been received and confirmed as accurate. Work has commenced in addressing the recommendations highlighted in the audit. The Cyber team have received the Cisco Implementing Advanced Cisco ASA Security and will be addressing the firewall rules starting in June 2020.	Director of Digital	Assistant Director of ICT	Jul-19	June 2020 December 2020 March 2021 July 2021 Now August 2021 Now February 2022 Now November 2022		Completed	December 2022 - Firewalls at the DGH's were upgraded from 555s to 4112s eighteen months-two years ago. A review/remediation was required due to gaps in the firewall rules being identified. The work to remediate has been done top down, with the process involving building up replacement rules and has reached a point where we are now at the continuous improvement stage, with the firewalls operational Current Position - As noted above, resources have been provided for cyber security and one of the posts is within the server team. The current position with the firewall is that the rules have not been changed to restrict access from NHS Wales, however in order to improve the security of the Health Board, a company has been engaged to undertake a firewall audit. The purpose of this is to look at the firewall configuration and rules, which will form the basis of the control moving forward. We note that control over changes to the firewall rules is moving to the cyber security team with training for the cyber security team booked with Cisco in order to do this. The process for changing the firewall rules has been improved with a standard form in place for requests, which are channelled through the cyber team for approval before being discussed and agreed at the Change Advisory Board (CAB). January 2021 - work is continuing on addressing the rules on the Firewalls where the bulk of the work should be completed by the end of February 2021. Additional hardware and software licenses have been procured for the upgrade of the Solarwinds network and performance management environment. A date has been set for the upgrade to be completed by Friday 12 February. Based on the progress made and the evidence that we reviewed we consider the original recommendation to be partially implemented and the remaining elements remain as Medium priority. July 2020 update: Firewall project to restart in August with gradual handover of firewall rules from Data Comms to Cyber Security Team. Training scheduled between Data Comms Team and Cyber Team to begin handover. We have an additional temporary resource within Cyber Security Team also looking at networking areas and Solarwinds. August 2020 Update - work on the updating of software versions on each firewall is now complete along with configuring each firewall as per recommendations. There has been an issue in auditing the rules on each firewall due to a licensing issues with Solarwinds. The ICT Department have requested a quote from the supplier on the cost of increasing the licenses on Solarwinds to address this issue. March 2021 - work is continuing to address the firewall rules with a review audit by SICL currently being procured. Work is still carrying on to get the new Solarwinds environment set up. May 2021 - a meeting has taken place with SICL and the firewall configuration files have been provided as part of the review process. Work on the firewall rules is continuing. In March ICT procured software called Skybox for a one year as a Proof of Concept. Once installed and configured the software will enable ICT to address more complex firewall rules and help manage the administration more effectively. The new Solarwinds environment is now up and running. July 2021 Update - The Skybox server has had to be rebuilt as the configuration ISO was out of date. There has been a few issues with the configuration, however the contract will not commence until the software is up and running. September 2021 - work is continuing on the installation of the Skybox application. Work has been delayed due to the Firewall replacement programme on the PCH and RGH Firewalls which is due to be completed by the end of October 2021. November 2021 - No further update provided January 2022 Update - End of year resources have been provided to improve network security, however requirements will remain. April 2022 Update - The SOP has still not been created. Director of Digital to review the work plan for the Cyber team and provide a date by which this will be completed. Date to be identified by the end of May 2022. June 2022 Update - Request to change date to November 2022. Significant progress around the re-configuration of main site firewall rules has been made by the Cyber lead for	

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Director ate Review Acute Medicine & A&E 04	Aug-20	Reasonable	1. A review of the policies and procedures saved to the intranet should be undertaken to ensure there is a central repository of all documents and all documents that are listed are still relevant, with all out of date policies reviewed and updated where necessary. 2. Where there are common policies across a number of departments, to avoid duplication and possible inconsistencies, consideration should be given to having a set of directorate wide policies with one copy saved and clear information on the lead area for the policy including who is responsible for reviewing and updating the policy.	Medium	The review of policies and procedures needs to be undertaken on each acute site and it is acknowledged that this is an area of concern with focussed attention needed over the next 6 months. There also needs to be clear guidance from the ILG on the process for the approval of policies and procedures in the new operating model.	Chief Operating Officer	ILG Directors/ General Manager	September 2020/December 2020	01/04/2021 Now April 2022 Now December 2022 Now February 2023		Part Completed	December 2022 Update - no change within the RTE area as a result of inadequate resources to complete this piece of work.	November 2020 Update - The planned review has been delayed due to the COVID pandemic and the timely appointment to the CSG supporting structure. RTE ILG January 2021 Update - The planned review has been delayed due to the COVID pandemic and the timely appointment to the CSG supporting structure. March 2021 Update - Final timing for the completion of this work will be reported by the end of April 2021. May 2021. A check has been made across the old Cwm Taf Directorates and a review has been taken on this issue. This does remain a key risk for old policies –and this will be a challenging piece of work to undertake with all the other priorities. Both Directorates do, however, confirm that the new policies that were developed as a result of changes involving covid 19 have been stored in one place and are accessible. July 2021 update. For RTE and MC ILG, no change – remains a key risk area. Will be addressed when capacity allows. September 2021 Update - This remains a key risk and represents a significant amount of work in an area where capacity is stretched. No further action to report, but it remains an issue about which the Service Group is aware. November 2021 Update - no action to report - deadline remains April 2022. February 2022 Update - the Directorate has started a task and finish group to review all policies and procedures and will update them pan CTM if they are organisation wide – support on this from corporate team and policies will be taken month by month through policy group chaired by a Consultant member of the medical staff. Given the size of the task the Directorate says that it will need a year for this to be complete. April 2022 Update - For MC, a monthly task and finish group is in place as part of the ED Improvement Programme. The aim is to review policies and procedures and the Directorate is updating its intranet page. So - for MC, complete. June 2022 - nothing further to add this month, will be pursued for August 2022 for RTE where it remains outstanding and is a challenging area for the CSG. August 2022 Update. For MC, this continues to be included in the Improvement Work underway - so complete. For RTE, this remains a task that the CSG cannot resource adequately. October 2022 Update - position unchanged. Directorate feels that there is not the resource to complete this task appropriately.
Risk Management 2021 03	Feb-21	Reasonable	Whilst we acknowledge that compiling a Training Needs Analysis is a new task that has been included on the Risk Management Improvement Plan, Management need to ensure that all departments and staff are provided with training on the new Risk Management Strategy, and the use Datix to record risks, as soon as possible. This will help ensure consistency of approach across the organisation.	Medium	A training needs analysis will be undertaken early in 2021. In the interim monthly risk training sessions via Microsoft Teams has been scheduled with an open invite for staff across ILG's to attend.	Director of Corporate Governance/ Board Secretary	Assistant Director of Governance & Risk	Apr-21	01/07/2021 Now October 2021 Now December 2021 31.12.2021 - Module 1 Training. Module 2, 3 and TNA - 31.3.2022 Now April 2022 Now October 2022 Now 31 December 2022		In progress	December 2022 Update - This recommendation is dependent on the implementation of the OFW Risk Module as the intention is that the training will include how to undertake a risk assessment utilising the risk module on Datix. The pace of implementation on the new module has slowed and therefore the work in this activity has not been progressed. A meeting has been scheduled in early December with a small cohort of risk leads across NHS Wales and the OFW System Lead to undertake some work on the progress of the module developments. A further update will be available following this meeting with a greater insight into an anticipated implementation date.	Update March 2021 A revised date is requested as the Assistant Director of Governance & Risk is now part of a small Task and Finish Group with other NHS Organisations in Wales to develop a risk training needs analysis that ensures a consistent approach across NHS Wales and avoids duplication. A first draft of a TNA has been developed and will be shared with the Health Board in due course. The training packages to support the TNA are being worked through by the group. Update May 2021 Training Needs Analysis currently being finalised within the Task and Finish Group. Will be shared with the Health Board once the training packages that align have been developed. Update July 2021 - Training Needs Analysis completed and will be shared across the Health Board one the training packages that align to the TNA have been developed. Level 1 Training Package- draft being shared with ELearning colleagues w/c 26th July 2021 to start development of ESR module. Level 2 - Training package development to commence August 2021. September 2021 Update - The Training Needs Analysis is complete, however, the Assistant Director of Governance & Risk is working with peers across NHS Wales to develop Level 1 - 3 Risk Training packages available on the ESR E-Learning platform. Level 1 is currently with ELearning Teams to finalise and Level 2 development has been commenced. An extension to the implementation date is requested to allow for the launch to coincide with the training packages being made available on E-Learning on an All Wales Basis. The Health Board is working with All Wales colleagues to ensure a consistent approach to risk is adopted and transferable across Wales. November 2021 Update - In Progress: Training Needs analysis complete launch of this will be in conjunction with the completion of the following modules. Module 1 Risk Training – developed and with Learning Management System (LMS) Team to finalise and upload to the LMS. Timescale: 31.12.2021. Module 2 – Risk Management in Practice Module 3 – Board Member Risk Awareness Module 2 development will commence in December 2021 and Module 3 - thereafter for completion by the end of March 2022. The TNA will be issued once all modules are complete. The Risk Community in Practice meet on a monthly basis with All Wales representatives progressing the training programmes as a cohesive group to ensure consistency across Wales in the approach to risk management. The monthly risk training will continue until the above is in place. Update January 2022 The TNA and development of an All Wales Risk Management Training package has been placed on hold whilst the Once For Wales Risk Management Module is finalised. The rationale for this decision is to ensure that any training developed is aligned to the new module that staff will be expected to use. The Health Board is represented on the Once For Wales Monthly Meetings and the more regular task and finish group meetings. In the meantime, risk management training continues within the Health Board with monthly sessions being held virtually over Teams. April 2022 Update - The implementation of the Once For Wales Risk Module within the Health Board is anticipated circa October 2022, with two pilot sites going live from the 1st April 2022. The All Wales Training Modules are being developed to align with the new approach and timescales. The TNA has been finalised and Module 1 of the training is in draft. Progress is monitored via the OFW Risk Module Meetings and the All Wales Risk Community of Practice for which the Assistant Director of Governance & Risk is a member. In the meantime, monthly Risk Sessions remain in place throughout 2022 run by the Assistant Director of Governance & Risk and the Heads of Quality & Safety within the ILGs. June 2022 Update - On track. Risk Training continues to be rolled out to service areas on a
Financial Systems 03	Apr-21	Reasonable	1. As part of the ongoing review of the Charitable Funds FCP the inconsistencies between the FCP and Scheme of Delegation should be resolved, and updates made where processes and appendices have been amended. 2. Consideration should be given to introducing tolerance levels, below which finance can approve variations in payment values, as opposed to requiring fund holder authorisation. 3. Relevant staff should be made aware of the revised FCP and old copies of forms removed from circulation.	Medium	Agreed, FCP needs to be reviewed in line with the Scheme of Delegation and updated.	Director of Finance	Head of Corporate Finance	Jun-21	01/08/2021 Now November 2021 Now December 2021 Now March 2022 Now June 2022 Now August 2022 Now October 2022 Now January 2023		In progress	December 2022 Update - Awaiting update from ICT on the change in process for authorisation of forms.	July 2021 Update - Charitable Funds have recently been moved onto the Oracle system which allows for greater consistency of governance and controls, these are currently being bedded in and reviewed. The FCP needs to be updated to reflect these changes. September 2021 Update - New Model Standing Financial Instructions are to be adopted by the board in October. Following this will require review of the full suite of FCPs, including Charitable Funds FCP. This has started and will be completed in the next couple of months. November 2021 Update - The Model Standing Financial Instructions are due to be approved by the Board on the 25th November 2021. The review of FCPs and SoDs is currently being undertaken and will be brought to the next Audit Committee for endorsement to the Board. January 2022 Update - The Model SFIs have now been approved. Work is ongoing to update the FCPs for Charitable Funds, in line with the move onto the Oracle system. This has been delayed due to audit of the Charitable Funds accounts, but will be a priority in the next month. April 2022 Update - This still requires updating. A review is currently being undertaken on the governance arrangements of the Charitable Funds which will impact on the FCP. June 2022 Update - The Charitable Funds FCP is currently being updated following the audit of the accounts which has further delayed the update. August 2022 Update - This still isn't completed. This should hopefully be updated when we update FCPs following the change in Scheme of Delegation update due to the restructure. This will be a significant piece of work. Hope to complete by October 2022. October 2022 Update - We have engaged with internal audit to discuss the changes to the forms which are included within the FCP and are in discussion with ICT on how we can make better use of digital signatures for forms. The Oracle process has given an opportunity to simplify the authorisation of expenditure process, which will significantly change the FCP and form. This is a continued piece of work which will streamline and
Sunnysi de Health & Wellbein g Centre 01	Aug-21	Reasonable	Management should confirm revised governance arrangements via a Project Execution Plan including: • effective cost management; • contractual relationships, values and payment arrangements; • committee reporting of project risks; • scheduled outputs from sub-groups for scrutiny; and • stakeholder engagement.	Medium	The Health Board will work with the external project manager to develop a Project Execution Plan to be signed off at the Project Board, this will provide a formalised single record of all of the above criteria which have been approved separately by Project Board.	Director of Finance	Head of Capital	Sep-21	Now January 2022 Now 31 March 2022 Now May 2022 Now August 2022 Now December 2022 Now March 2023		In progress	December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be March 2023	September 2021 Update - the PEP is being drafted however there have been delays in the same due to the administration of the contractor. It was anticipated the the completion contract would have been issued by this time however due to internal process at Linc Cymru this has been delayed to the end of September, as a result the PEP will not be completed until the new contractor is known and this is not likely to be until December 2021 at the earliest. November 2021 Update - the PEP will be drafted however there have been delays in the same due to the administration of the contractor. It was anticipated the the completion contract would have been issued by this time however due to internal process at Linc Cymru this has been delayed to mid November. As a result the PEP will not be completed until the new contractor is known and this is not likely to be until late January 2022 at the earliest. January 2022 Update The tender process has been extended at contractors request. The tender process closes on 9th Feb and will need a ca 3 week evaluation process. At that stage the revised costs will need to go back to WG for re-approval. Therefore it has been proposed to change the review date to 31. March 2022 when contractor, costs and timeline should be clearer to inform the contents of the PEP. April 2022 Update - ongoing however focus has been on the new contractor appointment and whether a disaggregated tender process will be required as this will completely change the way that reporting and contractual management lines work within the PEP. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift. August 2022 Update - there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. September 2021 Update - Remains in progress to be agreed with the new contractor when appointed. November 2021 Update - Remains in progress to be agreed with the new contractor when appointed. Update 31.01.22 the tender process has been extended at contractors request. The tender process closes on 9th Feb and will need a ca 3 week evaluation process. At that stage the revised costs will need to go back to WG for re-approval. Therefore it has been proposed to change the review date to 31. March 2022 when contractor, costs and timeline should be clearer to inform the report contents. April 2022 Update - With no contractor appointed as yet and no confirmed revised tender sum this is difficult to implement extended to give time for possible further tender and contractor appointment. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift. August 2022 Update - there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until December at the earliest
Sunnysi de Health & Wellbein g Centre 04	Aug-21	Reasonable	Management should ensure that individual cost provisions within the works information are reported to understand charges and adjustments to provisional sums.	Medium	The updated reporting template includes a section detailing provisional sums and contingencies and tracks through the release of provisional sums into actual costs, as well as all contingency items, these will be reported monthly to Project Board as part of the financial template. However there will need to be a further tender and revised provisional sums with the letting of a contract for completion therefore an extended target date is provided to ensure the most up to date information is captured	Director of Finance	Senior Project Manager	Mar-22	Now July 2022 Now December 2022 Now March 2023		In progress	December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be March 2023	

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Sunnysi de Health & Wellbeing Centre 05	Aug-21	Reasonable	Management should ensure provision of project manager and cost adviser reports, in support of the Welsh Government Dashboard return.	Medium	These will be included as required as soon as the project recommences, and a new contractor is appointed. This is likely to take at least a further 3-4 months hence the longer target date.	Director of Finance	Senior Project Manager	Jan-22	Now March 2022 Now July 2022 Now December 2022 Now March 2023		In progress	December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be March 2023	September 2021 Update - Remains in progress to be agreed with the new contractor when appointed. November 2021 Update - Remains in progress to be agreed with the new contractor when appointed. January 2022 Update The tender process has been extended at contractors request. The tender process closes on 9th Feb and will need a ca 3 week evaluation process. April 2022 Update - With no contractor appointed as yet and no confirmed revised tender sum this is difficult to implement extended to give time for possible further tender and contractor appointment. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift. August 2022 Update - there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until December at the earliest
Sunnysi de Health & Wellbeing Centre 07	Aug-21	Reasonable	Management should obtain documentation to which the client is entitled under the contract, including collateral warranties, and a copy of the construction performance bond, and confirm assurances provided at the latter.	Medium	These are available and will be supplied by the developer.	Director of Finance	Senior Project Manager	Sep-21	Now November 2021 Now January 2022 Now July 2022 Now December 2022 Now March 2023		In progress	December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be March 2023	September 2021 Update - Remains in progress to be provided by the new contractor when appointed. January 2022 Update - Remains in progress to be provided by the new contractor when appointed. The tender process closes on 9th Feb and will need a ca 3 week evaluation process. At that stage the revised costs will need to go back to WG for re-approval. Therefore it has been proposed to change the review date to 31 March 2022 when contractor, costs and timeline should be clearer to inform the report content. April 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift. August 22, there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until December at the earliest
Sunnysi de Health & Wellbeing Centre 10	Aug-21	Reasonable	Management should be provided with proposed contact variations and monitoring to facilitate timely Health Board scrutiny, in accordance with entitlements under the contract.	Medium	This will be provided when the project restarts and all design works are completed.	Director of Finance	Senior Project Manager	No Date Identified	01/03/2022 Now July 2022 Now December 2022 Now March 2023		In progress	December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be March 2023	September 2021 Update - To be completed and agreed with new contractor on appointment. November 2021 Update - To be completed and agreed with new contractor on appointment. January 2022 Update The tender process has been extended at contractors request. The tender process closes on 9th Feb and will need a ca 3 week evaluation process. At that stage the revised costs will need to go back to WG for re-approval. Therefore it has been proposed to change the review date to 31 March 2022 when contractor, costs and timeline should be clearer to inform the report content. April 2022 Update - See above - project remains on hold whilst new contractor appointed. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift. August 22, there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until December at the earliest
Sunnysi de Health & Wellbeing Centre 11	Aug-21	Reasonable	The Health Board require the developer to remind the contractor of its contractual obligations to formally notify of any delays (and their associated time/cost impact within the contractual time frames).	Medium	With the original contractor there was confidence that much of the time could be recovered and therefore no formal application had been made. Clearly with the current contractor going into administration there will need to be a new contractor appointment. The Health Board will ensure that the need for a contractual. notification of future delays is communicated to the new contractor.	Director of Finance	Senior Project Manager	Mar-22	Now July 2022 Now December 2022 Now March 2023		In progress	December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be March 2023	September 2021 Update - To be completed and agreed with new contractor on appointment. November 2021 Update - To be completed and agreed with new contractor on appointment. January 2022 Update - as per the above notes this can only be done post contractor appointment which has delayed due to tender period extensions and confirmed need for WG re-approval. April 2022 Update - See above - project remains on hold whilst new contractor appointed. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift. August 22, there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until December at the earliest
Sunnysi de Health & Wellbeing Centre 12	Aug-21	Reasonable	A costed risk register should be regularly maintained and reported to facilitate monitoring of the build.	Medium	A fully costed capital risk register is in existence and will continue to be kept up to date as risks are realised or not throughout the project, however this will be revisited with decision on process for and appointment of a new contractor.	Director of Finance	Head of Capital	Nov-21	Now March 2022 Now July 2022 Now December 2022 Now March 2023		In progress	December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be March 2023	September 2021 Update - In progress and development - risk of some slippage due to delays in the tender for the completion contract but all steps are being taken to ensure this is completed by November. November 2021 Update - To be completed and agreed with the Employers Agent once new contractor has been appointed. January 2022 Update - see notes above for revised timeline. April 2022 Update - See above - project remains on hold whilst new contractor appointed. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift. August 22, there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until December at the earliest
Sunnysi de Health & Wellbeing Centre 13	Aug-21	Reasonable	Management should actively monitor and report the value of residual construction cost risks v remaining contingency.	Medium	This is picked up in the appendix to the standard Highlight Report discussed in action 2.	Director of Finance	Head of Capital	Sep-21	Now March 2022 Now July 2022 Now December 2022 Now March 2023		In progress	December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be March 2023	September 2021 Update - One off exercise done to date but this will not be actively monitored until construction works recommence. November 2021 Update - One off exercise done to date but this will not be actively monitored until construction works recommence. January 2022 Update - see notes above for revised timeline. April 2022 Update - See above - project remains on hold whilst new contractor appointed. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift. August 22, there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until December at the earliest
Sunnysi de Health & Wellbeing Centre 15	Aug-21	Reasonable	The Health Board should obtain engrossed and signed copies of all relevant developer adviser contracts in accordance with entitlements to inform of potential liabilities and costs, and report relevant implications to appropriate groups/committees.	Medium	This cannot be fully achieved without the appointment of a new contractor. The Health Board will ensure that all contracts have been received and filed centrally. The new contractor contract will be provided by the developer on signature.	Director of Finance	Project Leader	Sep-21	Now January 2022 Now 31 March 2022 Now July 2022 Now December 2022 Now March 2023		In progress	December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be March 2023	September 2021 Update - Contracts for all save for the new contractor are complete - for the new contractor this will not be delivered until 2022. November 2021 Update - Contracts for all save for the new contractor are complete - for the new contractor this will not be delivered until 2022. January 2022 Update - see notes above for revised timeline. April 2022 Update - See above - project remains on hold whilst new contractor appointed. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift. August 22, there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until December at the earliest
Sunnysi de Health & Wellbeing Centre 18	Aug-21	Reasonable	Management should obtain signed lease agreements with relevant parties at the earliest opportunity.	Medium	The Primary Care lead will continue to work with NWSSP Specialist Estates Services to ensure that the lease is signed off as soon as possible.	Director of Finance	Primary Care Estates and Development Manager	Jan-22	Now 31 March 2022 Now July 2022 Now December 2022 Now March 2023		In progress	December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be March 2023	September 2021 Update - Ongoing with GPs partners however new contract and revised cost is required now to finalise this. November 2021 Update - Ongoing with GPs partners however new contract and revised cost is required now to finalise this. January 2022 Update - this will be delayed until after the new contractor costs and timeline is known. April 2022 Update - See above - project remains on hold whilst new contractor appointed. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift. August 22, there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until December at the earliest

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Sunnyside Health & Wellbeing Centre 19	Aug-21	Reasonable	Management should confirm an agreed service model with measurable outcomes for front line and support services.	Medium	The Bridgend Integrated Locality Group (ILG) will link with the Primary Care team over the service model and support functions. This will be developed during the construction period for the site and given that the completion is likely to slip to late 2/23 the target is to complete in order that any financial consequences are picked up in Integrated Medium Term Plan (IMTP) planning cycles.	Director of Finance	Bridgend ILG Community Lead	Mar-22	Now July 2022 Now December 2022 Now March 2023		In progress	December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be March 2023	September 2021 Update - Ongoing. Update - Ongoing. remains ongoing as programme remains unclear until contractor appointment. April 2022 Update - See above - project remains on hold whilst new contractor appointed. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift August 22, there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until November 2021 January 2022 Update -
Sunnyside Health & Wellbeing Centre 20	Aug-21	Reasonable	Objectives at the business case should be measurable.	Medium	The approved business case contained a Benefits Realisation Plan. This will be reviewed to ensure that the benefits are measurable and deliverable.	Director of Finance	Head of Capital	Jan-22	Now 31 March 2022 Now July 2022 Now December 2022 Now March 2023		In progress	December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be March 2023	September 2021 Update - Ongoing. 2021 Update - Ongoing. January 2022 Update - November 2021 January 2022 Update - may need to be tied in with new contractor appointment. April 2022 Update - See above - project remains on hold whilst new contractor appointed. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift August 22, there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until December at the earliest
Sunnyside Health & Wellbeing Centre 21	Aug-21	Reasonable	Management should review and confirm project objectives based on only measurable outcomes within a Benefits Realisation Plan.	Medium	Please see response above .	Director of Finance	Head of Capital	Jan-22	Now 31 March 2022 Now July 2022 Now December 2022 Now March 2023		In progress	December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be March 2023	September 2021 Update - Ongoing. 2021 Update - Ongoing. January 2022 Update - as per BRP. April 2022 Update - See above - project remains on hold whilst new contractor appointed. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift August 22, there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until December at the earliest
Welsh Language Standards Compliance 06	Oct-21	Reasonable	6.1) The importance of compliance with the Welsh Language Standards should be reiterated to all staff, and the implications of non-compliance should be considered for inclusion on departmental and ILG risk registers and subsequent monitoring. 6.2) The risk register should be reviewed to ensure the controls listed as being in place and the action marked as completed are an accurate reflection of the findings made during the audit review.	Medium	6.1) The Welsh Language Manager will develop regular communications to remind all staff of their responsibilities and the importance and benefits of complying with the Welsh Language Standards. These communications will be distributed to staff via a range of communications media, including social media. 6.2) The nominated senior ILG leads on the Welsh Language Working Group should discuss with department managers, the inclusion of non-compliance with the Standards on their departmental registers, to assist with the monitoring of progress and completion of outstanding actions. 6.3) The Welsh Language Manager will review the actions on the current Workforce and OD and Health Board Risk Registers to ensure that they are up to date and include the risks identified in this audit report. 6.4) The nominated ILG senior members of the Welsh Language Working Group will have responsibility for adding relevant and appropriate non-compliance issue to the ILG risk registers, which are monitored by the respective SMTs.	Director for People	Welsh Language Manager/ILG Leads/Head of Policy, Compliance and Agenda for Change	January 2022/October 2021	Now March 2022 Now June 2022 Now August 2022 Now October 2022 Now December 2022 Now January 2023		In progress	December 2022 update - The WL Steering Group has been deferred while some key appointments are still being made within Care Groups. The first meeting will convene in New Year.	November 2021 Update - The Risk Register has been updated. Although the risk register has been updated. The senior leadership of the ILGs have not received communication or action plans as the new Welsh Language Committee hasn't met. This means there is no progress with ILGs monitoring their compliance and updating their own risk registers. Jan 2022 update 6.1) A short communication plan will be written by the recently appointed Welsh Language Manager, including resources to share regarding the Welsh Language Standards i.e. videos and graphics to promote understanding of them. This will be discussed in a meeting arranged with the Asst Director of Communications and Engagement on 3 February 2022. 6.2) The inclusion of Welsh Language risks on the ILG Risk Registers will be an agenda item all forthcoming Welsh Language Committee meetings, with effect from 17 March 2022. 6.3) The Welsh Language Risk Register has been reviewed and appropriate risks added, including the findings of this audit. 6.4) The inclusion of Welsh Language risks on the ILG Risk Registers will be a standing agenda item on the new Welsh Language Committee, which is scheduled for 17 March 2022. 6.1) Regular communications are drafted and sent via staff updates with SharePoint reviewed regularly. 6.2) Departmental risk registers will be added to once weaknesses are identified through action planning 6.4) The inclusion of Welsh Language risks on the ILG Risk Registers will be a standing agenda item on the new Welsh Language Steering Group, which was scheduled for 17 March 2022 but new date to rescheduled June 2022 Actions points 6.1, 6.3 and 6.4 have been completed previously. 6.2) The inclusion of Welsh Language risks on the ILG Risk Registers will be an agenda item all forthcoming Welsh Language Committee meetings, which is in the process of being arranged. August 2022 Update - Work has continued to remind managers and staff of their Welsh Language responsibilities. This is picked up during routine department audits by the Welsh Language Team and in the bespoke departmental action plans. The identified Welsh Language WOD risks are reviewed and progress noted at the WOD Business Transformation SMT meeting. October 2022 Update - the revised ToR for the WL Steering Group confirms that the membership will comprise of senior Care Group leads who will be responsible for addressing non-compliance issues, monitor progress and ensure outstanding actions are completed and the outcomes reported back to the Steering Group. This process will commence following the first meeting of the WL Steering Group. April 2022 Update - No update this month due to sickness of Lead Nurse. Anticipated that there will be more to report at the next meeting. June 2022. The work to align the documentation with the new CHC Framework commenced in March and will be completed by end of June. There are weekly working group meetings to address the various aspects of the new CHC Framework to ensure that the process is compliant and transparent making transition from the old to new Framework is smoother for all our staff and patients. The working documents and associated processes will be uploaded onto CTM UHB Intranet Site by mid July. August 2022 Update. All documentation has been finalised and distributed to the teams. Discussion has taken place with Comms to put onto the intranet site by September 2022. October 2022 Update - A meeting has been arranged with the communication team to agree the webpage. All documents available and ready for upload.
CHC and FNC 1.1	Feb-22	Reasonable	1.1a Existing procedure documents and assessment forms, including those that are in draft format, should be reviewed and updated to reflect the revised WG CHC framework and any changes as a result of the new operating model in place within the Health Board. 1.1b Once finalised, management should ensure that they are accessible to all relevant staff and that staff are using the most up to date versions of the forms.	Medium	1.1a The CHC team are awaiting the release of the new Welsh Government CHC Framework, launch date due in February 2022 with an implementation date of 01.04.2022. All existing documentation and assessment forms will be reviewed and updated to reflect the revised WG CHC Framework, in readiness for implementation. 1.1b The CHC team will ensure that all reviewed, updated documents, following the implementation of the WG CHC framework in April 2022, will be accessible for all staff via the designated CHC page on the CTMUHB intranet site, to ensure staff are using the most current version of the forms.	Chief Operating Officer	Lead Nurse for CHC and NHS Funded Care	Apr-22	Now July 2022 Now September 2022 Now December 2022		In progress	December 2022 update: Admin have met with the communication team and both internet and intranet pages have now been created, Documents have begun to be published to both. Further documents to be added shortly. The intranet will facilitate quick and easy information sharing for members of staff. Pertinent documents (e.g. New appeals and disputes protocol) to be shared with relevant stakeholders, e.g. Local authorities. Communication team will show admin how to update the intranet so that any further amendments can be made quickly in future.	April 2022 Update - No update this month due to sickness of Lead Nurse. Anticipated that there will be more to report at the next meeting. June 2022. The work to align the documentation with the new CHC Framework commenced in March and will be completed by end of June. There are weekly working group meetings to address the various aspects of the new CHC Framework to ensure that the process is compliant and transparent making transition from the old to new Framework is smoother for all our staff and patients. The working documents and associated processes will be uploaded onto CTM UHB Intranet Site by mid July. August 2022 Update. All documentation has been finalised and distributed to the teams. Discussion has taken place with Comms to put onto the intranet site by September 2022. October 2022 Update - A meeting has been arranged with the communication team to agree the webpage. All documents available and ready for upload.
CHC and FNC 1.2	Feb-22	Reasonable	1.2 A terms of reference for the Clinical Service Group Panels and Integrated Locality Groups panels should be put in place to set out the roles of each panel, their decision-making responsibilities and membership and quoracy arrangements. When developing the ILG panels terms of reference, consideration should be given to decision making powers of the panel when they are making funding decisions on behalf of another ILG for cases where the individual does not reside in their ILG area.	Medium	1.2 • Clinical Service Group Terms of Reference are in draft and are to be finalised by March 31st 2022, to include decision-making responsibilities, membership and quoracy arrangements. • Integrated Locality Group Unit Panel Group Terms of Reference will be reviewed and updated in line with the CSG ToR above and will be approved by March 31st 2022.	Chief Operating Officer	Lead Nurse for CHC and NHS Funded Care	Mar-22	Now July 2022 Now October 2022 Now December 2022		In progress	December 2022 Update - Await new operating model. Terms to be reviewed in light of this once received.	April 2022 Update - No update this month due to sickness of Lead Nurse. Anticipated that there will be more to report at the next meeting. June 2022 Update. Terms of Reference have been updated, reviewed and are awaiting final sign off. August 2022 Update - no change. Further update at the next meeting. October 2022 Update - Terms of Reference that had been previously agreed, need to be re-reviewed in light of new operating model.
CHC and FNC 1.3	Feb-22	Reasonable	1.3 The CHC Financial Control Procedure should be reviewed by the finance team in conjunction with the CHC team and updated to reflect current processes and set up within the Health Board.	Medium	1.3 The Finance Team will review the Financial Control Procedure (FCP) in line with any changes identified in the new CHC Framework. The updated FCP will be an agenda item at the Audit Committee and a further review date agreed.	Chief Operating Officer	Finance Manager CHC/Finance Manager Commissioning and Contracting	May-22	Now August 2022 Now October 2022 Now December 2022		In progress	December 2022 Update - As a consequence of sickness this remains an outstanding issue, but Finance colleagues are aware and are working on it.	April 2022 Update - No update this month due to sickness of Lead Nurse. Anticipated that there will be more to report at the next meeting. June 2022. Colleagues from Finance have been approached to provide an update on the new Finance Control Procedure. August 2022 Update - response awaited from Finance. October 2022 Update - As a consequence of sickness this remains an outstanding issue, but Finance colleagues are aware and are working on it.

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IT Service Management Follow Up 03	Apr-22	Reasonable	The process of clarifying and agreeing digital services with the wider organisation should be completed.	Medium	The new Digital Director will be working with the Head of Service Management feeding back responses from the service	Director of Digital	Head of Service Management Director of Digital	01.09.2022	Now November 2022		Completed	December 2022 Update - Propose to close - process now in place	June 2022 Update - SLAs, Recovery Point Objective (RPO) and Recovery Time (RTO) figures will be agreed for each service as we establish and improve our documentation, service onboarding and management of services. This will be run in parallel with the development of the knowledge base but given the capacity and competing pressures. Update - work ongoing / will roll into the Autumn of 2022. Propose to change date to November 2022 August 2022 October 2022: On track to complete in November 2022
Digital Strategy	Apr-22	Reasonable	3.1. Work should continue to ensure benefits are fully defined within business cases, along with a baseline position and a process for benefits realisation. 3.2 Consideration should be given to defining an overall benefits position for the Digital Strategy.	Medium	All moderate to major digital developments now require a business case and are subject to a degree of scrutiny which incorporates not only the anticipated benefits but the process by which these benefits will be measured and actions taken where there is limited delivery. In regards to overall benefits measuring, the UHB is committed to ensuring that this is incorporated within the WG digital and data strategy and that there is alignment to the Value Based Health Care Programme. In addition to this, the Health Board is currently reviewing its operating model and there is an opportunity to re-align and strengthen the relationship and ways of working between major digital developments and the change hub where the majority of capacity for programme and project management, service change and benefits management. This review is planned to be complete by the end of September 2022	Director of Digital	Director of Digital	Qtr 3 2022/2023			In progress	December 2022 Update - Strategic Leadership Structure to be completed by end of December 2022 - proposal to appoint a new Assistant Director of Digital Transformation who will have benefits realisation within the portfolio	June 2022 Update - Operating model phase 1 nearing completion, 2nd stage yet to commence. 2022 - new operating model and proposed digital operating model to be completed by September 2022. October 2022: Current Strategic Leadership tier has been proposed and is under consultation. This is due to complete in early November 2022 and therefore on track for completion within Qtr 3 2022/2023. Benefits Realisation processes will be embedded into a new Digital Transformation function - subject to completion of the consultation August 2022
Overtime & Additional Hours 1.1b	May-22	Reasonable	Given the time and events that have passed, a reminder should be issued to all senior managers in relation to the Overtime and Additional Hours Policy, including the authorisation process to follow if payments outside of AFC are necessary.	Medium	The Workforce Policy Review Group will ensure that this is included in the policy and that the current and future versions of the Overtime Policy are shared with the managers within the UHB. The current policy is available via the intranet. Further communications will be sent out in the Staff Bulletin and via the ILG Heads of Workforce briefing, with the senior management Team and cascaded to managers on their email distribution lists.	Director for People	Head of Workforce Productivity and E-Systems / Assistant Director of Policy, Governance and Compliance	Jun-22	Now November 2022 Now January 2023		In progress	December 2022 - Work has commenced on reviewing the policy and will be taken to the January 2023 Employment Policy Review Group.	August 2022 Update - The Overtime Policy will be reviewed by the Workforce Policy Review Group in September 2022. The review will take into consideration the internal audit recommendations. October updated 2022 - A policy task and finish group has now been established to review this policy. The first meeting of the group will take place in October 2022 and will ensure audit recommendations are incorporated.
Overtime & Additional Hours 1.2	May-22	Reasonable	Procedure documents in relation to overtime should be developed and made available to those areas that do not currently use Health Roster. The procedure should cover key points such as how overtime is captured and any prior authorisation required, and the checking and authorisation process that managers should follow. A standardised claim form should form part of the procedure.	Medium	There currently is guidance contained in the Overtime Policy directing managers on overtime use and application. The WPRG will undertake to review this policy to ensure that it is fit for purpose and reflects the requirement of the audit recommendation.	Director for People	Assistant Director of Policy, Governance and Compliance	Nov-22	Now January 2023		In progress	December 2022 update - Work has commenced on reviewing the policy and will be taken to the January 2023 Employment Policy Review Group.	August 2022 Update - The Overtime Policy will be reviewed by the Workforce Policy Review Group in September 2022. The review will take into consideration the internal audit recommendations. October updated 2022 - A policy task and finish group has now been established to review this policy. The first meeting of the group will take place in October 2022 and will ensure audit recommendations are incorporated.
Overtime & Additional Hours 2.1	May-22	Reasonable	The value and practicality of using the overtime authorisation and justification checklist is to be considered. Consideration should be given to alternative approaches for capturing the justification and authorisation of overtime in advance of it being worked. For example, in some instances, it may be more efficient to have one justification checklist completed and approved per department but reviewed periodically.	Medium	The Overtime Policy review will be undertaken by the Workforce Policy Review Group (WPRG), in partnership with local trade union colleagues and key stakeholders. The revised Overtime Policy will set out the new, more practical approach for capturing the justification and authorisation of overtime in advance of it being worked in accordance with the Audit recommendation. Provision will be made within the revised Overtime Policy to address both circumstances i.e. consistent use of overtime and occasional use, ensuring that clear guidance is provided on how to manage both in Health Roster and outside of Health Roster.	Director for People	Assistant Director of Policy, Governance and Compliance	Nov-22	Now January 2023		In progress	December 2022 update - Work has commenced on reviewing the policy and will be taken to the January 2023 Employment Policy Review Group.	August 2022 Update - The Overtime Policy will be reviewed by the Workforce Policy Review Group in September 2022. The review will take into consideration the internal audit recommendations. October updated 2022 - A policy task and finish group has now been established to review this policy. The first meeting of the group will take place in October 2022 and will ensure audit recommendations are incorporated.
Overtime & Additional Hours 2.2	May-22	Reasonable	If the approach to using the overtime authorisation and justification checklist is to be consistently used in the future, then the information being captured should be reviewed and scrutinised in order to understand the underlying reasons for use of overtime and to aid the development of plans to address those issues.	Medium	The revised Overtime Policy will outline the responsibility of the Workforce Efficiency Team to regularly review and analyse the overtime authorisation and justification checklist data to provide the UHB with intelligence on the reasons for overtime, which will assist the organisation to review and develop the Workforce Plan to address the identified issues. The Workforce Efficiency Team will explore alternative more practical approaches for capturing the justification and authorisation of overtime in advance of it being worked in accordance with the Audit recommendation. This work will be undertaken in parallel with the review of the Overtime Policy, to ensure this process is reflected within. The new process will form the basis of a clear and auditable overtime justification and authorisation process.	Director for People	Assistant Director of Policy, Governance and Compliance /Head of Workforce Productivity and E-Systems	Nov-22	Now January 2023		In progress	December 2022 update - Work has commenced on reviewing the policy and will be taken to the January 2023 Employment Policy Review Group.	August 2022 Update - This work is being progressed by the Head of Workforce Efficiency and E-Systems. October updated 2022 - A policy task and finish group has now been established to review this policy. The first meeting of the group will take place in October 2022 and will ensure audit recommendations are incorporated.

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Overtime & Additional Hours 3.0	May-22	Reasonable	A standardised claim form for capturing overtime and additional hours should be in place, that incorporates the requirement for individuals to confirm the hours they have worked, and for management to authorise the claim ahead of input on pay return. Claim forms also need to be clear about the need to capture time net of breaks.	Medium	A single standardised claim form, for the use in all non-health roster areas will be developed by the WPRG and contained within the Overtime Policy, for all areas of the UHB to access and use. The form will be based on the standardised NWSSP Payroll form for overtime and additional hours claims, which will contain information on the shift worked, the date, time, rate of pay and who has approved and authorised the payment. Once the Overtime Policy is reviewed and ratified all former UHB overtime forms in circulation and use will be withdrawn (removed from SharePoint etc.) and Payroll instructed to only accept and process the new standard form for payment.	Director for People	Head of Workforce Productivity and E-Systems	Nov-22	Now January 2023		In progress	December 2022 update - Work has commenced on reviewing the policy and will be taken to the January 2023 Employment Policy Review Group.	August 2022 Update - The Overtime Policy will be reviewed by the Workforce Policy Review Group in September 2022. The review will take into consideration the internal audit recommendations. October updated 2022 - A policy task and finish group has now been established to review this policy. The first meeting of the group will take place in October 2022 and will ensure audit recommendations are incorporated.
Overtime & Additional Hours 4.0	May-22	Reasonable	Now that all Covid related agreements for payment of higher overtime rates have concluded, a review of payroll data should be carried out to identify departments that are continuing to pay staff outside of the AFC terms and conditions. Payroll codes set up specifically for such payments should be closed to prevent usage. Where it identified that payments outside AFC remain, discussions should be held with the departments to ascertain the reasons why. If necessary, the appropriate procedure should be followed to obtain authorisation in line with the scheme of delegation to continue with such payments.	Medium	Review of Payroll Overtime enhancement codes undertaken by Head of Workforce Productivity and e Systems with an NWSSP Payroll manager to ensure all non AFC payroll codes are closed immediately. The revised overtime policy will set out that all overtime and enhanced payments will be paid only in accordance with AFC. Should a department wish to deviate from these arrangements a discussion must take place with Executive Director for People.	Director for People	Head of Workforce Productivity and E-Systems Assistant Director of Policy, Governance and Compliance	July 2022 November 2022	Now January 2023		In progress	December 2022 update - Work has commenced on reviewing the policy and will be taken to the January 2023 People Policy Review Group.	August 2022 Update - The Overtime Policy will be reviewed by the Workforce Policy Review Group in September 2022. The review will take into consideration the internal audit recommendations. October updated 2022 - A policy task and finish group has now been established to review this policy. The first meeting of the group will take place in October 2022 and will ensure audit recommendations are incorporated.
Consultant Job Planning Follow Up 3.1	May-22	Reasonable	The new e-job planning guide should be updated to reflect the Health Board's position in respect of the recording of personal outcomes within job plans, and also the recording of Health Board, service or directorate outcomes. The Health Board should ensure that the revised job planning training materials include appropriate guidance on the recording of outcomes within job plans, in line with the e-job planning guide.	Medium	Development of and management of outcomes in job plans is a priority area of work for the Medical Director's team. This work has been assigned to the Assistant Medical Director (AMD) for Workforce to complete the framework of how this will be achieved. This will then be incorporated into the suggested documentation and training.	Medical Director	AMD for Workforce	Sep-22	Now December 2022		In progress	December 2022 Update - The BMA representatives have now withdrawn approval for the previous documentation shared, wanting further changes. These are still being agreed between both interested parties. It is believed an agreement will be struck in time for the next sitting if the LNC.	July 2022 Update - In progress - on target for September 2022 completion. 2022 update - Current Job planning process already has outcomes in the form of a division of work between Direct Clinical Care (DCC) and Supporting Professional Activities (SPA). The contractual position states having a DCC: SPA split of 7:3. In practice this varies with different departments and for different individuals. The average split for CTM is around 7.5-8 DCC activities and 2.5-2 SPAs. An agreement with the LNC has been reached but is awaiting final ratification, regarding the tariff for various SPA activities, bringing objectivity and equality across the 3 ILGs. (The last 2 LNC meetings got cancelled due to unavoidable circumstances). The DCC undertaken already has specific outcomes regarding the time (when) and site (where) the activity is undertaken. Some departments record the time that the SPA activity is undertaken on site, whereas some departments do not. There is recognition that one SPA activity can be contractually undertaken at home and that some SPA activities cannot have a fixed time in the week to undertake it. The workforce department is working towards having a greater detail in the level of outcomes both for DCC and SPA, but that requires improvement in data access and training of CDs and managers undertaking the job planning. It is envisaged that once the clinical leads in the new structure are appointed, the process for having more detailed outcomes in job planning can be prioritised. October 2022 Update - no update provided against this recommendation on this occasion
Consultant Job Planning 4.1	May-22	Reasonable	The discrepancies identified by management following their review of Anaesthetics SAS Doctors paper-based job plans and the e-job planning system should be resolved.	Medium	A paper dealing with the pay / job plan issue for the anaesthetics SAS doctors in PCH and RGH has been submitted to the Medical, Finance and HR Directors. A formal response directing action will be issued.	Medical Director	Medical Director	May-22	Now May 2023		Completed	December 2022 update - Complete. An agreement was made through the medical directors office to maintain the use of the impacted job plans outside of eJP.	June 2022 update - We have reviewed the situation. With a change in the new structure of the Health Board there will be a need to align specialities across the Health Board so there is an equitable JP approach. As such this issue will be part of that resolution. In the interim the current process that works will be maintained using an excel approach. Compliance can be monitored and reported by the CSG. July 2022 Update - On target for completion May 2023. October 2022 Update - On track for completion May 2023
Consultant Job Planning Follow Up 5.1	May-22	Reasonable	Residual work in relation to the principals of the ADH rate card and its subsequent approval should be completed.	Medium	A paper discussing the principles on which a rate card will be developed has been submitted to Director of People. Agreement of these principles will then result in the engagement of interested parties to develop the rate card.	Director for People	Director for People	Dec-22			In progress	December 2022 Update - This work has expanded further than our own Health Boards boundaries. There is now a national group that has met numerous times to decide and recommend a unified approach across Wales for rates paid for ADHs. Antony Gibson, the local lead for the rate card development is a member of this group, along with the AMD for Workforce and the Head of Workforce Productivity & E-Systems. This group will have a recommendation for rates finalised in December 2022. This recommendation will go to Welsh Government for comment, ratification and then implementation if approved.	August 2022 Update - The first meeting of the 'the unified transformation portfolio' sat on the 20th July. The work for the development of the rate card has been folded into the Medical Workforce productivity work stream. The rate card development and delivery has therefore been incorporated into the PID for the medical workforce productivity. October 2022 Update - The rate card development is now one of the work streams identified in the Medical Productivity Programme. The development of a rate card is being led by the Interim Unscheduled Care Group Medical Director, a task and finish group is being formed and further information on the work stream will be shared in due course.
Welsh Risk Pool Claims 1.1	Jun-22	Reasonable	Management should ensure that required documentation is submitted to the WRP within the specified timeframes and monitoring takes place to ensure compliance with this requirement.	Medium	1.1a Legal Services SOPs to be reviewed and updated. 1.1b Monitoring process to be implemented in respect of deadlines for various paperwork submissions. 1.1c Spot check audit to be undertaken bi-monthly on paperwork submissions against deadlines i.e. CMRs, LFERs etc.	Director of Nursing	Legal Services Manager	1.1a Dec 2022 1.1b June 2022 1.1c August 2022			In progress	December 2022 Update - 1.1a Some Legal Services SOPs have been reviewed and updated. Some are still in progress of being reviewed. 1.1b LFERs are regularly monitored via reports/trackers and dashboards. Datix Cymru has been updated to enable better tracking of red/amber deferred cases. These are regularly monitored via weekly data review meetings and Executive Patient Safety meeting. 1.1c Spot check audits undertaken by the Legal Services Manager Regular engagement with Welsh Risk Pool. LFER improvement plan devised, prioritising as appropriate, between legacy cases and new cases, as well as high value claims. £12.4 million has been approved by WRP for reimbursements in the last few months. LFERs have been given as a key responsibility for PSIM within the new operating model.	August 2022 Update 1.1a Legal Services SOP in progress of being reviewed. 1.1b LFERs are regularly monitored via reports/trackers and dashboards. Datix Cymru has been updated to enable better tracking of red/amber deferred cases. These are regularly monitored via weekly data review meetings and Executive Patient Safety meeting. 1.1c Spot check audits undertaken by the Legal Services Manager Regular engagement with Welsh Risk Pool. LFER improvement plan devised, prioritising as appropriate, between legacy cases and new cases, as well as high value claims. Date for submission of cases deferred over 6 months set for end of September. October 2022 Update 1.1a Legal Services SOP in progress of being reviewed. 1.1b LFERs are regularly monitored via reports/trackers and dashboards. Datix Cymru has been updated to enable better tracking of red/amber deferred cases. These are regularly monitored via weekly data review meetings and Executive Patient Safety meeting. 1.1c Spot check audits undertaken by the Legal Services Manager Regular engagement with Welsh Risk Pool. LFER improvement plan devised, prioritising as appropriate, between legacy cases and new cases, as well as high value claims. Date for submission of cases deferred over 6 months set for end of September. LFERs have been given as a key responsibility for PSIM within the new operating model.

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Welsh Risk Pool Claims	Jun-22	Reasonable	Procedures should be in place that provide staff with clear guidance on how to process claims, especially the dates that are to be used in relation to the 'Decision to Settle' and 'Final Payment', and the circumstances of when these dates should be updated in Datix. Guidance should also cover the other issues we identified including the correct process for capturing financial transactions in Datix and the process that should be followed if a claim is dismissed when taken to court.	Medium	2.1 Legal Services SOPs to be reviewed and updated and staff to be retrained where appropriate. 2.2 SOP to be devised to assist staff through the financial process if a claim is dismissed.	Director of Nursing	Legal Services Manager	Dec-22	Now January 2023		In progress	December 2022 Update - 2.1 Legal Services SOPs in process of being reviewed. 2.2 Financial SOP to be developed	August 2022 Update 2.1 Legal Services SOPs in process of being reviewed. 2.2 Financial SOP to be developed. October 2022 Update 2.1 Legal Services SOPs in process of being reviewed. 2.2 Financial SOP to be developed
Financial Systems 1.1	Jun-22	Reasonable	Guidance notes / desktop procedures should be developed to provide more detailed explanations on the budgetary control and virement processes to be followed to ensure compliance with the FCP.	Medium	An updated process document will be put in place for virements to ensure consistency and understanding across the Health Board.	Director of Finance	Head of Corporate Finance	Jul-22	Now January 2023		In progress	December 2022 Update - Process still being reviewed	August 2022 Update - All FCPs are being reviewed as part of the new delivery model and update of the SoD. Therefore the FCP will be updated once the new SoD has been approved. October 2022 Update - Need to review the appropriateness of the review of virements. Virements are done in line with Scheme of Delegation.
Financial Systems 6.2	Jun-22	Reasonable	In order to mitigate any form of error, virement journals being signed off by both the preparer and reviewer.	Medium	We will update the requirements of review/sign off as part of the updated process.	Director of Finance	Head of Corporate Finance	Jul-22	Now October 2022 Now January 2023		In progress	December 2022 Update - Process still being reviewed.	August 2022 Update - This will be updated in line with the update of FCP. October 2022 Update - Need to review the appropriateness of the review of virements. Virements are done in line with Scheme of Delegation.
Financial Systems 8.2	Jun-22	Reasonable	In cases where it is appropriate, management should explore the use of alternative mechanisms for raising orders and paying invoices, for example the use of 'call off' orders.	Medium	As above, we will identify the areas where retrospective orders are raised and review alternative mechanisms for order or payment.	Director of Finance	Head of Procurement	Mar-23			In progress	December 2022 update - Alternative methods of payments will be reviewed within the NO PO/Retrospective order review by March 2023 alongside the PO exemption list	August 22 update - Alternative methods of payments will be reviewed within the NO PO/Retrospective order review by March 2023. October 2022 update - Alternative methods of payments will be reviewed within the NO PO/Retrospective order review by March 2023
Financial Systems 8.3	Jun-22	Reasonable	Where a retrospective order is deemed appropriate, staff should be encouraged to complete the notes section of Oracle explaining the reason for use of a retrospective order, including details of who requested the goods or service to be procured.	Medium	Where retrospective orders are deemed acceptable, further training will be given to end users to ensure notes are completed within Oracle	Director of Finance	Head of Procurement	Mar-23			In progress	December 2022 Update - Refer to the update provided for 7.1. October 2022 - Retrospective review being undertaken as part of AW P2P T&F group, and further training needs will be identified by March 2023	August 2022 Update - Refer to the update provided for 7.1. October 2022 - Retrospective review being undertaken as part of AW P2P T&F group, and further training needs will be identified by March 2023
Financial Systems 8.4	Jun-22	Reasonable	Documentation to support all orders should be retained made available if required	Medium	Documentation will be made available via SharePoint.	Director of Finance	Head of Procurement	Mar-23			In progress	December 2022 - Documentation and information will be available through the development of the CTM SharePoint page which will be linked to the NWSSP SharePoint page with all relevant P2P information including virtual training guides by March 2023.	August 2022 - Documentation and information will be available through the development of the CTM SharePoint page which will be linked to the NWSSP SharePoint page with all relevant P2P information including virtual training guides by March 2023. October 2022 Update - Remains the same as the update provide in August 2022

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Financial Systems 9.1	Jun-22	Reasonable	As sending individual letters to staff when it is identified they are non-compliant with the policy is time consuming, consideration should be given to alternative methods of ensuring departments that are persistently non-compliant are made aware, with support and training provided in an attempt to prevent ongoing non-compliance.	Medium	Training on No PO and retrospective orders will be made available to respective areas. Non Compliance letters will still be issued.	Director of Finance	Head of Procurement	Jul-22	Now October 2022 Now March 2023		In progress	December 2022 update - Non compliance letters are being issued in relation to retrospective orders. As above the No PO policy approach is being reviewed within the FDU AWP2P forum and messaging is being strengthened to both HB and Supplier by January 2023 Best practice approach also being developed within FDU AW P2P. AW P2P T&F group work delayed and approach approved by AW P2P group and SRO 17th November. Training/Lunch and learn sessions continuing and retrospective letters still being issued. Retrospective order review for priority areas being identified by March 2023	Aug-2022 update - Non compliance letters are being issued in relation to retrospective orders. As above the No PO policy approach is being reviewed within the FDU AWP2P forum and messaging is being strengthened to both HB and Supplier by October 2022. Best practice approach also being developed within FDU AW P2P. October 2022 - AW P2P T&F group work delayed and approach being presented to AW P2P group and SRO 17th November. Training/Lunch and learn sessions continuing and retrospective letters still being issued. Retrospective order review for priority areas being identified by March 2023
Risk Management 2022 04	Aug-22	Reasonable	Management should ensure that for those risks highlighted, a review is undertaken as soon as practicable and the Datix system updated. Management should ensure that staff are reminded of the requirement to review and update risks in Datix in line with the timescales detailed in the Health Board guidance.	Medium	Risk Leads will be asked to ensure that Datix is updated to reflect the updates on the risks identified as being passed their review dates. Reminders to ensure risks are regularly updated will be included in the CTM Staff update and more prominently on the Risk Intranet Pages. Messaging will also continue via the training and regular meetings with risk leads.	Director of Corporate Governance	Assistant Director of Governance & Risk	Sep-22	Now 31 January 2023		In progress	December 2022 Update - On track: The Assistant Director of Governance & Risk, along with the Chief Operating Officer and/or Deputy Chief Operating Officers, has started to meet with Care Groups during October and November to review risks in terms of alignment to the new Care Group Model. The Organisational Risk Register will continue to be updated to reflect the changes being made as a result of this activity. Monthly risk training continues to reiterate the need for timely review. The consultation on the revised Risk Assessment Procedure has just concluded and this procedure has further clarified the Health Boards stated timescales for review based on the risk scoring. This Procedure is planned for approval in December 2022. The recent Staff Newsletter (November 2022) raised awareness in terms of the review of the risk assessment procedure, training dates and the dedicated risk pages on SharePoint which all support this recommendation.	October 2022 Update - The initial management action has now been superseded as the Executive Leadership Group approved the "Guiding principles for Quality Governance Accountability Arrangements during the transition to the new Operating Model", at its meeting on the 12th September 2022. For the purposes of these principles, the ELG have identified the period of "transition" to end on 31st January 2023. This includes the realignment of all open ILG Legacy Risks and establishing a workshop to review risks on the Organisational Risk Register in light of the new model.
CSG & ILG Quality Assurance 1.4	Aug-22	Reasonable	A review of the quality monitoring arrangements for Surgery CSG within Merthyr Cynon ILG should be undertaken to establish if the remit of the Surgery Governance Group and wider Acute Service Patient Safety Governance Group are able to provide the same level of quality monitoring and assurance that can be provided from a dedicated Quality and Safety Group for the CSG. If necessary, consideration should be given to having a dedicated Surgery Quality and Safety Group in line with other CSGs.	Medium	The health board is in transition period of adopting a new operating model. The current framework (Nov 2020) describes quality governance arrangements within the current model of Integrated Locality Groups (ILG's), including a template for Quality, Safety & Patient Experience (QSPE) meetings, terms of reference, frequency, agenda and more recently common quality measures. It is recognised that this clear direction was not extended to the Clinical Service Group (CSG) structure, which was very much in its early stages of development in 2020. This assurance audit was requested to explore the governance interface in relation to CSG, ILG and Health Board assurance, escalation and risk. This has been a very helpful activity in reaffirming the need to apply a standardised framework to CSGs for good governance and assurance from service point to Board line of sight. This granular governance will be articulated through the revised Quality & Patient Safety Framework and embedded within the new Care Group operating model.	Director of Nursing	Assistant Director Quality & Safety	Dec-22	Now January 2023		In progress	December 2022 Update - Care Group governance structures are being developed, The Children and Families Care Group are holding its first meeting on 1.12.22 with representation from both Clinical Service Groups. Structures being reviewed to ensure the golden thread between patient care, Planned Care Quality & Safety meeting and upwards reporting into Operational Management Board	October 2022 update-The health board continues to make changes in respect of its new operating model which includes quality governance and patient safety arrangements for CSG's and the Care Groups they sit within. Each Clinical Service Group will have a standardised assurance framework in place to describe how floor to board assurance is articulated within services, as well as standardised tools for annual work plans, quality assurance of incident management & investigation, Terms of Reference/Agenda for Quality, Patient Safety & Patient Experience Meetings and arrangements to share learning. Upward reporting and monitoring through to the Care Group will be based on agreed quality indicators, informed by work plans and a common reporting framework. These arrangements will be articulated in the revised Quality & Safety Framework due for publication in December 2022.
CSG & ILG Quality Assurance 3.0	Aug-22	Reasonable	All ILG Quality and Safety Groups and their constituent CSGs should establish annual quality assurance work plans that will allow focus, monitoring and reporting on their relevant quality issues and objectives in a targeted manner.	Medium	Response as in 1.1; The health board is in transition period of adopting a new operating model. The current framework (Nov 2020) describes quality governance arrangements within the current model of Integrated Locality Groups (ILGs), including a template for Quality, Safety & Patient Experience (QSPE) meetings, terms of reference, frequency, agenda and more recently common quality measures. It is recognised that this clear direction was not extended to the Clinical Service Group (CSG) structure, which was very much in its early stages of development in 2020. This assurance audit was requested to explore the governance interface in relation to CSG, ILG and Health Board assurance, escalation and risk. This has been a very helpful activity in reaffirming the need to apply a standardised framework to CSG's for good governance and assurance from service point to Board line of sight. This granular governance will be articulated through the revised Quality & Patient Safety Framework and embedded within the new Care Group operating model. In addition, the requirement of annual work plans for Clinical Service Groups will be re-established and monitored through the new Care Group model governance system. Progress against CSG annual plans will be upwardly reported by Care Groups to Quality and Safety Committee on a yearly basis.	Director of Nursing	Assistant Director Quality & Safety Care Group Nurse Directors	Dec-22	Now January 2023		In progress	December 2022 Update - Care Group governance structures are being developed, Planned Care held it's first meeting on 22.11.22 with representation from all 3 Clinical Service Groups - Surgery CSG structures being reviewed to ensure the golden thread between patient care, Planned Care Quality & Safety meeting and upwards reporting into Operational Management Board. There are already service wide assurance groups in place for maternity, gynaecology and integrated sexual health. The Care Group is working to align CYP accordingly however CYP already regularly hold Quality and Safety meetings. Both service groups will actively participate in the Children and Families Care Group QPSE Meetings from 1.12.22. Maternity and Neonates have developed a floor to board escalation framework which was updated and approved at Health Board Quality and Safety Committee in September 2022. Work is underway within the Care Group to now align the framework and ensure CYP are included.	October 2022 update-The health board continues to make changes in respect of its new operating model which includes quality governance and patient safety arrangements for CSG's and the Care Groups they sit within. Each Clinical Service Group will have a standardised assurance framework in place to describe how floor to board assurance is articulated within services, as well as standardised tools for annual work plans, quality assurance of incident management & investigation, Terms of Reference/Agenda for Quality, Patient Safety & Patient Experience Meetings and arrangements to share learning. Upward reporting and monitoring through to the Care Group will be based on agreed quality indicators, informed by work plans and a common reporting framework. These arrangements will be articulated in the revised Quality & Safety Framework due for publication in December 2022.
CSG & ILG Quality Assurance 4.0	Aug-22	Reasonable	It should be ensured that going forward there is Surgery CSG representation at the PCH Acute Services Patient Safety and Governance Group. Consideration should be given to reviewing the terms of reference for the ILG Quality, Patient Safety and Experience Group to include representatives from the CSGs so that quality matters for those areas can be discussed in greater detail.	Medium	Notwithstanding the pending changes to the operating model, this finding has been relayed to the Nurse Director of Merthyr Cynon ILG who is chair of the ILG QPSE group for corrective actions. This will also be highlighted in the Merthyr Cynon ILG quality and patient safety legacy document in preparation for the change in the operating model.	Director of Nursing	Merthyr Cynon ILG Nurse Director	Sep-22	Now October 2022 Now January 2023		In progress	December 2022 Update - PCH Surgery CSG are actively participating in the Planned Care Quality & Safety meeting which has met for the first time.	October 2022 update-The handover document is being finalised and will be completed by end of October 2022. The unscheduled care Director of Nursing is working closely with the planned care Director of Nursing during this phase until formal handover has been completed.

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Medical & Dental Rosterin g Follow Up Review 1.1	Aug-22	Reasonable	The Health Board should determine its long-term objective in the use of Health Roster for Medical and Dental staff to generate rosters and achieve the potential efficiencies the system will generate. If there is to be roll out of the rostering module, work should be carried out to determine those areas that are already expressing an interest in using this module. A new project plan should be developed with achievable timeframes and appropriate resources to support the roll out.	Medium	The Health Board has rolled out allocate health roster to all areas except Anaesthetics (ACT) & the Emergency Department (ED). ACT continue to use CLW, and ED have transitioned to health rota, an ED specific rostering system. Both specialist areas have been shown and trialled health roster. Neither want to transition to the allocate software after the trial and will therefore use the previously mentioned systems, as they offer additional functionality that health roster doesn't. There is no current plan to purchase the additional module 'Activity Manager' or to develop a project plan to roll out a package that has not been purchased by the UHB. There will be a full review of areas using health roster, to identify those only partially utilising the current capabilities of the system. Engagement sessions will be set with the areas identified. These sessions will be made with the express aim of understanding why the system isn't being fully utilised and how the Health Board can offer support to allow adoption of the system or understand and accept the reason why the particular specialty does not need the full use of the system	Medical Director & Director for People	AMD for Workforce	Dec-22			Completed	December 2022 update – Complete. All areas using Health Roster have been through a programme of training, with a recorded attendance, showcasing the system capabilities and how to use it. This does not include the areas in ACT and ED.	October 2022 Update - no update provided against this recommendation on this occasion
Medical & Dental Rosterin g Follow Up Review 2.1	Aug-22	Reasonable	The Health Board should determine its long-term objective in the use of Health Roster for Medical and Dental staff to generate rosters and achieve the potential efficiencies the system will generate. If there is to be roll out of the rostering module, work should be carried out to determine those areas that are already expressing an interest in using this module. A new project plan should be developed with achievable timeframes and appropriate resources to support the roll out.	Medium	The Health Board has rolled out allocate health roster to all areas except Anaesthetics (ACT) & the Emergency Department (ED). ACT continue to use CLW, and ED have transitioned to health rota, an ED specific rostering system. Both specialist areas have been shown and trialled health roster. Neither want to transition to the allocate software after the trial and will therefore use the previously mentioned systems, as they offer additional functionality that health roster doesn't. There is no current plan to purchase the additional module 'Activity Manager' or to develop a project plan to roll out a package that has not been purchased by the UHB. There will be a full review of areas using health roster, to identify those only partially utilising the current capabilities of the system. Engagement sessions will be set with the areas identified. These sessions will be made with the express aim of understanding why the system isn't being fully utilised and how the Health Board can offer support to allow adoption of the system or understand and accept the reason why the particular specialty does not need the full use of the system	Medical Director & Director for People	AMD for Workforce	Dec-22			Completed	December 2022 update – Complete. All areas using Health Roster have been through a programme of training, with a recorded attendance, showcasing the system capabilities and how to use it. This does not include the areas in ACT and ED.	October 2022 Update - no update provided against this recommendation on this occasion
Medical & Dental Rosterin g Follow Up Review 3.1	Aug-22	Reasonable	The draft Medics Rostering Policy should be further reviewed to remove any legacy references to the Nursing Rostering Policy. Feedback should then sought from the appropriate groups and approval obtained from the appropriate committee ahead of making the policy available to all relevant staff.	Medium	The draft has been reviewed substantially and is now complete. The policy has been submitted to the Medical Workforce Sustainability Group (MWSG) for review. This will be set as an agenda item for the next meeting and then progress through the formal Health Board route to ratification.	Medical Director & Director for People	Head of workforce productivity and E- Systems	Nov-22	Now February 2023		In progress	December 2022 update – The MWSG has not met since the policy was completed. The MWSG has now been disbanded as a formal group. The policy will now go through the Policy Review Group, and then progress to the LNC.	October 2022 Update - no update provided against this recommendation on this occasion
Medical & Dental Rosterin g Follow Up Review 3.2	Aug-22	Reasonable	For areas where the full roll out of Health Roster is not imminent, separate 'how to' guides on the local system used should be considered. The guides should include the step-by-step process for creating the rosters and also guides for users of the system, allowing consistency during unexpected periods of absence.	Medium	How to guides will be developed by ACT & ED for use of their respective systems.	Medical Director & Director for People	ACT Manager & Roster manager ED Manager & Roster manager	Nov-22			In progress	December 2022 Update - How to guides are yet to be developed or shared by Anaesthetics or Emergency Department (ED) colleagues.	October 2022 Update - no update provided against this recommendation on this occasion
Medical & Dental Rosterin g Follow Up Review 4.1	Aug-22	Reasonable	Management should ensure that the Study Leave policy is approved and circulated within the Health Board.	Medium	Discussion around agreeing a Health Board wide policy is still ongoing between the Medical Director and the BMA. This is due to the differences between provision for study leave contained in the previous Cwm Taf and Swansea Bay policies. Agreement needs to be reached between the involved parties, to allow for the new policy to progress and be ratified through the formal UHB policy route.	Medical Director & Director for People	Medical Director	Nov-22	Now December 2022		In progress	December 2022 update - To be discussed at LNC meeting on 8th December 2022	October 2022 Update - On track for completion November 2022

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Medical & Dental Rosterin g Follow Up Review 5.1	Aug-22	Reasonable	As the Health Board makes progress in increasing the job planning compliance rates, management need to ensure that rosters align to the updated job plans, including ensuring SPA and DCC sessions align to the agreed job plans.	Medium	As there is no automatic or software solution to ensuring rosters align to job plans, it is therefore a fundamental part of local management of the Medics working in each specialty. This is due to the service and roster managers being the responsible staff for determining the job plans and also administering the rostering system that these job plans align to. Workforce & OD will reiterate via a general communication the responsibility for aligning job plans to rosters is a fundamental part of running an effective service, that the local managers are responsible for.	Medical Director & Director for People	ILG Directors, CSG Managers and Deputy CSG Managers.	Sep-22	Now December 2022		Completed	December 2022 update – Complete. Training has been offered to all areas on job planning and relating it to activity on rosters. A general guide for job planning has also been issued and is available to all staff to access.	October 2022 Update - This will move to the Care Group leadership to ensure compliance. Whilst we are in transition this is being monitored centrally, but with individual departments being reminded of the need to address the shortfall and follow guidelines in JP. Acute Medicine Consultant and Nerys Conway and Head of Workforce Productivity and E-Systems to oversee in interim.
CAMHS Workforc e Follow Up Review 2.1	Aug-22	Reasonable	a) The SOP in relation to the set up and use of electronic staff files should be finalised. b) All current electronic files should be fully populated with documentation scanned from hard copy files. c) The roll out of electronic staff files to all other areas of the CSG should commence.	Medium	a) A SOP is being drafted by the Swansea Bay CAMHS locality Senior Nurses on the set up and use of electronic staff files and will be taken to the Quality, Patient Safety and Experience meeting for review and discussion prior to sign off. b) Swansea Bay CAMHS locality Senior Nurses will ensure all current electronic files will be fully populated with the documentation from the hard copy files c) CTM CAMHS locality will commence the roll out of electronic files following sign off of the SOP to approach and any learning from the Swansea Bay CAMHS team	Chief Operating Officer	a) Senior Nurses for Swansea Bay CAMHS locality b) Senior Nurses for Swansea Bay CAMHS locality c) Head of Nursing and Senior Nurses for each locality	a) End of October 2022 b) End of September 2022 c) End of November 2022	Should all be complete by November 2022 Now January 2023		In progress	December 2022 Update - All nursing electronic files in SB CAMHS have been fully populated with the documentation from the hard copies. SOP has been developed but requires review in CAMHS Quality, Safety and Patient Experience meeting which was cancelled in October due to limited attendance with next date in January 2023.	October 2022 Update - nursing electronic files in Swansea Bay CAMHS have been fully populated with the documentation from the hard copies. A draft SOP has been developed and will be discussed with teams in October prior to sign off.
Medical Records Management 1.1	Nov-22	Reasonable	The responsibilities of the Health Records departments across the Health Board should be standardised. Linked to this the procedures operating within each site should be standardised as much as possible, given the limitations imposed by digitisation.	Medium	Accept There are challenges to standardising the operational procedures of the Health Records teams due to the variances between the digital systems used within the Princess of Wales and the rest of the Health Board. It should also be noted that some of the Health Records personnel within the Health Board are not under the direct responsibility and accountability of the Director of Digital. The Health Board has devised a programme of work to standardise the PAS in use across the Health Board. This programme is planned until the Autumn of 2024. Process will be aligned as practically possible prior to the completion of the programme.	Director of Digital	Director of Digital	Qtr 2 2024/2025			In progress	December 2022 Update - Scoping and implementation work ongoing	
Medical Records Management 2.1	Nov-22	Reasonable	Work should start to identify records which could immediately be destroyed when the moratorium relating to the infected blood inquiry ends. These records should be moved to an alternate location.	Medium	Partial Agreement Identification of records to be destroyed can commence and complete by end of Qtr 3 2022/2023. The Health Board is currently reviewing its estate, with a view to reducing some of its existing facilities. An alternative location would need to be procured. This cannot be resolved quickly due to continued financial pressures for the Health Board. An alternative location cannot be procured within the existing financial envelope of the Health Board. Audit Note – We recognise the limitations to space and agree with the approach to identify the relevant records.	Director of Digital	Director of Digital	Qtr 3 2022/2023	Now March 2023		In progress	December 2022 Update - Work underway - plan to complete by end of QTR4 2022/2023	
Medical Records Management 2.2	Nov-22	Reasonable	Departments that use the facility should be requested to ensure that their records are stored safely and appropriately, and that they have an appropriate archiving and disposal process in place.	Medium	Agreed Review of all records stored within the Hub	Director of Digital	Director of Digital	Qtr 3 2022/2023			Completed	December 2022 Update - Propose to close - all records have now been reviewed	

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Medical Records Management 2.3	Nov-22	Reasonable	The risk associated with the leaking roof should be included on the departmental risk register, and appropriate actions defined.	Medium	Agreed Risk Register to be updated.	Director of Digital	Director of Digital	Qtr 3 2022/2023			Completed	December 2022 Update - Datix updated - propose to close	
Medical Records Management 3.1	Nov-22	Reasonable	Appropriate storage space and facilities for records should be provided.	Medium	Agreed Additional space has been identified on the Glanrhyd site.	Director of Digital	Director of Digital	Qtr 2 2022/2023			Completed	December 2022 Update - Propose to close - Glanrhyd site now handed over in its entirety to the Health Board from 14/11/2022	
Medical Records Management 3.2	Nov-22	Reasonable	Access to the records storage area should be restricted to health records staff	Medium	Disagree with recommendation. Capacity within the existing Health Records team at the Princess of Wales is limited. As such services need to be able to retrieve records to ensure timely delivery of services. These staff are familiar with the site and have been accessing records as part of routine business processes. Audit Note – Restricting records access to just health records staff is good practice. However, we acknowledge that there are limitations to staffing and operational practicalities make this difficult at the current time. We note that the agreed action in matters arising 1.1 and 4.2 may help address this matter.	Director of Digital	Director of Digital	N/A			Completed		
Medical Records Management 6.1	Nov-22	Reasonable	The underlying reason for failures should be established and corrected to prevent future issues. The progress of scanning and any issues should be reported within the structure referred to in MA4	Medium	Agreed Underlying Issue to be identified and reported.	Director of Digital	Director of Digital	Qtr 3 2022/2023			In progress	December 2022 Update - To be completed with the Medical Records review report from November 2022	
Health & Safety Management 06	Aug-20	Reasonable	The templates currently being used to undertake annual Health and Safety reviews should be reviewed to ensure they are accurately reflecting the Health and Safety issues within each department.	Low	The Health and Safety Team are developing an audit package for use across the CTMUHB. The package will provide assurance to ILGs and the Board that policies and procedures are being followed in all Service Group Wards and Departments. Once completed, the audit package will be presented to the Health, Safety and Fire Committee for approval.	Director for People	Head of Health, Safety & Fire	01/01/2021 31 May 2022	Now 01/07/2021 Trial Audit on Social Distancing completed August 2021. New completion date for audit package to be suitable for H&S Audits 31/01/2022 Now May 2022 Now September 2022 Now February 2023		Part Completed	December 2022 Update - First audit commenced in September 2022 and a selection of Wards and Departments have been highlighted to be audited (x30). Audit results will be presented to the next Health, Safety and Fire Sub Committee in February 2023.	APRIL 2021: An audit tool is being developed, taking learning from the social distancing audit tool developed. The package itself is developed, and by July we will have determined the key areas to be examined via the audit tool. This will be complete and ready to use by the end of July. A revised implementation date has been provided. July 2021 - Audit Package currently undergoing further testing due to some reporting issues on the AMaT system. SEPTEMBER 2021: The above audit findings were presented as a draft to the last Health, Safety and Fire Committee in September 2021. There are still some issues with the audit package producing an Executive summary of the audit undertaken. The Health, Safety and Fire Team are in further discussions with the Clinical Audit Team and AMaT to resolve this. Whilst awaiting this system fix an audit programme is being set up and will be rolled out once the system fixes have been completed. November 2021 - No further update provided. April 2022 Update - Health & Safety Team has been working closely with Clinical Audit colleagues to determine whether the AMaT system could be used to capture audit information. The Team were now working towards a revised target date of end of May 2022 to complete this recommendation. April 2022 Update - Health & Safety Team has been working closely with Clinical Audit colleagues to determine whether the AMaT system could be used to capture audit information. The Team were now working towards a revised target date of end of May 2022 to complete this recommendation. August 2022 Update - Following several other issues which had to be resolved with AMaT the Health and Safety Team will be undertaking a management audit of a selection of wards/departments throughout the month of September. Update October 2022 - First audit commenced in September 2022 and a selection of Wards and Departments have been highlighted to be audited. Audit results will be presented to the next Health, Safety and Fire Sub Committee.
Financial Systems 06	Apr-21	Reasonable	Management may want to consider creating a procedure, as it will help strengthen efficiencies, deliver best practice and more importantly it will provide added support should the department have new staff working in that area.	Low	Agreed. A manual for the fixed asset register will be created.	Director of Finance	Finance Manager	Sep-21	Now September 2022 Now November 2022 Now December 2022		In progress	December 2022 Update - A draft version has been completed and is being checked through, this will now be completed during December 2022.	July 2021 Update - Action on target to be completed by September 2021. September 2021 - No further update. November 2021 - No further update provided. January 2022 Update - Due to changes in post and the significant pressure on the team as a result of IFRS implementation and preparation for the new quinquennial revaluation this has been unable to be addressed. It is proposed that this is picked up post the year end audit process over the summer of 22/23 post IFRS 16 adoption. April 2022 - No further update to report. August 2022 Update - A user manual for the Fixed Asset register is in progress, we have started working on it but it is not yet complete. October 2022 Update - Implementation date remains November 22.

Ref	Date added	Assurance rating	Recommendation	Priority	Management Action Agreed	Responsible Executive Lead/Management Lead	Responsible Management Lead	Original Agreed Implementation Date	Revised Implementation Date	Status	Progress	Updates during this period/Latest Update	Previous Updates
Facilities Director Review (Workforce Arrangements) Follow up Sunnyside Health & Wellbeing Centre 09	Aug-21	Reasonable	Both sites Work should continue in relation to the procurement of a more up to date Portering management system that would allow the service to be delivered in a more efficient and effective manner.	Low	RGH / RTE and PCH / M&C 1. Work will continue to progress forward in view of managing rota alignment that will support service demands and pressures. This will be always flexible and open to change in view of changing service needs within the Hospitals. 2. A bid for funding for a new Porter Services IT management system solution (Symbiotic) has been submitted in the Facilities IMTP 2021-2022.	Chief Operating Officer	Facilities Regional Managers	Sep-21	Nov-22		Completed	December 2022 Update - the new version of PorterTrac is LIVE across all three DGH Sites. All Sites responsive to upgraded system. Further improvement to manage self serve system supporting trial across each Site. Facilities IMPT will continue to include funding need for new model as current extension to upgrade is one year period. Each Site will continue to review service demands and flow due to service pressures seeing changes with flow and demand.	September 2021 - No further update. December 2021 update - plans for Facilities to review other Porter Management Systems year 2022. Procurement will support any tender process. Staffing resources will continue to be managed with services pressures and demands and flexibility to work with the rota. February 2022 Update - confirmation from Facilities that this is under continual review and the completion date remains November 2022. April 2022 Update - Date for completion remains November 2022. June 2022 - no update available this month. August 2022 Update. Date for completion remains November 2022. In terms of progress, both MC and RTE can confirm that that point 1 is completed. New porter traversal has been procured and training / go live dates are awaited. October 2022 Update - date for completion remains November 2022.
Sunnyside Health & Wellbeing Centre 17	Aug-21	Reasonable	Performance of relevant parties should be monitored appropriately	Low	As above although there will be a delay with the appointment of a new contractor.	Director of Finance	Senior Project Manager	Sep-21	Now January 2022 for Contractor only Now 31 March 2022 Now July 2022 Now December 2022 Now March 2023		In progress	December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be March 2023	September 2021 Update - Complete for advisors but will not be complete for contractor until a new contractor is appointed. November 2021 Update - ongoing, awaiting contractor appointment. January 2022 Update - this has been further delayed as a result of a need to extend the tender period. April 2022 Update - See above - project remains on hold whilst new contractor appointed. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift. August 22, there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until December at the earliest
IT Service Management Follow Up 04 Financial Systems 6.1 Risk Management 2022 05	Apr-22	Reasonable	A process for monitoring the change process to ensure compliance with all the requirements of the process should be established.	Low	Will be reviewed by the Head of Service Management when in post	Director of Digital	Head of Service Management	01.08.2022	Now end of Q3 2022/2023		Completed	December 2022 Update - Propose to close - process now in place	June 2022 Update - Will be reviewed by the Head of Service Management once the 3 higher priority recommendations have been addressed. August 2022 - Propose to extend to end of Q3 2022/2023. October 2022: On track to complete by the end of Qtr 3 2022/2023
	Jun-22	Reasonable	In line with the Scheme of Delegation, management should ensure authorisation is sought and retained prior to virements being input on Oracle.	Low	Agreed, as per action 1, an updated process will be developed	Director of Finance	Head of Corporate Finance	Jul-22	Now October 2022 Now January 2023		In progress	December 2022 Update - Process still being reviewed alongside Ref 1.1 and 6.2	August 2022 Update - Will be updated in line with the update of FCP. October 2022 Update - Need to review the appropriateness of the review of virements. Virements are done in line with Scheme of Delegation.
	Aug-22	Reasonable	Management should consider the use of Datix for capturing all risks, this would allow for a consistent approach throughout the Health Board and provide greater effectiveness of monitoring.	Low	The ability to maintain a consistent approach to recording low level risks will be considered with a suggestion to align with the implementation of the new All Wales Risk Module on Datix where low level risks can be added to the system without generating the more detailed steps higher level risks require.	Director of Corporate Governance	Assistant Director of Governance & Risk	Oct-22	Now 31 December 2022 Now 31 March 2023		In progress	December 2022 Update - This recommendation is dependent on the implementation of the OFW Risk Module as the intention is that the training will include how to undertake a risk assessment utilising the risk module on Datix. The pace of implementation on the new module has slowed and therefore the work in this activity has not been progressed. A meeting has been scheduled in early December with a small cohort of risk leads across NHS Wales and the OFW System Lead to undertake some work on the progress of the module developments. A further update will be available following this meeting with a greater insight into an anticipated implementation date. In the meantime the revised Risk Assessment Procedure which is planned for approval in December 2022 mandates the use of Datix for all risks irrespective of scoring. The Risk Management Training also captures the Health Boards position on	October 2022 Update - This recommendation has been aligned to the implementation of the Datix Cymru Risk Module the implementation of the new module has been delayed. Progress is monitored via the OFW Risk Module Meetings which is next due to meet in October 2022 where a further update on timescales will be received. Furthermore, the current risk training encourages risk owners to include all risks to the Datix System and this will be reflected in the next iteration of the Risk Management Procedure.
CSG & ILG Quality Assurance 1.1	Aug-22	Reasonable	The terms of reference for the CSG Service Group Performance Review (SGPR) meetings should be reviewed and updated where necessary, including amending the frequency of meetings if deemed appropriate. CSGs should endeavour to hold their SGPR meetings in line with the frequency agreed in the terms of reference.	Low	The health board is in transition period of adopting a new operating model. The current framework (Nov 2020) describes quality governance arrangements within the current model of Integrated Locality Groups (ILG's), including a template for Quality, Safety & Patient Experience (QSPE) meetings, terms of reference, frequency, agenda and more recently common quality measures. It is recognised that this clear direction was not extended to the Clinical Service Group (CSG) structure, which was very much in its early stages of development in 2020. This assurance audit was requested to explore the governance interface in relation to CSG, ILG and Health Board assurance, escalation and risk. This has been a very helpful activity in reaffirming the need to apply a standardised framework to CSGs for good governance and assurance from service point to Board line of sight. This granular governance will be articulated through the revised Quality & Patient Safety Framework and embedded within the new Care Group operating model.	Director of Nursing	Assistant Director Quality & Safety	Dec-22	Now January 2023		In progress	December 2022 Update - Quality & Safety Framework first draft expected December 2022	October 2022 update-The health board continues to make changes in respect of its new operating model which includes quality governance and patient safety arrangements for CSG's and the Care Groups they sit within. Each Clinical Service Group will have a standardised assurance framework in place to describe how floor to board assurance is articulated within services, as well as standardised tools for annual work plans, quality assurance of incident management & investigation, Terms of Reference/Agenda for Quality, Patient Safety & Patient Experience Meetings and arrangements to share learning. Upward reporting and monitoring through to the Care Group will be based on agreed quality indicators, informed by work plans and a common reporting framework. These arrangements will be articulated in the revised Quality & Safety Framework due for publication in December 2022.
CSG & ILG Quality Assurance 2.0	Aug-22	Reasonable	Quality governance training should be provided to all relevant staff in the ILGs and their constituent CSGs to ensure a sound understanding of quality assurance principles and practices	Low	The Health Board launched a new Patient Safety Incident Management Framework and Toolkit in June 2022. This describes the responsibilities of colleagues in managing patient safety issues from an initial incident and investigation through to complaints, redress, inquests and claims. In July 2022, the Health Board also launched a rolling programme of patient safety investigation training, which includes good governance in relation to quality and patient safety, Datix and patient experience. The training also introduces the important concepts of psychological safety, human factor errors and safety thinking. Attendance is recorded on the Health Board's Electronic Record System, which ensures that those undertaking incident investigations are appropriately, and consistently trained to improve standards and performance. Bespoke Datix training has been rolled out by the Datix Management Team following the adoption of the Once for Wales incident module, and is ongoing. The corporate team have initiated good governance training in relation to assurance report writing and preparedness for Boards and Committees as well as Risk Management Awareness Training. Training sessions are supported by the Health Board's Communication channels, Intranet SharePoint system where further information and assistance for colleagues is signposted by the Patient Care and Safety site. A further opportunity to raise awareness and understanding of the quality assurance principles and practice to the wider workforce will be the publication of the Quality and Patient Safety Framework.	Director of Nursing	Assistant Director Quality & Safety	The nature of this action is ongoing; however, the new structure will provide an opportunity to target CSGs, Quality & Patient Safety Framework December 2022	Now January 2023		In progress	December 2022 Update - As previously identified the Patient Safety Incident Management Framework and Toolkit describes the responsibilities of colleagues in managing patient safety issues from an initial incident and investigation through to complaints, redress, inquests and claims. The rolling programme of patient safety investigation training/ RCA training which includes good governance in relation to quality and patient safety & Datix and patient experience has a rolling training programme every 6- 8 weeks due to room booking availability across all 3 sites. To date approx. 80 people have received training. As the organisational change takes place, the vision is for the all governance teams across the care groups to support with delivering this training. Further training is being scoped with the claims team as feedback from medical colleagues is more training is required around identifying breach of duty. Bespoke Datix training sessions are being offered to CSG's and departments by the Datix Management Team following the adoption of the Once for Wales incident module. The corporate team have continued good governance training in relation to assurance report writing and preparedness for Boards and Committees as well as Risk Management Awareness Training. A further opportunity to raise awareness and understanding of the quality assurance principles and practice to the wider workforce will be the publication of the Quality and Patient Safety Framework in December 2022 which will articulate how CSGs provide assurance through standardised frameworks, systems and processes.	October 2022 update-As previously identified the Patient Safety Incident Management Framework and Toolkit describes the responsibilities of colleagues in managing patient safety issues from an initial incident and investigation through to complaints, redress, inquests and claims. The rolling programme of patient safety investigation training, which includes good governance in relation to quality and patient safety, Datix and patient experience continues on a monthly basis. Bespoke Datix training sessions are being offered CSG's and departments by the Datix Management Team following the adoption of the Once for Wales incident module. The corporate team have continued good governance training in relation to assurance report writing and preparedness for Boards and Committees as well as Risk Management Awareness Training. A further opportunity to raise awareness and understanding of the quality assurance principles and practice to the wider workforce will be the publication of the Quality and Patient Safety Framework in December 2022 which will articulate how CSGs provide assurance through standardised frameworks, systems and processes.
CSG & ILG Quality Assurance 5.0 PCH Quality Assurance 1.1	Aug-22	Reasonable	For clarity, each CSG should consider mapping out its quality assurance reporting and oversight arrangements from the CSG up to the ILG Quality and Safety Group.	Low	This will be actioned through the new Quality and Patient Safety Framework as detailed in earlier agreed management actions.	Director of Nursing	Assistant Director Quality & Safety	Dec-22	Now January 2023		In progress	December 2022 Update - Quality & Safety Framework first draft expected December 2022	October 2022 update-This has been responded to within earlier updates in relation to the new Quality & Safety Framework.
	Jun-22	Substantial	The stakeholder engagement strategy will be defined.	Medium	Agreed. This will be included within the Project Execution Plan and will define key individuals/ groups and their responsibilities.	Director of Finance	Senior Responsible Officer	Aug-22			Completed	December 2022 Update - Recommendation actioned with PEP update presented to Project Board on 27/10/22.	August 2022 Update - Dialogue commenced with Project Manager to amend the PEP. October 2022 update - Final draft being agreed to amend the PEP

Red -

Orange -

Yellow - Action

Green - Action

Blue - Action

Ref	Date added	Assurance rating	Recommendation	Priority	Management Action Agreed	Responsible Executive Lead/Management Lead	Responsible Management Lead	Original Agreed Implementation Date	Revised Implementation Date	Status	Progress	Updates during this period/ Latest Update	Previous Updates
PCH Phase 1b Final Account 2.1	Nov-22	Substantial	The cost of changes to the Target Cost should be agreed promptly and prior to work commencing	Medium	Due to the need to maintain programme it is not always possible to obtain costs prior to work commencing. This is recognised in the NEC contract under clause 61.1 where the Contractor is charged with putting an instructed Compensation Event into effect despite costs not having been agreed. That said, the timescale for determining actual cost should not be as long as found in the testino. Performance has improved on the point in this respect.	Director of Finance	Responsible Officer	Nov-22			Completed	December 2022 Update - The recommendation is to be tested on subsequent audits.	
PCH Phase 1b Final Account 1.1	Nov-22	Substantial	The remaining subcontractor statements of final account will be obtained, and assurances provide to the UHB that these reconcile with the amounts claimed by the Supply Chain Partner.	Low	Agreed	Director of Finance	Senior Responsible Officer	Nov-22	Now March 2023		In progress	December 2022 Update - Statements of final account are being sought for the outstanding accounts.	

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Red -
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Yellow -
Green -
Blue - Action

Ref	Date added	Recommendation	Priority	Management Action Agreed	Responsible Executive Lead	Responsible Management Lead	Original Agreed Implementation Date	Revised Implementation Date	Status	Progress	Updates During this period/latest update	Previous Updates
R2 Follow Up Outpatient to Not Booked	Oct-17	Ensure compliance with revised administrative and booking processes across the organisation to avoid unnecessary retrospective validation of patient records.	Medium/ Low	The original review reported that the Health Board was undertaking unnecessary retrospective validation activities and this was an additional pressure on capacity which could be avoided. Unfortunately retrospective validation is still being undertaken by the Health Board. The latest figures reported in April 2017 show that the current volumes of patients without a target date was 1,129, however this is a significant improvement from the same time last year where the volume was 3,509. It remains an area of focus for the Health Board. Work continues to improve in this area. As part of the outpatient improvement theme new software has been introduced for clinicians to enable them to record the outcomes of their consultations in real time. Although only rolled out to a small selection of specialities the system has potential to improve recording of patient outcomes which will support the quality of patient data in respect of follow-ups. Performance data is also captured through the Qlik Sense system. This data analytics tool enables directorates and clinicians to interrogate a vast array of data to support day to day management and continuous improvement.	Chief Operating Officer			February 2021 Ongoing August 2021 Now December 2021 Now March 2022 Now June 2022 Now September 2022 Now February 2023		In Progress	December 2022 Update - following further advice from Audit Wales, a further question has been posed to Acute Services Managers asking for reassurance around the way that processes are working within the UHB. Response not yet received, anticipated by time of next meeting.	January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next month. March 2021. Implication of covid have meant that this issue has not received the appropriate management focus, however in the last month significant work has been undertaken on Demand and Capacity planning. This process has identified in detail the requirements and also the gaps and ILGs have been required to be clear about where they need additional support to deliver improved waiting times for current and future patients. Special importance is being attached to "other ways" of reducing lists and validation will be a focus of this process. This will be reported on in coming months via Performance Review and other meetings. Additional validation resource has been put into place as a short term response to dealing with the impact of Covid which has resulted in many patient pathways being impacted. While this is contrary to the recommendation, it has been a necessary response to the changed circumstances. May 2021 Update - Given the passage of time since this original review, thought will be given to discussing the recommendations of this audit with Audit colleagues. In the meantime, the UHB can offer assurance by confirming that the activity outlined in previous months is continuing and the Elective Recovery Plan is gathering pace and that it is monitored via weekly Board Meetings. July 2021 - work continues via the Planned Care and Unscheduled Care Programmes in line with Resetting. More information will be available at the next meeting. This information is now discussed at ILG level and then monthly at the Performance Review Meetings with the COO - where progress is demonstrated. Harm Reviews are also ongoing. Revised implementation date not provided. September 2021 Update - No change from the last comment. November 2021 Update - There is significant work underway on FUNB and related issues via the Planned Care Board including Follow Up Validations, SOS / PIFU projects, Attend Anywhere, DNA Work, Consultant Connect. There are robust mechanisms in place to monitor progress. Despite the progress and given the passage of time since this audit was completed, changes in management arrangements and the impact of covid 19, conversation is ongoing with colleagues in Audit to decide on how to answer this recommendation in a meaningful way. A meeting will be held before the next Audit Committee to discuss further. February 2022 Update - further discussion required with ILGs, evidence suggests that this is no longer an issue. To be confirmed at next meeting. April 2022 Update - Confirmation not received from all ILGs - anticipate very likely this will be received by the next meeting. June 2022 Update. Work continues as part of planned care recovery with Follow Up Validations, SOS / PIFU projects, Attend Anywhere, DNA Work, Consultant Connect. Progress has been monitored both through PCR Board and through ILG Performance meetings. However, the focus remains on clinical priority as the services recover. August 2022 - nothing further to report in this update. Date remains September 2022. October 2022 Update - following meeting with Acute Services Managers, issue clarified with AW colleague and meeting planned to decide on final comment.
Discharge Planning 03	Jan-18	Patient leaflet: Adapt the community hospital patient leaflet so it is relevant for patients staying in acute hospitals, setting out: ■ information about the discharge process, ■ how the patient and family will be kept informed of the discharge process; ■ arrangements that the patient may need to make (such as arrange transport); ■ information about follow-up care; and ■ the complaints process.	Medium/ Low	A patient information leaflet is already in place and used on the community hospital sites. The UHB will now consider the development of an acute hospital information leaflet.	Chief Operating Officer		Sep-18	February 2021 May 2021 August 2021 Now December 2021 Now June 2022 Now October 2022	Completed	December 2022 Update - In line with other areas, specific information is provided to patients within the former Merthyr Cynon Integrated Locality Group (ILG) when necessary though there is no consistent approach across all areas. The approach may need to be looked at going forward through CTM UHB.	January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next month. March 2021 Update - An Unscheduled Care Improvement Programme has been designed and constructed to focus on all aspects of urgent care. This specifically includes a work stream on discharge planning and managing stranded patients. The programme structure and governance has been reviewed and signed off by Exec and Management Board and is scheduled for review by the Q85 Committee in May 2021. Mobilisation of Unscheduled Care Improvement Board in April 2021 with the detailed project development of the identified work streams to be completed in May 2021 and beyond. Review of programme by Q85 Committee in May 2021 Update - The Q85 Committee approved the plans of the Urgent Care Improvement Programme (UCIP) in May 2021. The work streams include consideration of Flows in Hospitals and this issue will be picked up via that route. It is likely that there will need to be discussions with ILGs as the plans will be slightly different for each ILG. September 2021 Update. Following the continuation of covid pressures and the organisational focus on resetting elective services, this matter has not received dedicated management time. The ILGs can provide assurance that there are a number of diverse patient information leaflets and detailed advice is sought from their Patient Safety Heads. This information will be available at the next meeting of the Committee. November 2021 Update - a meeting has been held with Patient Safety colleagues to discuss this issue and the view is that there is significant information available through the UHB which would provide patients with a range of information of use to them. It is recognised that there is little standardisation and this will be reviewed again - this is an area where the impact of COVID 19 has had a real impact. February 2022 Update. Following discussion, all Nurse Directors have been asked specifically about the discharge information available, given that the implications of covid have made the development of a patient leaflet impossible. So far responses indicate that patients receive discharge information as appropriate even if not in one leaflet form. This will be confirmed at the next meeting. April 2022 Update - Confirmation received from two ILGs that there is appropriate discharge information available across sites - waiting for confirmation from one remaining ILG. Will then be complete. June 2022 Update. No further action here - will be a priority for August 2022. August 2022 Update - Final response awaited from one ILG, has been chased. October 2022 Update - No further update provided on this	
Clinical Coding Follow Up Review 01	Oct-19	Raising the importance of good quality medical records throughout the Health Board;	High	In 2014, we found that the quality of medical records across the Health Board was not of a good standard, with key information required for accurate clinical coding often missing or inappropriately filed. Our work has found that there continues to be issues with the quality of medical records within the Health Board. In 2018, NWS produced a report into clinical coding documentation. This review was undertaken as part of ongoing service improvement work to improve the quality of clinical coding data. The primary aim of this review was to assess the quality of the clinical documentation held within case notes. Overall administrative documentation was of good quality, but there were issues with loose paperwork and records being filed out of order. There were also issues with deceased notes and unplanned admissions. The quality of information for coders in the notes was poor. Only half of the clinical entries contained a diagnosis and of these, a third would be unable to be used for coding purposes. This report highlights that there are issues that need to be addressed by the Health Board. In our 2014 report, we noted the re-establishment of the Health Records Committee. The aim of this was to give the necessary focus to the quality of medical records to enable coders to code accurately. However, this Committee was disbanded in August 2017 and we are unaware of any new arrangements in place to monitor and ensure the quality of medical records.	Director of Digital		Not specified by the Health Board	October 2020 April 2021 Now March 2022 Now June 2022 Now October 2022 Now October 2023	In progress	December 2022 Update: External Review of Medical Records took place between 14 and 18 November 2022 as planned. Report due on 7 December 2022. On track to meet completion in October 2023 as outlined in the October 2022 update.	Update January 2020 The completeness of the documentation is the responsibility of multiple staff groups across the hospital sites. Both the content and quality of the record will be improved through the plans now being implemented to commence digitisation in November 2019. This process will reduce the risk of documents being lost from within the record as they will be scanned and held digitally. E-forms will also be introduced to capture information electronically, live at the point of care. These forms will be structured and will require the clinical user to provide answers to mandatory or questions and use standard terminology through the use of drop-down menus. This should aid completeness and accuracy, as well as legibility of information captured. Digitisation of the critical mass of active patients is expected to take 2 years to complete, but improvements will begin for individual patients from the point of go-live. Rollout of e-form development is planned to commence in April 2020 and this will involve a development programme gradually converting existing paper forms to e-forms. Work will be done to identify those which are highest priority for development, but this is likely to target the highest volume and least complex forms in the first stages. These measures will assist in regards to the completeness of the record and the timely availability of information. Greater focus is needed on every aspect of medical records management, which is clinically led and an organisation wide. November 2020 Update - The completeness of the documentation is the responsibility of multiple staff groups across the hospital sites. Both the content and quality of the record will be improved through the plans to commence digitization, which have been delayed due to COVID-19 until 2021. This process will reduce the risk of documents being lost from within the record as they will be scanned and held digitally. However it will not improve the quality of the case note itself without additional steps being taken prior to digitisation. E-forms will also be introduced to capture information electronically, live at the point of care. These forms will be structured and will require the clinical user to provide answers to mandatory questions and use standard terminology through the use of drop-down menus. This should aid completeness and accuracy, as well as legibility of information captured. Digitisation of the critical mass of active patients is expected to take 2 years to complete, but improvements will begin for individual patients from the point of go-live. Rollout of e-form development has also been delayed until 2021. This will involve a development programme gradually converting existing paper forms to e-forms. Work will be done to identify those which are highest priority for development, but this is likely to target the highest volume and least complex forms in the first stages. These measures will assist in regards to the completeness of the record and the timely availability of information. January 2021 Update In response to internal findings from 2014 in relation to the quality of medical records and the NWS 2018 report looking into the quality of clinical coding documentation, the Clinical Coding department has employed a coding trainer who will implement a coding education and engagement plan. The plan will cover areas such as the training of trainee coders on how to extract clinical information from health records and building/developing working relationships with staff across the UHB to improve on the quality and availability of the case notes. The CTIO software planned for implementation in early 2021 will provide clinical coding colleagues with real-time, single-view access to critical patient information on demand. Staff who were initially involved in the project are currently being invited to reconnect and to promote awareness of the project and its benefits among their colleagues. Terms of reference are currently being drafted for a Performance and Clinical Information Strategy Group (PCISG), the group among other functions will provide a forum for stakeholders to collaborate, monitor and address issues relating to clinical data quality. These are actions that the P&I Directorate can take forward, however we are eagerly anticipating any update as to what potential role a Health Records Committee or alternative plan will have on the quality of medical records within the UHB. May 2021 - No further update to report. July 2021. Information on this recommendation has been received and will be escalated to the ILGs for comment next quarter. Revised implementation date not provided. September 2021 Update. All of the processes previously described are still ongoing, including an aspect of training in the Junior Doctor Induction Course. Query has gone to Medical Records Manager as within ILGs at present it seems that this has not received significant management focus. Once the current wave of covid has passed then the allocation of time will be more possible. November 2021 Update - Processes are still ongoing and the date for completion remains March 2022. February 2022 Update. A response will be available at the next meeting - plan in place to meet the Manager for Medical Records in the next month. Target remains March 2022. April 2022 Update - nothing further in this month - will be chased again in the coming	
Clinical Coding Follow Up Review 03	Oct-19	Developing a programme of routine audits of medical records to provide assurance that the quality of medical records is improving;	Medium/ Low	The quality of the patient record has a direct impact on the coders ability to undertake their role. As highlighted previously, work by NWS into the quality of documentation highlighted concerns with loose paperwork, and the filing of deceased patient records. As part of the annual clinical audit and effectiveness plan, there is currently a Health Board wide audit of the quality of case notes. This audit is looking at documentation in case notes and is aligned to the health records committee, however this committee has been disbanded so we are unsure where the results of this audit are reviewed. The current audit plan shows that this audit was also undertaken last year but there is no record of the report. The results of the current audit are due for publication in March 2019.	Director of Digital		Not specified by the Health Board	October 2020 November 2021 Now June 2022 Now October 2022	In progress	October 2022 Update: Propose to close - processes are now in place to monitor the quality of the record and this progress is reported to the Digital Patient Notes Programme Board, the Information Governance Group and the Digital & Data Committee. December 2022 Update - It has been proposed that this recommendation remains open pending discussions between Audit Wales and the Director of Digital.	Update January 2020 The content and the quality of the Health record is the responsibility of all clinical users adding information to the record and this is monitored and reported by the Clinical Audit team. This is emphasised within staff induction programmes where the importance of accurate Health Records and the impact on Clinical Coding is noted. The Management Board have approved additional resource to recruit a Clinical Coding Auditor/Trainer and our stated intent within our IMTP is to take this action forward utilising this much needed resource. November 2020 Update - this audit work was previously undertaken by the Clinical Audit Department. They may be able to provide an update for this purpose. It was reported at the Health Records Committee but may be reported elsewhere as well. The Committee was not responsible for acting on this report. January 2021 Update The UHB Clinical Audit Team (CAT) currently undertake an annual audit of the quality of case notes which looks at the documentation in case notes and is aligned to the Health Records Committee (HRC) which no longer exists. The Performance and Clinical Information function will shortly begin conversations around areas of overlap between the HRC and PCISG. The outcome of which will inform which group will provide oversight and assurance responsibilities in relation to the results of CAT medical records quality audit. The newly appointed clinical coding trainer has previous experience with auditing and will be undertaking internal coding audits as a part of her responsibilities. The results of these internal coding audits will be made available to the leadership of the Performance and Information (P&I) Directorate and the relevant oversight and assurance groups. May 2021 - No further update to report. July 2021. Information on this recommendation has been received and will be escalated to the ILGs for comment next quarter. September 2021 Update. The Clinical Audit Team will be undertaking a documentation audit of both acute and community case notes during October / November 2021 using AMA1 (audit management software) to support the data capture. Clinical Audit facilitators will be taking a random sample of case notes to retrospectively conduct the audit and report publication is planned for the end of November. November 2021 Update - nothing further to report at this meeting. February 2022 Update. A response will be available at the next meeting - plan in place to meet the Manager for Medical Records in the next month. April 2022 Update - Nothing further in this month - will be chased again in the coming month. Pressure of work at present is significant. June 2022 - Update Will be available for August 2022. August 2022 - nothing further to report.	
Audit of Accounts Addendum 2020/2021 02	Aug-21	The Health Board should review its governance and procedures in place for the appointment of senior officers, and as part of the review ensure that it fully understands the extent of WG's delegated authority to the Health Board, and importantly, the decisions that WG has not delegated. The Health Board should ensure that minutes, particularly those of the Remuneration Committee, are clear. For example, minutes should make a clear distinction between when the Remuneration Committee has approved (or rejected) a business case; and when it has endorsed (or not endorsed) a business case that then needs the approval of the WG. In respect of retire and return cases, the Health Board should ensure that it has appropriate procedures in place for the consideration and approval/ rejection of business cases. The Health Board should record the process contemporaneously and provide accurate information to the payroll department.	Medium/Low	There is a context to the DoTHS delay, for example, which is that the situation was novel, and required Welsh Government banding for a new joint role, which took some time.	Director for People		Immediate	Now August 2022 Now October 2022 Now December 2022 Now March 2023	In Progress	December 2022 update - This policy work is now being taken forward in partnership with trade unions and OD colleagues to ensure the processes become fully embedded and enable employees and their managers to fully explore all flexible retirement options not just retire and return. It is anticipated that this work will be completed by March 2023.	September 2021 - No update received. November 2021 - No further update provided. April 2022 - The Health Board has reviewed its governance and procedures in place for the appointment of senior officers. The governance arrangements understands the extent of WG's delegated authority to the Health Board, including the decisions, which WG has not delegated. The Health Board's Retire and Return Policy is currently subject to review and will be discussed at the Workforce Policy Review Group on the 21 April 2022, prior to organisational wide consultation. The Policy will ensure appropriate procedures are in place for the consideration and approval / rejection of business cases. The Policy will be presented to the August 2022 People and Culture Committee for approval. June 2022 Update - The Health Board's Retire and Return Policy is currently subject to review and was discussed at the Workforce Policy Review Group on the 21 April 2022. The policy is now out to organisational wide consultation. The Policy will ensure appropriate procedures are in place for the consideration and approval / rejection of business cases. The Policy will be presented to the August 2022 People and Culture Committee for approval. August 2022 Update - The CTM Retire and Return Policy was not endorsed to be presented to the People and Culture Committee in August 2022 for approval, as the partnership WPRG agreed further work was needed to align to the policy to the additional NHS flexibilities options, which permits employees to access their NHS Pension without retiring. It has been agreed to the LPF will endorse the policy to be approved by the People and Culture Committee via Chair's action in advance of the November 2022 meeting. October 2022 Update - further to partnership discussions with Trade Union Colleagues, it has been agreed that this guidance requires further implication and incorporate clear justified business reasons for approving or rejecting applications based on the employee's retirement plans and the needs of the service. Extensive work has been undertaken to make the guidance fit for purpose. The group will also engage with OD to facilitate the cultural changes required, to ensure managers are aware of the benefits to the organisation of approving such requests. It is anticipated this guidance will go back to the LPF in December 2022 for endorsement and approval will be sought via Chair's action.	

Ref	Date added	Recommendation	Priority	Management Action Agreed	Responsible Executive Lead	Responsible Management Lead	Original Agreed Implementation Date	Revised Implementation Date	Status	Progress	Updates During this period/latest update	Previous Updates
Audit Wales/HI W Quality Governance Follow Up Review R1	Aug-21	The Health Board must agree organisational quality priorities and outcomes to support quality and patient safety. This should be reflected within an updated version of the Health Board's Quality Strategy.	High	Organisational quality priorities are expressed within the CTMUHB Annual Plan and IMTP for 2020-23 (see R2) It is anticipated that the Quality Priority Strategy will align to the organisational strategy work. The AMD for Quality is leading on this supported by Assistant Director of Quality, Safety and Patient Experience. The quality strategy is being progressed and the quality priorities have been published in the QGF. The QGF will be updated to reflect and align with the overall HB strategy once published. Success will be measured by the connection of the strategy to the everyday function of the HB – through our agreed quality governance architecture, quality metrics and performance, and in the experience of our staff and patients – connecting us to the overall vision and demonstrating how the thread provides connectivity to understanding the reason for our work.	Director of Nursing		Nov-21	01/06/2022 Now August 2022 Now September 2022 Now November 2022		Completed	December 2022 Update - The Quality Strategy was presented to Q&SC and signed off. It is currently in its final stages of preparation for translation and print.	September 2021 - No update received. November 2021 - No further update provided. January 2022 update In light of the recent publication of the National Quality & Safety Framework the organisation has undertaken a gap analysis and has presented the findings to the Quality & Safety Committee in December 2021. Timescales were agreed for a revised Quality and Safety Governance Framework to be presented to the Quality & Safety Committee in March 2022. The delivery of the Quality Strategy has been hampered by the delay of the organisational strategy work which is key to ensure alignment of both strategies. A first iteration of a draft Quality Strategy has been completed with work ongoing with a timescale for completion of end May 2022. Update April 2022 - Timescales were agreed for a revised Quality and Safety Governance Framework to be presented to the Quality & Safety Committee in March 2022 - this has been delayed by the proposed new operating model for the organisation to July 22. The delivery of the Quality Strategy has been hampered by the delay of the organisational strategy work which is key to ensure alignment of both strategies. A first iteration of a draft Quality Strategy has been completed with work ongoing with a timescale for completion of end May 2022. June update: Draft Quality Strategy is being further progressed with its status being at the pre engagement with stakeholders position. Internal and external stakeholders to be engaged with virtually to progress. Final draft Quality Strategy to be presented to July 2022 Quality & Safety Committee. July 2022 Update - Quality Strategy is in the stakeholder engagement phase and will be presented as a completed draft to Board in September 2022. October 2022 Update-further development work has taken place on the Quality Strategy following feedback on draft priorities. Draft priorities taken to Exec-led Pt Safety meeting, ELG, Q&S Committee, and stakeholder engagement sessions. A draft version of the strategy is being reviewed by the Executive Director of Therapies & Health Science week commencing: 10/10/22, with a plan for final review and sign off via Q&SC in November 2022
Audit Wales/HI W Quality Governance Follow Up Review R2.3	Aug-21	The Health Board needs to take a strategic and planned approach to improve risk management across the breadth of its services. This must ensure that all key strategies and frameworks are reviewed, updated and aligned to reflect the latest governance arrangements, specifically: a- The BAF reflects the objectives set out in the current IMTP and the Health Board's quality priorities b- The risk management strategy reflects the oversight arrangements for the BAF, the quality and patient safety governance framework and any changes to the management of risk within the Health Board c- The quality and patient safety governance framework must support the priorities set out in the Quality Strategy and align to the values and behaviours framework	High	The Health Board's overarching quality priorities published within the IMTP/Annual Plan for 2020-23 are as follows: • Strengthened focus on quality on strategic planning; • Individuals' voices are better heard; • Shared learning and continuous quality improvement; • Risk better articulated, shared and mitigated; • Strengthened two-way 'point of service delivery' to Board slight; and • Extensive review and improvement of the management of concerns and serious incidents. Review of the Quality Governance Framework to reflect the developed quality strategy and enhanced governance processes within ILG's. The revised framework will provide improved granular detail in respect of ILG governance that wasn't available at the previous refresh in November 2020. System testing through attendance at CSC/ILG Q&PSE governance meetings will be introduced for evidence/assurance that the framework is embedded.	Director of Nursing		Dec-21	01/03/2022 Now June 2022 Now December 2022		In Progress	December 2022 Update - The Quality & Safety Framework first draft will be available end of December 2022. Quality Strategy update as in R1.	September 2021 - No update received. November 2021 - No further update provided. January 2022 update As detailed above in R1, a revised Quality & Governance Framework will be presented to the Quality & Safety Committee in March 2022. Update April 2022 - Timescales were agreed for a revised Quality and Safety Governance Framework to be presented to the Quality & Safety Committee in March 2022 - this has been delayed by the proposed new operating model for the organisation to July 22. The delivery of the Quality Strategy has been hampered by the delay of the organisational strategy work which is key to ensure alignment of both strategies. A first iteration of a draft Quality Strategy has been completed with work ongoing with a timescale for completion of end May 2022. There is an ongoing internal audit commissioned of governance processes at service group level to inform the new Governance Framework, the audit team are currently undertaking fieldwork within 3 service groups and the results of this work will lead the design of the new framework granularity of ward to board assurance. July 2022 Update - The Quality & Patient Safety Governance Framework will be revised following implementation of the new operating model. Proposed first draft December 2022. Internal Audit Assurance report of our governance function with in the ILGs reviewed as providing reasonable assurance obtained overall and areas with substantial assurance, demonstrating our positive mechanisms for oversight, escalation and risk. We have a number of key matters arising from the audit which need addressing however with the new operating model I'm sure these are elements we can pick up/incorporate into the new operation model to provide assurance on all CSG's. October 2022 update - Quality Strategy update as above ref:R1. Quality goals and objectives within the strategy align with other key Health Board strategies and frameworks.
Audit Wales/HI W Quality Governance Follow Up ReviewR3.5	Aug-21	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	High	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.	Director of Nursing		Oct-21	Now June 2022 Now October 2022		Completed	December 2022 Update - The Quality Dashboard report to Q&SC continues to provide information and assurance on the breadth of health boards services and performance with spotlight focus on issues of concern to the Board. It is anticipated within the new operating model structure that in addition to the overarching report, each Care Group will be invited to present Q&PSE reports in turn to Q&SC to provide enhanced granular assurance.	September 2021 - No update received. November 2021 - No further update provided. January 2022 update Quality Dashboard and new metrics agreed at Quality & Safety Committee and presented at each meeting. Work continues in relation to developing population outcomes measures linking with the organisational outcome strategy work. Benchmarking opportunities across Wales remains limited. ILG performance meetings include a section on Quality & Safety metrics led by the Executive Nurse Director. Update April 22. Quality metrics and template reporting agreed by ILG Q&PSE and data team to ensure that Q&SC receive a robust, consistent measure across the HB. The NHS Delivery Unit are developing their quality & patient safety dashboards to permit a greater ability to benchmark across the organisations, as well as sharing and learning opportunities. July 2022 Update - ILG's present an agreed consistent set of Q&S metrics to committee and Boards. An overarching report is produced by the central team to illustrate themes and trends, hot spots and analysis. This will need refining within the new organisational model to maintain good line of sight on services. Further development of the data is planned to improve understanding, target and trajectory setting, bed days etc. The DU dashboards are included in the Q&SC quality dashboard report. OFW incident module functionality has been implemented since April 22. October 2022 Update - No further update provided on this occasion
Audit Wales/HI W Quality Governance Follow Up ReviewR3.6	Aug-21	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	High	As indicated above development of the Quality Strategy will commence at pace and align with the organisational strategy as it becomes available.	Director of Nursing		Nov-21	Now July 2022 Now August 2022 Now September 2022 Now November 2022		Completed	December 2022 Update - Quality Strategy complete (R1). Greater articulation and clarity in relation to responsibilities will be provided within the Q&S Framework.	September 2021 - No update received. November 2021 - No further update provided. January 2022 update-AS ABOVE. April 22 - The delivery of the Quality Strategy has been hampered by the delay of the organisational strategy work which is key to ensure alignment of both strategies. A first iteration of a draft Quality Strategy has been completed with work ongoing with a timescale for completion of end May 2022. June update: Draft Quality Strategy is being further progressed with its status being at the pre engagement with stakeholders position. Internal and external stakeholders to be engaged with virtually to progress. Final draft Quality Strategy to be presented to July 2022 Quality & Safety Committee. July 2022 Update - Quality Strategy is in the stakeholder engagement phase and will be presented as a completed draft to Board in September 2022. October 2022 update-Quality Strategy update as ref:R1. Clinical Executive Director attendance at weekly Patient Safety Meeting.
Audit Wales/HI W Quality Governance Follow Up Review R6.1	Aug-21	There needs to be sufficient focus and resources given to gathering, analysing, monitoring, and learning from patient experience across the Health Board. This must include use of real-time patient feedback.	High	Health Board purchased CIVICA (captures population feedback using a patient insight software platform)	Director of Nursing		Jul-21	Now December 2021 Now July 2022 Now March 2023		In Progress	December 2022 Update - There are still barriers in place within IT infrastructure support to progress the automation element of civica via sums. To ensure that feedback is received the team are looking at different mechanisms to ensure feedback is collated. Have your say cards are being completed and forwarded across to the civica team to upload on the system however this is limited due to staffing. Civica team are reviewing the equipment/boxes that are on sites across CTM to facilitate the collection of feedback to ensure these are in place. Pilot of volunteer patient feedback team is due to start in POW in December 22.	September 2021 Update - CIVICA PM appointed and produced timeline for roll out within CTM. 'Have your Say' generic people's feedback being placed as a link on the CTMUHB intranet page. Plan for Draft People's Engagement document by December 2021. Nov 21 Update - Pilot of Value Based Healthcare PROMs have gone live in Cardiology along with the launch of PREMIS and workforce reported experience measures (WREMS). Jan 2022 Update: Problems seen in automating Civica to CTM patients via SMS due to IT resource issues. Business Case is being completed to request additional resource for this. 2x kick start admin support officers to start Feb 2022 to help support the team and gather additional data collection from patients that are not digitally enabled and support in reporting and setting up/ maintenance of surveys within the system. Currently scoping out iPad within CTM to rollout the Civica App onto all service user groups for the Have your say survey and any bespoke surveys requested. Training has been provided to various user groups and set up on the system throughout Oct- Dec. Additional training days will be given from Feb 2022 onwards. Delays have been seen due to COVID-19. April 2022 Update - The Health Board launched the electronic 'Have your Say' and Generic Patient Experience Survey on the 13.02.22. Posters containing QR codes are displayed on notice boards in our hospital sites, KHHP and Dewi Sant. In addition links are available on our internal and external webpages, along promotion on available social media channels. A small card (like a business card) containing a QR code has been developed which will displayed in main thoroughfares such as Emergency Departments, Outpatients and community settings. They will be made available to staff that are providing services in patient's homes. Exploration is taking place as to how the posters/cards can be promoted within the wider non-health board community settings. From the 28.02.22, within the Bridgend and Merthyr & Cynon Localities, the PALS team are actively engaging with patients/ service users to promote the completion of the 'have your say' cards and generic survey. This is through paper copies being available in areas, which are collated and uploaded on to the system on a monthly basis. Along side this, within Merthyr & Cynon PALS Officers are present with Emergency Department at PCH and outpatients at YCC to capture feedback via iPADS. The number of area specific surveys continues to increase, with Staff engaging with patients and service users via links, QR codes and iPADS. June 2022 Update: To date CTM have received 2050 responses, has 18 active surveys, 10 surveys set up and 2 surveys closed on the system. There are 5 automated SMS surveys set up within the system and 33 active discussion with other service user groups within CTM. Work continues to promote the CIVICA system with patients and staff via social media and intranet pages. Number of specialities engaging with the team to explore the use of this system is increasing and there is evidence for staff use planned for June/July across other to demonstrate UPDATE SEPT 21. There have been 3 Shared Listening and Learning Forums since they were created. Prior to the next planned forums there is an opportunity to review the ToR for this forum to ensure it is delivering on the overall aim of shared learning across CTM UHB. There is an Executive commitment to develop a CTM UHB Learning Framework by the end of the year of which the Shared Listening & Learning Forum will form one vehicle for dissemination of learning. November 2021 - No further update provided. January 2022 update The organisations Listening & Learning Framework has been shared for consultation. A quarterly Shared Listening & Learning Forum is in place with key membership from across the central team and ILGs. April 22 - The Listening & Learning Framework had developed and will embark on next steps during May 22 comprising of a serious of engagement workshops to ensure that this is a cross organisational system that will ensure that our workforce learn and improve in a way that is relevant and easily accessible to them. July 2022 Update Listening & Learning Framework has been further developed and will be completed in draft for the September Q&S committee. A Listening & Learning Event is planned for September 2022 to facilitate the launch of the framework and share organisational good practice. October 2022 update: The Health Board has launched its Listening and Learning Framework in September 2022. This demonstrates how learning will be identified, triangulated, disseminated and implemented in practice to facilitate and embed a culture of appreciative enquiry and continually improving health care services and the experience of our workforce. The Listening & Learning Framework recognises that the Care Groups and Clinical Service Groups and Corporate Functions have internal governance and learning structures. This Framework, therefore, seeks to complement and build on these arrangements by adding a strategic approach to support the organisation to listen and learn lessons from a range of internal and external sources, to record, store and use this learning to share knowledge, shape change and create opportunities to develop excellence in practice. A Learning repository has been developed on SharePoint and is currently focussing on collecting learning from frequently occurring patient safety incidents. Inputting evidence will be applied in a phased approach and based on themes and trends arising from incidents and concerns, as well as evidence of good practice and improvement activities. A quality assurance process is in place to ensure the learning undertaken is
Audit Wales/HI W Quality Governance Follow Up Review R6.3	Aug-21	There needs to be sufficient focus and resources given to gathering, analysing, monitoring, and learning from patient experience across the Health Board. This must include use of real-time patient feedback.	High	Webpage on SharePoint set up to support learning & excellence across Health Board. Development of a social media site for the L&LF to use analytics on the social media and SharePoint site to explore the extent of colleague engagement and posting. Feedback from participants will be analysed in relation to what they have learned and how this has impacted upon their practice. For the medium and longer term would expect to see learning and improvement being applied in the workplace through our established quality metrics and patient experience feedback.	Director of Nursing		Jul-21	Now May 2022 Now September 2022 Now December 2022		Completed	December 2022 Update - This action is complete	

CTM
Internal
[date]

Red -
Orange -
Yellow -
Green -
Blue - Action

Ref	Date added	Recommendation	Priority	Management Action Agreed	Responsible Executive Lead	Responsible Management Lead	Original Agreed Implementation Date	Revised Implementation Date	Status	Progress	Updates During this period/latest update	Previous Updates
Audit Wales/HI W Quality Governance Follow Up Review R8.2	Aug-21	The Health Board needs to clarify accountabilities and responsibilities for quality and patient safety within directorates. This must include a review of the Heads of Nursing role in relation to site management and quality and patient safety.	High	There is still work ongoing however with the progress at the pace it is, the quality & safety system is becoming more robust daily. Within 3 months the processes will be embedded fully across CTM.	Director of Nursing		Mar-22	Now end of May 2022 Now December 2022 Now January 2023		In Progress	December 2022 - No further update against this action.	September 2021 - No update received. November 2021 - No further update provided. January 2022 Update Quality Plans, Quality Control and Quality Assurance have all now been agreed by Board resulting in the next phase of the maturity framework. Any service changes are now required to have a EQIA and depending on the outcome score of the EQI assessment will determine the sign off process by the Medical/Nurse Director. April 2022-Update Board self assessment of Quality Governance Maturity matrix for 28th April 2022-The Director of Nursing will recommend to the Board the results for Quality Planning, Quality Assessment and Quality Assurance. Quality Safety and Patient Experience forums now feature across all Clinical Service Groups. August 2022 Update - Safe 2 Start' daily meetings are now embedded across the 3 acute hospital sites. Attendance includes, Head of Patient Flow, Head of Nursing, Ward Managers, Lead and Senior Nurses. The aim of the meeting is to provide a staffing position for the day within the hospital, it focuses on Emergency Department demand and key quality and safety metrics relating to patient care. The 2 community hospital sites also undertake a daily Safe 2 Start meeting chaired by the Senior Nurses and this information feeds into the overarching HB daily planning and escalation. From a strategic perspective, in relation to the changes in the organisational operating model this requires a review of the governance framework to confirm arrangements for quality governance and patient safety within the Care Group Structure, there is an anticipated completion date of December 2022. October 2022 Update- The health board continues to make changes in respect of its new operating model which includes quality governance and patient safety arrangements for CSG's and the Care Groups they sit within. Each Clinical Service Group will have a standardised assurance framework in place to describe how floor to board assurance is articulated within services, as well as standardised tools for annual work plans, quality assurance of incident management & investigation. Terms of Reference/Agenda for Quality, Patient Safety & Patient Experience Meetings and arrangements for shared learning i.e. medicines safety, falls. Listening & Learning next event planned for March 23 with the theme of learning from external reviews.
Audit Wales/HI W Quality Governance Follow Up ReviewR8.6	Aug-21	The Health Board needs to clarify accountabilities and responsibilities for quality and patient safety within directorates. This must include a review of the Heads of Nursing role in relation to site management and quality and patient safety.	High	Quality Governance Framework to reflect enhanced governance processes	Director of Nursing		Dec-21	01/03/2022 Now June 2022 Now December 2022 Now January 2023		In Progress	December 2022 Update - Listening & Learning Framework launched. Repository of Learning in place and accepting themed learning i.e. medicines safety, falls. Listening & Learning next event planned for March 23 with the theme of learning from external reviews.	September 2021 - No update received. November 2021 - No further update provided. January 2022 update please cross reference with R1 A revised Quality and Safety Governance Framework is to be presented to the Quality & Safety Committee in March 2022. Update April 2022 - Timescales were agreed for a revised Quality and Safety Governance Framework to be presented to the Quality & Safety Committee in March 2022 - this has been delayed by the proposed new operating model for the organisation to July 22. The delivery of the Quality Strategy has been hampered by the delay of the organisational strategy work which is key to ensure alignment of both strategies. A first iteration of a draft Quality Strategy has been completed with work ongoing with a timescale for completion of end May 2022. There is an ongoing internal audit commissioned of governance processes at service group level to inform the new Governance Framework, the audit team are currently undertaking fieldwork within 3 service groups and the results of this work will lead the design of the new framework granularity of ward to board assurance. July 2022 Update - The Quality & Patient Safety Governance Framework will be revised following implementation of the new operating model. Proposed first draft December 2022. Internal Audit Assurance report of our governance function with in the ILGs reviewed as providing reasonable assurance obtained overall and areas with substantial assurance, demonstrating our positive mechanisms for oversight, escalation and risk. We have a number of key matters arising from the audit which need addressing however with the new operating model I'm sure these are elements we can pick up/incorporate into the new operation model to provide assurance on all CSG's. October 2022 update: The health board continues to make changes in respect of its new operating model which includes quality governance and patient safety arrangements for CSG's and the Care Groups they sit within. Each Clinical Service Group will have a standardised assurance framework in place to describe how floor to board assurance is articulated within services, as well as standardised tools for annual work plans, quality assurance of incident management & investigation, Terms of Reference/Agenda for Quality, Patient Safety & Patient Experience Meetings and arrangements to share learning. Upward reporting and monitoring through to the Care Group will be based on agreed quality indicators, informed by work plans and a common reporting framework. These arrangements will be articulated in the revised Quality & Safety Framework due for publication in December 2022. In addition to the comments above in relation to the Quality & Safety Framework and Quality Governance Plans for the CSG's and Care Groups, the Health Board has launched its Listening and Learning Framework in September 2022. This demonstrates how learning will be identified, triangulated, disseminated and implemented in practice to facilitate and embed a culture of appreciative enquiry and continually improving health care and the experience of our patients.
Audit Wales/HI W Quality Governance Follow Up Review R10.1	Aug-21	The Health Board must ensure there are clear and comprehensive risk management systems at directorate and corporate level, including the review and population of risk registers. This should include clarity around the escalation of risks and responsibilities at directorate and corporate level for risk registers. This must be reflected in the risk strategy.	High	Risk Training: including the development of a Training Needs Analysis (TNA) in line with All Wales developments, dissemination of the TNA across the Health Board, new risk training programmes which are aligned to the new TNA.	Director of Corporate Governance	Assistant Director of Governance & Risk	Oct-21	Now December 2021 Now April 2022 Now October 2022 Now 31 December 2022 Now 31 March 2023		In Progress	December 2022 Update - This recommendation is dependent on the implementation of the OFW Risk Module as the intention is that the training will include how to undertake a risk assessment utilising the risk module on Datix. The pace of implementation on the new module has slowed and therefore the work in this activity has not been progressed. A meeting has been scheduled in early December with a small cohort of risk leads across NHS Wales and the OFW System Lead to undertake some work on the progress of the module developments. A further update will be available following this meeting with a greater insight into an anticipated implementation date. In the meantime monthly training continues with sessions booked in for the remainder of 2022 and 2023. In the meantime the revised Risk Assessment Procedure which is planned for approval in December 2022 strengthening the process for risk and training opportunities.	September 2021 - No update received. November 2021 - No further update provided. January 2022 Update - The Training Needs Analysis is complete, however, the Assistant Director of Governance & Risk is working with peers across NHS Wales to develop Level 1 - 3 Risk Training packages available on the ESR E-Learning platform. Level 1 is currently with ELearning Teams to finalise and Level 2 development has been commenced. An extension to the implementation date is requested to allow for the launch to coincide with the training packages being made available on E-Learning on an All Wales Basis. The Health Board is working with All Wales colleagues to ensure a consistent approach to risk is adopted and transferable across Wales. November 2021 - The Training Needs Analysis is complete, however, the Assistant Director of Governance & Risk continues to work on an All Wales basis to develop Level 1 - 3 Risk Training packages available on the ESR E-Learning platform. Level 1 is currently with ELearning Teams to finalise and Level 2 development has been commenced. Update January 2022 The TNA and development of an All Wales Risk Management Training package has been placed on hold whilst the Once For Wales Risk Management Module is finalised. The rationale for this decision is to ensure that any training developed is aligned to the new module that staff will be expected to use. The Health Board is represented on the Once For Wales Monthly Meetings and the more regular task and finish group meetings. In the meantime, risk management training continues within the Health Board with monthly sessions being held virtually over Teams. April 2022 Update - The implementation of the Once For Wales Risk Module within the Health Board is anticipated circa October 2022, with two pilot sites going live from the 1st April 2022. The All Wales Training Modules are being developed to align with the new approach and timescales. The TNA has been finalised and Module 1 of the training is in draft. Progress is monitored via the OFW Risk Module Meetings and the All Wales Risk Community of Practice for which the Assistant Director of Governance & Risk is a member. June 2022 Update - On track. Risk Training continues to be rolled out to service areas on a monthly basis in partnership with ILG colleagues. August 2022 Update September 2021 Update - The Assistant Director of Governance Risk represents the Health Board on the All Wales working group for the new risk module and will review the risk management system and processes to align with the new system as it develops. Update January 2022 The Once For Wales Risk Management system is likely to be piloted in two sites prior to implementation across NHS Wales as a whole. As the Health Board is implementing the Incident Module in April 2022 it is anticipated that the OFW Risk Module will be implemented in the Health Board by the end of October 2022. An implementation plan will be developed in conjunction with the Health Board's internal Datix Team. The Health Board is represented on the Once For Wales Monthly Meetings and the more regular task and finish group meetings by the Assistant Director of Governance & Risk. April 2022 Update - The implementation of the Once For Wales Risk Module within the Health Board is anticipated circa October 2022, with two pilot sites going live from the 1st April 2022. The Health Board is represented on the relevant groups by the Assistant Director of Governance & Risk. June 2022 Update - Progressing on an All Wales basis. Implementation dependent on roll-out of risk module in Once for Wales. August 2022 Update Please refer to the update in R10.1 in relation to the position on the OFW Risk Module Implementation. In the absence of the new module the Health Board continues to mandate the currently risk module available via Datix for the management of Risk as outlined in the Health Boards Risk Management Policy, Strategy and Procedure. Within those documents is the clear process for assessing risk and escalation. October 2022 Update - This recommendation has been aligned to the implementation of the Once For Wales Risk Module to ensure that new training module September 2021 Update - Development of Framework for Learning will support this. November 2021 - Learning Framework under development, and review of assurance meetings to support across-organisational learning feeding into the review of the Health Board Operating Model. Timescales likely to slip due to the engagement on any potential changes to the Operating Model. Process for sign-off of LFERs being reviewed in line with the recommendations of the WRP Review (11.3 above). Update February 2022 - Learning Framework DRAFTED and out for consultation. Meetings arranged to discuss LFER responsibilities and monitoring with ILG triumvirate. Invites extended to Claims team to meetings with ILGs and CSGs. Weekly updates being collated and monitored on historical LFERs. LFER list all currently being transferred onto Datix IQ. Continued engagement with WRP in respect of improvement plan following the WRP review. Update April 2022 - LFER SOP developed and shared with ILGs/CSGs. All LFER reports now transferred onto Datix IQ. Issues discovered in relation to being Amber/Red Deferred cases. Therefore an internal spreadsheet tracker has been developed. This clearly identifies what LFERs are outstanding by ILG and CSG. Graphs developed with a target line to ensure ILGs are on track to meet the target. The first target was 44 by 1st April 2022 - We hit 40, with a further 4 submitted shortly thereafter. June 2022 - The Datix team and the Once for Wales team will be shortly moved into the Director of Corporate Governance's portfolio, with the OFW project coming to an end which will be subsumed into the day to day Datix management. Work continues in respect of LFERs with targets for historic cases and newly triggered cases not being met. Monitored and escalated to Executives every week. SBAR drafted with plan of action to ensure ownership and accountability of learning. Essential that this is taken forward as any outstanding cases over 6 months old will be recommended for a permanent deferral and will serve as a blocker for any future payments within specific service areas. Plans in place to address back log and manage current workload to prevent adding to the pressures and workload, all dependent on resources realised from operating model review and implementation. July 2022 Update 2022 Update - The Datix Team and OFW CM Datix will move to the Director of Corporate Governance from 1st August 2022. The OFW National September 2021 - No update received. November 2021 - No further update provided. January 2022 update Patient Safety team have undertaken a review of all of the backlog of incident and risk stratified incidents of a serious nature as a priority for actioning. ILG Head of Quality & Patient Safety are now responsible for ensuring that the backlog of incidents are reduced; monitoring of the backlog of incidents is through the weekly Executive Director led Patient Safety meeting by means of the 'Quality & Safety At A Glance' report. April 22 - the central PS team are undertaking risk stratification, data cleansing, reassignment and housekeeping to closure of historic open serious incidents. This work has been completed within maternity and neonatal services. It is anticipated that the central team will work with the ILG governance teams to establish quality assurance and closure panels to ensure that all SI's are investigated and patients engaged with as well as any learning and PTR considerations are managed appropriately. June 2022 Update - The Datix Team are supporting the ILGs to review and close down outstanding incidents within the Health Boards Legacy system. A batch update exercise was completed on the 07.06.22 based on strict set of criteria and following a robust assessment of risk. Further work is being undertaken to identify areas of high risk that require additional targeted support and those that be included in themed closure. Reports are provided on a weekly basis providing detail on the number of open incidents by Locality, service group and handler. July 2022 Update A further batch updating of incidents within the legacy system was completed 14.07.22 based on a strict risk assessed criteria. Support continues to be provided to all areas in relation to open incidents both in the Health Board's legacy system and Datix Cymru. Weekly reports are provided to all areas in relation to their open incidents. October 2022 update: Incidents identified as requiring data migration are in the process of being migrated across to Datix Cymru. Further assessment will be undertaken on the 01.08.22 to determine the level of risk associated with those open incidents remaining in the system. Assessment undertaken on 01.08.22 and outlined in updated SBAR Report. Batch update undertaken on the 16.08.22 based on criteria outlined in SBAR report agreed by Exec Team 15.08.22. The remaining incidents require individual review. A process is in place for those relating to maternity.
Audit Wales/HI W Quality Governance Follow Up Review R11.5	Aug-21	The oversight and governance of DATIX must be improved so that it is used as an effective management and learning tool. This should also include triangulation of information in relation to concerns, at a directorate or corporate level, and formal mechanisms to identify and share learning.	High	Ensure LFERs have local ownership and are shared across the HB localities, identifying themes and trends.	Director of Nursing	Head of Concerns & Legal Services	Dec-21	February 2022 Now March 2022 Now December 2022		Completed	December 2022 Update - A data update and validation exercise has taken place in CTM in respect of LFERs. A reconciliation has taken place with WRP and CTM data, with these correlating for the first time, therefore giving confidence in the data. Better reporting and tracking is now in place. The launch of the new Incident Management Framework reinforces the need for learning and capturing of learning within Datix Cymru. This has been supported with various training from the Central Patient Safety Team, Claims team and OFWCHS Datix Team. The LFER SOP and How to Guide remains extant. Changes will be required to the SOP when the changes following the operational model review are implemented, this will have greater focus on the PSIMs facilitating completion of the LFERs. Issues discovered in relation to being Amber/Red Deferred cases. Therefore an internal spreadsheet tracker has been developed. This clearly identifies what LFERs are outstanding by ILG and CSG. Graphs developed with a target line to ensure ILGs are on track to meet the target. The first target was 44 by 1st April 2022 - We hit 40, with a further 4 submitted shortly thereafter. June 2022 - The Datix team and the Once for Wales team will be shortly moved into the Director of Corporate Governance's portfolio, with the OFW project coming to an end which will be subsumed into the day to day Datix management. Work continues in respect of LFERs with targets for historic cases and newly triggered cases not being met. Monitored and escalated to Executives every week. SBAR drafted with plan of action to ensure ownership and accountability of learning. Essential that this is taken forward as any outstanding cases over 6 months old will be recommended for a permanent deferral and will serve as a blocker for any future payments within specific service areas. Plans in place to address back log and manage current workload to prevent adding to the pressures and workload, all dependent on resources realised from operating model review and implementation. 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Audit Wales/HI W Quality Governance Follow Up ReviewR11.6	Aug-21	The oversight and governance of DATIX must be improved so that it is used as an effective management and learning tool. This should also include triangulation of information in relation to concerns, at a directorate or corporate level, and formal mechanisms to identify and share learning.	High	Review all backlog incidents to eliminate duplicates and ensure correctly identified/categorised.	Director of Nursing		Oct-21	Now 31 August 2022 Now December 2022 Now January 2023		In Progress	December 2022 Update - There are no incidents within the holding area of the Health Board's legacy system. A small number remain under investigation which relate to delays in treatment or admission. These are currently being reviewed. For all incidents identified as requiring migration to Datix Cymru, the exercise has been completed. In relation to new incidents reported within Datix Cymru, a detailed data validation process is being produced, to be fully implemented across the Health Board from the 01.01.23. In addition to this weekly audits of closed incidents undertaken by the Business Intelligence Team are to be introduced.	September 2021 - No update received. November 2021 - No further update provided. January 2022 Update - Linked to R12.1 above. November 2021 - Revised procedures for concerns handling and categorisation to support effective triage underway in response to IA Audit on Concerns. Training programme under development to support new approach and will include customer care training at induction as well as more focussed training on investigation and complex case handling. In response to the WRP Review, training for Board members will be arranged. Update February 2022 - Included in Improvement Plan as per R12.4 above. Update April 2022 - Pilot triage process underway, however, not using the ideal model for triage. Too early to determine effectiveness. It is hoped that on reviewing the operating model that triage can be built into the new central Governance model going forward. June 2022 - Resource for central triage team identified from new operating model, will need to be move forward imminently due to current vacancies and inability to recruit to vacant posts due to inherited historic budget overspend. Policies and procedures will be revised following operating model changes and once complaints manager is in post. July 2022 Update - Work continues on the new Operational model, this incorporates 3 complaints triage posts which will assist with managing complaints more effectively, promoting early resolutions where possible and appropriate. The centralisation of Quality & Safety (including complaints), will ensure a consistent approach to complaints management across the Health Board. The Complaints Manager post has been out to advert and will be recruited into imminently. This will be supported by a staff member returning from secondment. These are scheduled to take place in August. A key priority will be the review of policies and procedures once the new operational model has been implemented. The launch of the new Incident Management Framework and the training which is in place to support this covers a number of elements including family support, psychological safety, staff support, investigation, breach of duty, causation, redress, claims and learning from events reports, sharing of learning. October 2022 Update - Work continues on the new Operational model, this includes a central complaints resource as well as triage posts which will assist with managing complaints more effectively, promoting early resolutions where possible and appropriate. The
Audit Wales/HI W Quality Governance Follow Up Review R12.5	Aug-21	The Health Board must ensure staff receive appropriate training in the investigation and management of concerns. In addition, directorate staff need to be empowered to take ownership of concerns and take forward improvement actions and learning	High	CTM Improvement Team supporting Concerns Mapping identifying a consistent approach that can be applied across the Health Board. Outcome and implementation to be informed by the internal audit.	Director of Nursing	Head of Concerns & Legal Services	Mar-21	Now March 2022 Now December 2022 Now January 2023		In Progress	December 2022 Update - Work continues on the new Operational model, this includes a central complaints resource as well as triage posts which will assist with managing complaints more effectively, promoting early resolutions where possible and appropriate. The centralisation of Quality & Safety (including complaints), will ensure a consistent approach to complaints management across the Health Board. The Complaints Manager has recently commenced in the role and the Head of Concerns has returned from secondment. A key priority remains the review of policies and procedures once the new operational model has been implemented. The launch of the new Incident Management Framework and the training which is in place to support this covers a number of elements including family support, psychological safety, staff support, investigation, breach of duty, causation, redress, claims and learning from events reports, sharing of learning. This has commenced and is ongoing	September 2021 Update - Linked to R12.1 above. November 2021 - Revised procedures for concerns handling and categorisation to support effective triage underway in response to IA Audit on Concerns. Training programme under development to support new approach and will include customer care training at induction as well as more focussed training on investigation and complex case handling. In response to the WRP Review, training for Board members will be arranged. Update February 2022 - Included in Improvement Plan as per R12.4 above. Update April 2022 - Pilot triage process underway, however, not using the ideal model for triage. Too early to determine effectiveness. It is hoped that on reviewing the operating model that triage can be built into the new central Governance model going forward. June 2022 - Resource for central triage team identified from new operating model, will need to be move forward imminently due to current vacancies and inability to recruit to vacant posts due to inherited historic budget overspend. Policies and procedures will be revised following operating model changes and once complaints manager is in post. July 2022 Update - Work continues on the new Operational model, this incorporates 3 complaints triage posts which will assist with managing complaints more effectively, promoting early resolutions where possible and appropriate. The centralisation of Quality & Safety (including complaints), will ensure a consistent approach to complaints management across the Health Board. The Complaints Manager post has been out to advert and will be recruited into imminently. This will be supported by a staff member returning from secondment. These are scheduled to take place in August. A key priority will be the review of policies and procedures once the new operational model has been implemented. The launch of the new Incident Management Framework and the training which is in place to support this covers a number of elements including family support, psychological safety, staff support, investigation, breach of duty, causation, redress, claims and learning from events reports, sharing of learning. October 2022 Update - Work continues on the new Operational model, this includes a central complaints resource as well as triage posts which will assist with managing complaints more effectively, promoting early resolutions where possible and appropriate. The

CTM
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Red -
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Ref	Date added	Recommendation	Priority	Management Action Agreed	Responsible Executive Lead	Responsible Management Lead	Original Agreed Implementation Date	Revised Implementation Date	Status	Progress	Updates During this period/latest update	Previous Updates
Audit Wales/HI W Quality Governance Follow Up Review R14.5	Aug-21	The Health Board must develop a stronger approach to organisational learning which takes account of all opportunities presented through concerns, clinical audit, patient and staff feedback, external reviews and learning from work undertaken in the Princess of Wales hospital.	High	Implementation of PREMS and CIVICA system to gather data on patient experience to inform learning and service enhancement and improvement. Project has been initiated and Project Manager appointed.	Director of Nursing		Sep-21	Now December 2021 No revised date for completion provided - currently in discussion Now March 2023		Part Completed	December 2022 Update - There are still barriers in place within IT infrastructure support to progress the automation element of civica via sms. To ensure that feedback is received the team are looking at different mechanisms to ensure feedback is collated. Have your say cards are being completed and forwarded across to the civica team to upload on the system however this is limited due to staffing. Civica team are reviewing the equipment/boxes that are on sites across CTM to facilitate the collection of feedback to ensure these are in place. Pilot of volunteer patient feedback team is due to start in POW in December 22.	September 2021 Update - PREMS fully operational across maternity services. CIVICA PM appointed and produced timeline for roll out within CTM. 'Have your say' generic people's feedback being placed as a link on the CTMUHB intranet page. Plan for Draft People's Engagement document by December 2021. November 2021 - No further update provided. Jan 2022 update- Have successfully implemented 7x surveys for maternity, Have your say & patient experience survey across CTMUHB, 1x Heart Failure survey and 2x paediatrics surveys. Currently in the process of implementing surveys for therapies, pathology and frailty nurse services within Feb. Actively scoping out surveys within: Cancer services, community resource team, critical care HDU/ITU, audiology, mental health, primary care, facilities, gynaecology, community dental services, endoscopy, wellness hub and haematology. 'Have your say' card has been replicated in electronic format and optional all waves survey attached, qtr. codes and posters on display across HB sites and on social media pages. Further exploration of SMS automation of surveys being explored but limited at present due to IT resource issues to support implementation. Delays have been seen due to COVID-19. April 2022-Update The Health Board launched the electronic "Have your Say" and Generic Patient Experience Survey on the 13.02.22. Posters containing QR codes are displayed on notice boards in our hospital sites, KHPH and Dewi Sant. In addition links are available on our internal and external webpages, along promotion on available social media channels. A small card (like a business card) containing a QR code has been developed which will be displayed in main thoroughfares such as Emergency Departments, Outpatients and community settings. They will be made available to staff that are providing services in patient's homes. Exploration is taking place as to how the posters/cards can be promoted within the wider non-health board community settings. From the 28.02.22, within the Bridgend and Merthyr & Cynon Localities, the PALS team are actively engaging with patients/ service users to promote the completion of the "have your say" cards and generic survey. This is through paper copies being available in areas, which are collated and uploaded on to the system on a monthly basis. Along side this, within Merthyr & Cynon PALS Officers are present with Emergency Department at PCH and outpatients at YCC to capture feedback via iPADS. The number of area specific surveys continues to increase, with Staff engaging with patients and service users via links, QR codes and iPADS. June 2022 update- Work continues to promote the CIVICA system with patients and staff via social media and intranet pages. A banner is being developed and will be located around CTM with a link to the "Have your say" survey and QR code. A WREM survey has been developed to evaluate the system with staff and the benefits of the system to the HB. Number of specialities engaging with the team to explore the use of the system is increasing and drop in sessions for staff are planned for June/July
Audit Wales/HI W Quality Governance Follow Up Review R14.13	Aug-21	The Health Board must develop a stronger approach to organisational learning which takes account of all opportunities presented through concerns, clinical audit, patient and staff feedback, external reviews and learning from work undertaken in the Princess of Wales hospital.	High	Work being undertaken with Improvement Cymru to scope work to develop and deploy a model ward and operational best practice guide to improve flow, quality and patient safety.	Director of Nursing		Jul-21	Now October 2021 Now March 2022 Now April 2023		In Progress	December 2022 Update - Listening & Learning Framework launched. Repository of Learning in place and accepting themed learning i.e. medicines safety, falls. Listening & Learning next even planned for March 23 with the theme of learning from external reviews.	SEPT 2021 UPDATE - Work continuing with IC, action detail reviewed after HIW inspection in Sept 21 requiring review of scope of work and delivery plan. UPDATE Nov 21. Head of Professional Standards leading a project to work with ILG governance leads and ILG Nurse directors to produce a ward/departement assurance framework. This will include ward assurance audits, annual audit cycle, single point of data capture and reporting. Also will scope most appropriate IT programme available. Paper to be presented at Q&S committee March 2022. 2022 update As part of the PCH Improvement Programme we have implemented a ward assurance framework and tested across all In-Patients wards on PCH. This information is now captured electronically on the AMaT system. Following the successful implementation of the ward assurance framework the same will now be rolled out across the organisation. August 2022 Update - No update received during this period October 2022 update - By way of establishing a baseline, a scoping exercise was undertaken during June 2022 across all clinical areas, which includes Paediatrics, all Adult in patient wards and maternity, where 6 standardised templates were used and the data inputted into AMaT. • Agreement to continue the 6 core audits evaluated and input data onto AMAT to provide ongoing assurance. • Continue representation at the All Wales Task and Finish Ward Assurance group
Audit Wales/HI W Quality Governance Follow Up Review R14.13	Dec-21	There needs to be improved visibility and oversight of clinical audit and improvement activities across directorates and at corporate level. This includes identification of outliers and maximising opportunities for sharing good practice and learning.	High	Undertake audit of compliance against Royal College of Anaesthesia (RCOA) Standards (ACSA process) identify and develop standards to meet with RCOA recommended GPICS (set standards by RCOA for Anaesthetic services) baseline and inform continuous improvement programmes and improve compliance against the standards.	Medical Director		Jul-24			In progress	December 2022 Update - On track for July 2024 completion	September 2021 Update - A baseline assessment against the ACSA standards being undertaken. This will then form the basis of the improvement programmes to develop the service. Completion of process and ACSA accreditation aim July 2024 (usual process 2 years expected from RCOA). Expectation for POW to follow however with theatre changes this will be difficult to complete. November 2021 Update - Theatre improvement programme has been established. April 2022 update - awaiting agreement on a standardised set of HB wide emergency department audits by the nursing unit and identification of a resource to support the Ward and Area module rollout, currently paused. June 2022 Update - on target for completion by July 2024. July 2022 Update - On track for completion July 2024. October 2022 Update - Remains in progress for completion by July 2024
Audit Wales/HI W Quality Governance Follow Up Review R14.13	Dec-21	The Health Board has undertaken specific work in mortality and harm in relation to COVID-19. However, as with other Health Boards, it has yet to finalise a standard framework to support the assessment of direct and indirect harm associated with COVID-19. The Health Board should produce a framework for assessing both direct and indirect harm from COVID-19 and ensure that the framework and an accompanying report outlining key issues are monitored by appropriate operational, strategic groups and reported the Board or one of its committees.	Medium/Low	The Health Board received an updated version of the NHS Wales National Framework - Management of Patient Safety Incidents following Nosocomial Transmission on the 16th November 2021. The National Framework contains four options and the Health Board is currently considering the option it will choose to adopt and take forward to assess the harm associated with Covid-19. The chosen option will then be considered at the Strategic Leadership Group in December 2021 and the Quality & Safety Committee in January 2022. Reports will be received and monitored through the Strategic Leadership Group and the Quality & Safety Committee. Reports to the Board will be via the Quality & Safety Committee Highlight Report to Board.	Director of Nursing		31st January 2022	Now March 2022 Now April 2024		In progress	December 2022 Update - Nosocomial Investigation programme for CTM in place via a dedicated team funded by Welsh Government until end March 2024. Investigation of nosocomial incidents in line with PTR commenced as per National Framework and monitored via a Delivery Unit National Nosocomial Covid-19 Operational Group. Data submitted monthly to the DU for onwards reporting to WG. Investigation of patient nosocomial investigations have commenced and now reporting bi-monthly to the CTM Nosocomial COVID-19 Programme Group chaired by Exec Nurse Director and onto Q&S Committee for the consent agenda.	January 2022 update 170 patients have been reviewed using the Nosocomial Framework; Welsh Government (WG) and the Delivery Unit are keen to ensure a level of consistency across Wales in relation to the investigation process of Nosocomial transmissions; several workshops have taken place with attendance including both the Nurse & Medical Directors in order to agree a unified approach; there is a hold on the current process as Welsh Government have agreed to provide health boards with funding to expedite the Nosocomial review investigations; health boards are currently waiting the allocation from WG. Quality & Safety Committee receive regular updates on the health boards position in relation to Nosocomial transmission reviews and the agreed unified approach. April 2022-update - Funding allocation received from WG to support the roll out of the Nosocomial reviews. A Lead Investigator is now in post and several other roles are currently being recruited to. Local Governance forum to be developed to track progress which will be reported into the monthly DU & Strategic Board meetings. The investigation process is likely to take 2 years as there are over 3000 reviews to be undertaken. Quality & Safety Committee will continue to receive regular updates. This work is being led by RTE ILG Nurse Director Carole Tookey and supported by the Patient Care & Safety central team. August 2022 Update - No update received during this period October 2022 Update - The Nosocomial COVID-19 Incident Management team have commenced in next October 2022 Update - The wellbeing of staff remains a key focus in the development and delivery of service recovery plans balancing the requirement for additional resource, and staff wellbeing.
Taking Care of the Carers R2	Dec-21	Considering workforce issues in recovery plans NHS bodies should ensure their recovery plans are based on a full and thorough consideration of all relevant workforce implications to ensure there is adequate capacity and capability in place to address the challenges and opportunities associated with recovering services. NHS bodies should also ensure they consider the wider legacy issues around staff wellbeing associated with the pandemic response to ensure they have sufficient capacity and capability to maintain safe, effective, and high-quality healthcare in the medium to long term.		The wellbeing of CTMHB workforce is central to plans to support the organisation to recovery from COVID-19. This is evidenced by the investment and scale of input and support provided by the Wellbeing Team to the workforce. Wellbeing will feature strongly through the IMTP to ensure that all colleagues feel supported in their work and able to access appropriate support depending upon their needs.	Director for People	Helen Watkins	Mar-22			Completed	December 2022 update - CTMUHB has maintained a high level of investment and continues to offer a wide range of evidenced based services to staff to promote positive wellbeing in the workforce and offer support, intervention and appropriate signposting when staff are struggling. The Wellbeing Service has broadened its scope to also include the promotion of healthy lifestyles and financial wellbeing signposting. Wellbeing is the first of ten strategic priorities for the People Services Directorate and is strongly featured in the IMTP	
Taking Care of the Carers R3	Dec-21	Evaluating the effectiveness and impact of the staff wellbeing offer NHS bodies should seek to reflect on their experiences of supporting staff wellbeing during the pandemic by evaluating fully the effectiveness and impact of their local packages of support in order to: (a) consider what worked well and what did not work so well; (b) understand its impact on staff wellbeing; (c) identify what they would do differently during another crisis; and, (d) establish which services, programmes, initiatives, and approaches introduced during the pandemic should be retained or reshaped to ensure staff continue to be supported throughout the recovery period and beyond. NHS bodies should ensure that staff are fully engaged and involved in the evaluation process.		UHB wide staff survey completed in Aug-Sept 2021 assessed the emotional wellbeing of staff and specifically asked for feedback on current wellbeing services and what more can be provided. Over 2,200 staff participated and gave their insights. In response to the data additional wellbeing workshops on managing sleep and unwinding after work have been developed and are being launched in December 2021. The survey will be repeated again in July 2022 Our Employee Assistance Program (Vivup) provision's activity and clinical outcome data is reviewed on a quarterly basis and we are currently satisfied that it continues to meet the counselling needs of our staff. All Wellbeing service offerings are subject request participant feedback and are regularly reviewed, amended and additional services are provided in response. As part of the Employee Experience work stream, members of the wellbeing service also regularly meet with staff to hear their views on wider issues that impact wellbeing including environmental, people, and process issues.	Director for People	Strategic Lead for Wellbeing	Dec 2021	Now February 2023		Completed	Dec 2022 update - The Wellbeing service completed the service review in January 2022 and implemented new workshops on managing sleep and unwinding after work in early 2022 in response to the 2021 Wellbeing Survey Findings. The Wellbeing Survey was repeated in September/October 2022 which 2,692 participants (21.1% of staff). The data has been analysed and the results for emotional wellbeing are similar to those of 2021 with the exception of an increase in stress and burnout rates in staff. The Wellbeing service will continue to provide existing services but will develop more intensive anxiety and stress / burnout management and treatment interventions in addition to the preventative workshops that they currently provide. The results found that 64% of staff do not engage in government recommended levels of physical activity. The Wellbeing Service will develop a Barriers to Exercise course to help staff identify and address what stops them looking after themselves in this way. 54% of staff were found to not eat the recommended five portions of fruit and vegetables a day. The Employee Experience service is working with Catering and other key stakeholders to introduce a Veg Pledge and to introduce fruit and veg stalls in POW and PCH, similar to the pilot that is currently underway at RGH. Both initiatives will increase the amount of healthy food available on site for staff to purchase. The Survey will be repeated again in May 2023. The Wellbeing Service continues to meet quarterly with Vivup and remains assured that the counselling and other services provided are clinically and cost effective. The next review will take place in January 2023. All Wellbeing Services interventions continue to be evaluated using a mixture of pre and post clinical outcome measures, participant feedback and feedback from other key stakeholders (e.g. managers and leaders, Trade Unions, Wellbeing Activists and colleagues within People Services). In May and Sept/October 2022 the Employee Experience and Wellbeing Service conducted roadshows across the Health Board to promote the service and to gain feedback on it, canvassing the views of staff regarding current pressures and what more we could be doing to support them. This question was also included in the Wellbeing Survey.	October 2022 Update – To avoid the summer holiday period, which negatively impacted participation in 2021, the decision was taken to commence the survey in September 2022. It was launched on 12th September and is due to close on 21st October. Once closed and the results analysed, the Wellbeing service will again use the data to review the relevance of current interventions, identify any gaps in service provision, and redesign the service according to the identified needs. This process will be completed by November 2022 and any new interventions launched by February 2023. Quarterly reviews continue to take place where we discuss the clinical outcome and activity data and we remain satisfied that Vivup continues to meet the counselling needs of our staff. We conducted Employee Experience and Wellbeing Roadshows in May 2022 and again in Sept / October 2022 in which we visited 12 sites to hear the views of staff. These will be repeated again in May 2023
Taking Care of the Carers R6	Dec-21	Building on local and national staff engagement arrangements NHS bodies should seek to build on existing local and national workforce engagement arrangements to ensure staff have continued opportunities to highlight their needs and share their views, particularly on issues relating to recovering, restarting, and resetting services. NHS bodies should ensure these arrangements support meaningful engagement with underrepresented staff groups, such as ethnic minority staff.		The Employee Experience and Wellbeing services engage regularly with staff to canvass their views on what more can be done to promote their wellbeing in work and enhance their experience of working for CTM. We work alongside and in collaboration with the BAME network, for example, putting on specialist training for them in providing peers support. We are currently undertaking a series of face to face Wellbeing Workshops with Catering and Portering staff whose lack of access to technology makes it harder for them to engage with our services electronically.	Director for People	Strategic Lead for Wellbeing	Completed October 2021	December 2022/Ongoing/ November 2022/January 2023		Completed	December 2022 update - The Wellbeing Service continue to provide bespoke interventions for facilities staff when required. The scoping exercise to identify any particular interventions that may be required for catering staff is on track. The Wellbeing Service has recently met with the chairs of the Race Equality Network, LGBTQ+ network and disabled network, to ensure that the services offered are appropriate and accessible to the staff whom these networks represent.	October 2022 Update - We are currently engaging with the Race Equality, LGBTQ+ and disabled networks to seek feedback on the accessibility and appropriateness of the services we offer with a view to amending our practices or delivering more bespoke services if required. During the past 9 months the Wellbeing Service has provided in house Menopause Cafes to Housekeeping staff at the request of managers within the service and will continue to do so if required. The service is also undertaking an exercise currently with Catering managers to explore further support options for staff who find it difficult to access our services via MS Teams. This scoping exercise will be completed by the end of November 2022 and new initiatives designed and delivered by Jan 2023 if required
Audit of Accounts Addendum 2021/22 R2	Aug-22	The Health Board should ensure that its related-party process is fully and properly applied to support the preparation of the 2022-23 financial statements.	Medium/Low	This was largely due to a transposition error between the reviewed working paper and the final document. We will ensure checks are made in future accounts.	Director of Finance		Apr-23			In Progress	December 2022 Update - On track for April 2023 completion	October 2022 Update - Will be completed when draft accounts prepared in April 2023.
Audit of Accounts Addendum 2021/22 R5	Aug-22	The Health Board should ensure that working papers provided at the start of the audit are as described in the deliverables document and have clear cross-referencing to the relevant figures in the financial statements. Also, where spreadsheets are the underlying form of evidence, the Health Board should ensure that all cell values have an appropriate audit trail and that they are never manually input.	Medium/Low	A change in process for the completion of audit working papers caused a delay and a member of the finance team who left at the end of the financial year also caused some issues with submitting working papers. We will ensure that audit deliverables are clearly communicated and deadlines for submission kept.	Director of Finance		Apr-23			In Progress	December 2022 Update - On track for April 2023 completion	October 2022 Update - Will be completed when draft accounts prepared in April 2023.
Audit of Accounts Addendum 2021/22 R6	Aug-22	The Health Board should ensure that all financial returns are made available by the Welsh Government deadlines and that the figures in the financial statements agree to those returns.	Medium/Low	This was an oversight on the return. We will ensure checks are made that all returns are fully completed.	Director of Finance		Apr-23			In Progress	December 2022 Update - On track for April 2023 completion	October 2022 Update - Will be completed when draft accounts prepared in April 2023.

Ref	Date added	Recommendation	Priority	Management Action Agreed	Responsible Executive Lead	Responsible Management Lead	Original Agreed Implementation Date	Revised Implementation Date	Status	Progress	Updates During this period/latest update	Previous Updates
Audit of Accounts Addendum 2021/22 R8	Aug-22	Prior to a valuation being undertaken, the Health Board should issue and agree a formal instruction to its valuers.	High	We will agree specifics with the valuers to include location, Gross Internal Area (GIA) and specification of the work.	Director of Finance		Sep-22	Now November 2022		Completed	November 2022 Update - Confirmation of the requirements for instructions to valuers has been received from Audit Wales. It is recommended that this recommendation can now be closed.	October 2022 Update - This risk remain in progress. We have discussed at Capital TAG to see if any organisations have a template that is in use already, this does not exist so we are working with audit to draft a template for future use
Audit of Accounts Addendum 2021/22 R10	Aug-22	Wherever possible, the Health Board should ensure that all Excel-based working papers include formulae and cell references which will provide a clearer audit trail.	Medium/Low	We encourage where possible to link working papers to source documentation and not hard code. We will reinforce this for the accounts in 2022/23.	Director of Finance		Apr-23			In Progress	December 2022 Update - On track for April 2023 completion	October 2022 Update - Will be completed when draft accounts prepared in April 2023.
Audit of Accounts Addendum 2021/22 R11	Aug-22	The Health Board should update its Medical Pay Financial Control Procedure to reflect the current process	High	This is being updated in line with other FCPs, it will go to Audit & Risk Committee for approval.	Director of Finance		Oct-22	Now December 2022		In Progress	December 2022 Update - Out for comment and review. On track for December 2022 completion.	October 2022 Update - A draft FCP has been updated and is currently been circulated for review and comment before being brought to the Audit & Risk Committee for sign off in December
Equality Impact Assessments R4	Nov-22	Reviewing public bodies' current approach for conducting EIAs: While there are examples of good practice related to distinct stages of the EIA process, all public bodies have lessons to learn about their overall approach. Public bodies should review their overall approach to EIAs considering the findings of this report and the detailed guidance available from the EHRC and the Practice Hub. We recognise that developments in response to our other recommendations and the Welsh Government's review of the PSED Wales specific regulations may have implications for current guidance in due course.		CTM UHB welcomes the report's recommendations for a national approach to clarifying the scope of the duty to impact assess policies and practice and developing guidance for integrated impact assessment. CTM UHB is currently reviewing the EIA process, in line with the findings of this report, and the guidance available from the EHRC and the Practice Hub. As such work has commenced on benchmarking against other NHS organisations. Quality Assurance measures are also being designed to monitor EIAs, as well as monitor the impact of the decisions in the context of the PSED. In addition, further staff guidance and policies will be developed to ensure that the EIA process is both robust and informed. Consideration will be given, as part of the review, to determine whether the EIA forms part of a wider integrated impact assessment.	Director for People	EDI Practitioner	Mar-23			In Progress	December 2022 update - A Working Group has been established to inform the review, with representation from key stakeholders. A benchmarking exercise against other NHS organisations is underway to gauge current best practices and whether an integrated assessment is needed. The possibility of a digitised assessment tool is being explored to allow for robust auditing processes.	

Cwm Taf Morgannwg University Health Board

Audit & Risk Committee Internal Audit Progress Report

December 2022

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 Institute of Internal Auditors.

Acknowledgement

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

Disclaimer notice - please note

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

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

1 Introduction

- 1.1 This progress report provides the Audit & Risk Committee (the 'Committee') with the current position of the work undertaken by Internal Audit as at **05 December 2022**. This report provides information on the status of progress of our reviews.
- 1.2 We report the progress made to date against individual assignments along with details regarding the delivery of the plans and any required updates.

2 Reports Issued

- 2.1 Since the October meeting of the Committee five reports have been finalised and we have ongoing fieldwork in relation to four reviews. A summary of the position of the finalised reports, including a summary of number of recommendations, is provided below in Table 1.

Table 1 – Summary of finalised reports

Assignments	High	Medium	Low	Total	Assurance rating
Clinical service group – Radiology:	-	-	-	-	
• Governance arrangements	1	3	-	4	Reasonable
• Risk management	1	-	-	1	Reasonable
• Workforce management	4	2	-	6	Limited
• Planning and performance	1	1	-	2	Reasonable
• Compliance with financial control procedures	1	1	-	2	Reasonable
Wellbeing	-	3	2	5	Reasonable
iCTM quality improvement team	2	3	-	5	Reasonable
Cyber security	-	1	1	2	Reasonable
Decarbonisation	-	-	-	-	Advisory

3 Delivering the Plan

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

Table 2 – Performance Indicators 2022/23

Indicator	Status	Actual	Target	Red	Amber	Green
Report turnaround: time from fieldwork completion to draft reporting [10 days]	Green	91% (10/11)	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [15 days per Internal Audit Charter]	Red	56% (5/9)	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 days]	Green	100% (9/9)	80%	v>20%	10%<v<20%	v<10%

4 Feedback

4.1 Our final reports are issued with a post audit questionnaire, which is our way of getting feedback on the audit process so that we can look to make improvements. In 22/23 we have issued the questionnaires in relation to the finalised reports, and have received seven responses to date.

Appendix A**Table 3: 2022/23 reviews on main programme of work**

Plan Ref.	Review	Rating	Review period	Status	Notes
27	Follow up - CAMHS - Workforce	Reasonable	1	Final	Went to August Committee
30	Follow up - Single cancer pathway: data quality and integrity	Reasonable	1	Final	Went to August Committee
1	Digital operating model	Limited	1	Final	Went to October Committee
6	Medical records management	Reasonable	1	Final	Went to October Committee
16	iCTM improvement team	Reasonable	3-1	Final	December Committee
3	Clinical service group review - Radiology	Reasonable/ Limited	1	Final	December Committee
9	Wellbeing	Reasonable	2	Final	December Committee
20	Cyber security	Reasonable	3	Final	December Committee
2	Decarbonisation	Advisory	4-2	Final	December Committee
8	Board awareness of digital	-	2	WIP	February Committee

Plan Ref.	Review	Rating	Review period	Status	Notes
4	Reasonable offer	-	± 2	WIP	February Committee
12	Medical variable pay	-	2	WIP	February Committee
26	Follow up - Fire safety	-	-	WIP	February Committee
28	Follow up - Bridgend transfer of IT	-	4	WIP	February Committee
N/A	Follow up - Facilities governance	-	3	Planning	Brief issued
24	Welsh Risk Pool	-	4	Planning	Brief issued
14	Risk management	-	3 4	Planning	Move to Q4 as prior year was delayed to 21/22 Q4. Brief issued.
18	Health system	-	3	Planning	Initial planning meeting held on 22.11.22
15	Performance monitoring and management	-	3	Planning	Planning meeting held on 22.11.22. Drafting brief.
13	Recruitment and retention	-	2 4	Planning	Planning meeting 11.07.22. Management request to move to Q4

Plan Ref.	Review	Rating	Review period	Status	Notes
10	Service configuration to meet cancer targets	-	≥ 4	Planning	Management request to move to Q4. Discussed with COO 01.12.22.
7	Financial systems (financial savings)	-	≥ 4	Planning	Request move to Q4 for implementation of OM.
17	Contract and SLA arrangements	-	3	Planning	Have received background information.
25	Decontamination	-	4	Planning	Planning meeting 21.12.22
11	Waiting list management	-	≥ 4	Planning	Discussed with COO 01.12.22.
N/A	Follow up - Patient pathway appointment management process	Q4	4	Fieldwork planned for January 2023	
21	Clinical governance and quality	-	4	-	Planning meeting 21.12.22
5	National incident framework	-	± 4	-	Moved to Q4 as DU have looked at and new framework needs time to embed. Planning meeting 21.12.22
29	Follow up - Concerns	-	4	-	-

Plan Ref.	Review	Rating	Review period	Status	Notes
22	Operating model	-	4	Defer	Following discussion with COO, plan to do this review following completion of phase 2.
N/A	Follow up - PoW theatres	-	4	Defer	Will defer to early 23/24 as project has paused.

Table 4: Status of PCH plan 2022/23

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

Assignment	Status	Assurance	Notes
1B Final Account	Final	Substantial	-
Validation of management action	Final	Substantial	-
Change, risk and contingency	WIP	-	Plan to bring to February Audit Committee.
Governance	Planned	-	Plan to bring to February Audit Committee.

Table 5: Hosted bodies plan 2022/23

Ref.	Review	Rating	Status	Notes
32	WHSCC – Quality unit	-	Final	-
33	WHSSC – Neurosciences	-	Final	-
31	EASC review	-	Planning	Had initial meeting. Awaiting information.
35	WHSSC – Mental health	-	Planning	Had scoping meeting. Fieldwork in January 2023

Decarbonisation Final Report

November 2022

NWSSP Audit and Assurance Services



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Report status:	Final
Draft report issued:	10 th November 2022
Management response received:	15 th November 2022
Final report issued:	18 th November 2022
Auditors:	NWSSP Audit & Assurance: Specialist Services Unit
Committee:	Audit Committee



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Acknowledgement
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1. Context

- 1.1 The Welsh Government is party to international agreements to reduce carbon emissions and control climate change, most notably those arising from the 2016 Paris Accord.
- 1.2 The “NHS Wales Decarbonisation Strategic Delivery Plan” was published in March 2021, setting interim targets (from a 2018/19 base) of a 16% reduction by 2025 and a 34% reduction by 2030.
- 1.3 In October 2021 the Welsh Government set out its second carbon budget, Net Zero Wales, which confirmed:

“Our ambition is for the public sector to be collectively net zero by 2030”.

Welsh Government, October 2021

- 1.4 NHS Wales is also required to comply with the Well-being of Future Generations (Wales) Act 2015. It requires public bodies in Wales to think about the long-term impact of their decisions, to work better with people, communities, and each other, and to prevent persistent problems such as poverty, health inequalities and climate change.

2. Background

- 2.1 In accordance with the “NHS Wales Decarbonisation Strategic Delivery Plan”, Health Boards, Trusts and Special Health Authorities were required to develop their own Decarbonisation Action Plans (DAP), demonstrating how NHS Wales organisations would implement the Strategic Delivery Plan initiatives. The DAP’s were submitted to Welsh Government in March 2022.
- 2.2 A peer review of DAP strategies was held on 12 July 2022 led by Welsh Government and attended by all NHS Wales organisations. The general conclusions across all plans were:
 - the targets detailed within the plans showed low aspirations;
 - there were concerns associated with their successful delivery, primarily due to resource availability (financial and physical); and
 - there were a small number of issues associated with their compilation/format.
- 2.3 Specific feedback was also provided to each organisation by Welsh Government.
- 2.4 Also in July 2022, Audit Wales issued their review of Public Sector Readiness for Net Zero Carbon by 2030 (fieldwork conducted between November 2021 and January 2022). The review included an assessment of NHS Wales organisations and concluded that:

“There is clear uncertainty about whether the public sector will meet its 2030 collective ambition. Our work identifies significant, common barriers to progress that public bodies must collectively address to meet the ambition of a net zero public sector by 2030. And while public bodies are demonstrating commitment to carbon reduction, they must now significantly ramp up their activities, increase collaboration and place decarbonisation at the heart of their day-to-day operations and decisions”.

Audit Wales, July 2022

- 2.5 In September 2022, Health bodies will be required to make two separate submissions to Welsh Government, the first of these being quantitative (i.e., showing progress against the baseline CO₂ figures set in 2019) and the second qualitative, being a report detailing progress against the DAP.

3. Approach

- 3.1 Audits were planned to be undertaken simultaneously across NHS Wales to provide assurance to respective NHS Wales bodies on their arrangements to reduce carbon emissions and control climate change as outlined above. Reviews were not scheduled at Public Health Wales or Health Education and Improvement Wales for 2022/23.
- 3.2 Risks to be considered included:
- Regulatory/legislative risk through not achieving mandated reductions in carbon emissions;
 - Reputational risk by failing to meet emission targets.
 - Failing key stakeholders by not reducing carbon emissions which have a detrimental effect on health, and thereby, not meeting the requirements of the Well-being of Future Generations (Wales) Act (2015).
- 3.3 Having reviewed all DAPs, supporting information for most NHS Wales bodies, and fully concluding the fieldwork at five of 11 audits, it was clear that in each instance the implementation plans had not been sufficiently developed to allow meaningful testing and to provide an assurance rating to respective Audit Committees.
- 3.4 Accordingly, the decision was taken to affirm common themes within this report, to provide an overview of the overarching position across NHS Wales. An action plan of common themes is provided at **Appendix A**.

4. Summary Observations

- 4.1 While there are variations between the NHS Wales bodies, broadly each is at an early stage of implementation. The following were common themes observed across those reviewed:

Governance

- Governance arrangements at a strategic level were generally good with senior leadership demonstrated.
- Recruiting to additional operational posts has proven difficult – with the limited appointments to date coming from the existing public sector staff pool. These appointments are key to being able to implement the agreed strategies (see **Management Action 1**).

Localised strategy

- All NHS Wales organisations supplied their Decarbonisation Action Plan (DAP) by 31 March 2022 detailing their response to the NHS Wales Decarbonisation Strategic Delivery Plan and the 46 associated initiatives.
- WG provided positive feedback to each organisation on their submissions but concluded overall that there were concerns associated with their successful delivery (primarily due to the availability of financial and physical resource), together with low aspirational targets detailed within the plans.
- Few of the strategies had been costed, and none had associated funding strategies – particularly noting that ring-fenced central funding for 2021/22 was £16m with no provision made in 2022/23 (see **Management Actions 2 & 3**).
- In each instance, the decarbonisation strategies were clearly part of corporate planning and included/reflected within the respective Integrated Medium-Term Plans (IMTPs).

Monitoring & reporting

- Organisations were ISO 14001 accredited ensuring that appropriate Environment Management Systems were in place to manage their environmental performance.
- Each NHS Wales organisation's performance will be assessed against baseline data prepared by the Carbon Trust. Issues have been identified with the baseline data and the disaggregation of the data for reporting purposes. Each organisation should seek assurance on the accuracy of the baseline data (see **Management Action 4**).
- Each NHS Wales organisation should ensure that appropriate engagement is established with NWSSP Procurement Services as a significant contributor to the carbon reductions outlined within respective DAPs and formalise arrangements as appropriate (see **Management Action 5**).

- Each organisation had met its obligations for national reporting to date.
- Internal reporting to date had understandably been limited, with the level of reporting increasing after Welsh Government's review of the DAPs.
- There was therefore a need to fully roll-out the structures to support appropriate monitoring and reporting within the NHS Wales organisations reviewed (see **Management Action 6**).
- It is important that the profile of decarbonisation is increased to reflect the challenge faced, for example general Terms of Reference are reviewed to reflect decarbonisation commitments, and decarbonisation is set as a standard agenda at all appropriate Executive meetings (see **Management Action 7**).
- Potential collaboration should be considered on an All-Wales basis, particularly in relation to consultancy advice and training resource (see **Management Actions 8 & 9**).

Project delivery

- The Welsh Government Estates Funding Advisory Board (EFAB) oversaw the allocation and delivery of the £16m decarbonisation funding for 2021/22 with each NHS Wales organisation successfully securing funding.
- In each instance, adequate records were retained to support the expenditure and the achievement of the original objectives; Post Project Completion Reports were produced and submitted to WG for all funded schemes.
- No ring-fenced WG capital funding was made available for 2022/23. WG offered up to £60k of revenue funding for schemes, however several NHS Wales organisations' bids could not be supported due to them being considered capital bids (see **Management Action 10**).
- NHS Wales Organisations were also self-funding initiatives from their discretionary programme. It is important that the cost benefit of these schemes is also subject to challenge and scrutiny for inclusion within the overall data (see **Management Action 11**).

5. Conclusion

- 5.1 In conclusion, whilst some progress has been observed, this has been restricted by the availability of financial and staff resource. The recommendations made aim to aid management in driving forward the strategies, whilst also highlighting some of the competing pressures/ risks.
- 5.2 It is recommended that an audit is scheduled for early 2023/24 with the proposed scope to include governance, strategy progress and implementation.
- 5.3 Additionally, as part of 2023/24 Internal Audit planning update, discussions will be held with management on the appropriateness of other areas within the decarbonisation programme including, for example:

- Procurement and supply chains.
- Application of “Best practice Pharmaceutical waste practice”.
- Transport.
- Fleet and business travel.
- Staff, patient, and visitor travel.
- Catering; and
- People and workforce e.g., training, policies, and working arrangements.

Appendix A: Common Management Action Plan

Ref.	Recommendation	Management Comment/ Agreed Action	Responsible Officer/ Deadline
MA 1	Appropriate strategies should be developed to ensure that recruitment and retention issues experienced to date do not impact significantly on the achievement of the DAPs.	Agree. The decarb portfolio is currently being managed within existing roles – CTM do not have a specific role for this agenda. The portfolio is being managed across planning, estates and facilities, communications and engagement, public health, and procurement, with oversight and SRO status conferred to the Director of Strategy and Transformation. We have funding from WG for one day a week admin support until 31/3/23. Due to the financial situation facing CTM it is unlikely that any further recruitment to support this portfolio will be possible in the near future, unless external funding was identified. An attempt was made to create a shared role with a Local Authority, but they were unable to commit.	Executive Director of Strategy & Transformation/ongoing
MA 2	DAPs should be fully costed to fully determine the total funding required.	Agree. As projects within the DAP are considered for implementation, they are costed to understand the financial impact. CTMUHB needs to work with partners to achieve this, as not all projects are for the HB to deliver. The costing in some areas is complex as it is not always clear how to cost the work. This work would benefit from a dedicated person(s) due to the complexity, but as set out above, additional recruitment is unlikely. This may have an impact on the full costing of the DAP.	Head of Finance/ongoing

Ref.	Recommendation	Management Comment/ Agreed Action	Responsible Officer/ Deadline
MA 3	DAPs should be supported by funding strategies e.g., differentiating between local/ national funding, revenue, or capital funding etc.	Agree. As above. CTMUHB is aware of accessing national funds where possible to support the delivery of the DAP in conjunction with our partners. However, due to the financial situation of the HB, it is likely there will be some challenging conversations moving forward in regard to what can/can't be delivered in the short – medium term.	Head of Finance/ongoing
MA 4	NHS Wales Organisation's baselines should be adequately scrutinised and challenged, as errors and overreporting has been identified in a few examples to date.	Agree. CTMUHB wrote to WG on the 9/9/22 outlining our concerns regarding this. To date, we have yet to receive a response. CTMUHB would also like to raise the difference in carbon emission reporting between EFPMS annual utilities emissions (via a form they use within NWSSP/estates) and the carbon emission template which has different formulas for WG reporting. Therefore, we are reporting two different figures regarding building emission calculations and would appreciate a national position on this.	Deputy Director of Strategy & Partnerships to follow up with (WG) by March 2023
MA 5	As a major contributor to the achievement of the targeted reductions appropriate engagement will be established with NWSSP	Agree. CTMUHB have invited the Head of Sustainability and Net Zero Management (NWSSP) to our environmental sustainability	Deputy Director of Strategy & Partnerships/in progress

Ref.	Recommendation	Management Comment/ Agreed Action	Responsible Officer/ Deadline
	Procurement Services (and formalised as appropriate).	board to provide national input/ oversight re procurement chain	
MA 6	Proposed management/accountability structures should be fully implemented as intended within the DAPs.	Agree. The decarbonisation agenda is managed through our newly established environmental sustainability board. This reports into the CTM Transformation Board which has oversight of the entire transformation portfolio and is chaired by the CEO of the HB.	Executive Director of Strategy & Transformation and Deputy Director of Strategy & Partnerships/in progress
MA 7	Where decarbonisation falls within the existing environmental remit of committees/ meetings, it is important that an appropriate profile is set. Terms of Reference and agendas should be reviewed to ensure that sufficient focus is provided.	Agree. This agenda is being reported into a board sub-committee – the Population Health and Partnerships committee and their TOR and reporting mechanisms reflect this.	Executive Director of Strategy & Transformation and Deputy Director of Strategy & Partnerships/complete
MA 8	Potential collaboration and common utilisation of decarbonisation resource should be considered on an All-Wales basis, particularly in relation to	Agree. CTMUHB are happy to collaborate on an all-Wales basis. Through the HSCCE programme funding allocation, our WOD team have developed an e-learning resource package which is soon to be launched on ESR. This has been led by Learning &	Learning & Organisational Development Manager/in progress

Ref.	Recommendation	Management Comment/ Agreed Action	Responsible Officer/ Deadline
	consultancy advice and training resource.	Organisational Development Manager and the product has been offered to all UHBs in Wales. As set out above we attempted a local partnership but were unsuccessful. Alignment of national messaging would help with this.	
MA 9	In accordance with the NHS Wales Decarbonisation Strategic Delivery Plan, HEIW/ collaborative training should be commissioned on an All-Wales basis to provide both common and tailored decarbonisation training.	Agree. CTMUHB are represented on the HEIW group which is specifically looking at decarb training.	Learning & Organisational Development Manager/In progress
MA10	Given the scarcity of funding, it is important that bids for funding are appropriately considered prior to submission.	Agree. Noted and will be actioned as appropriate.	Head of Finance/in progress
MA11	The same rigour and monitoring should be applied to internally commissioned/ funded initiatives to ensure the outcomes are adequately recorded/reported.	Agree. Due to the focus on delivering high quality service developments and CTMUHB current financial position, all new initiatives are subject to high levels of rigour and scrutiny. iCTM are exploring the addition of decarbonisation	Head of Finance & Head of PMO- in progress

Ref.	Recommendation	Management Comment/ Agreed Action	Responsible Officer/ Deadline
		measures/impact within the HBs business case template to try to improve how the decarb impact is captured.	



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

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

iCTM – Quality Improvement Team Final Internal Audit Report

November 2022

Cwm Taf Morgannwg University Health Board



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Review reference:	CTMUHB-2223-16
Report status:	Final
Fieldwork commencement:	04.07.2022
Fieldwork completion:	02.09.2022
Debrief meeting:	14.09.2022
Draft report issued:	14.09.22 & 28.10.22
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Auditors:	Ken Hughes, Audit Manager Emma Samways, Deputy Head of Internal Audit
Executive sign-off:	Greg Dix, Executive Director of Nursing, Midwifery and Patient Care
Distribution:	Marc Penny, Director of Improvement Paul Gimson, Assistant Director Improvement Culture, Capability & Delivery Dr Helen lane, Assistant Medical Director Quality Improvement
Committee:	Audit & Risk Committee



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Acknowledgement

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

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Executive Summary

Purpose

To provide assurance to the Audit and Risk Committee that there are effective controls, processes and procedures in place within the Quality Improvement team.

Overview

Matters which require management attention include:

- There were no guidance notes or Standard Operating Procedures (SOPs) in place in respect of the processes and activities undertaken by the Improvement team.
- There was no documented consideration of risks when planning and undertaking Improvement projects.
- Improvement projects captured on Life QI were not being adequately documented.
- The monitoring and reporting of the progress of projects was not regular or consistent.

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

Report Opinion



Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary¹

Objectives		Assurance
1	Improvement Team Aims & Objectives	Substantial
2	Procedures and Project Documentation	Limited
3	Alignment to Strategic Aims and Objectives	Reasonable
4	Alignment to new Care Group Structure	Reasonable
5	Monitoring of Outcomes	Reasonable
6	Risk Management Arrangements	Limited

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Procedures to be documented	2	Design	High
2	Improve project documentation and records	2 & 3	Operation	Medium
4	QI Faculty Framework to be updated	4	Operation	Medium
5	Limited project monitoring and reporting	5	Operation	Medium
6	Risk management arrangements to be documented	6	Operation	High

1. Introduction

- 1.1 Our review of iCTM Quality Improvement was completed in line with the 2022/23 Internal Audit Plan for Cwm Taf Morgannwg University Health Board (the 'Health Board' or 'organisation').
- 1.2 The Health Board formally launched the Improvement CTM (iCTM) directorate in November 2021. The new directorate aims to help drive quality and improvement across the organisation. The iCTM directorate consists of four functions: Change Hub; Quality Improvement; Value Based Healthcare; and Innovation.
- 1.3 We have previously undertaken an audit of the Change Hub, and this year our work focused on the Quality Improvement function and the processes and procedures that have been established within it.
- 1.4 The focus of the Quality Improvement (QI) team revolves around improving quality to ensure safe, effective, patient-centred, timely, efficient and equitable care. The Health Board acknowledges that those delivering care are often the best placed for generating improvement ideas. The QI team will therefore support teams and individuals across the Health Board to turn those ideas into reality.
- 1.5 As part of their support role, the QI team provide Health Board staff with access to the Life QI system. This system acts both as a framework so that staff can record relevant project information, and as a training resource as it contains guidance. The QI team have also recently launched the 'Simply Do' platform as a place for staff to submit improvement ideas that they may have.
- 1.6 In addition to their supporting role, the QI team are directly involved in the delivery of their own QI projects.
- 1.7 In undertaking our audit work, we were mindful that the Improvement team has only been in place for a short time and their internal processes and procedures are still developing.
- 1.8 The potential risks considered in this review were as follows:
 - Services do not improve leading to an increased risk of harm to patients.
 - Resources are not effectively used if quality improvement actions and initiatives fail to deliver the expected improvements.
 - The failure to improve quality in key areas of underperformance already identified may lead to reputational damage.

2. Detailed Audit Findings

Objective 1: The remit / aims of the Quality Improvement function have been defined and documented.

- 2.1 The iCTM Business Plan for 2022-25 has a section for each of the four teams that make up the iCTM Directorate. The Quality Improvement section sets out the aims and objectives of the Quality Improvement (QI) team and how their work will be delivered in accordance with the Health Board's organisational values. The role of the team has been described as a support function that all teams within the Health Board have access to, and can 'pull on', to help improve services.

Conclusion:

- 2.2 The aims and objectives of the QI team have been defined and documented. We have provided substantial assurance for this objective.

Objective 2: Processes, procedures, actions and initiatives designed to improve the quality of services are adequately documented.

- 2.3 Broadly, there are two main categories of improvement projects: those that the QI team support and provide advice for; and those that the team are directly involved in delivering. However, at the time of our fieldwork there was no documentation setting this out, or any formal written procedures in place in relation to the work of QI team. **(Matter Arising 1)**
- 2.4 We understand that the projects for which the QI team offer support and advice tend to be small scale and are considered 'safe to fail'. As such, management consider that there is no need for these projects to be approved before work starts. However, without procedures it is unclear how projects are classified as small scale or 'safe to fail'. **(Matter Arising 1)**
- 2.5 These small scale and 'safe to fail' projects should be captured on the Life QI system, which provides a framework for project owners, with support offered by the QI team if required. We understand that not all improvement projects across the Health Board are captured on this system. We acknowledge that ensuring all projects are recorded on the system may be difficult, and is outside of the control of the QI team, although there are benefits to capturing information in a consistent way. **(Matter Arising 1)**
- 2.6 While projects on the system have a 'project title', they may benefit from having a unique reference number, to avoid confusion as the number of projects increases. **(Matter Arising 1)**
- 2.7 A plan on a page document is completed for projects that the QI team is directly involved in delivering. The document captures the project background, objectives and stakeholders, but does not include information on risk. **(Matter Arising 1)**
- 2.8 There does not appear to be a central, comprehensive record of planned and active improvement projects and programmes that the QI team are involved in delivering. **(Matter Arising 2)**

- 2.9 The QI team are trialling a project workbook for larger scale projects. The workbook covers initiation, planning, delivery and monitoring, and closure and evaluation of projects. The workbook is more detailed and comprehensive than the Life QI system, and the 'plan on a page' document as it can be used to capture information such as roles and governance, a risk and issues log, action and decision log as well as a PID, so is more detailed than the information required by the Life QI system or the 'plan on a page' projects.
- 2.10 Our testing in relation to a sample of projects on the Life QI system identified that many key project documents that you would expect to be in place, such as a Project Initiation Document, costing and resource information and approvals was not present. We understand that in order to encourage innovation, project owners are not expected to complete some of the documents normally expected for larger scale projects. Instead, staff are encouraged to consider the project benefits against the risk of undertaking the project. Whilst we understand this approach, in the projects we sampled we were unable to evidence this. **(Matter Arising 2)**
- 2.11 Improvement projects, regardless of size, are not costed. As such, there is a risk that the cost of improvements may outweigh the potential benefits. Providing guidance relating to costing projects, aligned to the organisation's strategic aims and objectives, would enable savings to be identified and potentially re-invested. **(Matter Arising 2)**

Conclusion:

- 2.12 There are no documented guidance notes or Standard Operating Procedures (SOPs) in place, and there are numerous approaches to capturing information. These different approaches mean that there is no consistency in the information being held for each project. In addition, the lack of procedures meant that during our audit fieldwork, it was difficult to differentiate between project types and what project documentation should be recorded.
- 2.13 Part of the role of the QI team is to support and advise staff who are delivering their own QI projects. The Life QI system provides a framework for users, however not all projects are captured on the system. Without clear guidance it is unclear how this aspect of QI work is being managed by the QI team to ensure projects remain within the principles of small-scale and 'safe to fail'. We have provided limited assurance for this objective.

Objective 3: All quality improvement actions and initiatives undertaken are aligned to the organisation's strategic aims and objectives and are subject to appropriate approval with reasons clearly recorded.

- 2.14 The Life QI system has the facility to record if projects are aligned to strategic aims and objectives. The system has been mapped so that projects can be aligned to the CTM 2030 aims. We tested the alignment of a sample of active projects and found that in most cases projects were not consistently and explicitly aligned to the organisation's aims and objectives. **(Matter Arising 2)**
- 2.15 Management approval is not needed before starting small-scale projects that are recorded on the Life QI system. However, access to the system has to be set up

by a member of the QI team and is granted on the basis of a project plan, giving some element of oversight by the QI team.

2.16 We understand that the process for approving improvement projects and the work undertaken by the QI team is through a highlight report to the Improvement and Innovation Board (IIB), or the Senior Leadership Group (SLG), which sets out the process that has been undertaken and highlights activity to take forward. However, the approval process is not documented so it is unclear whether approval is via IIB or SLG or both. **(Matter Arising 1)**

2.17 The QI team have recently adopted a prioritisation matrix, created by the Change Hub, to prioritise requests to support and undertake work in line with the team's resources.

Conclusion:

2.18 Whilst some of the Life QI projects that we tested were clearly aligned to the Health Board's strategic aims and objectives, not all were. The process for approval of projects varies depending on the scale of the project, but this is not documented. We have provided reasonable assurance for this objective.

Objective 4: There are appropriate links between the directorate and the new Clinical Care Group structure within the revised CTM operating model, and this enables the directorate to influence and drive quality improvements across the organisation.

2.19 A 'faculty' framework provides a link between the QI team and the wider organisation. A Quality Improvement Faculty Framework document has been drafted that sets out the purpose of the framework and the role of Quality Improvement 'faculty' leads, it needs to be updated to reflect the new Clinical Care Group operating model.

2.20 We note that the roles described within the framework document were to be developed over a two-year period and would continue to evolve thereafter. Now would be an opportune time to review the document and the effectiveness of the framework to identify any issues arising from the implementation and operation of the framework within the existing ILG operating model, and to incorporate any improvements to an updated QI faculty framework document. **(Matter Arising 3)**

Conclusion:

2.21 The faculty framework in place provides a network for engagement with staff across the organisation to help drive improvement. However, the effectiveness of the framework has yet to be formally reviewed and aligned to the new Care Group structure. We have provided reasonable assurance for this objective.

Objective 5: There are measurable outcomes for quality improvement actions and initiatives, and these are regularly monitored and reported against.

- 2.22 We tested a sample of six active projects on the Life QI System and confirmed that project aims and objectives had been completed for all six projects. However, performance measures and indicators had only been set for three projects. We understand that progress had been made on all projects, but this had not been reflected in the Life QI system for five of the projects. **(Matter Arising 4)**
- 2.23 The QI team has a timetable setting out the regular meetings that the team are involved in is in place, which confirms regular monitoring taking place including feedback from the faculty leads.
- 2.24 The IIB regularly receive reports in relation to the work of the QI team and the projects they are involved in delivering. We did not see evidence of the IIB receiving progress reports in relation to projects captured on the Life QI system. While the IIB has a strategic role, and detail about individual projects may not be appropriate, they may benefit from summarised information and the outcomes and lessons to share as projects conclude. **(Matter Arising 4)**

Conclusion:

- 2.25 Whilst aims and objectives are set for projects, measurable outcomes are not being set in all cases. While project progress is monitored by project leads, this is not being adequately recorded on the Life QI system. Reporting to the IIB could be expanded to include overview data of Life QI projects. We have provided reasonable assurance for this objective.

Objective 6: The risks associated with quality improvement actions and initiatives are captured and adequately managed.

- 2.26 The Health Board has an organisation wide Risk Management Policy and Strategy that the QI team should follow when undertaking risk assessments and developing a QI risk register. We understand that this had been identified by the team but at the time of our fieldwork this had not progressed. **(Matter Arising 5)**
- 2.27 Similarly, there was no evidence of risk assessments at the outset of a Life QI projects, and risk registers or risk logs were not maintained for individual projects. From our discussions with project leads it was apparent that some of the projects have significant risks, and although the project leads were aware of them, they were not formally documented and consequently may not be effectively managed. **(Matter Arising 5)**

Conclusion:

- 2.28 There is no QI team risk register in place, and no guidance on how project or team risks should be identified and managed. There was no evidence on the Life QI system, or Plan on a Page document, that risks were being considered when setting up improvement projects. We have provided limited assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Standard Operating Procedures and systems used (Design)	Potential Impact
There are no Standard Operating Procedures (SOPs) in place to provide guidance to the QI team and other staff on how the different types of QI work should be captured. There are a number of approaches to QI work meaning that varying levels of information are captured at initiation stage and throughout the life of the project. <u>Life QI</u> This system is used for small scale and 'safe to fail' improvement projects across the Health Board. We note: • Management consider that capturing all improvement activity on Life QI would not be practical. However, the lack of procedures means there is no guidance on the criteria for capturing improvement projects on the system. If QI work is not consistently recorded on the system it is unclear how the QI team ensures successful improvement ideas and lessons are widely shared, and duplication of projects are avoided. • Management do not expect projects captured on Life QI to be approved before starting. It is unclear how the Health Board decides if a project is 'small scale' and 'safe to fail'. • Projects are not given unique reference numbers, which may lead to confusion as the number of projects increases. <u>'Plan on a page'</u> This form is used for small scale projects that the QI team are directly involved in delivering. It captures basic information about the project such as background, objectives, milestones, key stakeholders and progress. However, the template does not require project risks to be identified or assessed.	• Improvement projects not being adequately recorded. • Improvement projects 'fall under the radar' without an accurate, comprehensive record of all QI activity, leading to a lack of monitoring and support and the failure of projects.

Our testing of a small number of projects within the Life QI system identified some instances where a 'plan on a page' had been completed. Clear guidance would set out if this approach should be adopted for all of these projects. We are aware that highlight reports are taken to the Innovation and Improvement Board (IIB) and Senior Leadership Group (SLG) and understand that this is where approvals will take place of QI projects that the team are involved in delivering, but this process is not documented. During the audit we also saw a project workbook that is being trialled on a small number of larger projects that the QI team are involved in delivering. The workbook is more detailed and comprehensive than the 'plan on a page' as it includes information such as project initiation, roles and governance, risk and issues log, an action and decision log and has closure and evaluation sections.		
Recommendations		Priority
1.1	Procedural guidance should be developed that set out the difference between projects that the QI team are involved in delivering and projects where the team operate in a supportive role.	Medium
1.2a	A review of the approach for capturing project initiation information in relation to proposed projects should be undertaken. Where possible a consistent approach, that is not burdensome on staff, yet contains enough detail to allow meaningful initiation decisions to be made, should be adopted. The current 'plan on a page' template could be considered for this but should be reviewed to ensure necessary information is included, especially in relation to benefits and risks and where possible the cost and resource implications.	High
1.2b	The procedural guidance mentioned in 1.1 should set out the criteria of what is deemed small scale and 'safe to fail'. The guidance should sit alongside the 'plan on a page' template to help staff make informed decisions regarding the size and risk associated with their QI project and encouraging them to seek the support and advice of the QI team if they feel their project falls outside the criteria.	

1.3a	A decision should be made regarding which QI projects the QI team expect to see recorded on the Life QI system and the instances where projects do not need to be recorded. Whilst we acknowledge that capturing QI projects on the Life QI system is outside of the control of the QI team, the procedural guidance should include the QI team's expectations of staff in relation to using the system.	Medium	
1.3b	The benefits of capturing all QI information in one place should also be emphasised as part of the guidance.		
1.3c	Consideration should be given to each project captured on the Life QI system having a unique reference number to allow ease of reference going forward.		
1.4	Procedural guidance for use by the QI team in relation to the projects they are directly involved in delivery should be developed and should include, but not be limited to: initiating a project; recording the key elements of a project such as the rationale, expected benefits and outcomes, estimated costs, staff resource requirements and risks; obtaining approval; monitoring and reporting projects. Furthermore, consideration should be given to using the project workbook currently being trailed as the mechanism for capturing QI project information. The workbook should be reviewed and tailored to meet the needs of the Health Board.	High	
Agreed Management Action		Target Date	Responsible Officer
1.1	As part of the response to this audit we are producing an overarching set of procedures and guidance for the iCTM Improvement Team which will incorporate this recommendation. This will be supported by a documented and recorded approval process for projects we agree to support.	January 2023	Paul Gimson - Assistant Director Improvement Culture, Capability & Delivery

1.2a & 1.2b	As part of the response to this audit we will produce an overarching set of procedures and guidance which will incorporate this recommendation. To support this we have already reviewed our procedures in line with the recommendations of this audit. The plan on a page format has been altered to ensure it covers the areas outlined in the audit and a new 'project initiation' form has been created to capture the required details. The project workbook is being used for our pressure damage work and its use will be reviewed and spread as appropriate. Training has been altered to include specific advice on what is deemed safe-to-fail and this will be incorporated into the guidance.	December 2022	Paul Gimson - Assistant Director Improvement Culture, Capability & Delivery
1.3a & 1.3b	We will review our use of LifeQI as a repository for project information. While it may be suitable for this purpose a separate database hosted centrally may be a more appropriate response. However we will review the guidance that supports LifeQI and support the recommendations elsewhere in this report about ensuring a more consistent approach to how it is used. We will develop a reference number system that links to whatever database solution is devised.	March 2023	Paul Gimson - Assistant Director Improvement Culture, Capability & Delivery
1.4	As part of its response to this audit we are producing an overarching set of procedures and guidance for the iCTM Improvement Team which will incorporate this recommendation. The success of 'project workbook' will be reviewed following its use on our Community Acquired Pressure Ulcer project alongside other tools being developed by the Change Hub with a view to adopting a standard approach. A new form has been created to help us properly assess incoming requests for support in line with the audit recommendations.	December 2022	Paul Gimson - Assistant Director Improvement Culture, Capability & Delivery

Matter Arising 2: Project documentation (Operation)	Potential Impact
We undertook a review of the Life QI system to identify what project information was recorded. We note: • None of the sampled projects contained a project justification or business case. • 3/6 did not contain performance measures our outcome targets against which success could be measured. • None contained risk assessment information. • None of the projects had cost information. • The Life QI system has the facility to record 'linked priorities' which can be used to align projects to the Health Board’s strategic aims and objectives. 4/6 had not recorded linked priorities. For Life QI projects that are considered to be small scale and ‘safe to fail’, staff are encouraged to consider the benefits of a project against the risks. We understand that for this reason components of the projects such as costings or performance measures are not necessary, as they may stifle innovation. While we acknowledge that this approach may help innovation, it means that considerations such as how a project is ‘small scale’, ‘safe to fail’, or that benefits outweigh risks are not clear. As identified in Matter Arising 1, the use of a revised ‘plan on a page’ document for Life QI projects could help capture basic information at initiation stage and allow an informed decision to be made before proceeding with the project. Projects that the QI team are directly involved in delivering, are not captured on Life QI. There is no central, comprehensive record of planned and active projects and programmes that the team oversee. As such, no testing has been carried out in relation to those projects.	• The cost of improvements outweigh the benefits. • Resources are not effectively used if quality improvement actions and initiatives fail to deliver the expected improvements. • Incomplete records and lack of audit trail. • The team being unable to evidence how improvements have helped the organisation achieve its strategic aims and objectives.

Recommendations		Priority	
2.1	A comprehensive central record should be maintained of all improvement activity carried out by the QI team. This should include a unique project reference number and the status of each project or programme and the date it was approved.	Medium	
2.2	All Improvement projects should be aligned to the organisation's strategic aims and objectives, and this should be captured within project documentation.	Medium	
Agreed Management Action		Target Date	Responsible Officer
2.1	We are developing a solution which will be based either on use of the existing LifeQI system or a new centrally held database.	January 2023	Paul Gimson - Assistant Director Improvement Culture, Capability & Delivery
2.2	As part of its response to this audit we are producing an overarching set of procedures and guidance for the iCTM Improvement Team which will incorporate this recommendation. Life QI and other software will be adapted to facilitate this.	January 2023	Paul Gimson - Assistant Director Improvement Culture, Capability & Delivery

Matter Arising 3: QI Faculty Framework (Operation)		Potential Impact	
There is a QI Faculty Framework that sets out the links between the QI team and the QI Faculty leads within the Integrated Locality Groups (ILGs). The framework is in draft format and needs updating as it is currently aligned to the Integrated Locality Group (ILG) structure. We note that the roles described within the framework document are expected to be developed over a two-year period and would continue to evolve thereafter. Now would therefore be an opportune time to review and document the effectiveness of the framework, and any issues arising from the implementation and operation of the framework within the existing ILG operating model and incorporate any improvements to an updated QI faculty framework document.		The established QI faculty framework becoming out of date and no longer fit for purpose.	
Recommendations		Priority	
3.1	The QI Faculty Framework should be reviewed. The review should cover the effectiveness of the operation of the framework since its implementation, and re-alignment to the new Care Group structure currently being implemented across the Health Board.	Medium	
3.2	The updated faculty framework document should be formally approved with the date of approval and issue recorded on the document.	Low	
Agreed Management Action		Target Date	Responsible Officer
3.1	As part of its response to this audit we are producing an overarching set of procedures and guidance for the iCTM Improvement Team which will incorporate this recommendation. A review of the Faculty Framework is underway but will be dependent on the roll out of the new organisation structure which is still in progress.	January 2023	Paul Gimson - Assistant Director Improvement Culture, Capability & Delivery

3.2	As part of its response to this audit we are producing an overarching set of procedures and guidance for the iCTM Improvement Team which will incorporate this recommendation.	March 2023	Paul Gimson - Assistant Director Improvement Culture, Capability & Delivery

Matter Arising 4: Project Monitoring and Reporting (Operation)	Potential Impact
We tested a sample of six active projects from the Life QI system to confirm if measures of performance or success has been added by the project owners. This information had been included for three of the projects. Without performance information it may be difficult to monitor projects and determine the success when the project is at its conclusion. We also note that project progress information on the Life QI system was not up to date for 5/6 of the projects that we tested. We did not receive a response from one project lead. In addition, we identified one further completed project where the responsible officer had left the Health Board. As the Life QI system was not up to date, it would not be possible to determine from the system the outcome of the project and more importantly good practice, and lessons learnt during the project may be lost. The IIB has a strategic focus. We reviewed the minutes of IIB meetings together with the progress reports submitted by the Improvement team and identified that there is ongoing reporting on projects that the QI team are involved in delivering. We note that the QI team do not take progress reports against individual projects that are captured on the Life QI system to the IIB. As such, there appears to be no form of monitoring or overview reporting in relation to the Life QI projects. It is unclear how progress is monitored and, as projects conclude, how themes and good practice are identified for wider sharing across the Health Board.	The performance and progress of improvement projects not being effectively monitored and poorly performing projects being allowed to continue.
Recommendations	Priority
4.1 Where possible performance measures and / or indicators should be drawn up and recorded for all improvement projects to allow easier monitoring of success during and at the conclusion of a project.	Medium
4.2 To facilitate wider sharing of information and the lessons and good practice arising from improvement projects, the QI team should liaise with Project Leads to remind them of the	Medium

	importance of keeping the Life QI system updated with progress on their projects and against any performance measures and / or indicators on a regular basis.		
4.3	Monitoring of the projects captured on the Life QI system should be carried by the QI team so they can maintain an oversight of the current status of projects and either remind project owners of the importance of keeping the system up to date or determine if they are in need of support from the QI team to progress the project. Monitoring of Life QI information will also enable the QI team to provide the IIB with periodic updates on data such as the number of live projects, topics and themes, completed projects and their outcomes and lessons for sharing.		Medium
Agreed Management Action		Target Date	Responsible Officer
4.1	The nature of improvement and our approach to nurturing improvement skills as opposed to direct involvement in project may make this difficult to implement for every project. However we will include this in our new procedural guidelines and where possible include it within the scope of improvement projects.	January 2023	Paul Gimson - Assistant Director Improvement Culture, Capability & Delivery
4.2	As part of its response to this audit we are producing an overarching set of procedures and guidance for the iCTM Improvement Team which will incorporate this recommendation. Clearer guidance on the use of LifeQI and the accountability associated with receiving a license will be part of this guidance.	January 2023	Paul Gimson - Assistant Director Improvement Culture, Capability & Delivery
4.3	As part of its response to this audit we are producing an overarching set of procedures and guidance for the iCTM Improvement Team which will incorporate this recommendation. More specifically members of the team	January 2023	Paul Gimson - Assistant Director Improvement Culture, Capability & Delivery

	will be assigned specific responsibilities around the monitoring of projects and we will incorporate a monthly review of projects on Life QI within our wider QI faculty structure.		

Matter Arising 5: Risk Management Arrangements (Design)	Potential Impact
We understand that risks relating to QI projects have been managed on a project-by-project basis. Risk logs are considered by the Improvement Programme Board and if necessary, are escalated to the organisational risk register. However, there is no specific guidance relating to improvement project risk. We understand that the small-scale projects are considered low risk and 'safe to fail'. However, we reviewed a sample of six active small projects, but there was no evidence that risk had been considered. Small projects are logged on the Life QI system, but this does not have a field specifically for recording risk, or the facility to create a project risk log or risk register. From our discussions with projects leads it appears that, while some projects may have associated risks, these are not documented so it was unclear how effectively the risks are managed. As these projects do not require approval before starting, there is no mechanism to 'sense check' the proposed relative level of risk. At the time of our fieldwork, management has identified the need to undertake risk assessments in line with the Health Board policy and develop a QI team risk register, as risks in relation to Quality Improvement work and the team had not been captured.	Project and team risks are not identified and effectively managed.
Recommendations	Priority
5.1 Management should develop and document processes for Project Leads to follow to allow identification and assessment of project risks, in order to determine if projects are low risk and therefore suitable to progress as Life QI projects. A risk log should be created for each project and reviewed throughout the project to ensure that potential risks, including those that may jeopardise the success of the project, or outweigh its benefits are identified and managed.	High

5.2	We note that Risk Management training has been provided to the Change Hub team. This training should be rolled out to the QI team in order facilitate them in developing their own risk register.	High	
Agreed Management Action		Target Date	Responsible Officer
5.1	We are working closely with our Corporate Risk Management Team to implement this recommendation and incorporate a risk assessment and register into our procedural guidance.	December 2022	Paul Gimson - Assistant Director Improvement Culture, Capability & Delivery & Cally Hamblyn – Assistant Director or Governance & Risk
5.2	We are working closely with our Corporate Risk Management Team are organising this training to ensure it is part of our induction process and regularly updated.	December 2022	Paul Gimson - Assistant Director Improvement Culture, Capability & Delivery & Cally Hamblyn – Assistant Director or Governance & Risk

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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



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

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

Radiology Service Review

Final Internal Audit Report

October 2022

Cwm Taf Morgannwg University Health Board



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Auditors:	Sharon Edwards, Principal Auditor Elizabeth Vincent, Principal Auditor Emma Samways, Deputy Head of Internal Audit
Executive sign-off:	Gethin Hughes, Chief Operating Officer
Distribution:	Stuart Hackwell, Locality Group Director Sally Bolt, Clinical Director Bronwyn Baldwin, Interim CSG Manager Paul Johnston & Sharon Donovan Superintendent Radiographers
Committee:	Audit & Risk Committee



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Acknowledgement

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Executive Summary

Purpose

The overall objective of the audit was to evaluate and determine the adequacy of the systems and controls in place within the Radiology service in relation to key assurance areas.

Overview

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

- Reviewing policies and procedures to ensure all are up to date, accessible and standardised where relevant across sites.
- Having more comprehensive monitoring of the risk register in the relevant committees.
- Ensuring complete and accurate records are maintained to enable the management of absence.
- Undertaking Personal Develop Reviews (PDRs) for all staff annually.
- Confirming the accuracy of individual’s mandatory training requirements and ensuring all staff complete training in line with those requirements.
- Reviewing and agreeing Consultant job plans on annual basis.
- Undertaking workforce planning to allow the service to better plan for the future.
- Having a greater control and awareness over medical agency use.

Assurance summary

Due to the wide range of areas covered in our Clinical Service Group reviews, we do not provide an overall assurance opinion. Instead, we have provided separate assurance opinions for each of the areas that we reviewed.

Assurance Area		Assurance
1	Governance Arrangements	Reasonable
2	Risk Management	Reasonable
3	Workforce Management	Limited
4	Planning and Performance	Reasonable
5	Compliance with relevant FCPs	Reasonable

Key Matters Arising		Assurance Area	Control Design or Operation	Recommendation Priority
Governance Arrangements				
1	Terms of Reference for Committees and Groups	1	Design	Medium
2	Conduct of Committees and Groups	1	Operation	Medium
3	Policies and Procedures	1	Operation	High
4	Declarations of Interest	1	Operation	Medium

Key Matters Arising		Assurance Area	Control Design or Operation	Recommendation Priority
Risk Management				
5	Risk Monitoring	2	Operation	High
Workforce				
6	Sickness Absence	3	Operation	High
7	Annual Leave	3	Operation	Medium
8	TOIL	3	Operation	Medium
9	PDRs	3	Operation	High
10	Mandatory Training	3	Operation	High
11	Consultant Job Plans	3	Operation	High
Planning and Performance				
12	Workforce Planning	4	Operation	High
13	Consistency in Monitoring Arrangements	4	Operation	Medium
Compliance with FCPs				
14	CRES target information	5	Operation	Medium
15	Medical Agency use	5	Operation	High

1. Introduction

- 1.1 Our audit of the Radiology Service was completed in line with the 2022/23 Internal Audit Plan for Cwm Taf Morgannwg University Health Board (the 'Health Board').
- 1.2 Radiology, along with Pathology and Medical Records, form the Clinical Support Services Clinical Service Group (CSG), that is hosted by Rhondda Taf Ely Integrated Locality Group (ILG) on behalf of the Health Board. Radiology services operate from all three of the Health Board's localities and our review and testing focussed on the three main hospital sites of Royal Glamorgan Hospital (RGH), Princess of Wales Hospital (POW) and Prince Charles Hospital (PCH).
- 1.3 An Interim CSG Manager started in post a month before our audit fieldwork began. Prior to that time, the CSG has had a prolonged period of staff absence at that level, resulting in interim management arrangements in the form of the Clinical Director and Acute Services Manager taking on additional responsibilities to ensure the continued running of the service.
- 1.4 Over the last few years, as part of the Internal Audit programme, we have reviewed the management arrangements and compliance with key financial documents in a number of the Health Board's CSGs. This year's programme continues with this theme.
- 1.5 The relevant Executive Director lead for the assignment is the Chief Operating Officer.
- 1.6 The potential risks considered in the review were as follows:
 - The CSG is not appropriately governed which could result in a service that is not being delivered safely and effectively.
 - Services are not effectively planned.
 - Risks materialise as they have not been identified and / or addressed.
 - Reduced service provision / additional costs due to inappropriate or unauthorised absence.
 - Staff performance is not effectively assessed and addressed.
 - CSG objectives are not achieved as a result of demand and capacity data failing to be properly used and monitored
 - Inappropriate or unauthorised decisions are made if staff are unaware of the relevant key documents.
 - Inappropriate or unauthorised decisions due to non-compliance with legislation or corporate and operational policies.
 - Financial expenditure unnecessarily incurred.

2. Detailed Audit Findings

Area for assurance 1: Governance Arrangements

Governance Committees and Groups

- 2.1 A number of committees and groups oversee the governance arrangements and operation of the Radiology service. The committees and groups structure is identified in a single document which maps the various meetings and reporting lines between them.
- 2.2 There have been recent revisions to the governance arrangements with the introduction of a Radiology Management Team Business Meeting. While we understand that this will be a pivotal group that all other committees and groups report into, at the time our fieldwork, the group had yet to meet. We note that subsequently a Terms of Reference (ToRs) has been finalised and the group has met.
- 2.3 We saw evidence of the ILG monitoring governance at a CSG level through the monthly Performance Review meetings. However, the meetings varied in coverage, with some focused on the Radiology service, and others including information on the other services in the CSG, such as Pathology and Medical Records. This lack of consistency in coverage has been highlighted in paragraph 2.34 as it has an impact on the ability to monitor Radiology performance effectively.
- 2.4 We note that there is no ToR for the Performance Review meeting. The ToR for the Radiology Quality, Improvement & Governance meeting pre-dates the merger with Bridgend. As such, the remit of these groups is not clear, meaning there may be duplication in coverage, or areas may not be getting the required level of scrutiny. **(Matter Arising 1)** Furthermore, the quarterly Quality, Improvement & Governance group has not met since September 2021 due to staffing constraints. **(Matter Arising 2)**
- 2.5 While the Radiology service is provided across all three localities, there does not appear to be a consistent approach to governance and monitoring arrangements across the sites. We understand that the PoW team have monthly governance meetings, although no documentation in relation them was provided to us. Since January 2022, RGH have held similar meetings, although the ToR has not yet been finalised. There is no equivalent meeting at PCH. **(Matter Arising 2)**

Policies and Procedures

- 2.6 Radiology policies and procedures are available to staff through localised SharePoint sites. However, we understand that numerous documents have passed their review date, and in many cases multiple versions of a document exist due to there being a version for the former Cwm Taf sites and a PoW site version. We note that management are undertaking an exercise to identify existing policies and procedures from across the three localities, with a view to reviewing, revising and amalgamating where necessary. However, progress has been slow due to resource constraints. **(Matter Arising 3)**

Declaration of Interest

- 2.7 Our testing identified that declarations of interest or 'nil' returns were not in place for all Radiology staff that should have completed them. **(Matter Arising 4)**

Conclusion:

- 2.8 We note that management are aware of some of the governance issues that the service is facing. The work to define the governance structure and introduce the Radiology Management Team Business meetings will be key to the success of the structure. Further work is needed to ensure that the committees and groups that feed into the Radiology Management Team Business meetings are aware of their responsibilities and meet regularly and consistently across the service. We acknowledge that the implementation of the Health Board's revised operating model may have some impact. We have provided Reasonable Assurance in this area.

Area for assurance 2: Risk Management

- 2.9 Management have been cleansing the risk register to ensure that only risks and not issues are captured. Risks, including lower scoring risks, are recorded in the Datix risk management module by the Superintendent Radiographer. There are twelve risks on the Radiology risk register, with seven relating to all three localities. Only one risk is categorised as a 'high risk', with the remaining eleven 'moderate' or 'low' risks.
- 2.10 Risks on the register include a number in relation to the demand placed on the service and the related capacity issues. Linked to this is the risk of the impact on patient diagnosis and treatment if the service is unable to report radiology examinations in a timely manner. We note that these risks are categorised as Health Board wide risks, but our review of performance data shows that the backlog is greater for some localities than in others. Therefore it may be more appropriate to have these risks captured on locality risk registers, to allow reflection of the different level of concern in each area.
- 2.11 Our review of risks in Datix confirmed that all had evidence of review by the designated risk handler within the last four months. However, it was not always clear what that review entailed, as in many cases the narrative outlining the controls that are in place had not been updated for some time. **(Matter Arising 5)**
- 2.12 In line with the Risk Management Policy, we saw evidence of the one high scoring risk being monitored at an ILG level during the monthly Performance Review meetings. We are also aware that managing risk is a standard agenda item for the Quality, Improvement & Governance Group. However, as the group has not met since September 2021, we were unable to see where moderate and low risks, and the risk register in its entirety, is being monitored. **(Matter Arising 5)**
- 2.13 Furthermore, we did not see evidence of risks being discussed at a locality level in governance departmental meetings (where they exist). Some demand and capacity related risks are more of an issue in certain localities, therefore a more

granulated approach to these risks, and monitoring at a locality level, may be more beneficial. **(Matter Arising 5)**

Conclusion:

- 2.14 We can see that the Datix system is regularly being used to manage risk. However, the lack of narrative updates within the system and evidence of review in meetings makes it hard to determine the level of review that is taking place and to establish how risks are escalated and de-escalated through the service. We have provided Reasonable Assurance in this area.

Area for assurance 3: Workforce

Sickness Absence

- 2.15 We tested a sample of staff absences from across the three localities to ensure compliance with the All Wales Managing Attendance at Work Policy. The level of documentation to confirm compliance with the policy varied, and we were not provided with supporting information for our sampled items from PCH. At RGH and POW, where more information was available, our testing identified: a number of discrepancies between paper records and ESR; incomplete records; and a lack of information to evidence that repeated absences had been managed in line with the 'prompts' set out in the policy. **(Matter Arising 6)**

Managing Leave

- 2.16 All sites have principles in place setting out how many staff at each band can take leave at any one time. When reviewing the rosters, we could see that in the main, these principles were being followed.
- 2.17 RGH and PCH use Health Roster, therefore annual leave is booked and approved via the rostering system, with automatic feeds into ESR. As such we did not test this process. At the time of our fieldwork POW were in the process of migrating from paper annual leave records to using ESR, and were 'parallel running' both systems while staff familiarised themselves with ESR. However, staff continue to use paper records and our testing identified a small number of minor errors that would not have occurred if the leave had been booked directly on ESR. **(Matter Arising 7)**
- 2.18 We understand that TOIL is not used at PCH. If staff work additional hours, they are paid overtime or use the hours against their 'make up' shift. However, a report from Health Roster shows staff with hours owing to them and vice versa. We understand that these balances are linked to the way the rostering system is being used in PCH to capture information, as opposed to it being TOIL balances. The same report shows 18 RGH members of staff had a TOIL balance, the highest value being 7.5hours, suggesting that TOIL, is in the main being effectively managed. However, when reviewing the Health Roster system with a member of staff some discrepancies were identified that required further investigation. **(Matter Arising 8)**
- 2.19 As POW do not use Health Roster, manual TOIL records are maintained. Whilst our testing did not identify any obvious errors, the forms were heavily annotated and

difficult to review, making them more susceptible to errors. We also note due to covid staff have had high TOIL balances over the last few years, which more recently staff have been able to take the time back. **(Matter Arising 8)**

PDR & Mandatory Training Compliance

- 2.20 The service is struggling to achieve the required compliance levels both for PDRs and mandatory training. Whilst compliance data has been provided to the service at their request, or when asked by workforce to improve compliance rates, more recently the service has asked for data each month.
- 2.21 At the time of our fieldwork approximately 57% of staff did not have an up-to-date PDR, with some staff not having had a PDR meeting since before the pandemic. There are also a number of staff without PDRs that are due increments in the forthcoming year. The lack of a PDR logged in ESR could have an impact on staff being moved to their next pay point. **(Matter Arising 9)**
- 2.22 The mandatory training compliance rate against the Health Board core modules was 52%. Some staff must complete additional levels in the core modules. Management have expressed concerns that some of these additional allocated levels are inappropriate for the role. In addition, some staff will have professional qualifications over and above their ESR requirements, but this information is not captured in ESR.
- 2.23 Aside from some potential inaccuracies in the ESR requirements impacting on compliance rates, our testing has identified that there remain a number of staff who are not undertaking their mandatory training. In an effort to overcome this, the Interim CSG manager has introduced a 'module of the month' as a way to encourage staff to update their training. **(Matter Arising 10)**

Staff Rosters

- 2.24 There are two different rostering systems in place across the three sites. RGH and PCH use Health Roster, while POW use spreadsheets. All sites have roster templates, however the shift patterns adopted varies in approach. Our testing showed that where possible, rosters are created in line with the templates, although this is not always possible where there are staffing vacancies. Agency staff are used if available, but given the speciality of the service, this is not always possible.
- 2.25 We confirmed that rosters are generated in a timely manner ahead of the period start date. Where possible the roster creators ensure fixed working patterns, annual leave requests, and day off preferences are granted.
- 2.26 Our testing in relation to TOIL has highlighted some inaccuracies with the way in which information is being captured in Health Roster at PCH, as some staff had extremely high or low TOIL balances. **(Matter Arising 8)**

Consultant Job Plans

- 2.27 The pause in requirements to undertake annual consultant job plan reviews, coupled with the management resource issues faced by the service, has had a direct impact on the job planning compliance rates. At the time of our review, we understand that the low compliance rate has yet to be addressed.
- 2.28 Through our discussions we identified errors with the data held in the Allocate system. We also established that the recently published job planning procedure was not being used by management to progress the job plans of the Consultants that are not signing them off in a timely manner. **(Matter Arising 11)**

Conclusion:

- 2.29 Our testing in relation to workforce across the three sites has identified a number of issues at site level and had also highlighted the different operating practices in place across the service. We have provided Limited Assurance in this area.

Area for assurance 4: Planning and Performance

Planning Arrangements

- 2.30 For 2022/23 the Health Board stood down its localised IMTP planning process due to ongoing covid pressures. There was no requirement for the Radiology Service or the wider Clinical Support Services CSG to create an IMTP or annual plan. Instead, planning took place at an ILG level, with a focus on the completion of finance templates. CSGs were required to identify key priorities for the 2022/23 for monitoring through their Performance Review meetings, although there was no funding for service developments. They were also involved in developing their Cash Releasing Efficiency Savings (CRES) plans.
- 2.31 In addition, formal workforce plans have not been required for 2022/23. There has been no workforce planning outside of IMTP requirements to enable the CSG to more effectively manage its workforce in terms of vacancies and future retirements. **(Matter Arising 12)**

Monitoring Performance

- 2.32 The monthly Performance Review meetings monitor against the carried forward IMTP priorities; quality measures including concerns, complaints, Serious Incidents and harm reviews; workforce key indicators such as sickness levels, PDR and mandatory training compliance rates and job planning completion rates; and service delivery performance rates. More detailed monitoring of quality matters happens at the Integrated Quality & Governance Group, but this group has not met since September 2021.
- 2.33 Our analysis of the workforce performance data identified that some of the target compliance rates varied from month to month and were not in line with the WG targets. **(Matter Arising 13)**
- 2.34 We also note that the format of some of the workforce, quality data and service delivery data contained in slide decks varied between months. Some had granulated information on the Radiology service, or information broken down by

locality, but this was not always available, and some months contained no data for the CSG as a whole. As such, it is difficult to identify the performance position of the Radiology service. **(Matter Arising 13)**

- 2.35 As noted above there are governance meetings in two of the three localities, although we have only sighted papers for one locality. It is during these meetings that we would expect to see more granulated performance monitoring taking place. Whilst we could see performance being discussed at the RGH governance meeting, detailed reports and data is not taken to the meetings to facilitate performance monitoring. We acknowledge that this group is in its infancy and is yet to develop a Terms of Reference. **(Matter Arising 13)**

Conclusion:

- 2.36 As a hosted service, we have reviewed aspects of the service provision in all three ILGs and there are clear differences across the sites for example the approach to performance monitoring. We acknowledge that the CSG manager staffing issues have probably exacerbated this. However, going forward, the changes to the operating model should help Radiology address a number of the matters that we have identified. We have provided Reasonable Assurance in this area.

Area for assurance 5: Compliance with FCPs

Budgetary Control

- 2.37 The Interim CSG Manager is the overall budget holder for the Radiology Service, although the Superintendent Registrars, and three site leads, also have responsibility for budget monitoring. For 2022/23 there was no requirement for budget holders to formally agree and sign off acceptance of their budget, as in the main they were rolled over from 2021/22. The only changes were to allow for inflation and the new CRES targets.
- 2.38 The service area has a close working relationship with its Finance Business Partner, who provides information and support to the senior managers when requested.
- 2.39 The Interim CSG Manager receives a monthly finance pack, and along with other senior staff has access to QlikView where finance and staff reports can be reviewed, and they can drill down to analyse cost information in more detail. QlikView training has recently been provided by the Finance Business Partner to the senior staff.
- 2.40 High level budget monitoring was seen to take place at the monthly Performance Review meetings. However, we noted that information in relation to the CRES target and plans is not clear to understand and lacks any detail to be meaningful. **(Matter Arising 14)** During the course of our audit, the Interim CSG Manager re-introduced monthly Business Meetings. The Finance Business Partner was seen to be in attendance at the two meetings held to date, where finance updates were provided.

Medical Variable Pay

- 2.41 Due to vacancies, the service regularly needs to use medical agency staff. However, a reduction in agency staff spend is highlighted in the monthly Performance Review reports as an opportunity to help achieve the CRES target.

Our testing has identified that there appears to be a lack of oversight in relation to agency usage. Numerous staff had to be contacted in order to determine who some of the agency staff being paid were, and to confirm details of the days worked. This lack of oversight appears to be the cause of a large accrual for an agency medic that did not work for the service as planned. **(Matter Arising 15)**

- 2.42 For the sample of agency staff we reviewed, we were unable to obtain any documentation to confirm that rates of pay paid to agency consultants was below the WG price cap or that appropriate authorisation had been sought to exceed the cap. **(Matter Arising 15)** However, we have seen an email exchange for a future agency booking that was being arranged as we were undertaking the audit. In this case it was acknowledged that the rate of pay was above the WG price cap and ILG Director is seen to challenge the rate in comparison to usual rates and request confirmation that the cost is being covered by existing vacancies.

Conclusion:

- 2.43 The resource issues around the lack of a CSG Manager earlier in the year have potentially had an impact on the level of oversight and scrutiny that was applied to expenditure including on medical agency staff. We have seen that more robust processes are now being introduced with budget monitoring training being arranged and challenge of agency use and rates. We have provided Reasonable Assurance in this area.

Appendix A: Management Action Plan

Governance Arrangements

Matter Arising 1: Terms of Reference for Committees & Groups (Design)			Potential Impact
In relation to the key groups within the CSG, we identified the following: - There was no Terms of Reference (ToR) for the Radiology Performance Group meeting. This is a key meeting that reports on risk, quality, financial and workforce information to the ILG. The group meet each month and key CSG staff and Business Partners attend. As there is no ToR it is unclear if the right people attend, the quoracy arrangements, or if the group is fulfilling its intended purpose. - The ToR for the Quality, Improvement & Governance group was due for review in January 2022 and pre-date the April 2020 operating model. The ToR do not reflect that Radiology is a service hosted by RTE and does not identify how quality improvement assurance is provided by the two other ILGs.			The CSG is not appropriately governed which could result in a service that is not being delivered safely and effectively.
Recommendations			Priority
1.1	The Terms of Reference for all groups and committees should be reviewed to ensure they are up to date and relevant, including information such as purpose and remit of the group, attendees and quoracy arrangements, frequency of meetings and arrangements for rescheduling.		Medium
Agreed Management Actions		Target Date	Responsible Officer
1.1	Due to the HB restructure, the previous Radiology Performance Meeting Forum has been stood down and replaced with a weekly Care Group Radiology Performance Review. ToR to be sourced from the Executive Office to reflect attendees, quoracy and frequency of the meetings while the care group structure beds in.	31 December 2022	Executive Office
	A Radiology Quality, Improvement & Governance Structure Meeting has been arranged to update the governance meeting arrangements, reporting structure and review of ToR on 9/11/2022.	9 November 2022	Clinical Service Manager Senior Superintendents

			Clinical Lead for Quality and Governance Health and Safety Leads

Matter Arising 2: Conduct of Committees & Groups (Operation)		Potential Impact
Through our review of agendas, minutes and action logs of the key groups we identified: - The Quality Improvement & Governance group, which should meet quarterly, has not met since September 2021, due to staff availability including the Chair. We also note that there is no Vice Chair in place. - There are monthly departmental meetings at RGH, and while we understand that there are similar meetings at PoW, we have seen papers relating to these meetings. No similar meeting takes place at PCH. The committee and groups structure diagram identifies that these meetings feed into the overarching Radiology Management Team Business Meeting. - While there is an action log relating to the Performance Review meetings, we did not see evidence of the process for following up the actions at subsequent meetings to ensure they have been implemented or carried forward.		The CSG is not appropriately governed which could result in a service that is not being delivered safely and effectively.
Recommendations		Priority
2.1	a) Where scheduled quarterly meetings fail to take place, to prevent large time gaps, consideration should be given to rearranging the meeting, as opposed to waiting to next scheduled quarterly meeting. b) To prevent Quality Improvement & Governance group meetings being cancelled when the Chair is not available, a Vice-Chair should be appointed.	Medium
2.2	Consistent approaches to monitoring and governance arrangements should be in place across the localities. Where groups exist that operate on a locality basis, standardised terms of reference should be in place.	Medium
2.3	It should be ensured that action logs generated after meetings are followed up at future meetings, to confirm that work has been undertaken and the action closed or carried forward.	Medium

Agreed Management Actions		Target Date	Responsible Officer
2.1	a) The service management team have scheduled quarterly meetings from December 2022 through to April 2024. The Radiology Quality, Improvement & Governance Structure Meeting arranged on 9 November 2022 will address the quoracy structure and appointment of Vice Chair to ensure that the meetings are not cancelled unless there is not quorate. In the event of a cancelation the members will review the agenda to assess whether there are any urgent matters that require action and re-arrange the meetings as necessary. b) The Terms of Reference for the Quality & Governance Group will be reviewed and updated on 9 November 2022. This will identify a Vice Chair for the meetings.	30 th November 2022	Clinical Service Manager Clinical Lead for Quality and Governance Senior Superintendents Health and Safety Leads
2.2	The Terms of Reference for all existing groups will be reviewed to ensure that there is a standardised approach.	31 st December 2022	Clinical Service Manager
2.3	A review of the action log will be a standing item on all meeting agendas. This is currently in operation for the Radiology Quality, Improvement & Governance Meetings. The new Care Group Performance Review produces an action log following the meeting, which can be evidenced.	Complete	Clinical Service Manager Executive Office

Matter Arising 3: Policies and procedures (Operation)		Potential Impact	
Management are undertaking a review of Radiology policies and procedures across the three localities. Since the merger with Bridgend, limited work has been carried out to refine the policies and procedures. Management is aware that there may be duplication, processes across sites not standardised and many policies and procedures are out of date or no longer valid. At the time of our review, management were working to identify all of the existing policies and procedures within Radiology before undertaking a review. We note that staff have access to policies and procedures via their local SharePoint sites.		Inappropriate or unsafe decisions made due to operational policies being out of date and not reflecting current legislation or best practice. Inconsistencies in working practices across sites.	
Recommendations		Priority	
3.1	a) Due to the volume of policies and procedures that require reviewing, a plan should be developed with clear objectives, targets and responsible officers to ensure that all are reviewed and disseminated to staff in a timely manner. Once a list of all existing policies and procedures has been created, work needs to progress collectively across all localities to determine what needs to be updated, deleted, or amalgamated, while also recognising that some policies are site specific. b) Going forward, a policy and procedure register should be maintained identifying the document owner and the review dates in order to make it easier to keep them up to date.	High	
3.2	Consideration should be given to having a standard agenda item during the Radiology Management Team Business Meeting in relation to policies and procedures, to ensure that all staff are aware of what is due for review and to ensure that there is consistent communication in relation to new policies or policy updates following changes in legislation or guidance.	Medium	
Agreed Management Actions		Target Date	Responsible Officer
3.1	a) A review of all policies and procedures will be scheduled and responsible officers identified to oversee the process of updating, deleting or amalgamating. A formal circulation list for review of any policies / procedures has been developed. A	June 30 th 2023	Senior Superintendents Clinical Leads

	Radiology adapted Policy for the Management and Authorisation of Radiology documents has been drafted for ratification on 1 December 2022. b) A policy and procedure register is established and maintained to identify the owner and review dates. Investigation to try and automate reminders for policy review via Sharepoint underway.	June 30 th 2023	Superintendent Radiographers Clinical Leads Health & Safety Leads
3.2	The Radiology Management Team Business Meeting agenda will be changed on the 17th October 2022 to ensure that is a standing item relating to policies and procedures to review and ratify.	Completed	Clinical Services Manager

Matter Arising 4: Declaration of interest (Operation)		Potential Impact
We identified 44 staff members who should have completed a declaration of interest or nil return for 2021/22. However, we were only able to confirm returns for eleven members of staff. We note that there were a small number of new employees that came into post after these dates, so would not be included in the committee reports. Furthermore, we understand that other members of staff had completed declarations, but were not showing in the reports. It is unclear why this was the case. We note that no reminders had been sent to prompt staff to complete their returns.		Personal interests are not considered meaning inappropriate decisions are made.
Recommendations		Priority
a) Acknowledging that for 2022/23 the Standards of Behaviour Policy has been amended, and less categories of staff will be required to make a return, relevant staff within Radiology should be reminded of the relevance of the policy and the requirement to comply with it and complete an annual return. Where individuals fail to make a return, managers should continue to prompt staff to do so. b) Management should work with the Committee team to identify any gaps in the declaration of interest reporting.		Medium
Agreed Management Actions	Target Date	Responsible Officer
a) The register of the declaration of interest information is maintained by the Corporate Service Department and submissions are registered and updated through this Department. A request for any outstanding declaration of interest will be made to the Corporate Services Department to identify those individual where these are outstanding and the relevant staff will be prompted to complete. b) A system of review will be agreed with the Corporate Services Department.	31 st December 2022	Corporate Services Manager/Clinical Service Manager

Risk Management

Matter Arising 5: Risk monitoring (Operation)	Potential Impact
The Radiology risk register contains 12 risks ranging in score from 2 to 16. One risk is assigned to a member of staff that has left the CSG. This is a low scoring risk. <u>Monitoring in Datix</u> We looked at the risks on Datix and confirmed that they had evidence of review in the past four months. However, in most cases it appeared that 'controls in place' entry had not been updated. For five risks the controls information had not been updated since 2021, and there was one risk with no review date recorded against the controls. For example: • One risk cites as a control, the purchase of equipment with 2021/22 capital funds, at which point the risk can be closed. The risk remains open, and there is no update to state that the equipment wasn't purchased. • One risk refers to a pilot project that started in 2020. In March 2021 the pilot is recorded as 'ongoing', but there is no further information. <u>Monitoring in committees</u> The Quality, Improvement & Governance Group agenda has a standard item on managing risk. Our review of minutes from the meetings that took place in 2021 identified that their focus was on cleansing the register. The group has not met since September 2021 so it is not clear where the risk register, and more specifically where moderate rated risks, are monitored. As stated in Matter Arising 2, we understand that monthly departmental meetings are held at POW and RGH, though not at PCH. We have not been given papers for the POW meetings, so cannot establish if the risk register and risks specific to that site are discussed. We did not see risk being discussed in the papers of the RGH meetings. From our review of performance data we note that certain demand and capacity issues impact some localities more than others. Therefore, more granulated risk registers and localised monitoring would be beneficial.	Risks materialise as they have not been monitored and action taken not taken to address them or escalate where necessary.

Recommendations		Priority	
5.1	When risks are reviewed within Datix, the narrative in the 'controls in place' or notes section should be updated for changes since the previous review.	Medium	
5.2	A risk management monitoring structure should be established, ensuring that the risk register is a standing agenda item for relevant committees or groups. Lower scoring and more localised risks should be monitored at the localised departmental meetings, with the moderate and higher scoring risks, along with oversight of the whole risk register considered at Quality Improvement & Governance Group and where appropriate, reported to the ILG Radiology Performance Review Group. There should be a clear escalation process between the groups.	High	
Agreed Management Actions		Target Date	Responsible Officer
5.1	A review of the risk register will be undertaken to establish those that can be closed and a regular review of the Datix and the controls in place scheduled into monthly meetings. Advice will be taken from the newly centralised corporate Governance Team in relation to management of the Risk Register.	30 th November 2022	Superintendent Radiographers Clinical Service Manager Care Group Service Director
5.2	As described above a risk management monitoring system will be established with the Quality Improvement & Governance Group having oversight of the register and an escalation process for moderate and high risks.	31 st December 2022	Clinical Lead for Quality and Governance Senior Superintendents

Workforce

Matter Arising 6: Absence Management (Operation)	Potential Impact
Each locality is at a different stage of transferring their paper-based staff personal files to electronic personal folders, to allow easier management access. At the time of our review the files were still mostly paper-based. To ensure compliance with the All Wales Managing Attendance at work policy, we tested a sample of absences across the three localities based on their levels of sickness. We identified: <u>PCH</u> We were unable to test the five periods of sickness that we sampled as no self-certification forms, RTW forms or other paperwork relating to the absences had been completed. For two of the employees, the period of absence would have triggered a prompt under the policy, but there was no documentation in relation to this. <u>RGH</u> For the seven periods of sickness we sampled, a number of discrepancies were identified. These were: • Self-certification forms - 3/7 the absence end dates did not reconcile to ESR, 2/7 the reason for absence was not recorded, 2/7 the form was not signed by the manager, 1/7 the form was completed four weeks after the RTW date, as opposed to when the absence took place. • RTW forms - 3/7 were not completed within 7 days of the actual return to work, though we acknowledge that shift patterns had an impact on this. 1/7 was not signed by the manager. • Medical certificates - 3/7 required medical certificates. In one case the certificates did not cover the full period of absences with 10 days being uncertified. • Prompts - 2/7 a prompt had been met, but an informal or formal interview was not carried out. We also saw other instances where prompts were not instigated at management discretion, however the rationale for this was not documented. <u>POW</u> We selected five periods of sickness to review, although one employee remained absent at the time of our fieldwork. From the remaining four a small number of discrepancies were identified.	Sickness is not properly recorded resulting in incorrect pay. Sickness is not properly managed resulting in additional costs as shifts have to be covered by agency or bank staff. Sickness is not well managed so effecting staff wellbeing.

- Self-certification forms - 3/4 the absence end dates did not reconcile to ESR; 1/4 the form was not signed by the manager.
- Prompts - where prompts had been met, we were informed of the reason why a decision had been made to not progress through an informal or formal interview, however the reasons were not always documented.

Recommendations		Priority	
6.1	In order for absence to be properly managed and pay not to be affected, comprehensive and accurate documentation in relation to each episode of sickness should be maintained. Management should ensure that self-certification and return to work forms are fully completed in a timely manner following the employee's return. All information contained on self-certification forms, RTW forms and ESR should correspond, and the period of absence should be fully covered by self-certification forms or medical certificates.	High	
6.2	Where periods of absence result in a prompt being breached, appropriate action in line with the Managing Attendance Policy should be taken. Where a manager exercises their discretion and chooses not to undertake an informal or formal warning, this decision should be documented on the individual's file.	Medium	
6.3	The roll out of electronic staff files across the service should progress with all electronic files fully populated with documentation scanned from hard copy files. Consideration should be given to replicating the Standard Operating Procedure developed in other CSGs (such as CAMHS) in relation to the set up and use of electronic staff files.	Medium	
Agreed Management Actions		Target Date	Responsible Officer
6.1	All superintendents will be advised of the need to maintain comprehensive and accurate documentation in relation to each episode of sickness absence and ensuring that all documentation is completed in a timely manner in line with the Managing Attendance Policy. A request will be made to workforce for Sickness/Absence Management Training.	31 st December 2022	Site Superintendent Radiographers

6.2	All superintendents will be advised of the need to maintain accurate documentation of all decision taken including those outside of the Managing Attendance Policy.	31 st December 2022	Superintendent Radiographers
6.3	The service will liaise with other recommended CSGs who have implemented areas of good practice based on previous findings to establish a Standard Operating Procedures for the electronic files.	31 st January 2023	Clinical Services Manager

Matter Arising 7: Annual leave (Operation)		Potential Impact
At the time of our audit fieldwork staff at POW were in the processes of transitioning from paper annual leave records to the use of ESR. The two systems were to run in parallel whilst staff got used to using ESR. However, when we undertook a small amount of testing of the annual leave records, we identified that the majority of staff were using paper records and not ESR. We identified a small number of errors when reviewing the paper records, including one member of staff who had requested and had authorised the same leave day twice. We also saw errors in the carry forward balances. These errors may not have occurred if the ESR system was used to manage annual leave.		Inaccurate records exist resulting in staff taking too much or not enough leave in a year. Services are not effectively planned.
Recommendation		Priority
Management should remind staff of the importance of using ESR for requesting and authorising annual leave. Once management are assured that the correct opening balances are captured within ESR, the use of paper records should cease, to prevent confusion and duplication.		Medium
Agreed Management Action	Target Date	Responsible Officer
The teams will be encouraged to ensure all leave is recorded on ESR system and if any problems are encountered will escalate to ESR team and Care Group Service Director.	30 th November 2022	Clinical Service Group Manager Superintendent Radiographers

Matter Arising 8: TOIL (Operation)	Potential Impact
As PCH and RGH use Health Roster, TOIL should be calculated in the system, though there is a need for management to manually adjust times when someone works longer hours and accrues time or when hours are taken back. Through our review we identified: - PCH do not appear to be capturing hours correctly as the values showing in the system seemed excessive. - At RGH, we identified some discrepancies in relation to the balances for one group of staff that would suggest that some manual adjustments were not being input. Furthermore, forms should be completed by staff when requesting to take back TOIL. There was no supporting documentation for the small sample that we tested. Whilst managers will be aware that TOIL has been taken, as they make the adjustment on Health Roster, this will not be until after the event. The forms allow for approval in advance. As POW Radiology staff do not use Health Roster manual records are maintained. The records that we reviewed did not appear to be fit for purpose as they were annotated and difficult to follow. There were no boxes on the forms to capture basic information such as the employee's name, the reason for working the additional hours, brought forward or carry forward balances, signature of employee or manager when requesting / approving entries. Whilst this information was mostly present on the forms, it was often in the form of handwritten notes added to the form. Of the 42 staff who have TOIL balances, eleven had each built up more than 30 hours of TOIL, with one staff member having a balance of 69 hours. Our analysis shows these balances have built up over a number of years and more recently staff have been able to take back some of the hours they are owed.	Time is inappropriately accrued and taken off causing an impact on the provision of the service or the need to backfill shifts with bank / agency staff.
Recommendations	Priority
8.1 a) A review on the approach to how TOIL is managed across the service should be undertaken to ensure there is some level of consistency (between accruing hours and being paid overtime) and staff are being treated equally, whilst meeting the needs of the service in each area. b) Consideration should be given to the number of hours staff are able to accrue as TOIL, given that resource constraints can impact the ability for staff to take the hours back.	Medium

8.2	Where Health Roster is in use, it should be ensured accurate entries and adjustments are made in order for the system to capture meaningful data that staff and management can use to manage TOIL.	Medium	
8.3	Where paper records remain in use, they should be reviewed and updated to ensure they are fit for purpose and capture all relevant information in format that allows staff and management to manage TOIL effectively.	Low	
Agreed Management Actions		Target Date	Responsible Officer
8.1	a) A review of the approach to TOIL will be undertaken across the three localities to ensure a consistency of approach. b) An agreement will be established to the maximum number of hours that can be accrued as TOIL considering the impact of the ability to take back hours and the potential impact of the service.	February 2023	Clinical Service Manager Site Superintendent Radiographers
8.2	A review of the current systems to record TOIL will be undertaken to establish which system is most effective and applied across the localities.	February 2023	Clinical Service Manager Site Super intendent Radiographers
8.3	A review of the current systems to record TOIL will be undertaken to establish which system is most effective and applied across the localities.	February 2023	Clinical Service Manager Site Super intendent Radiographers

Matter Arising 9: PDRs (Operation)					Potential Impact
We were provided with a July 2022 PDR compliance report which showed that 57% of staff did not have an up-to-date PDR. Analysis by locality shows:					Staff performance is not effectively assessed and addressed.
Locality	% of PDRs out-of-date	Number of out-of-date PDRs	Number where last PDR is before 2020	Number that has an out-of-date PDR and an increment in 2022	
PCH	67%	51	26	32	
RGH	75%	43	6	25	
POW	40%	59	9	39	
As the table demonstrates, compliance rates are low across all three localities. There are numerous staff who have not had a PDR for many years, including from the years prior the pandemic. There are also many staff who are due increments but have not had a PDR. This is concerning as it is our understanding that the automatic progression through increment points is ceasing, and progression will not happen if ESR is not showing that a PDR has been completed within the last year.					
From our conversations with managers in all localities, it was clear that whilst they are aware of their PDR compliance rates, each locality was receiving data in different ways. Some were requesting reports from Learning & Development, whilst others were sent data from their Workforce Business Partners, though this tended to be ad hoc when they were being chased to improve compliance, as opposed to regular reports.					
In some localities we evidenced PDR planners created to tackle the backlog and ensure reviews are carried out 8–12 weeks ahead of increment dates. However, staff resourcing issues have meant most reviews are cancelled to maintain clinical services.					

Recommendation		Priority
In line with Welsh Government and Health Board targets, all staff should participate in a PDR on an annual basis. We acknowledge that the service will always need to prioritise clinical activity, but in order to achieve set targets, the service should develop an action plan outlining a realistic approach to tackle the backlog, prioritising those with future increment dates. Consideration must also be given to developing a sustainable way of maintaining PDR compliance rates once the backlog has been cleared. As part of addressing the backlog, staff should be reminded that it is their PDR and therefore they need to engage in the process and complete any relevant paperwork ahead of the meeting, allowing the actual meeting to be more meaningful and efficient.		High
Agreed Management Action	Target Date	Responsible Officer
An action plan will be developed to address the backlog of PDRs and establishing a sustainable system of maintaining PDR compliance in line the with WG and Health Board targets. Robust monitoring arrangements at corporate and at Care Group level will need to be implemented. All staff will be reminded of the importance of having a PDR, including the need for pay progressing, and the need to engage meaningfully in the process.	January 2023	Clinical Service Manager Super intendent Radiographers

Matter Arising 10: Mandatory training (Operation)	Potential Impact
Welsh Government has identified 10 core training modules that all NHS staff should complete, and an 85% compliance target has been set. The Health Board has identified, based on roles, additional levels of training against some of the core modules. For example, Infection, Prevention and Control has four levels of training. The July 2022 Core Mandatory Training report shows that Radiology has an overall compliance rate of 52% against the 10 core modules at all levels. The breakdown for the main sites was: PCH – 53%; POW – 50% and RGH – 44%. During our fieldwork, management expressed their concerns that staff are required to complete additional levels that may not be relevant to their role, or having up to seven levels in one module to complete. There is an appeals process that allows managers to inform the Learning & Development (L&D) team if the requirements set up in ESR are not appropriate for the role. Furthermore, it is our understanding that if training at the higher levels of a module is completed, then ESR will automatically update to show completion at the lower levels. So, having additional levels allocated should not impact overall compliance rates if each person completes their highest-level training. In addition, professional training may exceed core training, but staff still have to do the core training in order to demonstrate compliance. For example, the core module on resuscitation may not be necessary for a person in a clinical role who has been professionally trained in this area. As noted above, we understand that it is possible for managers to contact the L&D team so that training and qualifications outside of the core modules can be captured in ESR and reflected in the compliance reports. In summary, there are likely to be some cases where staff have had additional training modules or levels inappropriately added to their ESR record, there are also likely to be some staff that are professionally trained above the mandatory training requirements. However, there are also a number of staff who are just not completing the mandatory training as required. Our analysis across the 10 modules shows: • Highest compliance rate was for Equality, Diversity & Human rights – 75% (1 Level) • Lowest compliance rate was for Resuscitation – 26% (7 levels) – this could be linked to clinical professional training superseding ESR requirements. • Information Governance is the only other module with only 1 level of training and the compliance rate for that was 52%, so compliance in this case is not linked to the number of levels or professional clinical training.	Staff performance is not effectively assessed and addressed.

Recommendations		Priority	
10.1	Work should be undertaken to ensure the training requirements and achievements captured in ESR are accurate: • Management should identify if there are staff that have completed higher levels of training yet are not showing as compliant at the lower levels and inform the Learning & Development team, as that may indicate an issue with the set up in ESR that will need resolving. • Management should identify staff that they believe do not need to undertake training at the higher levels identified (or any additional modules). They should follow the appeals process and work with the subject matter leads to determine what is the right level for that role, so that ESR can be amended for the individual and where necessary the wider staffing group. • If management feel staff are professionally qualified above the requirements of any of the ESR modules then they should liaise with L&D to have this information captured on the ESR records, so that non-completion of the ESR modules does not impact compliance rates.	High	
10.2	The Clinical Service Group should ensure that staff are reminded that undertaking level one training in the core skills modules is in line with Welsh Government expectations, and that training at higher levels is a Health Board expectation for that role. It should be ensured that all staff are provided with the opportunity to undertake their mandatory training.	High	
Agreed Management Actions		Target Date	Responsible Officer
10.1	The Service will undertake a review of the training requirement and achievements captured in ESR to: • Identify if there are staff that have completed higher levels of training yet are not showing as compliant at the lower levels and inform the Learning & Development team, as that may indicate an issue with the set up in ESR that will need resolving. • Identify staff that they believe do not need to undertake training at the higher levels identified (or any additional modules). They should follow the appeals process and work with the subject matter leads to determine what is the right	March 2023	Clinical Service Manager Super intendent Radiographers

	level for that role, so that ESR can be amended for the individual and where necessary the wider staffing group. Identify staff are who are professionally qualified above the requirements of any of the ESR modules and liaise with L&D to have this information captured on the ESR records, so that non-completion of the ESR modules does not impact compliance rates.		
10.2	The Service will remind staff that undertaking level one training in the core skills modules is in line with Welsh Government expectations, and that training at higher levels is a Health Board expectation for that role and that staff are provided with the opportunity to undertake their mandatory training. Ongoing support at Executive Level will be required to address role requirements.	March 2023	Clinical Service Manager Super intendent Radiographers

Matter Arising 11: Consultant Job Plans (Operation)	Potential Impact
Consultant job planning requirements were paused during the pandemic. In addition, the Clinical Director, who has a key role in the job planning process, was heavily involved in the general running of the CSG as there was no manager in post, which impacted on job planning activity. A report from the Allocate system identifies 34 members of staff who have job planning requirements, of which seven had been signed off, with the remainder either 'in discussion' or 'awaiting sign off' by the Consultant. However, it appears that the report was not accurate as at least four members of staff listed, had retired or left the service. Our analysis shows that of those reported as 'in discussion' or 'awaiting sign off', one had been at the Consultant sign off stage since November 2019, with the most recent awaiting sign off by the Consultant since November 2021, suggesting that these were not awaiting sign off as a result of recent job planning review meetings. Management were unaware of the recently produced job planning procedure, that allows job plans to be automatically signed off as agreed, if Consultants fail to agree them in a timely manner. Since our fieldwork, management have been in contact with the Allocate team to invoke this process, also to request retired staff be removed from the system and new staff be added to the system. They have also asked for support in relation to some specific queries. It is our understanding that these requests remain unresolved. We reviewed a schedule of job planning appointments between May and July 2022 for the POW Consultants. We note that appointments had been rearranged and where they had happened the Allocate system did not appear to have been updated. There is no similar schedule for PCH or RGH Consultants.	Disputes may arise between the Health Board and Consultants where signed contracts are not in place. Splits between clinical sessions and personal development sessions are not in line with WG guidance, leaving the Health Board with a deficit in capacity.
Recommendations	Priority
11.1 Consultant job plans should be reviewed and agreed on an annual basis, with planning discussions commencing in enough time to get the plan signed off ahead of the job plan start period.	High
11.2 Management should ensure that the recently produced job planning procedure is made available. Once planning meetings have taken place, if there are delays in sign off, the steps outlined in the procedure should be followed, to ensure timely sign off. The CSG should continue to liaise with the Allocate team to ensure the data in the system is accurate, all users have the required access and queries get resolved.	Medium

Agreed Management Actions		Target Date	Responsible Officer
11.1	A programme of reviewing consultant job plans has commenced with a target date of completing these by January 2023 and a system is established to ensure that these are reviewed on annual basis.	January 2023	Clinical Director Clinical Service Manager
11.2	The hierarchy on Allocate is now a true reflection of the consultant establishment and as job plans are being scheduled access to Allocate is being arranged.	January 2023	Clinical Director Clinical Service Manager

Planning and Performance

Matter Arising 12: Workforce Planning (Operation)		Potential Impact
Due to the change in IMTP / Annual Planning requirements for 2022/23, CSGs were not asked to produce detailed workforce plans to feed into the wider IMTP process. We note that due to the previous CSG management staffing issues there is no localised workforce plan, which would be helpful given the workforce issues faced by the service. We understand that work has begun to develop a plan, although this has yet to be formalised. A risk has been added to the risk register in relation of this matter.		The CSG's objectives are not achieved, and services not delivered effectively.
Recommendations		Priority
A detailed workforce plan should be developed by the CSG in conjunction with their Workforce Business Partner that incorporates both the current workforce situation, plus longer-term plans in relation to areas such as known retirements.		High
Agreed Management Action	Target Date	Responsible Officer
The Service Group now sits in the Diagnostic and Therapies Care Group since September 2022 and the Care Group Director and Medical Director will work with the teams to advise of the workforce plan required for the IMTP/Annual Plan for 2023/24. On receipt of this advice the Service Group will work with the Workforce Business Partners to articulate the current workforce issues and medium and longer term plans.	30 th November 2022	Care Group Service Director Care Group Medical Director

Matter Arising 13: Consistency in monitoring arrangements (Operation)	Potential Impact
Our testing confirmed that monitoring against non-financial performance targets was taking place in a number of the groups and committees within the CSG. However, we note the following points: • Updates on the previous IMTP priorities are included in the slide packs presented to the Performance Review meetings. A table, listing the priorities, a RAG rating and the actions required for the next period is included. However, the 'action in next period' is not always an action but a status update. Furthermore, where there are actions, it is difficult to identify where these are captured in the meeting action log. As reported in Matter Arising 2 it does not appear that the action logs are reviewed in future meetings to ensure work has taken place to address the tasks. • In relation to workforce information presented to the Performance Review meeting, some slide packs presented the data for Radiology and Pathology separately, whereas in more recent months, the data was for the whole CSG, including Medical Records. This made it difficult to determine the performance position of just the Radiology service. The workforce compliance targets appear to need a greater level of clarity. For example, in March and April 2022 the PDR compliance target was 49% and 51% respectively. Both months were then reporting achievement of the target. It is assumed that these are internal targets, set by the CSG, as the Welsh Government (WG) target is 85%. So, RAG rating these as green, does not show the true picture against WG's targets. Conversely, for mandatory training, the targets in March and April 2022 were stated as 97% and 100% whereas the WG target is 85%. • The format of the quality data and information varied between the Performance Review meetings. More recent meetings had less detail and the information was about the CSG as a whole, with no split into the constituent parts as appeared in earlier meetings. • Monitoring against cancer targets and Referral to Treatment (RTT) targets data was split by POW and RGH/PCH. We acknowledge that this is linked to the different data systems that information is held on. However, this makes it difficult to monitor performance at each locality. • The May 2022 Performance Review meeting had no workforce data and very little quality performance information.	Corrective action is not taken if management are not provided with accurate and consistent performance information.

- The minutes of the September 2021 Integrated Quality & Governance Group states against the mandatory training agenda item that they were 'not aware of any specific items for discussion'. Yet at that time the compliance rate was only 49%.
- We have only been able to evidence departmental governance meetings taking place in RGH. Whilst we could see workforce performance discussed, no data was presented at the group. It is at departmental meetings we would have anticipated seeing key performance data specific to that locality being discussed. We acknowledged that the RGH group is in its infancy.

Recommendation**Priority**

To allow more effective monitoring, improvements should be made to the data and reporting format of information taken to the Performance Review meetings, including:

- Having a level of consistency in the data so that management can differentiate between the data of the constituent services within the CSG. Similarly, where necessary the breakdown of data across localities should be in place.
- Performance data on areas such as workforce and quality should be presented at every meeting.
- Where performance targets are included, it should be clear if the target is an internal CSG one. Any Health Board and Welsh Government targets should also be included and reported against to allow comparisons to other CSGs.
- IMTP priority updates and actions should be better articulated to determine what is actually an action, with the action log for that meeting capturing the required work.

There should be a clear link between the higher-level performance information discussed at the Performance review Meeting and what is disseminated down to the Integrated Quality and Governance Group and the departmental / locality governance groups. Departmental (locality) meetings should be used to monitor performance such as PDRs and mandatory training at a more granular level.

Medium

Agreed Management Action	Target Date	Responsible Officer
A new system of Performance Review across the Care Group has now been established with weekly meetings with the Chief Operating Officer and monthly Business Meetings. The exact format of the Business Meetings has yet to be finalised but it is anticipated that they will: • Have a level of consistency and accuracy in the data so that management can differentiate between the data of the constituent services within the CSG and plan to address gaps. • Report Performance data on areas such as workforce and quality and risks at every meeting. • Include any Health Board and Welsh Government targets and trajectories towards achieving them. • Include any IMTP priorities and actions in the wider health board IMTP.	31 st December 2022	Care Group Director

FCP Compliance

Matter Arising 14: CRES target information (Operation)		Potential Impact
Our review of the Performance Review meeting slide decks for April and May 2022 identified that a high-level financial update is provided. This incorporates information on the CRES target. However, we note the following: - In the finance summary slide, the value recorded as the 'Annual Budget' is not the annual CRES target for the service, but the balance of what remains to be achieved in the remainder of the year. The use of the term 'annual budget' could be misinterpreted by the report reader. - There is no information in relation to what schemes have been identified to achieve the CRES target, therefore we could not determine if plans are in place for achieving the whole target. Similarly, there is no information on likelihood of achieving the savings for those schemes that have been identified. There is also no information on how the monthly budget values have been generated. They do not appear to be one twelfth of the annual budget. The CRES information in its current format should be more detailed to help the reader clearly interpret the information.		Decisions are made based on inaccurate or mis-understood information. Corrective action is not taken, where full information is not available.
Recommendation		Priority
A review of the format of the CRES information presented during the Performance Review meetings should be undertaken, to ensure the data is more meaningful and easier to interpret. Details about the CRES schemes that have been identified in the relation to the overall target, and progress and likelihood of achieving each scheme should also be presented.		Medium
Agreed Management Action	Target Date	Responsible Officer
A review of the format of the CRES information presented during the Performance Review meetings will be undertaken, to ensure the data is more meaningful and easier to interpret.	31 st December 2022	Finance Business Partner Clinical Service Manager

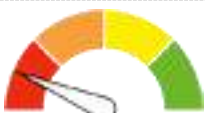
Matter Arising 15: Medical agency use (Operation)		Potential Impact
A report from the Oracle finance systems showed that nearly £97k had been spent on agency staff in quarter one. Our analysis identified that the costs mostly related to two individuals. We attempted to carry out testing to confirm that the correct authorisation process, had been followed, namely budget holder approval to seek agency use and appropriate authorisation if the hourly rates exceeded the WG price cap. In both cases we were not able to determine if the correct process had been applied. Whilst the standard hourly base rate of pay for both consultants was the same, and below the WG price cap value, the total hourly rate in the finance system exceeded the WG cap. The FCP states that the cap rate is based on the total rate to be paid to the agency including all additional costs such as agency commission, allowances for holiday pay, travel costs and accommodation costs. Despite contacting various staff within the CSG and the Workforce Business Partner, we were not able to obtain documentation to support what appears to be payments above the WG cap rate. For one of the consultants in the sample, we identified an accrued cost for 70 hours work. It transpired that while this person was booked to work these hours, they actually worked one day. While the financial impact had only been accrued and not paid, it showed within the financial position of the Radiology service, and the discrepancy was not identified until we undertook our testing. Furthermore, the finance reports show two identical payments in consecutive weeks for this consultant. Given only one day was worked, we have questioned with finance if this is a duplicate payment, but have yet to receive a response. Whilst undertaking our testing, we saw numerous emails from multiple people within the CSG and workforce across multiple sites in an attempt to be provided with information. It is clear that there is no single point of information or knowledge in relation to the use of agency staff across Radiology and to ensure the service is complying with the medical variable pay FCP.		Inconsistent approaches to the engagement of medical agency workers and their rates of pay. Inappropriate or unauthorised payments made at higher rates.
Recommendations		Priority
15.1	Staff who engage medical agency staff should be familiar with the requirements set out in the Medical Variable Pay Financial Control Procedure and ensure that they can demonstrate the rates that will be paid to agency staff and the appropriate authorisation where rates exceed the WG pay cap.	High
15.2	Consideration should be given to having a single point of contact within Radiology for managing the engagement of medical agency staff. This should allow a more co-ordinated approach to agency usage and	Medium

	reduce the risk of non-compliance with the FCP, errors with payments and financial records and potentially greater opportunity for agency staff to be utilised across multiple sites as demand fluctuates.	
Agreed Management Actions		Target Date
15.1	Staff who engage medical agency staff are familiar with the requirements set out in the Medical Variable Pay Financial Control Procedure and it can demonstrated the rates that will be paid to agency staff is appropriate to level of authorisation where rates exceed the WG pay cap. The evidence required is held by Retinue.	Completed
15.2	There are two individuals who engage medical agency staff in the Service. The Interim Radiology Service Manager (RGH and PCH) and the Superintendent Radiographer (POW) These individuals provide cross cover for each other.	Completed

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

Appendix C – Detailed Scope and Objectives

Governance arrangements

- Appropriate governance structures are in place with clear reporting lines that support the key operational functions of finance, workforce, planning and performance, and quality and patient safety.
- The committees and groups within the governance structure are operating effectively with support from business partners.
- There are appropriate mechanisms in place to ensure new legislative, regulatory and patient safety information received is disseminated and actioned on a timely basis, with policies and procedures owned and kept up to date. The
- Declarations of interest (or nil returns) are submitted for all relevant staff and the clinical service group is aware of the declarations made.

Risk management

- The CSG has applied the Health Board's risk management strategy, ensuring risks are appropriately identified, assessed and recorded, with risk owners identified for each risk and mitigation plans in place where appropriate.
- Risk is monitored and reported on within key groups in the CSG.
- Risks associated with demand and capacity and quality and patient safety are appropriately captured.

Workforce management

- Sickness absence is appropriately recorded, monitored and managed in accordance with the All Wales Managing Attendance at Work policy.
- Annual leave is appropriately planned, requested, recorded and authorised.
- Flexi time and Time off in Lieu (TOIL) is appropriately monitored and managed in accordance with local procedures and processes.
- The PDR process is actively monitored and managed.
- Mandatory training compliance is actively monitored and managed.
- Staff rosters are planned and approved in line with agreed templates to ensure optimum workforce deployment and minimum use of overtime or agency staff to achieve safe staffing levels.
- Consultant job plans are reviewed and agreed annually and monitored to ensure that clinical activity is delivered in line with the agreed job plans.

Planning and performance

- The CSG has appropriate arrangements in place to ensure that its annual plan is developed in accordance with the Health Board's corporate planning framework.

-
- Budget holders and other relevant staff are appropriately engaged in the development of the CSG's annual plan.
 - Workforce planning arrangements exist to establish and plan for known future changes to the CSG. For example, key staff due to retire within three years.
 - Budget holders have agreed efficiency plans in place and monitor performance against the targets. Appropriate action and recovery plans are in place where required, should targets begin to show an adverse variance.
 - The CSG has appropriate non-financial performance measures and key performance indicators in place that cover relevant service delivery and cross-cutting themes such as workforce and quality. These are formally reviewed and reported on a regular basis. Appropriate action and recovery plans are in place where required, should targets begin to show an adverse variance.
 - Demand and capacity plans are regularly used as business planning tools for managing the CSG and are monitored and reported on to ensure they remain fit for purpose.

Compliance with FCPs

- The Radiology Service's compliance with relevant Financial Control Procedures (FCPs) and the associated elements of the Scheme of Delegation. (Focus to be on the Budgetary Control and Medical Variable Pay FCPs)



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

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

Staff Wellbeing Final Internal Audit Report December 2022

Cwm Taf Morgannwg University Health Board



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Auditors:	Emma Samways, Deputy Head of Internal Audit Stuart Bodman, Principal Internal Auditor
Executive sign-off:	Hywel Daniel, Executive Director for People
Distribution:	Michelle Hurley-Tyers, Assistant Director of Employee Experience and Wellbeing Clare Wright, Strategic Lead for Wellbeing, Consultant Clinical Psychologist & Systemic Psychotherapist
Committee:	Audit & Risk Committee



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

Acknowledgement

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

Disclaimer notice - please note

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

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Executive Summary

Purpose

The overall objective of the audit was to review the arrangements and processes in place relating to provision of staff wellbeing services.

Overview

The key matters which require management attention include:

- Timely revision and update of the wellbeing priorities workplan.
- Low uptake and absence of analysis of completed annual staff wellbeing surveys.
- Maximisation of rollout and revision to format of annual staff wellbeing surveys.
- Low recruitment/participation of wellbeing activists within Merthyr and Cynon locality area.
- No People and OD Directorate sub-group or locality based wellbeing groups.

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

Report Opinion

Reasonable



Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved

Assurance summary¹

Objectives		Assurance
1	An appropriate framework and governance arrangements are in place.	Reasonable
2	Engagement with staff has taken place to identify issues or gaps in provision.	Reasonable
3	Appropriate training and resources are available.	Substantial
4	The effectiveness of wellbeing initiatives is regularly monitored.	Reasonable

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

Key Matters Arising		Objective	Control Design or Operation	Recommendation Priority
2	Review and updating of the wellbeing priorities workplan	1	Operation	Medium
3	Staff wellbeing survey completion and analysis	2	Operation	Medium
5	Monitoring and reporting of wellbeing activity and outcomes	4	Operation	Medium

1. Introduction

- 1.1 Our audit of staff wellbeing was completed as part of the 2022/23 Internal Audit Plan for Cwm Taf Morgannwg University Health Board (the 'Health Board').
- 1.2 The Health Board has a legal obligation for the general health, safety and emotional wellbeing of its employees and promoting a healthy and supportive working environment. The Health Board places a high value on maintaining a healthy and safe working environment for all its employees and recognises its duty of care extends to their mental health as well as their physical health at work.
- 1.3 The Health Board has a dedicated Employee Wellbeing Service, concentrating efforts on providing proactive, preventative wellbeing services to staff, rather than waiting for staff to report that they are struggling before intervening.
- 1.4 The potential risks we considered while doing this review were as follows:
 - Negative impact on service delivery and patient care.
 - Higher levels of staff absence or staff turnover with negative impact on productivity resulting in greater stress on the workforce.
 - Adverse effect on employees' health and wellbeing.

2. Detailed Audit Findings

Objective 1: An appropriate framework and governance arrangements are in place to co-ordinate wellbeing activities across the Health Board.

- 2.1 The Health Board has a specific strategic wellbeing objective that forms one of the 10 'People Priorities' as part of the 'Inspiring People' strategic aim from CTM 2030: 'Our Health Our Future'. Work is underway to establish an Inspiring People Insight Group that will oversee the implementation of this strategic aim and the delivery of the wellbeing objective.
- 2.2 The aims and delivery of the strategic wellbeing objective aligns to the Welsh Government funded 'Time to Change' mental health employer 'Pledge Change Action Plan', which is an organisational commitment to mental health wellbeing and awareness.
- 2.3 Following the formation of a dedicated Employee Wellbeing Service (EWS), and in line with best practice, an Employee Wellbeing Policy has been drafted. While we understand that wellbeing policies are not mandated, we note that the Health Board has worked with Public Health Wales to take this policy forward. The policy was approved by the Health Board Policy Group in October 2022 and at the time of our audit fieldwork was to be reviewed by the Local Partnership Forum and approved by the People and Culture committee. **(Matter Arising 1).**
- 2.4 The draft policy sets out the links between wellbeing and the CTM 2030 strategic aims. The policy sets out the wellbeing responsibilities of individuals, the Board and managers, and the areas that the EWS are responsible for delivering. The EWS underpins and co-ordinates the delivery of the wellbeing services across the

organisation in order to help achieve the Health Board's strategic wellbeing objective.

- 2.5 There are three strands that underpin the wellbeing objective: emotional; financial; and physical wellbeing. A stepped care approach has been adopted for the emotional and financial strands, with 'Care Pathways' in place. The physical wellbeing strand is supported by a range of associated wellbeing projects and initiatives.
- 2.6 The 'Care Pathways' are not themselves plans of work for the EWS, but are a pictorial signposting of the wellbeing services available to staff, setting out steps or levels of care and the interventions available, aligned to how a member of staff might be feeling.
- 2.7 Much of the work of the EWS is reactive and driven by demand from staff and managers. The team has a series of wellbeing priorities that link to the emotional, financial and physical strands. These priorities are captured and monitored by an overarching Wellbeing Priorities workplan that includes the wellbeing objectives, actions and outputs, key dates and a progress RAG rating. Each workplan is for a six-month period. However, the workplan covering the period of July to December 2022 was generated in October 2022, three months after the start of the period it related to. **(Matter Arising 2)**

Conclusion:

- 2.8 The Health Board has set out its objective in relation to wellbeing which aligns to the CTM 2030 strategic aims. There is a draft Employee Wellbeing policy to support the wellbeing objective. Six-monthly workplan are in place setting out the priorities of the EWS for that period, however the workplan for the period July to December 2022 was not generated in a timely manner. We have provided reasonable assurance against this objective.

Objective 2: Engagement with staff has taken place to identify issues or gaps in provision.

- 2.9 The dedicated EWS was set up in 2020. Its work has mostly been driven by responding to the needs arising from the pandemic. The EWS offers both proactive and reactive services and support to Health Board staff groups, across localities in accordance with staff needs.
- 2.10 In recent months Staff Wellbeing Roadshows have been run by the EWS that serve a dual purpose. The roadshows have enabled the EWS to promote the wellbeing service at prominent locations across the Health Board estate. The roadshows have also been used to promote and encourage the completion of the 2022 Staff Wellbeing Survey, which will inform the future delivery requirements of the EWS.
- 2.11 Staff engagement and awareness of wellbeing support is furthered by 'Wellbeing Activists'. These are members of staff from across the Health Board that volunteer to provide local awareness and *'assist in the creation and maintenance of bespoke wellbeing initiatives within departments'*. These staff have been trained in wellbeing. Key elements of the Activists role are to provide awareness of the 'Care

Pathways' available to staff, promotion of the Staff Wellbeing Survey, and to support the EWS apply wellbeing methods.

2.12 At the time of our audit, there were over 90 Wellbeing Activists representing a wide range of staff groups and professional specialities. However, the number of activists in the former Merthyr Cynon ILG was far lower than the other two ILGs. **(Matter Arising 4)**

2.13 During 2020, as a result of the pandemic, the first Staff Wellbeing survey was issued. This was followed up with a further survey later in 2020 and another survey in 2021. At the time of our audit, the 2022 survey period was concluding. We understand that the EWS has encouraged staff to complete the survey as the results will shape future wellbeing services. The Surveys were accessible through the Health Board internet and social media. In areas where IT access is limited the Wellbeing team visited departments to provide face to face sessions to help complete the survey. This was in addition to the promotional work at the roadshows.

2.14 The 2021 Staff Wellbeing Survey had a 21% response rate. We understand that no analysis of the data relating to the surveys that were completed was undertaken by the EWS in order to identify any areas of the Health Board where uptake was low or non-existent. We note that terminology used to describe Clinical Service Groups or departments differs, making it more difficult for the Wellbeing team to analyse results and spot patterns in the data. **(Matter Arising 3)**

Conclusion:

2.15 The EWS has engaged with staff in a number of proactive and meaningful ways. Given the importance of the Staff Wellbeing Survey as a key tool to identify staff wellbeing perceptions and needs, further work is required both to improve completion rates and in the analysis of survey outcomes. We have provided reasonable assurance against this objective.

Objective 3: Appropriate training and resources are available.

2.16 The Employee Wellbeing Service consists of Clinical Psychologists, Wellbeing Counsellors and Practitioners, and support staff.

2.17 The team have dedicated Wellbeing Services pages on the Health Board internet site, highlighting the services they offer and the process for contacting the team. We note that EWS has made the pages available through the intranet as research has shown that staff often access these services from away from the work environment.

2.18 In addition, 'Care Pathway' documents have been placed at prominent locations on hospital sites, to help those that do not have easy access to IT and ensure they are also aware of wellbeing services available.

2.19 EWS can be accessed using a generic Wellbeing email that is monitored daily, with a target to provide responses within two working days. At the time of our review there were no waiting lists for access to wellbeing services, and the EWS maintain spreadsheets that record and monitor all requests and referrals.

-
- 2.20 The wellbeing resources provided by the EWS is based on the requests made by individuals and/or line management. As such this is a demand led service determined by an individual and their specific needs as presented to the Wellbeing Service who attempt to provide the appropriate type of support.
- 2.21 The team use the data gathered on the demand for courses and services and the feedback receive after provision of a service to determine the future provision. Where necessary course content will be changed and updated based on the feedback they receive.
- 2.22 In addition, there are wellbeing training courses for line managers, to provide them with the necessary skills for helping staff with wellbeing issues. The Health Board's revised Personal Development Review (PDR) process includes a 'Staying Well Plan' for staff and managers to complete to help identify wellbeing needs.

Conclusion:

- 2.23 The EWS provides a comprehensive and accessible range of resources and training options for staff and managers. This is underpinned by its alignment to the PDR process. We have provided substantial assurance against this objective.

Objective 4: The effectiveness of wellbeing initiatives is regularly monitored.

- 2.24 The Health Board assesses its progress against the wellbeing strategic objective through a staff experience and wellbeing report, every six months, to the People & Culture Committee. The report includes the Wellbeing Priorities Workplan which provides progress updates, and a RAG rating, on the key elements of the work.
- 2.25 The People & Culture Committee also receives an annual EWS dashboard. This dashboard provides data against a number of metrics such as attendance on courses and the number of contacts made to the team. We acknowledge that setting targets in relation to the metrics that the team report on would not be meaningful, given the nature of the services provided.
- 2.26 The Employee Wellbeing team monitors activity from the online Vivup Employee Assistance Programme (EAP). The EAP provides a 24/7 telephone support service, counselling and on-line guided self-help workbooks to staff who undertake courses, interventions or training provided by the Wellbeing Service. Quarterly reports of activity and clinical outcomes are analysed by the team to help inform future service provision.
- 2.27 Until recently wellbeing groups were in place in the Bridgend and Merthyr Cynon ILGs, though no group existed in Rhondda Taff Ely ILG. Whilst the groups were informal, they served as a forum for wellbeing ideas and to feedback on local challenges. The groups were stood down as a result of changes to the operating model, and it is unclear if these local groups will operate under the new operating model. **(Matter Arising 5)**
- 2.28 Monitoring also used to take place the Employee Experience and Wellbeing Steering Group. This bi-monthly group has not met since June 2021. As such, at the time of our review there were no People and OD Directorate Sub-Group or locality based wellbeing groups operating to provide oversight and monitoring of

wellbeing initiatives and activities. Although, an 'Inspiring People' group is due to be launched in January 2023 that will play a part in monitoring the wellbeing activities of the Health Board. **(Matter Arising 5)**

Conclusion:

- 2.29 Whilst wellbeing activity monitoring is undertaken within the Employee Wellbeing Service, and there is reporting of activity to the People & Culture Committee, localised wellbeing groups are not operational. The Inspiring People group should provide local representation at its meetings to ensure the staff wellbeing across the geographical area of the Health Board. We have provided reasonable assurance against this objective.

Appendix A: Management Action Plan

Matter Arising 1: Approval of Wellbeing Policy (Operation)		Potential Impact
The draft Employee Wellbeing policy has recently been approved by the Health Board Policy Group. It is yet to be reviewed by the Local Partnership Forum ahead of being approved by the People and Culture committee.		Staff and managers unaware of their responsibilities in relation to wellbeing. Lack of consistency in approach.
Recommendation		Priority
1.1a	The draft Employee Wellbeing policy should be reviewed by the Local Partnership Group at the earliest opportunity, ahead of being presented to the People and Culture committee for approval.	Low
1.1b	Once finalised, staff should be made aware of the policy's existence.	
Agreed Management Action		Target Date
1.1a	CTM acknowledges the recommendation, the policy has been drafted and commenced the process for approval. It is on the agenda for discussion at the next Local Partnership Forum (LPF) meeting in December. Once approved it will then be taken to People and Culture Committee for chairs action.	31/12/22
1.1b	Once ratified, all staff and stakeholders will be informed and it will be made available to all staff via publication on the appropriate SharePoint sites and the Wellbeing website pages.	
		Responsible Officer
		Head of Policy, Compliance and Agenda for Change for LPF Strategic Lead for Employee Experience and Wellbeing. Strategic Lead for Employee Experience and Wellbeing for People and Culture Committee.

Matter Arising 2: Review and updating of Wellbeing Priorities Workplan (Operation)		Potential Impact
We acknowledge that the Wellbeing Service has to be responsive and reactive in nature, and at times may have competing priorities. However, the team also generate a Wellbeing Priorities Workplan setting out the forthcoming wellbeing work activities for the Employee Wellbeing Service. The plan is refreshed every six months, we note that the workplan for the period July to December 2022, was not refreshed and updated until October 2022. As such, it appears that the plan was not reviewed or updated before the start of the six-month period that it covers.		Negative impact on service delivery if priorities due for delivery are delayed and not monitored.
Recommendation		Priority
2.1 The Wellbeing Priorities Workplan should be reviewed and updated before the start of the six-month period that it covers. This will ensure a current and accurate position of the work to be undertaken.		Medium
Agreed Management Action	Target Date	Responsible Officer
2.1 A Wellbeing Service is predominately reactive in nature and responsive to the changing needs of the staff population. To be effective, the service has to react to these changing needs in a flexible and timely manner. To support the proactive element of the service a Wellbeing Priorities Workplan is developed; however, the plan can and will be impacted by reactive priorities that arise which can result in the plan not necessarily recognising the current and accurate position of the work being undertaken. The work plan will continue to evolve and will be developed based on anticipated activity in the following 6-month period. In response to this specific action, the team will revisit the Workplan in December 2022.	31/12/2022	Strategic Lead for Employee Experience, Inclusion and Wellbeing

Matter Arising 3: Staff Wellbeing Survey Completion and Review (Operation)	Potential Impact
The Wellbeing Staff Survey findings are a key source of information for the Wellbeing Service in determining its future service provision. Data from the 2021 survey showed that the response rate was relatively low (21% of the Health Board staff). While the data shows the ILG and Clinical Service Group or department of the respondent, there has been no analysis of the data to identify areas with low completion rates or no responses. This type of analysis could be used to target areas in future surveys. During our analysis we established that of the responders, the response rate across the three ILG was fairly even: • Bridgend ILG – 29% • Merthyr Cynon ILG - 26% • Rhondda Taff Ely ILG – 33% In some cases, details of the CSG or department within the ILG was missing. It is acknowledged that this may be due to some staff working in small teams and wanting to remain anonymous. We identified that the terminology used to describe the ILG and CSG or department varied. For example, there were four variations used for the term 'outpatients', suggesting that 'free text' fields are used, making analysis of the data more difficult.	The resources of the Wellbeing team are not used in the most efficient way. The needs of staff are not fully captured.
Recommendations	Priority
3.1 For future staff surveys, analysis work should be undertaken in relation to where respondents were located and the return rates by Clinical Services Groups / departments, so as to aid identification of those areas where more targeting and awareness work is needed to encourage completion of future surveys.	Medium

3.2	To help analysis of the data, where relevant, future Wellbeing surveys should incorporate 'drop down' menus for responders to choose pre-set answers as opposed to 'free text' fields.	Low	
Agreed Management Action		Target Date	Responsible Officer
3.1	At the time of running the current 2022 survey the new care group model had only just launched, work to reflect this in organisational hierarchies is still ongoing to include every staff member within the Health Board, the highest context marker in conducting the Wellbeing survey is to make the survey feel as assessable to as many staff as possible. In order to support small departments where staff may feel they could be identifiable, the Team are exploring how it could introduce a free text entry where staff would not need to indicate the area where they work.	Next survey 31/05/2023	Strategic Lead for Employee Experience, Inclusion and Wellbeing
3.2	To further support the action in 3.1, the Team will also explore the introduction of 'Drop Down' menus where location identification at a department level does not present a risk in terms of staff becoming identifiable.	31/05/2023	Strategic Lead for Employee Experience, Inclusion and Wellbeing

Matter Arising 4: Wellbeing Activists in Merthyr & Cynon ILG (Operation)			Potential Impact
At the time of our audit there were 90 Wellbeing Activists in place across the Health Board representing a range of clinical, nursing, managerial and support staff groups, departments and locations. However, Wellbeing Activist numbers are low at the former Merthyr & Cynon ILG (six), whereas Bridgend ILG has 21 and Rhondda Taff Ely ILG has 63.			Areas of the Health Board are unaware of wellbeing services available to them.
Recommendation			Priority
4.1	To maximise potential uptake of Wellbeing Activists in the former Merthyr & Cynon ILG locality, awareness and engagement work should be undertaken to build relationships, confidence and trust with staff.		Low
Agreed Management Action		Target Date	Responsible Officer
4.1	Work is already underway to increase the number of Wellbeing Activists in underrepresented areas, by promoting the work of those already providing this role locally and by informing staff within services of similar work going on in the same service on another site. Activity is also underway to identify the number of activists in the new Care Group Model to be able to reflect this position moving forward.	31/03/2023	Strategic Lead for Employee Experience, Inclusion and Wellbeing

Matter Arising 5: Monitoring and Reporting of Wellbeing Activity and Outcomes (Operation)		Potential Impact	
The Employee Wellbeing Service collates and monitors activity and outcomes relating to the work it undertakes. The outcome of this work helps determine future service delivery. Historically, the wellbeing activity was discussed the Health Board's Employee Experience and Wellbeing Steering Group and also at two ILG Wellbeing Groups; Merthyr & Cynon ILG and Bridgend ILG respectively. No ILG Wellbeing Group existed for Rhondda Taf Ely ILG. However, these forums are no longer operational, and currently there is no group within the organisation to which the Employee Wellbeing Service reports its activity. We understand that in January 2023 an 'Inspiring People' group, will be established that will pick up these matters at a corporate level, however the more localised arrangements under the revised operating model are unknown.		Effective monitoring does not take place resulting in poor service delivery.	
Recommendation		Priority	
5.1	The 'Inspiring People' Group should provide a return to a formal and regular oversight and monitoring of the Wellbeing Priorities Workplan and the work of the Employee Wellbeing Services as whole. However, arrangements under the new operating model structure for locality based wellbeing groups should be made to ensure localised communication is not lost.	Medium	
Agreed Management Action		Target Date	Responsible Officer
5.1	The Inspiring People Group will provide a mechanism for overseeing and reporting on Health and Wellbeing activity and through its representation provide an opportunity to test new ideas and share learning. The need to maintain good communication to wellbeing groups within the service is recognised	31.1.2023 (inaugural meeting)	Assistant Director of OD & Wellbeing

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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



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

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

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

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Document reference: 123A2017

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

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Audit and Risk Committee Update

About this document

- 1 This document provides the Audit and Risk Committee with an update on current and planned Audit Wales work. Accounts and performance audit work are considered, and information is also provided on the Auditor General’s wider programme of national value-for-money examinations and the work of our Good Practice Exchange (GPX).

Financial audit update

- 2 **Exhibit 1** summarises the recent and current work.

Exhibit 1 – Accounts audit work

Area of work	Current status
Audit of the Health Board’s 2021-22 Charitable Financial Statements	We presented our Audit Plan to the Charity’s Trustee Members on 10 November. On the same date we received the draft financial statements. We have commenced the audit and are scheduled to complete our detailed testing in December. Trustee Members will be considering the audited financial statements on 26 January 2023. The Charity Commission’s deadline for the audited financial statements is 31 January 2023.
Audit of the Health Board’s 2022-23 Performance Report, Accountability Report and Financial Statements	We expect to start audit planning in February 2023.

Performance audit update

- 3 The following tables set out the performance audit work included in our current and previous Audit Plans, summarising:
- completed work since the last Audit and Risk Committee update (**Exhibit 2**);
 - work that is currently underway (**Exhibit 3**); and
 - planned work not yet started or revised (**Exhibit 4**).

Exhibit 2 – Work completed

Area of work	Considered by Audit and Risk Committee
2022 Audit Plan	April 2022
Cwm Taf Morgannwg Health and Social Care Partnership - Transformation Leadership Programme Board	December 2022
Review of the commissioning and contracting arrangements post Bridgend boundary change	December 2022

Exhibit 3 – Work currently underway

Topic and relevant Executive Lead	Focus of the work	Current status and Audit and Risk Committee consideration
Orthopaedic services – follow up Executive Lead – Director of Operations	This review will examine the progress made in response to our 2015 recommendations. The findings from this work will inform the recovery planning discussions that are starting to take place locally and help identify where there are opportunities to do things differently as the service looks to tackle the significant elective backlog challenges. Our findings will be summarised into a single national report with supplementary outputs setting out the local position for each health board.	We are preparing an all-Wales summary report, and considering preparation of a discrete Annex for each Health Board. Planned date for consideration: February 2023

Topic and relevant Executive Lead	Focus of the work	Current status and Audit and Risk Committee consideration
Structured Assessment 2022	The structured assessment work will build on the baseline governance review by assessing the corporate arrangements in place at the SHA in relation to: • Governance and leadership. • Financial management. • Strategic planning, and • Managing the workforce, digital, resources, estates, and other physical assets.	Draft report to be issued for clearance in December Planned date for consideration: February 2023
Review of the temporary closure of the Ysbty Cwm Cynon Minor Injuries Unit (Local work 2022)	Following the temporary closure of the Minor Injuries Unit at Ysbyty Cwm Cynon closure, we undertook a high-level review to examine the issues surrounding the temporary closure.	In clearance with the Health Board Planned date for consideration: February 2023
Review of Unscheduled Care Executive Lead – Director of Operations	This work will examine different aspects of the unscheduled care system and will include analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. Once completed, we will use this data analysis to determine which aspects of the unscheduled care system to review in more detail.	Blog and data tool published in April 2022 Project brief issued in July 2022, with fieldwork now underway

Exhibit 4 – Planned work not yet started or revised

Topic and relevant Executive Lead	Focus of the work	Current status and Audit and Risk Committee consideration
Joint Review Follow up (Local work 2022)	This work will be a follow-up of the recommendations made in the Joint Review Report from 2019.	The updated terms of reference have been issued and agreed. We have received the Health Board's self-assessment, and will be undertaking substantive fieldwork in February 2023. Date for consideration to be confirmed
All-Wales thematic on workforce planning arrangements	This work will examine the workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. It will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs. The work will be tailored to align to the responsibilities of individual NHS bodies in respect of workforce planning.	Date for consideration to be confirmed

Good Practice events and products

- 4 In addition to the audit work set out above, we continue to seek opportunities for finding and sharing good practice from all-Wales audit work through our forward planning, programme design and good practice research.
- 5 Details of future events are available on the GPX website. Events include sharing a range of perspectives on the impact the pandemic has had on public services in Wales two years on from the start of the pandemic. The most recent events were held during October 2022, focussing on Tackling Poverty in Wales (resources are available [here](#)). .

NHS-related national studies and related products

- 6 The Audit Committee may also be interested in the Auditor General's wider programme of national value for money studies, some of which focus on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Administration and Public Accounts Committee to support its scrutiny of public expenditure.
- 7 **Exhibit 5** provides information on the NHS-related or relevant national studies published since our last Committee Update. It also includes all-Wales summaries of work undertaken locally in the NHS.

Exhibit 5 – NHS-related or relevant studies and all-Wales summary reports

Title	Publication Date
Cyber Resilience Follow Up Report to be received in Private Session	October 2022
<u>National Fraud Initiative 2020-21</u> Contained in Papers with Management Response	October 2022
<u>Equality Impact Assessment: More than a tick box exercise?</u> Contained in Papers with Management Response	September 2022
<u>NHS Wales Finances Data Tool - up to March 2022</u>	August 2022

Appendix 1 – Key messages from recent national publications

National Fraud initiative 2020-21

- 8 The cumulative outcomes from the National Fraud Initiative (NFI) in Wales since 1996 are now £49.4 million. Across the UK, the cumulative total of NFI outcomes are now £2.37 billion.
- 9 The NFI is a counter-fraud exercise across the UK public sector, which aims to prevent and detect fraud.
- 10 An NFI outcome describes the overall amounts for fraud, overpayments and error that are detected by the NFI exercise and an estimate of future losses that it prevents.
- 11 Whilst the majority of Welsh NFI participants display a strong commitment to counter fraud, 13 of the 22 Welsh local authorities identified 95% of the fraud and error outcomes achieved by Welsh local authorities.
- 12 Our report makes several recommendations for participants in the NFI exercise including maximising the benefits of participation, acting on the results and also asking audit committees to review the NFI self-appraisal checklist. The Health Board has compiled a management response to these.

Equality Impact Assessments: More than a tick box exercise?

- 13 Our work looked at the overall approach to undertaking Equality Impact Assessments in public bodies in Wales. We concentrated on the 44 public bodies originally subject to the Well-being of Future Generations (Wales) Act 2015.
- 14 We focussed primarily on understanding public bodies' approaches with a view to finding good or interesting practice and identifying any common areas for improvement. We did not evaluate individual public bodies' approaches in detail.
- 15 Our findings highlight examples of good practice in aspects of the Equality Impact Assessment process across the public bodies we looked at. However, there are areas for improvement around the following themes:
 - Greater clarity over which type of policies must be impact assessed.
 - Greater clarity about the arrangements for assessing the impact of collaborative policies and practices.
 - Greater clarity about expectations to consider the Public Sector Equality Duty as part of an integrated impact assessment.
 - Better monitoring of the actual impacts of policies and practices on people.
 - A shift in the mindsets and cultures to move Equality Impact Assessments away from being seen as an add-on 'tick box' exercise.

- 16 Our report makes several recommendations for Welsh Government to address and one to public bodies requiring them to review their approach to Equality Impact Assessments considering the findings within the report and detailed guidance available on the Equality and Human Rights Commission and Practice Hub. The Health Board has compiled a management response to these.



Audit Wales

24 Cathedral Road

Cardiff CF11 9LJ

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

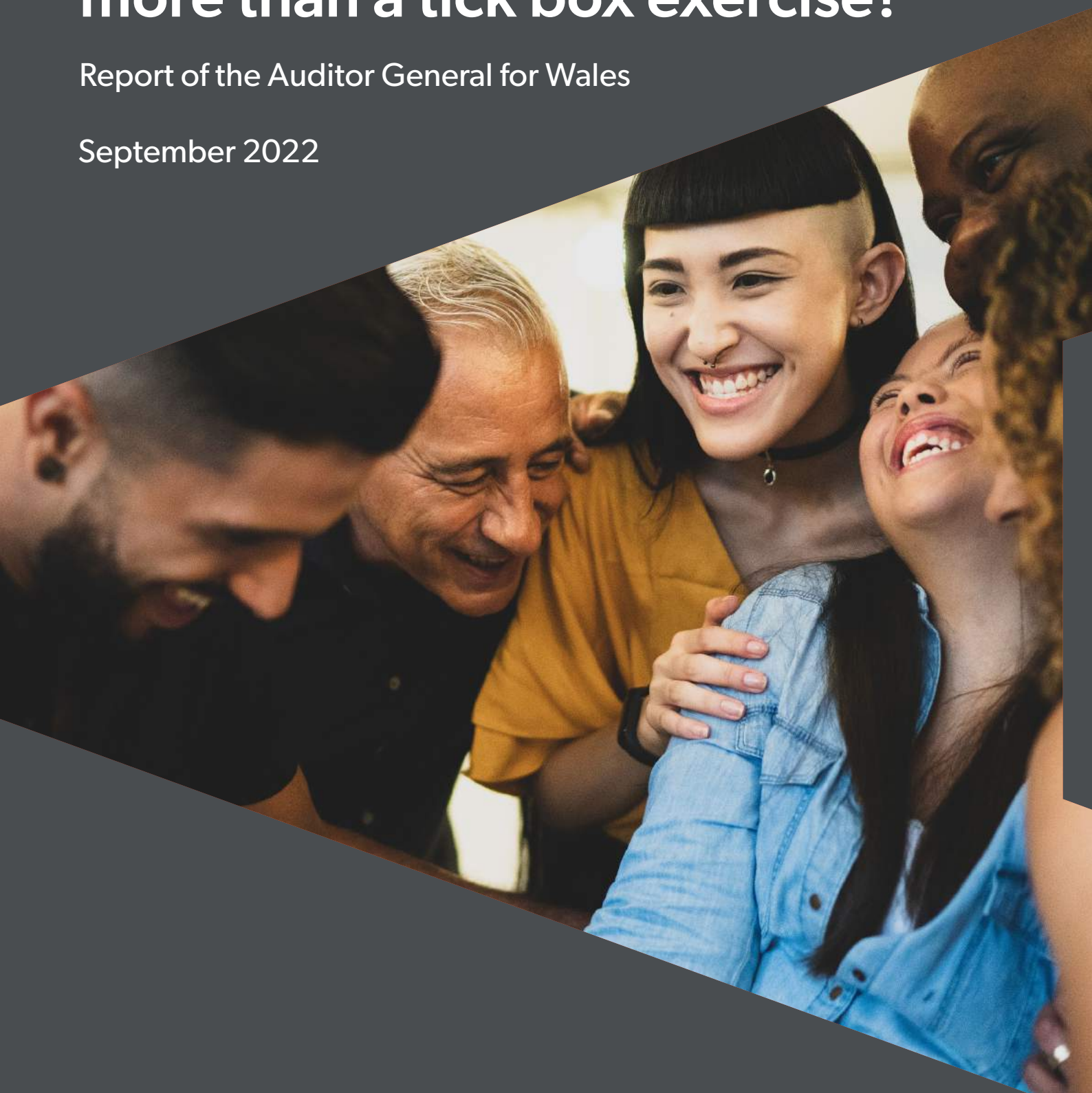
Website: www.audit.wales

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

Equality Impact Assessments: more than a tick box exercise?

Report of the Auditor General for Wales

September 2022



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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

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Auditor General's foreword

Discrimination and inequality continue to impact on the quality of life and life chances of people in Wales. My Picture of Public Services 2021 report highlighted that the COVID-19 pandemic had amplified some of the entrenched inequalities in our communities. Black Lives Matter, MeToo and other social movements have brought issues of discrimination and inequality to the forefront of public policy and debate.

Equality Impact Assessment (EIA) is an important part of the approach to tackling inequality in Wales. EIAs help public services meet their legal duties to avoid discrimination in the decisions they make and to promote equality of opportunity and cohesion.

Done well, EIAs are more than a means to show compliance. They support the growth of a mind-set and culture that put issues of equality at the heart of decision-making and policy development.

Our work shows that within individual public bodies there are good examples of aspects of the process of conducting an EIA. Through this report, I want to help all public bodies learn from those that are doing well and trying new approaches.

However, what we have seen and heard tells us that public bodies in Wales tend to use their EIAs defensively. Too often, they seem like a tick box exercise to show that the body has thought about equality issues in case of challenge. While legal challenge is of course an important risk to manage, this approach means public bodies are not using EIAs to their full potential, especially in terms of promoting equality and cohesion.

I hope this report will be of interest to anybody involved in public services and with an interest in tackling inequality and promoting equality. However, I want this work to be more than interesting. It needs to have an impact. Specifically, I expect:

- the Welsh Government to respond to the recommendations to work with partners to improve and update the overall approach to EIAs;
- all public bodies to respond to the recommendation that they review their own approaches to EIAs, including mindset and culture, drawing on the findings of this report; and
- those involved in scrutiny to use this report to challenge their organisation's overall approach to EIAs and the quality of individual EIAs used to inform their decisions.

I am pleased to say that this work has already had positive impacts. Our fieldwork questions have prompted some public bodies to check aspects of their own arrangements. And we have shared emerging findings with some public bodies that were updating their approach to EIAs. Closer to home, at Audit Wales, we are looking closely at our own processes and procedures to reflect the lessons identified in this work.

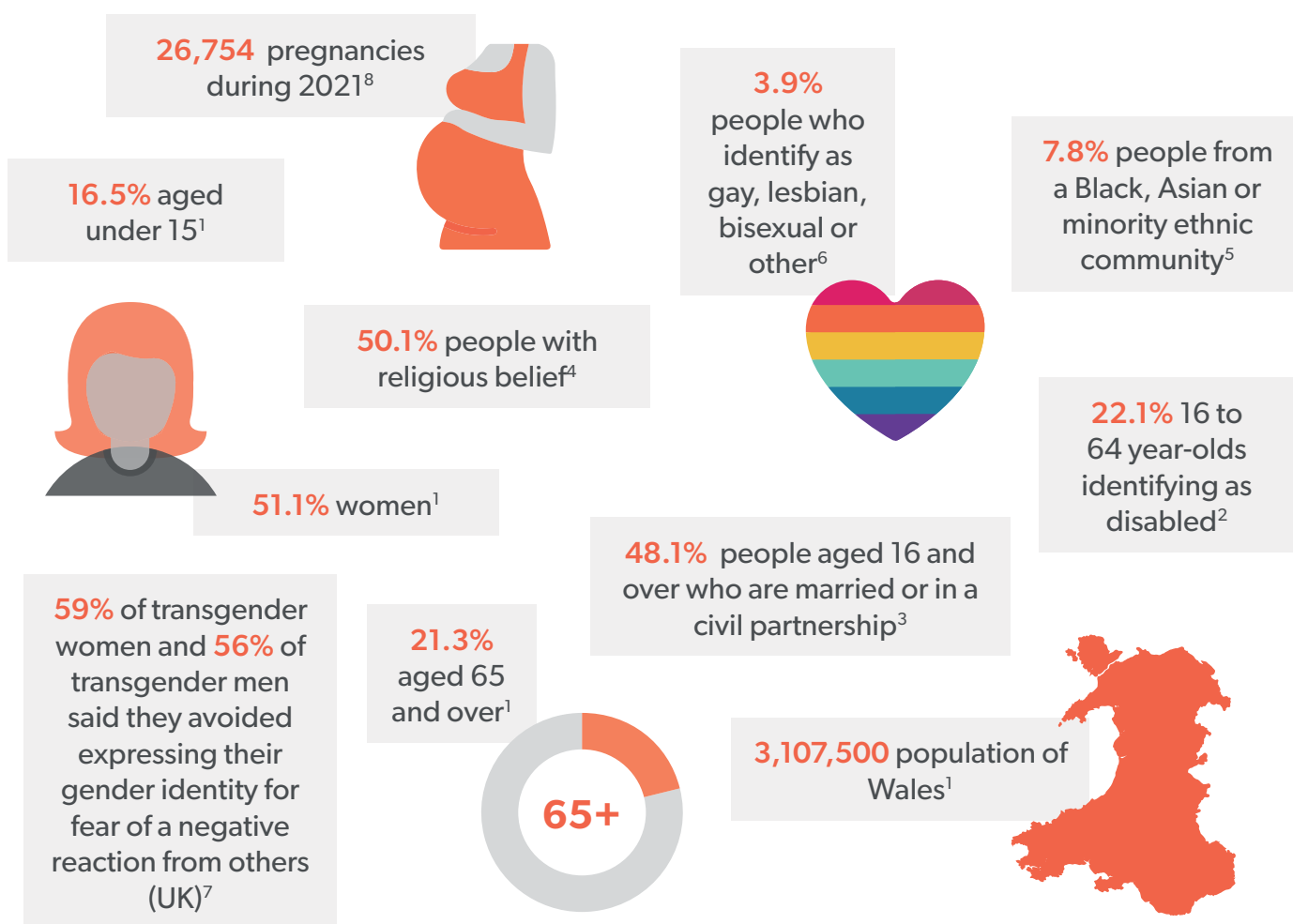


Adrian Crompton

Auditor General for Wales

Key facts

We set out below some key facts about the population in Wales in the context of the nine protected characteristics under the Equality Act 2010.



Sources:

- 1 Office of National Statistics (ONS), Population and household estimates, Census 2021, June 2022
- 2 StatsWales, Disability by age and sex (Equality Act definition) (2018-2020)
- 3 StatsWales, Marital status by age and sex (2018-2020)
- 4 StatsWales, Religion status by age (2018-2020)
- 5 ONS, Population estimates by ethnic group, England and Wales December 2021 (data for 2019)
- 6 StatsWales, Sexual identity by year, 2019
- 7 Government Equalities Office, National LGBT Survey, July 2018 (survey ran for 12 weeks from July 2017)
- 8 StatsWales, Initial assessment indicators for Wales, by mother's age, 2021

Key messages

Context

- 1 Tackling inequality is a long-standing goal of the Welsh Government. It features prominently in the 2021-2026 Programme for Government which includes the objective to 'celebrate diversity and move to eliminate inequality in all of its forms'¹. The Well-being of Future Generations (Wales) Act 2015 makes 'A more equal Wales' a national goal. It defines this as 'a society that enables people to fulfil their potential no matter what their background or circumstances (including their socio-economic background and circumstances)'.
- 2 Equality Impact Assessment (EIA) is an important part of the approach to tackling discrimination and promoting equality in Wales. The Equality Act 2010 introduced the Public Sector Equality Duty (PSED) across Great Britain (**Exhibit 1**). The Welsh Government has made its own regulations² setting out some Wales specific duties that bodies listed in the Act need to follow to meet the PSED. Public bodies subject to the Act must assess the likely impacts of proposed policies or practices or proposed changes to existing policies or practices on their ability to meet the PSED. In doing so, they must comply with specific requirements to engage with groups likely to be impacted and monitor actual impacts.

1 Welsh Government, Programme for Government: update, December 2021

2 The Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011

Exhibit 1: the Public Sector Equality Duty and protected characteristics

The PSED requires public bodies, in exercising their functions, to have due regard to the need to:

- eliminate unlawful discrimination, harassment, victimisation, and any other conduct prohibited by the Act;
- advance equality of opportunity between people who share a protected characteristic and people who do not share it; and
- foster good relations between people who share a protected characteristic and people who do not share it.

The protected characteristics are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

The Act and the Wales specific duties apply to public bodies including councils, NHS bodies, fire and rescue services, national parks, education bodies (further and higher education bodies and maintained schools), and the Welsh Government and some of its sponsored bodies.

- 3 An EIA can provide evidence that the body has met the PSED. There have been legal challenges to decisions based on the lack or adequacy of an EIA. Moreover, EIAs support good policy and decision-making more generally by:
 - **ensuring decisions impact protected groups in a fair way** – EIAs can demonstrate what, if any, action could be taken to mitigate the impact on one or more protected groups negatively affected by a decision and to promote equality and cohesion;
 - **support evidence-based policy or decision-making** – EIA is a clear and structured way to collect, assess and present relevant evidence to support decisions; and
 - **making decision-making more transparent** – EIAs must be published where they show there is or is likely to be a substantial impact.

- 4 As well as the PSED, the Equality Act 2010 included provision for a new socio-economic duty for public bodies³. The socio-economic duty came into force in Wales on 31 March 2021. It requires that public bodies, ‘when making decisions of a strategic nature about how to exercise its functions, have due regard to the desirability of exercising them in a way that is designed to reduce the inequalities of outcome which result from socio-economic disadvantage’. The Welsh Government advises public bodies to consider the socio-economic duty as part of existing processes, including impact assessments. We are currently reviewing local government’s work to tackle poverty, including aspects of the socio-economic duty and the lived experience of people experiencing poverty.

About this report

- 5 We looked at the overall approach to undertaking EIAs in public bodies in Wales. To focus our work, we concentrated on the 44 public bodies originally subject to the Well-being of Future Generations (Wales) Act 2015. The main groups covered by the PSED that we did not include were the education bodies – further and higher education institutions and maintained schools – and Corporate Joint Committees.
- 6 We focused primarily on understanding public bodies’ approaches with a view to finding good or interesting practice and identifying any common areas for improvement. We did not evaluate individual public bodies’ approaches in detail. **Appendix 1** has more detail on our audit approach and methods. Where we identify individual bodies’ practices, this is not to say that they are necessarily alone in having good or interesting practices in that area.
- 7 Parts one to three of this report set out the findings from our consideration of the EIA process at the 44 public bodies. Below, we set out the main areas for improvement we identified. These include issues that go beyond how public bodies are conducting specific parts of the processes and offer insight about the overall approach to assessing the impacts of policies and practices and the underpinning mindset and culture.
- 8 The Welsh Government is currently reviewing the PSED Wales specific regulations. We have framed our key improvement areas and recommendations in the context of the opportunity the review offers to clarify aspects of the overall approach to EIAs in Wales.

3 The duty lay dormant on the statute book as the UK Government did not commence it. The Wales Act 2017 gave new powers to the Welsh Ministers and allowed them to commence the duty in Wales. It covers most types of public bodies subject to the PSED.

Key improvement areas

- 9 Positively, there are examples of good practice in aspects of the EIA process across the public bodies we looked at. There is also non-statutory guidance from the Equality and Human Rights Commission (EHRC)⁴ and on the [Equality Impact Assessment In Wales Practice Hub](#) (the Practice Hub) about the detailed processes for conducting an EIA. Many public bodies use this guidance to shape their approaches. However, there are areas for improvement (**Exhibit 2**).

Exhibit 2: key improvement areas for EIA

	Greater clarity over which type of policies and practices must be impact assessed
	Greater clarity about the arrangements for assessing the impact of collaborative policies and practices
	Greater clarity about expectations to consider the PSED as part of an integrated impact assessment
	Better and more timely identification of the practical impacts of decisions on people and how different protected characteristics intersect
	More engagement and involvement of people with protected characteristics
	Better monitoring of the actual impacts of policies and practices on people
	A shift in the mindsets and cultures to move EIA away from being seen as an add-on 'tick box' exercise

4 Equality and Human Rights Commission, Assessing Impact and the Equality Duty: A Guide for Listed Public Authorities in Wales, October 2014; and Equality and Human Rights Commission, Technical Guidance on the Public Sector Equality Duty: Wales, August 2014.

Greater clarity over which type of policies and practices must be impact assessed

- 10 There is scope for the Welsh Government, working with partners, to clarify its expectations around which type of policies and practices must be impact assessed. As drafted, the Welsh specific duties require public bodies to assess all new policies or practices, or those under review. However, the EHRC's non-statutory guidance recognises that 'policies and practices' is a broad category and says public bodies may need to prioritise. It introduces the concepts of 'proportionality' and 'relevance', which it says public bodies can apply through a process known as 'screening'.
- 11 We think the current position is open to interpretation in terms of whether proportionality and relevance mean public bodies should: (a) prioritise big decisions, like budget decisions or major service change; or (b) prioritise decisions that are likely to have a big impact on certain groups, for example, small scale decisions could have a large impact on one section of the population. Further, many bodies have interpreted proportionality as determining the amount of work needing to be done to assess impacts, rather than whether a policy or practice needs an EIA.
- 12 The EIAs or screening decisions that public bodies publish are usually those that go to their boards or cabinets. They therefore tend to be at the more strategic or impactful end of the scale. While we did not examine in detail practices at individual bodies, we think there is a risk that public bodies may be informally filtering out smaller scale policies and practices that do not require decisions from boards or cabinet, even though they may impact on people with protected characteristics.

Greater clarity about the arrangements for assessing the impact of collaborative policies and practices

- 13 There is scope to clarify how public bodies should do EIAs in an environment of increasing collaboration. The law places duties on individual public bodies. Since the legislation came into force, public bodies are increasingly developing plans and delivering services through collaborative arrangements. The Welsh Government updated the legislation to extend the PSED and Wales specific duties to Corporate Joint Committees in local government, but there are other collaborative arrangements not covered. These include Public Services Boards and Regional Partnership Boards as well as multiple service specific collaborations.

- 14 The Welsh Government has not produced stand-alone guidance on the use of EIAs by collaborative arrangements, although guidance for Public Services Boards highlights EIA requirements for individual public bodies⁵. The EHRC's 2014 guidance predates the creation of many of these arrangements and offers high level advice that there should be a shared approach but does not say how this should work in practice.

Greater clarity about expectations to consider the PSED as part of an integrated impact assessment

- 15 Increasingly, public bodies are integrating their EIAs with other impact assessments. While there is no legal requirement to integrate assessments, the Welsh Government's guidance on the Well-being of Future Generations (Wales) Act⁶ emphasises the opportunities for bodies to integrate their approach to different duties, including those under the Equality Act 2010. Many of the equality officers⁷ we spoke to said that integrating impact assessments led to a streamlined process and a more rounded approach to thinking about impacts. The key downside can be that the assessment is longer and can appear daunting. Our review of EIAs also identified a risk that integrated impact assessments dilute the focus on the impacts of policies and practices on people with protected characteristics.
- 16 Public bodies are inconsistent in what they include in an integrated impact assessment. Mostly, they collate separate assessments in one document, rather than produce a truly integrated analysis of impacts. There is no specific guidance to support public bodies in conducting integrated impact assessments. Many equality officers would welcome clearer guidance from the Welsh Government about its expectations.

Better and more timely identification of the practical impacts of decisions on people and how different protected characteristics intersect

- 17 There are examples of EIAs that clearly identify likely impacts on groups of people. However, many EIAs we reviewed were descriptive. They identified that a policy or practice might impact on a group of people. But they did not show how it would impact people's lives in practice. This makes it more difficult for decision-makers to assess how important the likely impacts are and if any mitigating measures proposed would be sufficient.

5 Welsh Government, Shared Purpose: Shared Future Statutory Guidance on the Well-being of Future Generations (Wales) Act 2015 (SFSP 3: Collective Role (public service boards)), February 2016.

6 Welsh Government, Shared Purpose: Shared Future Statutory Guidance on the Well-being of Future Generations (Wales) Act 2015 (SFSP 2: Individual Role (public bodies)), February 2016.

7 We have used the term 'equality officer' throughout this report to refer to staff in public bodies with specific lead specialist roles for equality, whether that be their full-time job or part of their role. The way these roles are structured, and their seniority, varies.

- 18 In general, public bodies tend to identify negative impacts that they need to mitigate where possible. They are less likely to identify potential ways that the policy or practice could positively promote equality of opportunity and cohesion, even though this is a requirement of the PSED. Few public bodies have fully grasped the complexity of identifying likely impacts of policies and practices. None of the EIAs we looked at considered what is known as 'intersectionality'; the way that different protected characteristics combine. For example, while an EIA may identify impacts for Muslim people, it may not recognise that impacts could be very different for a Muslim woman compared to a Muslim man.
- 19 Many public bodies are thinking about how to identify the cumulative impacts of multiple decisions but few are doing so. Most do not have supporting systems that would enable those conducting EIAs to access the information needed about other decisions.
- 20 Most public bodies' formal processes and guidance say they will start thinking about impacts very early in the policy development process. However, many of the equality officers recognised that in practice EIAs often start late in the process, sometimes very shortly before a decision is due to be taken. This reduces the scope to shape the policy or practice and to mitigate impacts.

More engagement and involvement of people with protected characteristics

- 21 There are examples of public bodies seeking views from people with protected characteristics and drawing on their lived experience as part of the EIA. However, some third sector bodies are concerned that this does not happen nearly enough. We found that where public bodies seek views these often form part of a broader open consultation rather than focussing on specific groups with protected characteristics.
- 22 Some third sector organisations said that listening to people with protected characteristics was the action that would most improve EIAs. National representative public bodies could not always respond to the number of requests to take part in EIAs they receive and did not always have knowledge or information to respond to local issues.

Better monitoring of the actual impacts of policies and practices on people

- 23 Public bodies need to do more to monitor the impact of policies or decisions on protected groups. Equality officers at individual public bodies identified very few examples of public bodies monitoring the actual impacts of a policy or decision once implemented. Those examples put forward generally reflected broader monitoring of a policy's objectives rather than whether the impacts identified in the EIA materialised or whether there were other unanticipated impacts.

A shift in the mindsets and cultures that moves EIA away from being seen as an add-on 'tick box' exercise

- 24 From what we have seen there has not been a sufficient change in the mindset and culture in public services to put issues of equality at the heart of policy making. The mindset revealed by the EIA is often defensive: using EIAs to prove the body has paid due regard to equality in case of political or legal challenge. Often, the EIA seems like an additional 'tick box' exercise to be complied with rather than a tool to promote equality.



Recommendations

Recommendations

Clarifying the scope of the duty to impact assess policies and practices

- R1 There is scope for confusion about which type of policies and practices must be subject to an assessment for their impact on the public sector equality duty. **The Welsh Government should clarify its interpretation of the duty, including whether and how it expects public bodies to apply any test of proportionality and relevance.**

Building a picture of what good integrated impact assessment looks like

- R2 Many public bodies carry out integrated impact assessments that include consideration of the PSED alongside other duties. But practice is inconsistent and often involved collating multiple assessments in one place, rather than being truly integrated, **to help maximise the intended benefits of integrated impact assessments, the Welsh Government should work with key stakeholders with an interest in the areas commonly covered by integrated impact assessments and those with lived experiences, to share learning and work towards a shared understanding of what good looks like for an integrated impact assessment.**

Recommendations

Applying the equality duties to collaborative public bodies and partnerships

R3 The public sector landscape has changed since the introduction of the PSED and the Welsh specific duties, with an increasing focus on collaborative planning and delivery. **The Welsh Government should review whether it needs to update the Wales specific regulations to cover a wider range of collaborative and partnership arrangements. These include public services boards, regional partnership boards and other service specific partnerships.**

Reviewing public bodies' current approach for conducting EIAs

R4 While there are examples of good practice related to distinct stages of the EIA process, all public bodies have lessons to learn about their overall approach. **Public bodies should review their overall approach to EIAs considering the findings of this report and the detailed guidance available from the EHRC and the Practice Hub. We recognise that developments in response to our other recommendations and the Welsh Government's review of the PSED Wales specific regulations may have implications for current guidance in due course.**



Supporting arrangements for conducting EIAs

01

- 1.1 Conducting an EIA can be complicated. Good support can help make the process of conducting EIAs easier and more effective by having a clearly spelled-out approach and process, underpinned by clear guidance and training. And public bodies can have expert advice to hand to support those involved in assessing the impacts of decisions.

Setting out the organisation's approach to EIA

What we looked for

A clearly spelled-out approach to EIA for the organisation, including whether the EIA should form part of a wider integrated impact assessment.

What we found

Almost all public bodies had a set process for conducting an EIA, although these vary from a stand-alone EIA to producing integrated impact assessments covering a wide and varying range of other legal duties and policy priorities.



Strategic equality plans

- 1.2 All 44 public bodies met the requirement to produce a Strategic Equality Plan (SEP). The SEP must include an organisation's equality objectives, how they will measure progress on meeting objectives, and how they will promote knowledge and understanding of the general and specific duty. The SEP must also set out the public bodies' arrangements for assessing the likely impact of policies and practices on their ability to meet the PSED. However, in our review of SEPs we found that only 17 of the 44 bodies did so and to varying degrees of detail.
- 1.3 A few public bodies have gone further than simply describing arrangements. For example, Conwy County Borough Council's SEP describes in detail its process for EIA, how its Cabinet uses EIAs to support decision-making, and scrutiny committees' role in ensuring the quality of EIAs. The Council's SEP also explains how it has used EIAs to inform its equality objectives.

Organisational approach – integrated and stand-alone assessments

- 1.4 Nearly all public bodies (42 of 44) have a set process for undertaking EIAs. Most said that they put information on intranet sites, alongside supporting documents, contacts and most often a Word template for completion. Our review of EIAs found no standard format across public bodies, although most closely followed the approach set out in the Practice Hub. Members of the North Wales Public Sector Equality Network⁸ have worked together to develop a standard template which most members of the network have adopted at least in part.
- 1.5 In around two-thirds (30 of 44) of public bodies we spoke to, the EIA forms part of a wider integrated impact assessment. There is no common approach to integrated impact assessments and no national guidance on what should be covered. There are some assessments that public bodies commonly include alongside the PSED (**Exhibit 3**). Some include other legal duties as well as policy priorities and practical considerations, such as finance. For example, the Welsh Government's integrated impact assessments sometimes cover climate change impacts, health impacts and economic impacts as well as a wide range of other legal duties, depending on the nature of the policy or practice.

⁸ The North Wales Public Sector Equality Network is an informal network of public bodies working together to advance equality. Representation includes North Wales local authorities, Betsi Cadwaladr University Health Board, North Wales Police and Police Authority, North Wales Fire and Rescue Service, Welsh Ambulance Services NHS Trust, and Snowdonia National Park Authority.

Exhibit 3: assessments commonly included in an integrated impact assessment alongside the EIA

Well-being of Future Generations	The Well-being of Future Generations (Wales) Act 2015 introduced seven well-being goals for Wales. It also established the sustainable development principle and five ways of working – long-term, integration, involvement, collaboration, and prevention – to demonstrate application of the principle. An integrated impact assessment may also include an assessment of the policy or practice against the seven goals, public bodies' individual well-being objectives and/or the five ways of working specified in the Act.
Welsh Language	The Welsh Language (Wales) Measure 2011 declares that the Welsh language has official status in Wales. It makes provision to promote and facilitate the use of the Welsh language and to treat Welsh no less favourably than English through the Welsh language standards. Part of applying the standards means that public bodies must consider the effects their policy decisions on the Welsh language.
Environmental impacts	There are various duties to carry out environmental impact assessments depending on the nature of the proposed policy or practice. These range from strategic assessments of plans and programmes to assessments of projects that potentially impact on habitats and biodiversity.
UN Convention on the Rights of the Child	The Rights of Children and Young Persons (Wales) Measure 2011 embeds consideration of the United Nations Convention on the Rights of the Child and the optional protocols into Welsh law. The UN Convention consists of 41 articles, which set out a wide range of types of rights including rights to life and basic survival needs, rights to development including education and play, rights to protection, including safeguarding from abuse and exploitation, and rights to participation and express opinions.

Socio-economic	The Socio-economic duty came into force on 31 March 2021. When making strategic decisions, such as deciding priorities and setting objectives, public bodies must consider how they can reduce inequalities associated with socio-economic disadvantage.

- 1.6 Most integrated impact assessments involve collating separate impact assessments into a document template. Few seem to be a truly integrated impact assessment. Some public bodies are trying to make the connections between assessments and reduce duplication. For example, Carmarthenshire County Council, Powys County Council, Gwynedd Council, Denbighshire County Council and Wrexham County Borough Council have each developed, or are developing, an IT solution to bring together the relevant information needed to inform an integrated impact assessment.
- 1.7 Very few public bodies solely assess the impact on the PSED even when they do not consider their assessments to be integrated. In those public bodies that report having a standalone EIA process, the EIA often also includes Welsh-language and socio-economic impacts.
- 1.8 Previous research has found length is a barrier to the use of impact assessments in decision-making⁹. It was hard for us to judge any EIA or integrated impact assessment as too long as many factors affect the length including the nature of the policy or decision and the number of assessments undertaken. We reviewed some documents that were very long; for example, the integrated impact assessment of the Welsh Government’s remote working policy was 45,000 words (average reading time 2.5 hours). The majority for which a word count was easily identifiable ranged between 2,500 and 7,500 words (average reading time 8 to 25 minutes).
- 1.9 Most public bodies that have chosen not to integrate their assessments had considered the option. Reasons for not integrating assessments included a concern that there would be insufficient regard to the PSED. This may be a valid concern. Our review suggests that, in some cases, the PSED is covered in limited detail and appeared secondary to other considerations even though all the public bodies we spoke to who conduct integrated impact assessments felt they sufficiently covered the equality element.

9 Grace, C., Reducing Complexity and Adding Value: A Strategic Approach to Impact Assessment in the Welsh Government, Public Policy Institute for Wales, February 2016.

Specialist support and expertise

What we looked for

That there is specialist support and expertise available in the organisation to those conducting EIAs.

What we found

In most cases, policy leads are responsible for conducting EIAs and can access support from colleagues with knowledge in equality related issues and an in-depth understanding of the organisation's process for conducting an EIA.



- 1.10 In almost all public bodies, responsibility to undertake an EIA lies with the lead officer developing or reviewing a policy or practice. This is partly pragmatic, due to the number of EIAs public bodies conduct. Equality officers told us this approach meant that EIAs benefitted from policy leads' expertise on the topic area. However, they identified drawbacks, including the difficulty of ensuring consistency, getting EIAs started at the right time and ensuring quality.
- 1.11 All public bodies have equality officers (or equivalent) with knowledge in general equality issues and a detailed understanding of the organisation's EIA process. In all public bodies, staff conducting EIAs can ask equality officers for guidance when required. EIAs are mostly conducted without the input of an equality officer. The process at Aneurin Bevan University Health Board is one exception to this, where the first step for anyone who thinks they need to undertake an EIA is to contact the Equality Diversity and Inclusion specialist to discuss the proposed policy or practice and agree what actions they need to take, with ongoing support also provided. In smaller public bodies, where an EIA is more likely to relate to staff policies and decisions, the lead for conducting the EIA is frequently an HR officer who is also the equality officer.

Guidance to support those conducting an EIA

What we looked for

That there is guidance to support those conducting an EIA, setting out what they need to do and when, in line with the duties and their organisation's chosen approach.

What we found

There is non-statutory national guidance and support available setting out some good practice in the stages of an EIA, although there are gaps, notably in terms of integrated impact assessments. Most public bodies have also produced their own guidance to support their EIA process.



External guidance

- 1.12 The Welsh Government has not published statutory guidance on the application of the PSED in Wales or the Welsh specific duties. The EHRC published non-statutory guidance on the Welsh specific duties in 2014. Welsh Government guidance encourages public bodies to integrate different duties. But there is no specific national guidance on how to conduct integrated impact assessments and what should be included.
- 1.13 The Welsh Government, Welsh Local Government Association, and NHS Centre for Equality and Human Rights jointly developed the Practice Hub in 2015-16. This online resource provides information and support to public bodies in Wales to undertake EIAs. It provides a detailed eight step guide to good practice in undertaking EIA and gives information on the Welsh specific duties.

Internal guidance

- 1.14 Internally, most public bodies have produced guidance to support their EIA process. The format and detail of the guidance and quality vary across public bodies. Some provide step-by-step guidance which outlines the process and steps for completing an EIA. Some embed practical information and links within templates.
- 1.15 A few public bodies do not provide guidance on their individual processes. Some of these provide direct one-to-one support from an equality officer (or equivalent) to the individual completing the assessment. Others signpost staff to the external guidance on the Practice Hub.

Training

What we looked for

That training on conducting an EIA is available for staff involved in developing EIAs and those that use them for decision-making.

What we found

Most public bodies offer training to those involved with EIAs through a variety of media.



- 1.16 Around two-thirds (31 of 44) public bodies we spoke to provide formal training to officers who are likely to complete or have an interest in EIA. This training frequently extends to elected members, board members and decision-makers.
- 1.17 Methods of training vary. Some offer face-to-face delivery of training, with much of this via video calls since the start of the COVID-19 pandemic. Many public bodies include online modules and e-learning tools on equality, and EIAs as part of their general staff training. Those public bodies that do not offer formal training nevertheless provide one-to-one support to individuals conducting EIAs and upskill them through the process.

Quality assurance

What we looked for

An approach to ensuring the quality of the EIA process.

What we found

Half of public bodies had an approach to quality assurance, which varied from a simple sign-off on individual EIAs to more comprehensive peer learning to support improvement of the whole EIA process.



- 1.18 Half (22) of the public bodies have a quality assurance process in place for their EIA. The approach varies greatly. For some, quality assurance is about the quality of individual EIAs. Some require an EIA to be signed off by a senior officer. In Cardiff and Vale University Health Board, the lead officer conducting the EIA will work with an equality officer and a representative from Public Health Wales to review and interrogate the content of the EIA during its development. Other public bodies have begun to take a 'peer review' approach to developing EIA with input from experts from across the organisation.
- 1.19 A small number of public bodies use quality assurance to test the quality of their overall approach. For example, the Arts Council of Wales conducts an annual sample review of EIAs and uses the findings to improve the process.



Assessing impacts

02

- 2.1 The Wales specific duties require listed public bodies to assess the likely impact of proposed policies and practices, or those under review, on their ability to comply with the PSED. In doing so, they must have regard to certain types of information that they hold and meet specific requirements to engage with people or organisations that represent people with one or more protected characteristics. EHRC guidance and the Practice Hub set out in detail the steps public bodies can take to fulfil these requirements.

Screening

What we looked for

A clear approach to determining if an equality impact assessment is required.

What we found

Just over half of public bodies have a process for screening although many have stopped using screening, some due to risk of confusion or 'gaming' by staff.



- 2.2 There are no statutory exemptions setting out policies and practices that do not need to be assessed. However, the EHRC guidance and the practice hub include a 'screening' process to determine which policies or practices should have a full EIA.
- 2.3 Just over half (24 of 44) of public bodies we spoke to said that they have a screening process. Screening is most often a document template which an officer developing or reviewing a process or policy uses to determine whether they anticipate any impact on protected groups. The approach ranges in practice from a separate short impact assessment to a set of screening questions at the beginning of the full assessment template which determine whether to proceed with the full EIA.
- 2.4 Where a body decides it does not need a full EIA, they will usually retain a copy of the screening tool as evidence that it has considered the PSED. Most public bodies with a screening process will document the decision not to go ahead with a full EIA in the supporting papers that go to the cabinet or board.

- 2.5 Most often, the policy lead keeps the detailed record of screening. However, a few public bodies are trying to strengthen practice and ensure central records are maintained. For example, Cardiff Council has developed an online assessment tool to support policy leads through the process and encourage consideration of impact at the earliest stages of policy development. As well as sending advice and guidance to the officer completing the online assessment, the tool also sends a copy of the screening information to the equality officers.
- 2.6 The 20 public bodies who do not have a screening process had often consciously removed the screening step. Many said screening was an unnecessary step, as there are very few of their decisions that will not have potential to impact on the PSED. Some public bodies said that there was also scope for confusion, with lead officers completing a screening form, thinking it was an EIA. Others were concerned that some officers may 'game' the process: tailoring their responses to screening in a way designed to result in a decision that no further assessment was required.
- 2.7 Those public bodies that do not have a screening process usually provide additional guidance or a process chart, clarifying when to conduct a full EIA. All public bodies also offer the lead officer an opportunity to consult with an equality officer.

Timing

What we looked for

EIAs being started at an early stage to inform the development of a policy or decision.

What we found

All public bodies intend to carry out an EIA as early as possible, but many recognise this is often not the case in practice, and in some cases EIAs are very late in the policy development or decision-making process.



- 2.8 All 44 public bodies intend that EIAs should be started as early in the development or review of a policy as possible. But many public bodies acknowledged that this often does not happen in practice.
- 2.9 The timing of EIAs is affected by whether policy leads know that they are required to do an EIA and if resources – staff and time – are available at the appropriate point. Sometimes, if public bodies must make decisions very quickly, they either do not do an EIA or do them late in the decision-making process. This can be too late to consider changing a policy to lessen any possible negative impact or to build on positive impacts.
- 2.10 Decisions at the start of the COVID-19 pandemic were often made without an EIA. This reflected the urgency of decisions but meant that the impact on vulnerable people was not formally assessed. In August 2020, the Senedd's Equality, Local Government and Communities Committee¹⁰ recommended that the Welsh Government should ensure that each major policy or legislative decision is accompanied by an effective equality impact assessment, and an analysis of the impact on human rights. The Welsh Government accepted the recommendation, and since August 2020 has published dozens of impact assessments related to the COVID-19 pandemic on its website.

¹⁰ Senedd Equality, Local Government and Communities Committee, Into sharp relief: inequality and the pandemic, August 2020.

- 2.11 In most public bodies, papers accompanying decisions that go to cabinets or boards contain a box or section that refers to consideration of the equality duties. This serves as a backstop to prevent public bodies from making decisions without any regard to the duties, even though this generally would be very late in the process.

Use of evidence

What we looked for

Use of a range of evidence to support the assessment, including the views of those likely to be impacted and data on lived experience.

What we found

Public bodies use a mix of evidence, although there are gaps in available data on some protected characteristics and the inclusion of the views and lived experiences of people with protected characteristics is patchy.



Quantitative data

- 2.12 EIAs need a sound evidence base to inform their conclusions. The depth and detail of the information base vary across organisations and by assessment. The depth of information and analysis often depends on the scale of the decision and the availability of relevant and specific evidence.
- 2.13 All public bodies expect to include some quantitative data, such as demographic information or service level data. Around two-thirds (29 out of 44) of public bodies include at least some examples of internal information sources and point to publicly available data in their guidance and templates. Some go further. For example, Merthyr Tydfil County Borough Council includes in its guidance a detailed list of sources where policy leads can find relevant evidence, with embedded links to external data sources.
- 2.14 There are some significant data gaps in the data that is available to public bodies. Generally, there is little information available about some protected characteristics, particularly sexual orientation, gender reassignment, and pregnancy and maternity. Data that is available at a national level is sometimes not available at a health board, council, or ward level, which makes it difficult for public bodies to understand their local populations with protected characteristics.

Qualitative information

- 2.15 The inclusion of qualitative information based on the views and experiences of people with protected characteristics is also patchy. When introducing new policies or changing services public bodies often undertake a consultation exercise. In the examples we saw, these were often targeted to the public in general, and it was difficult to see if the public body had sought to engage specifically with people from protected groups.
- 2.16 Nonetheless, we did see examples of EIAs where evidence from engagement with groups was covered. For example, when Snowdonia National Park Authority undertook an EIA on its communication and engagement strategy, the assessment considered how the strategy could engage with people who speak languages other than English or Welsh. It also considered impacts on those who were digitally excluded, a group that is more likely to include older people and more women than men.
- 2.17 Some respondents to our general call for evidence said that drawing more on the views and experience of people with protected characteristics would improve the quality of EIAs. This includes engaging with individuals and grassroots organisations as well as national organisations representing protected groups. Some respondents said that public bodies should do more to publicise consultations by a range of means, including but not restricted to social media.
- 2.18 Some all-Wales third sector bodies responding to our call for evidence said that they were often asked to provide views for EIA and that some cannot respond to all the requests they receive. Sometimes they do not have information on local services and impacts.
- 2.19 A few public bodies are trying to draw on the lived experience of people with protected characteristics through different forms of consultation. Some use existing networks for staff with protected characteristics to understand different perspectives. Others, draw on existing relationships with third sector groups to understand the lived experience.

Identifying and mitigating likely impacts

What we looked for

Clear identification of likely impacts, including positive impacts in promoting equality, as well as negative ones.

Some consideration of cumulative impacts arising from other decisions that impact the same group or groups and how different protected characteristics combine (intersectionality).

Clear recommendations for mitigating negative impacts that have been acted on before the decision is made.

What we found

While there are examples of public bodies identifying specific impacts, often EIAs describe impacts in very broad terms. Very few identify the cumulative impacts of multiple decisions on groups or consider how different protected characteristics intersect. Very few can show how recommendations for mitigating impacts are followed through.



Specific impacts

- 2.20 Positively, our review of EIAs found examples of public bodies clearly identifying specific likely impact of policies or practices on protected groups. However, many EIAs included statistics to describe the population of people with protected characteristics without being clear how the policy or practice would likely impact on them. We also observed a tendency for EIAs to focus on negative impacts, thereby missing positive impacts and opportunities to improve cohesion and reduce inequalities.
- 2.21 We found that most EIAs reviewed provided data and information on each protected group separately. For example, the EIA on Conwy County Borough Council's Older Peoples' Domiciliary Care Finance and Commissioning Project set out the likely impact on people with each protected characteristic.

2.22 Most public bodies' approaches to EIA involve making recommendations to overcome negative impacts. Public bodies should incorporate mitigating actions into the policy development process, recognising it is not always possible to mitigate all negative impacts, such as with reductions in service. Very few public bodies have a process in place to track whether they have implemented the mitigating actions, after a decision is taken. In Hywel Dda University Health Board, the EIA has an associated action plan with a review date. In Aneurin Bevan University Health Board the Equality, Diversity, and Inclusion specialist keeps a database of actions arising from EIAs for monitoring purposes.

Intersectionality

2.23 Increasingly, it is understood that inequality is intersectional. People's characteristics interact in a complex way to give a unique experience of inequality. For example, the experience of a Muslim woman cannot separate 'female' and her experience as a Muslim. It will differ from that of a Muslim man and of a non-Muslim woman. However, we did not see examples of such nuanced understandings of inequality in the examples we reviewed.

Cumulative impacts

2.24 Public bodies in Wales make many decisions each year that, taken together, can be very detrimental to people from protected groups. For example, one respondent to our call for evidence gave the example of how individual decisions to reduce or close facilities and services such as public toilets, library services, day centres, and bus services had a cumulative impact on many older people who use the services. They said that, while each individual decision might not be significant, together they meant that some older people were becoming isolated.

2.25 The few instances we found where public bodies have begun to give thought to cumulative impacts tend to be when public bodies are making several decisions at the same time. For example, councils usually undertake a cumulative approach to assessing the impacts of their proposed budget each year. Individual service changes being proposed because of budget changes are assessed simultaneously allowing a better overview of potential impacts for the budget.

2.26 Typically, however, public bodies make decisions separately. One of the respondents to our call for evidence to decision-makers highlighted that it is difficult in principle to predict the likely impacts of multiple decisions in a complex landscape. Practically, the ability to take account of impacts from other decisions relies on the policy lead knowing about other decisions within an organisation and having access to the EIAs. A small number of public bodies are trying to address this information gap by using an IT solution to undertake the EIA (**paragraph 1.6**). This way, the assessment of impact for each policy change and decision is held centrally, making it easier for policy leads to bring together the information.

Decision-making

What we looked for

That the EIA and likely impacts it identifies are considered at the point of decision-making.

What we found

Equality officers' views varied around the extent to which their organisations prioritised the EIA in decision-making. Most respondents to our general call for evidence said public bodies did not pay sufficient regard to protected characteristics. The small number of responses from decision-makers suggest a view that the EIA is seen as a 'tick box exercise'.



- 2.27 The consideration given to EIAs in decision-making varies across public bodies in Wales. In general, equality officers felt that decision-makers take assurance in knowing that the policy lead has completed an EIA. Decision-makers will have access to a summary or the complete EIA accompanying each decision in their cabinet or board papers.
- 2.28 The equality officers we spoke to had mixed views over the extent to which their organisations placed sufficient weight on the EIA in decision-making. Over three-quarters of respondents to our general call for evidence who answered the question (29 of 37) disagreed that public bodies in Wales give appropriate due regard to people with protected characteristics when developing policies or making changes to services.
- 2.29 Generally, equality officers were not aware of instances where decision-makers challenged the content or recommendations of an EIA at the point of decision. Most felt that the accompanying EIA should have considered and shaped the policy sufficiently that there would be no need for such challenge at that late stage.
- 2.30 We only received ten responses to our call for evidence from decision-makers. While it is hard to draw conclusions from such a limited evidence base, it is notable that three of the ten referred to EIAs being used like a 'tick box'.



Reporting and monitoring impacts

03

- 3.1 Public bodies must publish reports of the assessments where they show a substantial impact (or likely impact) on their ability to meet the PSED. They must also monitor the actual impact of the policies and practices subject to an equality impact assessment.

Reporting

What we looked for

Public information about decisions and a clear description of how the EIA has influenced the decision-making.

What we found

Most public bodies publish some of their EIAs as part of a wider set of papers and they are often not easy to find.



- 3.2 Almost all public bodies in Wales publish their EIAs, at least in part. Typically, they publish EIAs with decision-related papers, such as cabinet or board papers. There is usually a section on the body's website which holds all the papers for each meeting and is accessible to the public¹¹. There are a few exceptions in some of the smaller public bodies, who do not routinely publish their EIAs.
- 3.3 It can often be difficult to find EIAs which relate to a specific decision on public bodies' websites. The EIAs which feature more prominently and are easier to locate often relate to strategic decisions such as budgets or key corporate strategies. Newport City Council have tried to bring EIAs into a central location on their website to make them more easily accessible, while recognising that this approach relies on the individuals completing EIAs sharing them for publication, which sometimes does not happen.

¹¹ In some instances, bodies do not publish EIAs if they form part of a paper that is held back from publication due to its confidential or sensitive nature. However, these EIAs can sometimes be obtained via a Freedom of Information request if someone has a particular interest in seeing them.

Monitoring impacts

What we looked for

A clear approach to monitoring the impacts of the decision after it is implemented, including those identified as part of EIA as well as any unexpected impacts.

What we found

Very few public bodies monitor the impact of the decisions in the context of the PSED.



- 3.4 Some public bodies require those completing EIAs to identify a review date when monitoring is supposed to occur. We saw examples where EIAs set out plans for monitoring. For example, a Powys Teaching Health Board EIA included plans for monitoring service use after a change in surgery opening hours and for an independent evaluation of the service change. Also, Conwy County Borough Council's EIA for its review of domiciliary care included detailed arrangements for monitoring the impact using data and information that are routinely reported, including individual feedback from people receiving care.
- 3.5 However, equality officers had seen little evidence of the impact of policies and practices being monitored in light of the EIA. Those public bodies that outlined a monitoring process were often referring to the monitoring of an implementation of a policy or practice against its objectives or targets, not the impact that the decision had on people with protected characteristics.
- 3.6 In general, public bodies do not consider the impacts of policies and practices in terms of the PSED until there is another decision due on the same policy or practice. At that point, the body conducts a new EIA. Many of the equality officers we spoke to seemed unsure about how, in practice, they would monitor the impact of a decision on protected groups and would welcome more guidance.

Challenging EIAs

What we looked for

That the organisation identifies and applies lessons from any challenge to decisions on the basis of equality or the quality of the EIA.

What we found

Many equality officers did not think there had been any challenges to EIAs conducted by their organisation, but where there has been challenge some public bodies are using it as a learning opportunity.



- 3.7 Decisions made by public bodies can be challenged based on the EIA. Public bodies that do not have a clear record showing that they have considered the likely impacts of their decisions for people with protected characteristics leave themselves open to challenge. This could potentially include a judicial review. Some equality officers did not know what process someone would use to challenge an EIA. The majority said that any challenges would go through their general complaints process, with the involvement of the relevant service, equality officers and legal team.
- 3.8 Many equality officers thought there had not been any challenge to an EIA conducted by their organisation. Those that were aware of challenge taking place said that it was something that happens infrequently. Almost half of respondents to our general call for evidence who answered the question (17 of 35) said they had challenged some aspect of an EIA. We do not know if this was a formal or informal challenge.
- 3.9 Equality officers who had experienced challenge to an EIA said their organisation can resolve the issues either by making changes to a policy or practice, or by providing evidence that they had considered the impacts. Respondents to our general call for evidence gave examples of issues they raised being resolved. For example, one had objected to the EIA conducted on a new bus interchange because the council had not sought the views of people with protected characteristics on the proposals. Following their intervention, people with low vision visited the site and suggested changes to make the interchange more accessible.

3.10 While there are positive examples of public bodies responding to challenge, several respondents to our general call for evidence who had challenged aspects of an EIA reported not receiving any response to their challenge. A few equality officers told us that their organisation had learnt from the experience of having an EIA challenged. One had used examples of challenge from other public bodies to inform its EIA training as a particularly useful way of making impacts more easily understood to lead officers conducting EIAs.



Appendices

1 Audit approach and methods

1 Audit approach and methods

Audit approach

Our main aim was to provide insight about the approach to EIAs undertaken across the public sector in Wales. We wanted to highlight good practice and identify opportunities to improve. To help shape our thinking about what good practice to look for, we drew heavily on existing guidance materials, in particular that produced by the Equality and Human Rights Commission (EHRC) and the [Equality Impact Assessment in Wales Practice Hub](#) hosted by Public Health Wales NHS Trust.

We set out to explore to what extent public bodies have integrated their approach to undertaking EIAs, including the new socio-economic duty and the cumulative impact of decisions. We also explored what difficulties public bodies experience that affect the quality and timeliness of EIAs. We looked at how public bodies monitor the impact of decisions on their population. Each of the sub-sections in the main body of this report describes what we were looking for through our work.

In looking across the public bodies, we focused on the 44 public bodies originally subject to the Well-being of Future Generations (Wales) Act 2015. The Auditor General for Wales is the external auditor of each of these bodies, which include local authorities, health boards and some NHS trusts, national parks, and fire and rescue services. They also include the Welsh Government and some of its sponsored bodies. Our audit coverage did not include education bodies – further education, higher education or maintained schools – that are subject to the PSED. It also did not include the four Corporate Joint Committees (CJCs) established by the Local Government and Elections (Wales) Act 2021 and which are subject to the PSED.

Audit methods

Document review: We reviewed documents from each of the 44 public bodies, including those relating to the equality plans and details of the organisation's EIA process. We also reviewed details of their process for integrated impact assessments. We reviewed a sample of 29 EIAs provided by public bodies: 11 by local authorities, eight by health bodies, two fire and rescue, two national parks and six by the Welsh Government or its sponsored bodies.

Interviews: We interviewed the equality officers or their equivalent in each of the 44 bodies. We have used the term 'equality officer' throughout this report to refer to staff in public bodies with specific lead specialist roles for equality, whether that be their full-time job or part of their role. The way these roles are structured, and their seniority, varies.

Call for evidence: We sought wider views about people's experience of EIAs through a call for evidence between October 2021 and June 2022. We publicised this generally and in particular to third sector organisations. We received 40 responses, 23 from individuals and 15 responding on behalf of an organisation (two did not say).

We also sought the views of decision-makers through a separate call for evidence open between February and June 2022. We received ten responses (eight from individuals working in local authorities, one health and one fire and rescue).

While the responses we received to the calls for evidence are not necessarily representative of individuals, the third sector or decision-makers, they have provided useful detail which we have included through the report and which informed our overall analysis.

Stakeholder engagement: The EHRC is responsible for promoting and enforcing equality and non-discrimination laws. We met with officials in the EHRC Wales Team regularly throughout our work, discussing our scope and emerging findings. We also met with the Welsh Local Government Association's equality network and the Chair of the All-Wales NHS Equality Leadership Group. We interviewed officials from the Welsh Government with responsibility for equality policy.

Wider audit intelligence: We drew on existing intelligence from our local financial and performance audit work, where that was relevant to equality impact assessments.



Audit Wales

24 Cathedral Road

Cardiff

CF11 9LJ

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

We welcome telephone calls in
Welsh and English.

E-mail: info@audit.wales

Website: www.audit.wales

Equality Impact Assessments: More than a tick box exercise? Management Response

September 2022

Recommendation	Management response	Completion date	Responsible officer
Reviewing public bodies' current approach for conducting EIAs R4 While there are examples of good practice related to distinct stages of the EIA process, all public bodies have lessons to learn about their overall approach. Public bodies should review their overall approach to EIAs considering the findings of this report and the detailed guidance available from the EHRC and the Practice Hub. We recognise that developments in response to our other recommendations and the Welsh Government's review of the PSED Wales specific regulations may have implications for current guidance in due course.	CTM UHB welcomes the report's recommendations for a national approach to clarifying the scope of the duty to impact assess policies and practice and developing guidance for integrated impact assessment. CTM UHB is currently reviewing the EIA process, in line with the findings of this report, and the guidance available from the EHRC and the Practice Hub. As such work has commenced on benchmarking against other NHS organisations. Quality Assurance measures are also being designed to monitor EIAs, as well as monitor the impact of the decisions in the context of the PSED. In addition, further staff guidance and policies will be developed to ensure that the EIA process is both robust and informed. Consideration will be given, as part of the review, to determine whether the EIA forms part of a wider integrated impact assessment.	March 2023	EDI Practitioner

Commissioning and contracting arrangements post Bridgend boundary change - Swansea Bay and Cwm Taf Morgannwg University Health Boards

Audit year: 2020-21

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This document is also available in Welsh.

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Summary report

Introduction

- 1 On 1 April 2019, the Welsh Government introduced changes to the boundaries of Abertawe Bro Morgannwg University Health Board (ABMUHB) and Cwm Taf University Health Board. Neath Port Talbot, Singleton and Morriston Hospitals, and services relating to the Swansea and Neath Port Talbot population became part of the new Swansea Bay University Health Board (UHB). The Princess of Wales Hospital, formerly part of ABMUHB, became part of the new Cwm Taf Morgannwg University Health Board (CTMUHB). Commissioning responsibility for the health needs of the Bridgend population transferred to CTMUHB.
- 2 Planning for the new arrangements started in June 2018, when a monthly Joint Transition Board (JTB) was established as a sub-committee of each health board. Its remit to provide oversight and implement the decision of the Welsh Government to realign the health board boundaries for the Bridgend County Borough. This group was established to operate until the transition date of the 1 April 2019.
- 3 However, while most Bridgend services transferred to CTMUHB on the 1 April 2019, it was not possible to transfer all. Several services required further work to disaggregate them from their original arrangement and integrate them into the wider service provision of the new organisations. To ensure that services continued to be delivered, arrangements were made to commission services from each health board. This resulted in two Long Term Agreements (LTAs) between CTMUHB and Swansea Bay UHB for the provision and commissioning of services. Also established were ninety clinical or service specific Service Level Agreements (SLAs), and twenty-one corporate SLAs¹. At this point it was expected that these SLAs would be in place for on average 12 months to allow more time for the health boards to disaggregate, decommission and plan future service models.
- 4 Both health boards acknowledged a consequential budgetary impact of the Bridgend transfer in their 2019-20 Integrated Medium-Term Plans or Annual Plans. Non-recurrent funding of £10 million was made available by the Welsh Government to support the transition process for 2019-20.
- 5 Our work examined the robustness of the arrangements for overseeing and managing the contractual agreements established following the realignment of the health board boundaries in 2019. We also considered the programme for service disaggregation (for relevant services), and whether the arrangements support future regional service models being explored by the two health boards.

¹ A Service Level Agreement (SLA) is defined as a contract between a service provider and a customer. It details the nature, quality, and scope of the service to be provided. A Long-Term Agreement (LTA) means any contract or agreement with an unexpired term (inclusive of extension periods) in excess of one year. Usually between 3 to 5 years. Individual service lines relate to the provision of specific clinical services.

Summary report

Key messages

- 6 Overall, we found **that the contract arrangements are sound supported by good operational oversight and project management. However, there has been no clear programme for disaggregation of services until recently, and the lack of commissioning capacity and programme management, alongside the impact of COVID-19 has meant that the original timetable has not been met. Oversight and scrutiny of the programme at Board and Committee level within both health boards also needs to be improved, as well as the management of risk.**
- 7 We found that there are comprehensive programme arrangements in place to provide operational oversight of the Bridgend commissioning arrangements. The current operational governance arrangements work well, with clear leadership and involvement from all relevant corporate functions. Agendas for meetings are well managed although some agendas can be full and operational and clinical staff are not always involved. However, oversight of the total programme at Board and Committee level within both health boards is not sufficient, with only limited updates provided to the Board in Swansea Bay UHB.
- 8 Arrangements for monitoring the contracts are sound, and regular information is provided to the operational groups to ensure scrutiny. Changes to any contracts are managed well, although there is scope to ensure that any impacts from service changes are appropriately assessed. A joint risk register is in place, which captures the risks appropriately, however there is no clear process for escalation of these risks to the relevant health board risk register.
- 9 Although there has been progress in disaggregating services, the anticipated time to disaggregate all contracts was underestimated and up until recently, there has been no clear disaggregation plan in place. The capacity of the commissioning teams has not been enough to enable effective programme management and compounded with the impact of COVID-19 has affected the ability to disaggregate services at the expected rate. While a plan is now in place, without additional capacity, the ability to disaggregate remaining contracts will be hindered.

Recommendations

- 10 Recommendations arising from this audit are detailed in **Exhibit 1**. The Health Board's management responses to these recommendations is currently being finalised and the management response will be presented to the February 2022 Audit and Risk Committee.

Summary report

Exhibit 1: recommendations

Recommendations	
Commissioning and Contracting Group	
R1	We observed good scrutiny by the commissioning and contracting group. However, there were significant agendas which were challenging to cover in the allotted meeting times and there were a lack of operational and clinical representation. The health boards should: • Review the time allotted to meetings, or review the content of agendas to ensure that agenda items can receive sufficient discussions; and • Ensure appropriate membership at the group so that issues from operational and clinical staff are raised.
Programme oversight	
R2	Up until recently, there has been no plan for the disaggregation of services and oversight and scrutiny at Board and Committee level has been lacking. A plan for 2022-23 is now in place but oversight still needs to be improved. The health boards should: • Develop a programme with clear timescales for the future disaggregation of services, where appropriate, that goes beyond 2022-23. The programme needs to be informed by the respective health board clinical service plans and communicated within the health boards, including clinical staff. • Use the plan to facilitate monitoring of delivery and increase the level of oversight and scrutiny of the disaggregation programme through the relevant Board and Committee structures within both health boards.
Impact assessments	
R3	Our work identified that service users and patients' needs are not routinely assessed when variations to agreements are made, and we have seen no evidence of the use of quality impact assessments. The health boards should implement a process for conducting impact assessments when making changes to the way in which services are delivered for the Bridgend population.
Risk management	
R3	Our work identified that there was no clear link between the risk registers managed by the commissioning and contracting group to the health board risk

Summary report

Recommendations
registers. The health boards should review the risk management process associated with the transition so that risks are linked and reflected in individual health board corporate risk registers.

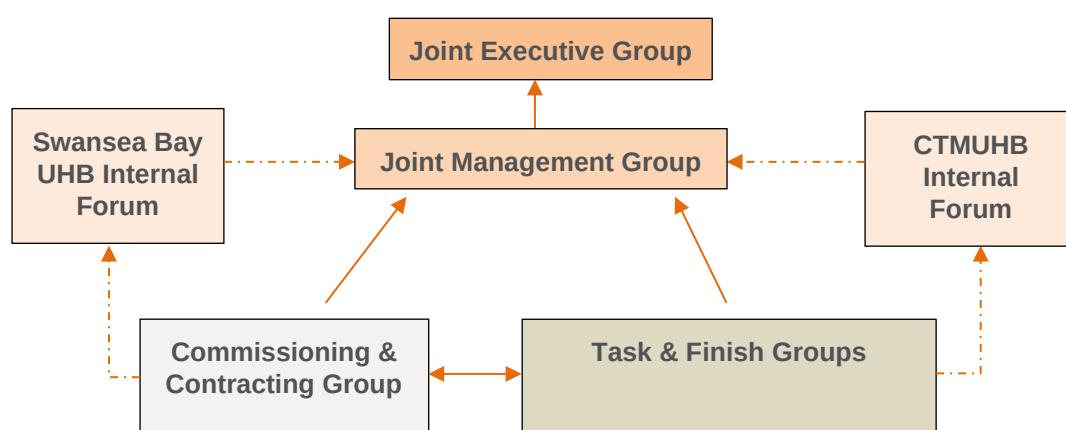
Detailed report

Governance arrangements

- 11 Our work considered whether the governance arrangements established following the Bridgend transition ensured effective oversight of the commissioning arrangements and the disaggregation of services.
- 12 We found that **there are comprehensive programme arrangements in place to provide operational oversight of the Bridgend commissioning arrangements, however, oversight and scrutiny at Board and committee level needs to be improved at both health boards.**
- 13 We found that the membership of the JTB was comprehensive, including the chairs and chief executives of each health board, the Transition Programme Director, an independent member from each health board, trade union members from each health board, executive directors and key officers as required. Other key members of the group included senior representatives from Bridgend County Borough Council (BCBC), a representative from Audit Wales in an observer/critical friend capacity, and a representative from the Welsh Government.
- 14 The JTB also established a Joint Transition Programme Group (JTPG) to implement the required changes at an operational level across each health board. The JTPG met monthly and was chaired by the Transition Programme Director, working on behalf of both health boards. To manage the activity, the JTPG developed a programme of work which was delivered through twelve workstreams. These workstreams covered a range of areas including capital and estates, information technology and finance.
- 15 These arrangements were established to operate until the transition date of the 1 April 2019 and were both stood down on the 23 April 2019. It was clear from the handover and legacy statements at the time that the disaggregation of services both clinically and corporately was significantly complex, and many areas still required significant work to be disaggregated.
- 16 To govern the relationship between the two organisations during the transition process, both health boards agreed a Memorandum of Understanding (MOU). The MOU has supported good working relationships between the two health boards, setting out key principles and expectations in respect of:
 - overseeing the contractual arrangements and service provision,
 - the process for reconciliation of disagreements regarding the performance of LTAs and SLAs and how this would be followed,
 - ensuring that any future service change is consulted upon,
 - completing and closing the legacy of the service and commissioning issues arising from the boundary transfer, and
 - establishing joint strategic planning arrangements to support the development of agreed service models for the populations of both health boards.

- 17 Following the disbanding of the JTB and JTPG in April 2019, operational oversight of the LTAs and SLAs was transferred to the Commissioning and Contracting Group (CCG). This group comprises of management representatives from commissioning and finance functions of each organisation. However, discussions between senior management at both health boards identified the need for senior oversight and strategic direction of the programme. A Joint Executive Group (JEG) was established in August 2019 to provide this, along with a comprehensive programme management structure, outlined in **Exhibit 2**.

Exhibit 2: Transition Programme Management Structure



Source: Joint Planning and Commissioning Arrangements – Swansea Bay and Cwm Taf Morgannwg University Health Boards - 30 September 2019

- 18 The programme management structure outlined in **Exhibit 2** was still operational at the time of our review. Our fieldwork included observations of both the Contract and Commissioning Group (CCG)² and the Joint Management Group (JMG)³, and a review of associated agendas and papers. We found that both were well organised with formal agendas and reports available in advance of the meetings.
- 19 In respect of the CCG, we found that the agenda included comprehensive minutes of the previous meeting which assigned named individual for actions, with clear timescales for delivery. There were separate agenda items for corporate SLAs and the outstanding issues around these as well as outstanding LTA issues. Action

² The CCG oversees the programme of strategic commissioning work. The group also ensures that the monitoring of the LTAs and SLAs is undertaken effectively.

³ The JMG is responsible for developing and monitoring the programme plan, and ensuring interdependencies and risks are managed and mitigating actions are in place when plans are off-track. The group is co-chaired by the directors of planning. Membership includes CCG leads as well as human resources, finance, and quality representatives. The group meets monthly.

notes were reviewed at the start of the meeting which included a mixture of routine 'housekeeping' issues such as invoicing, and operational issues such as the progress of cessation forms for services no longer to be provided. A separate log is kept for pending adjustments and cessations. We observed good mature discussion and agreement on issues. However, the agenda was full which meant that some issues were rushed particularly towards the end on corporate SLAs. We noted that there were no operational staff in attendance, all were from corporate planning or finance. We are aware that clinical teams have contacted the commissioning team regarding numerous services, but this is more adhoc than routine. This could mean that clinical and operational issues and implications are being missed. **(Recommendation 1)**

- 20 In respect of the JMG, we found that meetings included representatives from workforce, finance, digital, operations, nursing, and commissioning and contracting staff. The group is more strategic in nature than the CCG and the business of the meeting reflected this. There was also a standing agenda item on operational issues.
- 21 Minutes of the JEG⁴ were also reviewed. We found detailed evidence notes and monitoring of progress being undertaken. There is good attendance from members as well. However, from our review of committee terms of reference (TOR) we were unable to review a TOR for the Joint Executive Group and the Joint Management Group TOR had not been reviewed since March 2020. There were plans to update both these documents in January 2022.
- 22 We have also reviewed oversight of the programme at Board and committee level at both health boards. We found that in Swansea Bay UHB, the Board receive a routine update paper which contains a highlight of issues from the JEG. An update was provided at the May 2022 Board meeting, noting that the JEG had last met in March 2022. In CTMUHB, we found that there had been no progress update to Board since November 2020, other than reference to a discussion held in the Planning, Performance and Finance Committee as part of the committee highlight report in May 2022 **(Recommendation 2)**.
- 23 At committee level, we found no oversight and scrutiny of the commissioning arrangements relating to Bridgend at either of the health boards, except for detailed discussions on the disaggregation of digital services through the Digital and Data Committee at CTMUHB, with risks escalated to the Board by the committee chair. However, since our work, a disaggregation plan (referred to in more detail later in this report) has been discussed at the Planning, Performance and Finance Committee at CTMUHB following a request by the JMG for a plan to be in place for 2022-23. This has not been discussed at committee level in

⁴ The JEG is the Programme Board with overall accountability for setting the strategic direction of the programme. Membership includes the chief executives and key executive directors and assistant directors from both health boards. It meets bi-monthly and is co-chaired by the chief executives.

Swansea Bay UHB although updates to the Board indicate what changes will be made during the financial year.

Establishment and monitoring of the agreements

- 24 Our work considered whether the arrangements established following the Bridgend transition were sufficiently comprehensive and robust to facilitate effective contract management.
- 25 We found that **arrangements to establish and monitor the LTAs and SLAs are working well but escalation of project risks to corporate risk registers needs improvement and more could be done to consider impact.**

Establishment of the agreements

Processes for establishing agreements work well although more could be done to consider the impact of service changes on patients

- 26 On 1 April 2019 over two hundred services transferred to CTMUHB. Very few of these had been disaggregated from the former ABMUHB. To continue to support the delivery of these services post the transition and to enable further work to be undertaken to disaggregate the services several long-term agreements (LTA) and service level agreements (SLA) were put in place. The MOU contained a detailed appendix which set out the provider status as of 1 April 2019 for all the services covered by the LTAs and SLAs.
- 27 All the LTAs and SLAs in place adhere to a standard template which contains common terms and conditions including end dates, termination, and notice periods. However, it is not tailored to specific services although agreed generic standards for service provision, quality, costs, activity, KPIs and staff numbers are included as appendices. This, standard documentation, is common across Wales. This is felt to be a pragmatic arrangement for both health boards as it keeps paperwork to a minimum. Any variations are documented through a 'Cease or amend' form which is completed and signed by both sides before any change can happen. This process is managed through the CCG, and we have observed this process during our work.
- 28 A hard copy of each of the LTAs and SLAs is signed by the relevant health board executive, and there is also an electronic version. They are signed every year, and these are usually rolled over, or any changes are highlighted. There have been no reported issues with payments or funding. The sign off arrangements are as required in the Health Boards Standing Financial Instructions. Once signed they are then noted by the Board.
- 29 Variations to service and finance is allowed and it is the appropriate heads of service who are responsible for delivery and negotiation of variations with support from the corporate departments such as finance, contracting and workforce. These

'Cease or amend' forms are filled in by the heads of service in both health boards ensuring that a collaborative approach is taken.

- 30 Service users and patients' needs however are not routinely assessed when variations to the LTAs and SLAs are made. There is an expectation that when changes are proposed, the relevant service leads would be talking to patients and getting their views as part of their normal business. We have seen no evidence of the use of quality impact assessments for example. The generic level of detail contained in the contracts also means that it is difficult to monitor the quality and impact of individual services (**Recommendation 3**). However, we have seen evidence that health boards speak regularly to their respective Community Health Council and the third sector, and any proposed changes with a direct impact on patient care are discussed through the JEG. Any major changes would be subject to a formal consultation period.

Monitoring the agreements

Arrangements to monitor agreements are working well despite the need for some performance data to still go through a manual process

- 31 There are good monitoring arrangements in place. A full list of LTAs and SLAs is maintained by the health boards, and routinely included in the CCG agenda. An update in March 2022 showed that at the time of the boundary change, there were two LTAs which related to Bridgend Services. These set out commissioning spend of £11,334,000 by CTMUHB of services provided by Swansea Bay UHB, and £19,489,000 by Swansea Bay UHB to CTMUHB.
- 32 In addition, supporting these LTAs were 58 SLAs covering a wide range of clinical or service specific areas where Swansea Bay UHB was the provider to the Bridgend population, representing a total cost of £17.8 million. Similarly, CTMUHB is the provider of services to the Swansea Bay population. At the time of the boundary change, there were thirty-two clinical or service specific SLAs representing a total cost of £4.8 million.
- 33 The clinical or service specific SLAs cover a wide range of activity such as the provision of pathology and mortuary services, as well as staff costs (medical and non-medical), where staff work in the other health board's services. There are also clinical capacity SLAs whereby the facilities are owned by one health board, but the provision of services and staff are managed by the other. The costs of the clinical capacity SLAs are based on activity.
- 34 As well as clinical and service specific SLA, a total of twenty-one corporate SLAs were also in place. The majority of these related to the provision of services by CTMUHB to Swansea Bay UHB and covered a range of corporate services including patient registration, estates and facilities, occupation health, counter fraud, and finance.

- 35 Data is agreed between the health boards before being presented to the CCG meetings where performance is discussed. Regular reports include details of activity in the LTAs and SLAs which is quantified in financial terms. Our fieldwork suggests that there are no issues with the performance data available to Swansea Bay UHB but there were issues with CTMUHB data provided by Swansea Bay UHB as this required 'cleansing' which had to be done manually. This was because the data for Princess of Wales Hospital is collected by Swansea Bay UHB systems and sent to CTMUHB for consideration. However, it is worth noting that there have been no issues or disputes about data quality, or its timeliness specifically raised with us.
- 36 Due to COVID-19, LTAs and clinical capacity SLAs were put on a block contract arrangement for the 2020-21 and 2021-22 financial years with values based on 2019-20 performance. This was per the All-Wales agreement and was intended to protect organisations from financial risk whilst efforts focussed on COVID-19 rather than planned care activity. Prior to this the agreements worked on a 'bottom line' basis and any over or under performance would be offset as part of an end of year reconciliation exercise. Financial risks are held centrally for activity and are not reflected in divisional budgets throughout the year, except for in-year adjustments made to workforce which are reflected.
- 37 Also due to the COVID-19 pandemic, meetings of the CCG, JEG and JMG in April and May 2020 were postponed. The CCG meeting reconvened at the end of June 2020 and continued to review the LTA and SLA positions. Meetings of the JEG and JMG also resumed and have run as per expected since this date. The block contract arrangement was stood down for 2022-23.

Risk management

There are good controls in place to manage risk associated with the transfer of services although the escalation of high risks to corporate risk registers needs to be improved

- 38 Both health boards have agreed to keep a joint risk register and proactively manage risks associated with the transfer of services relating to Bridgend. Risks are escalated as required in line with the escalation arrangements set out in the paper "Joint Planning and Commissioning Arrangements Swansea Bay and Cwm Taf Morgannwg University Health Boards" agreed in September 2019. The joint risk register forms part of the JEG agenda. It is also discussed at the CCG. Operational departments also keep a risk register of issues, and these are fed into the CCG. Similarly, risks identified at the CCG are sent to operational departments for response.
- 39 From our review of the joint risk register, this is being reviewed at each CCG meeting, with evidence of risks being added and modified. The November 2021 CCG meeting considered the joint risk register in detail, which at that time

contained seven risks. However, although there is a joint risk register for both health boards, it was unclear how this links to the corporate risk registers for each health board. For example, the joint risk register reported in November 2021 had several high risks – one focused on the lack of support from NWIS to support the disaggregation of the digital systems, and one focused on the COVID-19 pressures at Neath Port Talbot Hospital and the ability for Swansea Bay to provide the capacity to support delivery of services for CTMUHB.

- 40 Our review found that CTMUHB's corporate risk register did not contain reference to the Neath Porth Talbot Hospital risk, which was scored at 16. Although the digital services risk was articulated, it could have provided more detail. This issue was also raised by the CTMUHB's Internal Audit report on Bridgend Transfer of Information Services, which was issued in December 2021. At Swansea Bay, we found a similar picture with coverage of the digital services risk in the corporate risk register but no direct reference to the SLA risk and the COVID-19 pressures at Neath Port Talbot Hospital, although the service pressures were recognised overall.
- 41 Subsequently the risk associated with Neath Port Talbot Hospital has changed. Neath Port Talbot Hospital forms a key part of Swansea Bay's plan to recover planned care services, however the health board's ability to put its recovery plan in to action is hindered by the fact that part of the facility is used to host services run by CTMUHB. As such, Swansea Bay UHB has served notice to CTMUHB for those services to leave Neath Port Talbot Hospital by 31 March 2023. This has also led to CTMUHB to escalate the disaggregation of digital services, serving notice of the withdrawal of ICT services from Swansea Bay UHB by 31 March 2023.
- 42 Although this new risk relating to Neath Port Talbot Hospital, and the digital services risk are both recognised as risks for both health board's IMTPs for 2022-23, there remains limited reference in corporate risk registers (**Recommendation 4**).

Longer-term post transition arrangements and future service disaggregation

- 43 Our work considered whether the health boards were working towards a jointly agreed programme and clear plans for disaggregation, and that sufficient capacity to support the process was in place.
- 44 We found that **the anticipated time to disaggregate services was underestimated, with limited capacity to support the process and up until recently, there has been no clear disaggregation plan in place. While a plan is now in place, without additional capacity, the ability to disaggregate remaining contracts will be hindered, and opportunities to look more broadly at regional working may be being missed.**

Contracting and commissioning capacity

Capacity to support the transition process has hindered progress

- 45 At the beginning of the transition process in 2018-19, the capacity of the commissioning teams in both health boards was focused on the Bridgend transition, with the Assistant Director of Commissioning at CTMUHB leading the transition work stream which oversaw the development of the LTAs and SLAs. Additional transition resource was also provided to the work stream. A commissioning manager at CTMUHB was seconded into the work stream on a full-time basis for a 6-month period before taking up a secondment to a joint post between health and social care.
- 46 There was recognition in September 2019 that the transfer of services represented a substantial programme of work which required resource to ensure it could be concluded within two years. Whilst there is a significant amount of resource from teams within both health boards supporting the ongoing transition work, there has been no dedicated resource to manage the programme in either health board since April 2020. Both health boards agree that the work continues to consume a significant amount of finance, strategy and planning staff resource which is resulting in slower progress. In addition, CTMUHB has also had capacity issues within the Bridgend Integrated Locality Group which has affected their local planning capacity.
- 47 During the three-year period 2019-22, the number of clinical and service specific SLAs has reduced by just 18 (20%). This is a reduction in value of £3.5 million. An update to the JEG in March 2022, shown in **Exhibit 3** outlines the number and values of the SLAs in place at the start of 2022-23 compared with the start of 2019-20. This shows there remains significant work to do to disaggregate services and reduce the number of SLAs in place.

Exhibit 3: Number and value of service level agreements

		2019-20	2022-23	Change
Provision of services by Swansea Bay UHB to CTMUHB	Number	58	48	↓ 10
	Value	£17,727,929	£15,801,495	↓ £1,926,434
Provision of services by CTMUHB to Swansea Bay UHB	Number	32	24	↓ 8
	Value	£4,792,089	£3,261,989	↓ £1,530,100

Source Joint Executive Group March 2022

- 48 On 1 April 2022, the number of corporate SLAs had reduced from 21 to 12. These have a total value of £3.5 million with digital services accounting for over 52% of the total value at £1.8 million
- 49 With the current resource level, both health boards estimate it will take another five years to disaggregate the current SLAs. With additional resource, both health boards indicate that the programme of work could be reduced to two years. At the JEG in October 2021, a proposal was made for additional funding of £271,447 per annum for the following additional roles:
- Joint Transition Manager
 - Finance Manager - CTMUHB
 - Finance Manager – Swansea Bay UHB
 - Information Analyst
 - Support Officer
- 50 At the time of reporting, the Welsh Government had approved additional funding of £100,000 between the two health boards, although none of the posts had been recruited to.
- 51 To support the disaggregation programme, CTMUHB has recently restructured its commissioning team and is recruiting two additional posts, one of which will be dedicated to the Bridgend work. However, without the additional capacity in place, the future disaggregation of services and SLAs will be constrained by the capacity available in existing planning, commissioning, finance, and HR departments to undertake the detailed planning, engagement and consultation required.

Disaggregation plans

The health boards have lacked a plan to support disaggregation, but this has now been rectified

- 52 When the transition programme was established, it was recognised by both health boards that many of the commissioning arrangements were short term arrangements that required further work to disaggregate services and decommission the corresponding SLAs. The JEG agreed in August 2019 that the programme would last around two years, and that the need for ongoing requirement for joint planning arrangements at an executive level would be reviewed at the end of the two-year period, i.e., August 2021. At the time of our work in 2021 and early 2022, the need for joint planning arrangements remained with a significant amount of work to disaggregate services still to do (as set out in **Exhibit 3**), including complex disaggregation of the digital services SLA.
- 53 In our interviews, some service leads indicated that they were not aware of a longer-term programme or an overall clinical strategy to disaggregate services, and that had one been in place, it should be widely shared, and clinical input would be essential. At the time of our fieldwork, there was no agreed strategic programme in place to support the remaining disaggregation. We were informed that discussions had commenced but these had been impacted by COVID-19, but that work was ongoing. The intention was to have a regional strategic plan especially around Neath Port Talbot Hospital as soon as practicable, which gave imminent concerns that CTMUHB would need to remove all their services from Neath Port Talbot Hospital at that time by March 2022, including breast, cardiology, and orthopaedics services.
- 54 As referenced in paragraph 23, a disaggregation plan for 2022-23 has subsequently been put in place. This sets out the focus on several corporate and clinical SLAs, and LTAs and supports the process for CTMUHB to vacate Neath Port Talbot Hospital by 31 March 2023. Breast and orthopaedic services were priority areas for quarters one and two of 2022-23, with breast services now confirmed as being provided from within CTMUHB facilities. We are unaware as to how widely shared the disaggregation plan has been with operational and clinical staff.
- 55 The recent Internal Audit report to CTMUHB in December 2021 on the Bridgend Transfer of Informatics Services gave limited assurance on the progress on moving digital services. The report highlighted both the need for significant network upgrades and investment to effectively transfer the services. At the time of the internal audit report, there was a business case in place for additional resources, however no additional funding has been received, and CTMUHB were having to take a tactical approach to the transfer. COVID-19 has affected the pace of this, but CTMUHB have recently appointed a dedicated programme manager for the digital element of the disaggregation programme to drive forward progress in this area. As referenced in paragraph 23, CTMUHB will be withdrawing digital services

from Swansea Bay UHB by 31 March 2023 with the ICT SLA a key feature of the disaggregation plan for 2022-23. However, concerns have been raised that financial considerations will affect the speed and progress that can be made.

Wider regional working

Although the focus has been on the disaggregation of services, there may be opportunities for wider regional working

- 56 The transition of Bridgend services has focused the attention of both health boards on disaggregating services however in doing so, opportunities for potential wider regional working may have been missed.
- 57 Opportunities for wider strategic change, transformation and potential regional working have been discussed at JEG but some feel that the opportunities are limited. This is because natural patient flows are not between Swansea Bay UHB and CTMUHB. Rather, CTMUHB patients flow to Cardiff and Vale UHB and Swansea Bay UHB patients flow to and from Hywel Dda UHB. It is felt that these flows hinder opportunities to realise regional working between CTMUHB and Swansea Bay UHB, however that is not to say that both health boards should be complacent on the direction of travel of each other.
- 58 In addition to the transfer legacy issues, there are a range of strategic planning areas which are emerging as both health boards seek to deliver their clinical services plans. At the time of our work, CTMUHB was undertaking work to develop its longer-term clinical strategy which will help to shape future clinical service provision. At the same time, Swansea Bay UHB was revisiting its clinical service plan and developing its three centres of excellence centred around its three main hospital sites. The issue of service provision and the disaggregation of LTAs and SLAs need to feature in these discussions as there are clear implications. However, there is scope for both health boards to consider whether there are opportunities to work together more broadly to support the wider delivery of respective clinical strategies.
- 59 Areas for potential regional working include pathology services and the GP out of hours service, where local services are facing challenges, for example, in relation to recruitment, and which could be delivered on a wider regional footprint.



Audit Wales

24 Cathedral Road
Cardiff CF11 9LJ

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and
telephone calls in Welsh and English.
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Transformational Leadership Programme Board – Baseline Governance Review – Cwm Taf Morgannwg Regional Partnership Board

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Summary report

Introduction

- 1 Regional Partnership Boards (RPBs) have been established to manage and develop services to secure strategic planning and partnership working between local authorities and Local Health Boards.
- 2 Following a ministerial decision in 2018¹, Bridgend County Borough Council moved from the Abertawe Bro Morgannwg Regional Partnership Board to the Cwm Taf Morgannwg Regional Partnership Board (CTM RPB) in April 2019. The boundary change has provided a fresh opportunity for partners to learn from one another and develop more cohesive partnership arrangements to deliver better outcomes for people across the Cwm Taf Morgannwg region.
- 3 The CTM RPB has established a governance framework (**Appendix 2**) which includes a Transformation Leadership Programme Board (TLPB). The purpose of the TLPB is to oversee the transformation, development, and delivery of identified regional services as directed by the RPB. The TLPB has senior representation from Cwm Taf Morgannwg University Health Board (CTM UHB), Bridgend, Merthyr Tydfil and Rhondda Cynon Taf councils, the third sector and regional carer/service user groups. The TLPB also coordinates and oversees the work of three programme boards: Children's, Adults, and a cross cutting programme board². These programme boards are responsible for the operational delivery of the RPB's priorities.
- 4 Our review sought to gain assurance that the health board and the three councils are working together effectively through the aegis of the Transformation Leadership Programme Board to support regional integrated working across the Cwm Taf Morgannwg region. Our review sought to answer the question: **Are the Transformation Leadership Programme Board arrangements supporting the four bodies³ to develop effective and sustainable approaches to regional working?**
- 5 We undertook fieldwork between November 2021 and January 2022 and met with key individuals from the three local authorities, the health board, as well as third sector partners. We also observed meetings of the TLPB and other sub-groups including the Children's Services Programme Board, the Adult Services Programme Board, and the Finance Sub-group. We presented our findings to representatives from CTM UHB and the three councils in March.

¹ Written Statement: Health board boundary change: Bridgend (25 February 2019) | GOV.WALES

² Although this was not operational at the time of our review

³ Cwm Taf Morgannwg University Health Board (CTMUHB), Rhondda Cynon Taf County Borough Council (RCTCBC), Merthyr Tydfil County Borough Council (MTCBC) and Bridgend County Borough Council (BCBC)

Key findings

- 6 Overall, we found **that the Transformation Leadership Programme Board is well-placed to develop stronger regional working building on the productive relationships over the past 18 months. However, it needs to ensure its planning is more integrated and longer term, strengthen aspects of its governance arrangements and be more ambitious in using its combined core resources to have a greater impact on the Cwm Taf Morgannwg region.**
- 7 In terms of planning arrangements, we found that:
- there was consideration of the sustainable development principle within strategic plans. However, the four bodies are named bodies under the Well-being of Future Generations (Wales) Act and the RPB provides a vital mechanism to help deliver the bodies' well-being objectives and the national well-being goals. As the Act has been in place for seven years, we would now expect public bodies to be able to demonstrate that the Act is integral to their thinking and genuinely shaping what they do.
 - planning was moving from a short-term basis to a more medium-term basis with an increased focus on a 5-year planning period. However, strategic plans require a more integrated approach to developing a longer-term perspective, which is supportive of partners' plans and will deliver a stronger regional identity. The TLPB needs to ensure that its planning is driven by the population's needs rather than the funding regime.
 - despite a good communications and engagement strategy in place, there is a need to improve the understanding of the RPB's purpose amongst some stakeholders.
 - there are also opportunities to improve the TLPB internal engagement arrangements, especially in relation to increasing the voices of non-statutory partners.
- 8 In terms of governance arrangements, we found that:
- there was a strong working relationship between the key partners and the Regional Commissioning Unit (RCU), which supports the RPB. However, the TLPB needs to consider how it can build capacity to support the TLPB and resolve the over-reliance on one individual within the RCU.
 - chairing of the TLPB Board meetings was effective and we saw strong synergy between the meetings we observed. However, we found some variation in the quality of meeting papers, and limited evidence of scrutiny and challenge.
 - there was a lack of maturity around key performance metrics and milestones, with the new outcomes and performance dashboard yet to be implemented.
 - the finance sub-group was well structured, with constructive discussions and there was detailed financial reporting.

- the Cross-Cutting Programme Board was not yet operational, despite this being a key part of the governance architecture designed to oversee the development and delivery of regional cross-cutting services.
- risk management is an area that needs to be strengthened with the need for better articulation of shared risks, prioritisation, and mitigating actions.

9 In terms of resources, we found that:

- the TLPB was developing its approach to the new Health and Social Care Regional Integrated Funding (RIF) regime including around tapered and match funding and has subsequently met the deadline for submission of its return to Welsh Government.
- whilst there are examples of pooled funding and shared resources, these are limited, and the public bodies need to consider how they can use their combined core resources more effectively to deliver the TLPB's plans and address the significant health and social care challenges in the region. The partners have developed stronger relationships during the pandemic and need to build on these to do this.
- like many areas in the public sector, there are significant workforce challenges in the region and there needs to be a regional and strategic approach to addressing these.

10 Our findings are set out in more detail in Appendix 1 in the form of the presentation we delivered to representatives from Cwm Taf Morgannwg University Health Board, Bridgend, Merthyr Tydfil and Rhondda Cynon Taf councils on 8 March 2022. We have reflected the comments raised by these representatives during the feedback session in the material included in **Appendix 1**.

Recommendations

11 Recommendations arising from this audit are detailed in **Exhibit 1**. The TLPB management response to these recommendations will be summarised in Appendix 3 once considered by the relevant stakeholders.

Exhibit 1: recommendations

Recommendations	
Strategic planning and applying the sustainable development principle	
R1	Our work found opportunities for the TLPB to strengthen its planning arrangements and demonstrate how it is acting in accordance with the sustainable development principle (as set out in the Well-being of Future

Recommendations

Generations (Wales) Act). The principle should be integral to the TLPB's thinking and genuinely shaping what it does by:

- a) taking a longer-term approach to its planning beyond five years,
- b) ensuring greater integration between the long-term plans of the four statutory bodies of the TLPB, and
- c) improving involvement of all members of the TLPB to ensure an increased voice for non-statutory partners and a better understanding of the purpose of the RPB more generally.

Governance Arrangements

- R2 The Cross-Cutting Programme Board is yet to be established. It is intended to oversee the development and delivery of regional cross-cutting services and could have a role ensuring a more coherent and impactful integrated community model. The TLPB should establish the programme board to ensure that decision making arrangements are in place to help resolve cross-cutting issues and risks brought to the attention of the RPB.

Performance Management

- R3 The outcomes and performance framework was still being finalised at the time of our review. The TLPB needs to finalise and implement the framework, ensuring it contains quantitative and qualitative measures that will enable the RPB to demonstrate outcomes and impact.

Risk Management

- R4 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.

Regional Commissioning Unit

- R5 Our work found that the lack of capacity within the RCU was leading to some delays in progressing actions. The work of the RCU is crucial to the continuing success of the TLPB. The TLPB needs to consider how it can build capacity and maximise resources to support the TLPB and minimise overreliance on a small team.

Recommendations

Use of Resources

- R6 Improving the health and social care outcomes of the region will require efficient and effective use of combined resources. Our work found that there had been some limited examples of pooled budgets and other arrangements for sharing resources. The TLPB needs to explore more innovative ways of sharing and pooling core resources across the region to maximise its impact and outcomes for the Cwm Taf Morgannwg population.
-

Regional workforce planning

- R7 Like many parts of the public sector, the region is experiencing significant workforce challenges. The TLPB needs to consider how it can facilitate a regional and strategic approach to addressing these challenges and to help it deliver its priorities.

Appendix 1



Purpose of feedback session



- To discuss and agree findings
- To discuss and agree next steps including report clearance process

Purpose and focus of review



- To gain assurance that the health board and the three councils are working together effectively through the aegis of the TLPB to support regional integrated working across the Cwm Taf Morgannwg region.
- Main review question: Are the TLPB arrangements supporting the four bodies to develop effective and sustainable approaches to regional working ?

Areas of focus

- Is there an effective approach to strategic planning?
- Are the governance arrangements supporting the TLPB to work effectively?
- Is the TLPB using its resources effectively to support the delivery of regional priorities?

Overall conclusions



Building on the productive working relationships over the past 18 months, the TLPB is well -placed to develop stronger regional working, but there needs to be more longer-term thinking, strengthening aspects of governance arrangements, and improved regional and innovative use of resources to have a demonstrable impact on the Cwm Taf Morgannwg region

- Planning is moving from a short -term basis to focussing over a 5 -year period. Strategic planning will require a more integrated approach to developing a longer -term perspective and stronger regional identity.
- Core governance arrangements are aligned and supported by strong relationships and robust support from the RCU; regional scrutiny, performance management and risk management need to be further strengthened.
- TLPB is continuing to develop its approach to regional deployment of its resources in the medium term, it now needs to build on the effective partnership working shown in the pandemic and become more ambitious; using its resources differently to leverage the impact of all partners to address the significant health and social care challenges in the region.

Is there an effective approach to strategic planning?



Planning is moving from a short -term basis to focussing over a 5 -year period. Strategic planning will require a more integrated approach to developing a longer -term perspective and stronger regional identity

Strengths

- Draft plans indicate a strengthening of the integration agenda and longer -term view.
- Evidence of consideration of the Well-Being of Future Generations Act and sustainable development within their strategic plans.
- RCU described as the 'engine room' for coordinating plans.
- Communication and Engagement Strategy demonstrates positive intent, and is externally focused

Challenges

- Whilst the move to a 5 year period is positive, there is still the need to focus more longer term, and align to partner organisations' longer term ambitions
- Need to strengthen demonstration of the integration of the Well -being of Future Generations (Wales) Act
- Communication and engagement strategy cited poor understanding of RPB purpose.
- Internal engagement needs to be strengthened with increased voice of non -statutory partners
- Opportunity to strengthen the regional identity

Are the governance arrangements supporting the Board to work effectively?



Core governance arrangements are aligned and supported by strong relationships and robust support from the RCU; regional scrutiny, performance management and risk management need to be further strengthened

Strengths

- Strong working relationships and effective chairing of Board.
- Good alignment of meetings and timeliness of papers noted.
- Systems and processes of governance and assurance in transition.
- Financial Sub-Group appears well structured with detailed financial information and reporting in evidence.
- RCU's role in governance very highly regarded by interviewees.

Challenges

- Very few examples of challenge observed in meetings attended.
- Cross-Cutting Working Group not operational.
- Variation in quality of Board meeting papers.
- Regional risk management needs further strengthening around shared risks, prioritisation and mitigating actions.
- Lack of maturity around key regional performance metrics and milestones
- Residual lack of clarity around tapered and match funding needs swift resolution.
- RCU are key to success but dependent on one individual
- All partners need to more proactively performance manage their regional priorities

Is the TLPB using its resources effectively to support the delivery of regional priorities?



TLPB is continuing to develop its approach to regional deployment of its resources in the medium term, it now needs to build on the effective partnership working shown in the pandemic and become more ambitious; using its resources differently to leverage the impact of all partners to address the significant health and social care challenges in the region.

Strengths

- Delivery plans demonstrate that resources are being used against their stated aims.
- Some pooled budgets
- Internally, 'the right people are in the room'
- Externally, there is evidence of activities to strengthen public voice and input in line with WFG Act.
- Developing its approach to the new Health and Social Care Regional Integrated Funding regime

Challenges

- Need to improve equity of input and resourcing to reflect needs of smaller non-statutory partners
- Secure further opportunities to unleash potential of 'regional' pooled budgets and mainstreaming programmes
- Need robust assurance of delivery around regional priorities within the plan; and sufficient resources to deliver across the 5 year timeline
- Opportunity to work more collaboratively to develop a regional and strategic approach to addressing regional workforce challenges

Areas to address



Strategic Planning

- Create a stronger sense of regional identity and purpose - co-created with all stakeholders
- Structures that support culture change and wider stakeholder input for longer -term planning
- Stronger consideration of the five ways of working including longer term thinking, collaboration and integration.

Governance

- Increase scrutiny and challenge
- Develop regional roadmap with milestones and objectives
- Improve performance management, including performance metrics
- Strengthen regional risk management arrangements

Resources

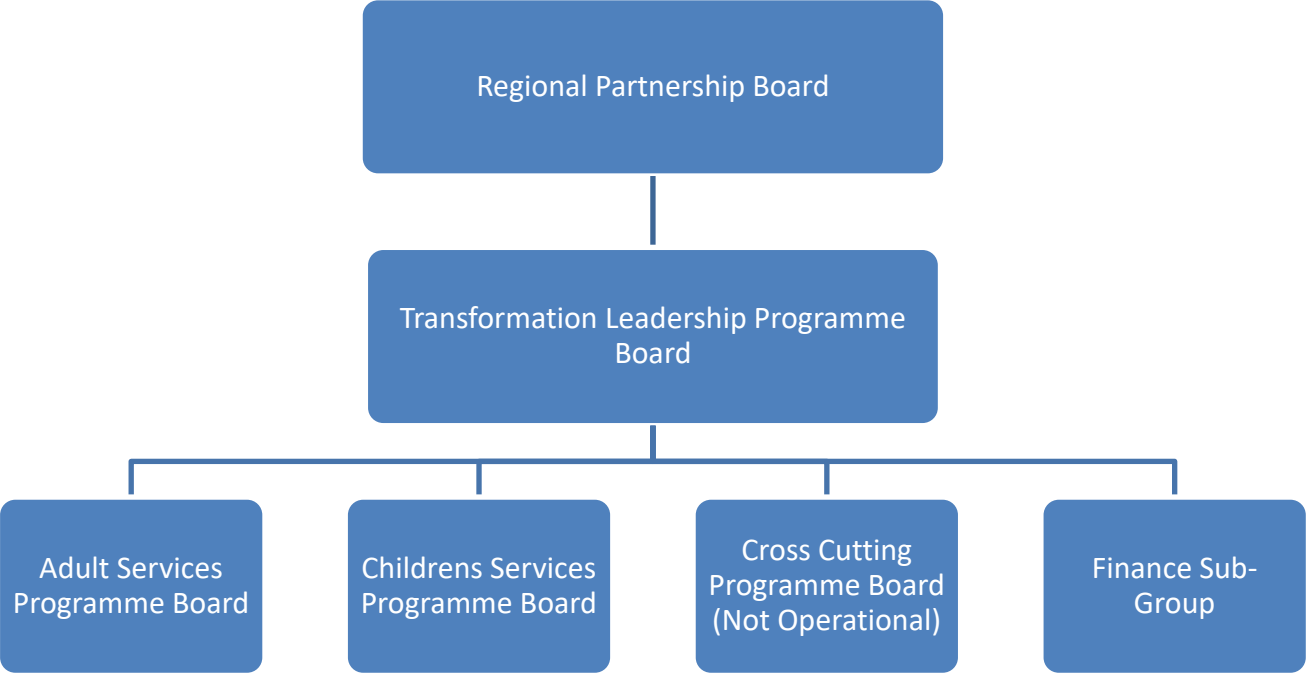
- Use resources differently and consider more innovative ways of sharing resources across the region to maximise their impact.
- Assure that you are maximising resources to enable the TLPB to deliver the priorities within the plan

Next steps



- Reflect upon discussion and feedback from session
- Draft report
- Clear report

Appendix 2 – Governance structure



Appendix 3

Management response to audit recommendations

Exhibit 1: management response

Ref	Recommendation	Management response	Completion date	Responsible officer
R1	Strategic planning and applying the sustainable development principle Our work found opportunities for the TLPB to strengthen its planning arrangements and demonstrate how it is acting in accordance with the sustainable development principle (as set out in the Well-being of Future Generations (Wales) Act). The principle should be integral to the TLPB's thinking and genuinely shaping what it does by: a) taking a longer-term approach to its planning beyond five years,	Agreed. Although the sustainable development principle is a fundamental consideration in all decision making, this will be made more explicit in reports to	31 March 2023	Head of RCU

Ref	Recommendation	Management response	Completion date	Responsible officer
	b) ensuring greater integration between the long-term plans of the four statutory bodies of the TLPB, and c) improving involvement of all members of the TLPB to ensure an increased voice for non-statutory partners and a better understanding of the purpose of the RPB more generally.	TLPB and RPB going forward. Transition to a new delivery plan has been completed and work will continue to integrate the long-term plans of the four statutory bodies improve involvement of non-statutory partners		
R2	Governance Arrangements The Cross-Cutting Programme Board is yet to be established. It is intended to oversee the development and delivery of regional cross-cutting services and could have a role ensuring a more coherent and impactful integrated community model. The TLPB should establish the programme board to ensure that decision making arrangements are in place to help resolve cross-cutting issues and risks brought to the attention of the RPB.	Agreed. The governance arrangements beneath the RPB will be reviewed to establish a new integrated leadership board and integrated resources group.	30 July 2022	Chair TLPB

Ref	Recommendation	Management response	Completion date	Responsible officer
R3	Performance Management The outcomes and performance framework was still being finalised at the time of our review. The TLPB needs to finalise and implement the framework, ensuring it contains quantitative and qualitative measures that will enable the RPB to demonstrate outcomes and impact.	Agreed. Work is ongoing in relation to the performance framework in support of the new delivery plan and this will also need to reflect changes arising from the population needs assessment.	30 September 2022	Head of RCU
R4	Risk Management Our work found areas of risk management that need to be improved, particularly in relation to regional workforce planning. The TLPB should strengthen regional risk management arrangements by improving the identification and prioritisation of shared risks and ensuring mitigating actions are robust and clearly articulated.	Agreed. Within the new governance structure there will be an integrated resources group which will be tasked to develop the risk management framework.	31 March 2023	Chair TLPB

Ref	Recommendation	Management response	Completion date	Responsible officer
R5	Regional Commissioning Unit Our work found that the lack of capacity within the RCU was leading to some delays in progressing actions. The work of the RCU is crucial to the continuing success of the TLPB. The TLPB needs to consider how it can build capacity and maximise resources to support the TLPB and minimise overreliance on a small team.	Agreed. Additional infrastructure has been agreed to support dementia work and NEST framework and capital. Additional capacity will also be identified from partner organisations to support the programme delivery.	31 December 2022	Head of RCU
R6	Use of Resources Improving the health and social care outcomes of the region will require efficient and effective use of combined resources. Our work found that there had been some limited examples of pooled budgets and other arrangements for sharing resources. The TLPB needs to explore more innovative ways of sharing and pooling core	Agreed. The development of the RIF delivery plan is only one funding stream and TLPB recognises that we will need to align core budgets, for example	31 March 2023	Chair TLPB

Ref	Recommendation	Management response	Completion date	Responsible officer
	resources across the region to maximise its impact and outcomes for the Cwm Taf Morgannwg population.	around children with complex needs. This will be addressed through the planning cycle in advance of 2023/24		
R7	Regional workforce planning Like many parts of the public sector, the region is experiencing significant workforce challenges. The TLPB needs to consider how it can facilitate a regional and strategic approach to addressing these challenges and to help it deliver its priorities.	Agreed. Regional workforce development arrangements exist through SCWDP Board workforce development group and work is underway to strengthen links with RPB and Health	31 March 2023	Chair TLPB



Audit Wales
24 Cathedral Road
Cardiff CF11 9LJ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

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