CTMUHB Audit & Risk Committee

Mon 13 February 2023, 14:15 - 16:15

Virtually via Microsoft Teams

Agenda

14:15 - 14:20
5 min

1. PRELIMINARY MATTERS

1.1. Welcome & Introductions

Information *Patsy Roseblade, Committee Chair*

1.2. Apologies for Absence

Information *Patsy Roseblade, Committee Chair*

1.3. Declarations of Interest

Information *Patsy Roseblade, Committee Chair*

14:20 - 14:25
5 min

2. CONSENT AGENDA

2.1. FOR APPROVAL

2.1.1. Unconfirmed Minutes of the In Committee meeting held on 12 December 2022

Decision *Patsy Roseblade, Committee Chair*

2.1.1 Unconfirmed Minutes In Committee CTMUHB ARC 12 December 2022 ARC 13 February 2023.pdf (2 pages)

2.1.2. Audit & Risk Committee Annual Cycle of Business for 2023

Decision *Patsy Roseblade, Committee Chair*

2.1.2a Audit & Risk Committee Cycle of Business - Cover Paper ARC 13 February 2023.pdf (2 pages)
2.1.2b Audit Risk Committee Cycle of Business ARC 13 February 2023.pdf (4 pages)

2.2. FOR NOTING

2.2.1. Audit & Risk Committee Forward Work Programme

Information *Patsy Roseblade, Committee Chair*

2.2.1 Audit & Risk Committee Forward Work Plan ARC 13 February 2023.pdf (2 pages)

2.2.2. Annual Report Timetable 2022-2023

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

2.2.2a AR 22-23 Proposed Timetable 22-23 Cover ARC 13 February 2023.pdf (2 pages)
2.2.2b Appendix 1 AR Timetable & Content Requirements 2022-2023v2 Jan 2023 ARC 13 February 2023.pdf (6 pages)

14:25 - 14:30
5 min

3. MAIN AGENDA

3.1. Unconfirmed Minutes of the meeting held on 12 December 2022

Discussion *Patsy Roseblade, Committee Chair*

3.1 Unconfirmed Minutes CTMUHB ARC 12 December 2022 ARC 13 February 2023.pdf (11 pages)

3.2. Audit & Risk Committee Action Log

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

3.2 Audit & Risk Committee Action Log ARC 13 February 2023.pdf (7 pages)

3.3. Matters Arising not Contained within the Action Log

Discussion *Patsy Roseblade*

14:30 - 14:50
20 min

4. SUSTAINING OUR FUTURE

4.1. Local Counter Fraud Report

Discussion *Matthew Evans, Local Counter Fraud Specialist*

4.1a Local Counter Fraud Update Report ARC 13 February 2023.pdf (2 pages)
4.1b Local Counter Fraud Update Report Feb 23 ARC 13 February 2023.pdf (3 pages)
4.1c Appendix 1 Counter Fraud Benchmark Report ARC 13 February 2023.pdf (6 pages)
4.1d Appendix 2 Counter Fraud Investigations Update ARC 13 February 2023.pdf (8 pages)

4.2. Losses & Special Payments Report

Discussion *Sally May, Director of Finance*

4.2a Losses Special Payments Report February 2023 ARC 13 February 2023.pdf (11 pages)
4.2b Report Appendices Dec 22 ARC 13 December 2023.pdf (12 pages)

4.3. Procurement & Scheme of Delegation Report

Discussion *Sally May, Director of Finance*

4.3 Scheme of Delegation Report ARC 13 February 2023.pdf (6 pages)

14:50 - 16:05
75 min

5. IMPROVING CARE

5.1. Organisational Risk Register

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

5.1a Organisational Risk Register - ARC - February 2023.pdf (5 pages)
5.1b Appendix 1 Organisational Risk Register - Final January 2023 - ARC 8.2.23.pdf (13 pages)

5.2. Audit Recommendations Tracker

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

5.2a Audit Recommendations Tracker Update Report ARC 13 February 2023.pdf (6 pages)
5.2b Appendix 1 Internal Audit Recommendations Tracker ARC 13 February 2023.pdf (29 pages)
5.2c Appendix 2 External Audit Recommendations Tracker ARC 13 February 2023.pdf (4 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 ARC 13 February 2023.pdf (9 pages)

5.3.2. Internal Audit Review - Wellbeing

Discussion *Paul Dalton, Head of Internal Audit*

5.3.2 IA Staff Wellbeing - updated Final Internal Audit Report ARC 13 February 2023.pdf (16 pages)

5.3.3. Internal Audit Follow Up Review - Fire Safety

Discussion *Paul Dalton, Head of Internal Audit*

5.3.3 IA CTM Fire Safety follow-up Final report ARC 13 February 2023.pdf (14 pages)

5.3.4. Internal Audit Review - Medical Variable Pay

Discussion *Paul Dalton, Head of Internal Audit*

5.3.4 Medical Variable Pay- Agency Costs Internal Audit Final Report ARC 13 February 2023.pdf (21 pages)

5.4. AUDIT WALES

5.4.1. Audit Wales Audit & Risk Committee Update

Discussion *Audit Wales*

5.4.1 AW CTM AC Update February 2023 ARC 13 February 2023.pdf (10 pages)

5.4.2. Audit Wales Review - Ysbyty Cwm Cynon Minor Injuries Unit

Discussion *Audit Wales*

5.4.2 Audit Wales YCC MIU Report ARC 13 February 2023.pdf (20 pages)

5.4.3. Audit Wales Review of Commissioning and Contracting Arrangements (CTM & Swansea Bay) - including Management Response

Discussion *Audit Wales*

5.4.3 AW CTMSB SLA Review (1) ARC 13 February 2023.pdf (26 pages)

16:05 - 16:10
5 min

6. ANY OTHER BUSINESS

Information *Patsy, Roseblade, Committee Chair*

16:10 - 16:15
5 min

7. COMMITTEE HIGHLIGHT REPORT TO BOARD

Discussion *Patsy Roseblade, Committee Chair*

16:15 - 16:15
0 min

8. HOW DID WE DO IN THIS MEETING

Discussion *Patsy Roseblade, Committee Chair*

16:15 - 16:15
0 min

9. DATE AND TIME OF NEXT MEETING - WEDNESDAY 19 APRIL 2023 AT 10:00AM

Agenda Item Number: 2.1.1

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) Audit & Risk In Committee held on the 12 December 2022 as a Virtual Meeting via Microsoft Teams

Members Present:

Patsy Roseblade	Independent Member (Chair)
Ian Wells	Independent Member
Carolyn Donoghue	Independent Member

In Attendance:

Darren Griffiths	Audit Wales
Mark Jones	Audit Wales
Paul Dalton	NWSSP – Internal Audit & Assurance
Emma Samways	NWSSP – Internal Audit & Assurance
Sally May	Executive Director of Finance
Cally Hamblyn	Assistant Director of Governance & Risk
Paul Chilcott	Lead Infrastructure Architect
Stuart Morris	Director of Digital
Andrew Nelson	Chief Information Officer
Emma Walters	Corporate Governance Manager (Secretariat)

Unconfirmed

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.

1.2 Apologies for Absence

Apologies for absence were received from:

- Jayne Sadgrove, Health Board Vice Chair/Independent Member

1.3 Declarations of Interest

No declarations of interest were received prior to the meeting.

2.0.0 MAIN AGENDA

2.1 INTERNAL AUDIT

2.1.1 Internal Audit Follow Up Review – Cyber Security

P Dalton presented Members with the report which had been allocated a reasonable assurance rating. S Morris advised that the report had been welcomed by the Team.

Resolution: The report was **NOTED**.

2.2.0 AUDIT WALES

2.2.1 Audit Wales Follow Up Review – Cyber Resilience

D Griffiths presented the report which was a national review. S Morris advised that he welcomed the report and confirmed that the report aligned with the work being undertaken by the Team.

Members supported the suggestion for a further discussion on this matter to take place at a future Board Development Session. Members noted that a Cyber Security awareness raising session was held for all staff in October 2022, which was supported by South Wales Police and was received well by colleagues who attended.

Resolution: The report was **NOTED.**

Action: Board Development Session to be held on Cyber Security and Cyber Resilience.

3.0.0 ANY OTHER BUSINESS

A discussion was held in relation to Risk 4664 and it was agreed that in future a separate risk register discussion needed to be held In Committee regarding this risk due to the potential system vulnerabilities which could be exposed should any detail be received in the public domain

4.0.0 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Monday 13 February 2023 at 2:15pm.

5.0.0 CLOSE

Unconfirmed

AGENDA ITEM
2.1.2

AUDIT & RISK COMMITTEE

AUDIT & RISK COMMITTEE CYCLE OF BUSINESS

Date of meeting	13/02/2023
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 APPROVAL

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 2023 to 31 December 2023.

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 **APPROVE** the Committee Cycle of Business.

Audit & Risk Committee

Cycle of Business

(1st January 2023 – 31st December 2023)

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 2023 to 31st December 2023.

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 2023 – 31st December 2023)

Item of Business	Executive Lead	Reporting period	Jan 2023	Feb 2023	Mar 2023	April 2023	May 2023	June 2023	July 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023
Consent Agenda														
Minutes of the previous Board Meeting	Director of Corporate Governance	All Regular Meetings		✓		✓		✓		✓		✓		✓
Audit & Risk Committee Annual Cycle of Business	Director of Corporate Governance	All Regular Meetings		✓		✓		✓		✓		✓		✓
Committee Forward Work Programme	Director of Corporate Governance	All Regular Meetings		✓		✓		✓		✓		✓		✓
Audit & Risk Committee Annual Report	Director of Corporate Governance	Annually								✓				
Audit & Risk Committee Annual Self-Assessment	Director of Corporate Governance	Annually												✓
Audit & Risk Committee Terms of Reference	Director of Corporate Governance	Annually										✓		
Declarations of Interest and Gifts & Hospitality Report	Director of Corporate Governance	Quarterly				✓				✓				✓
Clinical Audit Annual Plan	Medical Director	Annually				✓								
Clinical Audit Annual Report	Medical Director	Annually												✓
Governance														
Action Log	Director of Corporate Governance	All Regular Meetings		✓		✓		✓		✓		✓		✓
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		✓				✓		✓				✓
Procurements & Scheme of Delegation Report	Director of Finance	All Regular meetings		✓		✓		✓		✓		✓		✓

Item of Business	Executive Lead	Reporting period	Jan 2023	Feb 2023	Mar 2023	April 2023	May 2023	June 2023	July 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023
Local Counter Fraud Report	Director of Finance	All Regular Meetings		✓		✓		✓		✓		✓		✓
Counter Fraud Annual Report	Head of Local Counter Fraud	Annually				✓								
Counter Fraud Annual Self Review	Head of Local Counter Fraud	Annually				✓								
Counter Fraud Draft Work plan	Head of Local Counter Fraud	Annually				✓								
Post Payment Verification Annual Report	Post Payment Verification Manager	Annually				✓								
Post Payment Verification Mid-Year Update	Post Payment Verification Manager	Annually										✓		
Improving Care														
Audit Recommendations Tracker	Director of Corporate Governance	All regular meetings		✓		✓		✓		✓		✓		✓
Organisational Risk Register	Director of Corporate Governance	All regular meetings		✓		✓		✓		✓		✓		✓
Consultant Job Planning	Medical Director	Bi-Annually				✓						✓		
Medical Rostering	Medical Director	Bi-Annually				✓						✓		
Internal Audit Progress Report	Head of Internal Audit	All Regular Meetings		✓		✓		✓		✓		✓		✓
Internal Audit Annual Audit Plan	Head of Internal Audit	Annually				✓								
Internal Audit Reviews	Head of Internal Audit	All regular meetings		✓		✓		✓		✓		✓		✓
Head of Internal Audit Opinion and Annual Report	Head of Internal Audit	Annually						✓						
Audit & Risk Committee Update	Audit Wales	All regular meetings		✓		✓		✓		✓		✓		✓
Audit Wales Review Reports (as relevant)	Audit Wales	All regular meetings		✓		✓		✓		✓		✓		✓
Audit Wales Annual Audit Report	Audit Wales	Annually				✓								
Audit Wales Audit Plan 2022	Audit Wales	Annually				✓								

Item of Business	Executive Lead	Reporting period	Jan 2023	Feb 2023	Mar 2023	April 2023	May 2023	June 2023	July 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023
Audit Wales Audit of the Financial Statements (ISA 260) Report (Including the letter of representation and Audit Opinion)	Audit Wales	Annually						✓						
Structured Assessment	Audit Wales	Annually				✓								
Audit of Financial Statements Addendum Report (if required)	Audit Wales	Annually								✓				
Hosted Bodies														
WHSSC Internal Audit Recommendations Tracker	WHSSC Director of Finance	All regular meetings		✓		✓		✓		✓		✓		✓
WHSSC Corporate Risk Assurance Framework including the risk register.	WHSSC Committee Secretary/Head of Corporate Services	All regular meetings		✓		✓		✓		✓		✓		✓
WHSSC Governance Statement	WHSSC Committee Secretary/Head of Corporate Services	Annually						✓						
EASC Risk Register	Chief Ambulance Services Commissioner	All regular meetings		✓		✓		✓		✓		✓		✓
EASC Governance Statement	Chief Ambulance Services Commissioner	Annually						✓						
WHSSC & EASC Annual Accounts	WHSSC/EASC	Annually						✓						
National Imaging Academy for Wales Hosted Compliance Statement.	Director of the National Imaging Academy	Annually						✓						
National Imaging Academy for Wales Risk Register	Director of the National Imaging Academy	Bi-Annually		✓						✓				

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item 2.2.1

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**
Proposed approach suggested by the Director of Corporate Governance	Additional Item	Endoscopy JAG Accreditation Closure report - Progress and Associated Risk Mitigation	Chief Operating Officer	13 February 2023 – **Deferred to 19 April 2023 as per action log update**
Advised at the meeting held on 12 December 2022 that this report would be presented to the June 2023 meeting	Additional Item	National Fraud Initiative progress and outcomes.	Local Counter Fraud Specialist	21 June 2023
Email request from the Assistant Director of Governance & Risk	Additional Item	Annual Report Timetable 2022-2023	Assistant Director of Governance & Risk	13 February 2023 – **On agenda**
Action agreed at the April 2022 meeting	Additional Item	End of Year Post Payment Verification Report	All Wales Post Payment	11 October 2022 – **Completed**

			Verification Manager	
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 - **Completed** Report received at the meeting held on 12 December 2022.
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 – **Completed**

AGENDA ITEM
2.2.2

AUDIT & RISK COMMITTEE

PROPOSED TIMETABLE
ANNUAL REPORT 2022-2023

Date of meeting	13.02.2023
FOI Status	Open
If closed please indicate reason	Not applicable – Public Meeting
Prepared by	Wendy Penrhyn-Jones, Head of Corporate Governance & Board Business
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**
Executive Leadership Group Meeting	30.01.23	NOTED

ACRONYMS	
	None identified.

1. SITUATION/BACKGROUND

1.1 The Annual Report encompassing the required reporting elements set out in the Manual for Accounts will be presented at the Health Board's Annual General Meeting on 27th July 2023.

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

2.1 There is a detailed timetable enclosed at Appendix 1, supporting the development of the Annual Report led by the Assistant Director of Governance & Risk and Head of Corporate Governance & Board Business.

2.2 The timetable highlights proposed amendments and/or requirements in order to accommodate the reporting process as far as it is currently known. Therefore there may be a need to make some changes once

confirmation of the final Manual for Accounts content is published by Welsh Government.

2.3 The timetable has been shared with Health Board officers that will be responsible for completing the various elements of the report. Meetings are also in the process of taking place to discuss the reporting requirements in greater detail.

2.4 Audit Wales and Internal Audit have received a copy of the timetable.

2.5 As in previous years the suite of Annual Report documents will be presented electronically at the Annual General Meeting.

3 KEY RISKS/MATTERS FOR ESCALATION TO THE COMMITTEE

3.1 The final timetable for submission of the accounts is yet to be confirmed and therefore the dates within Appendix 1 are subject to change.

3.2 It is recognised that timescales are challenging and it is therefore hoped that any changes we are required to accommodate are minimal.

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
Equality impact assessment (EQIA) completed	No (Include further detail below)
	EQIA 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 Well-being Objectives	Provide high quality, evidence based, and accessible care.

5. RECOMMENDATION

5.1 The Audit & Risk Committee is asked to **NOTE** the arrangements currently in place in respect of the delivery of the Annual Report process for 2022-2023.

Annual Report and Accounts Timetable – 2022-2023

blue text indicates a change in requirements from previous year's submission

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

Main Tasks		Lead	February 2023	March 2023	April 2023	May 2023	June 2023	July 2023
Audited Financial Statements		Sally May, Executive Director of Finance Owen James, Head of Corporate Finance	**DRAFTING**	**DRAFTING**	Draft Accounts to Welsh Government / Audit Wales by **Fri 28th April 2023**	Draft Accounts to Audit & Risk Committee (Extra-ordinary meeting circa **16th May 2023)** Draft Accounts	Extraordinary Meeting of Audit & Risk Committee and Health Board **Monday 12th June 2023** FINAL version to be included as part of Annual Report submission to Welsh Government /Audit Wales by **Wed 14th June 2023** Welsh Translation **15th June 2023– 13th July 2023**	**AGM 27th July 2023**
Performance Report (within Annual Report) • Performance Overview	*Purpose of **overview** is to give the user a short (no more than 10 to 15 pages) summary of the organisation, its purpose, the key risks to the achievement of its objectives and how it has performed during the year. (Reference Annex 7 MFA)* *Overview must include:* • *a short summary explaining the purpose of the overview section and its structure.* • *statement from the Chief Executive providing their perspective on the performance of the organisation over the period.* • *a statement of the purpose and activities of the organisation, including a brief description of the business model and environment, organisational structure, objectives and strategies.* • *A performance appraisal which provides a synopsis of the performance analysis discussed below and an assessment of the entity's progress towards achieving its objectives.* ***Performance Assessment** must cover whether the performance has met expectation and provision of explanations where this is not the case. Also the key issues and risks that could affect the entity in delivering its objectives and affect its future performance and plans. The description of the risks should be sufficiently specific that it is easily understood why they are important. How the risks have been managed and how the risks have changed through the period. Significant changes should he highlighted and explained with reference to where relevant disclosures have been made elsewhere in the ARA such as the accountability or performance report. An explanation of the adoption of the going concern basis, and where this might be called into doubt (expected in extremely limited circumstances).*	Gethin Hughes Chief Operating Officer, Sarah James/ Julie Denley Deputy COOs Sara Thomas, Interim Deputy Director of Public Health Linda Prosser, Executive Director of Strategy & Transformation, Vicky Wallace, Deputy Director of Strategy and Partnerships & Elizabeth Beadle, Assistant Director of Transformation, Strategic and Operational Planning	**DRAFTING**	**Submissions by 12noon 9th March 2023**	Draft to Senior Leadership Group Meeting for comment **12th April 2023 for return by 19th April 2023** Circulate out of Committee to Planning, Performance and Finance Committee **on 25th April 2023** to gain endorsement for submission of draft to **WG by Fri 5th May 2023.**	Draft to Welsh Government / Audit Wales as part of draft Annual Report by **Friday 5th May 2023 – request comments by the 15th May 2023.**	Amendments made so that final version can be submitted for approval to Extra ordinary Audit & Risk Committee & Health Board **Mon 12th June 2023** FINAL version to be included within as part of Annual Report submission to Welsh Government /Audit Wales by **Wed 14th June 2023** Welsh Translation **15th June 2023– 14th July 2023**	**AGM 27th July 2023**

Main Tasks		Lead	February 2023	March 2023	April 2023	May 2023	June 2023	July 2023
	Performance Analysis *section provide a detailed performance summary of how their entity measures its performance, more detailed integrated performance analysis and long-term expenditure trend analysis where appropriate. It provides a cohesive and consistent understanding of performance from across the ARA. As a minimum, the performance analysis must include a short explanation of the purpose of the section and its structure in terms of:* ○ *how the entity measures performance i.e., what the entity sees as its key performance measures, how it checks performance against those measures, and narrative to explain the link between KPI's, risk and uncertainty;* ○ *a detailed analysis and explanation of the development and performance of the entity during the year and an explanation of the relationships and linkages between different pieces of information. This analysis will include a financial review which will utilise a wide range of key financial data from the financial statements section of the accounts. Trend data presenting balance sheet movements for assets and liabilities and detail on the type of spend incurred (on employees, equipment or buildings) are considered best practice in such a financial review;* ○ *Further detail on the risk profile of the organisation, expanding on the summary offered in the performance overview, to describe how risks have affected the organisation achieving its objectives - how such risks have been mitigated; how such mitigation may affect future performance plans; significant changes in risks, including their likelihood and impact; new and emerging risks; how both existing and new risks could affect performance and delivery of plans in future years.* • *Non-financial information, including social matters respect for human rights, diversity, anti-corruption and anti-bribery matters.* • *A summary of how equality of service delivery to different groups has been passed through the organisation should be considered as part of best practice disclosure. This is a mandatory disclosure requirement for NHS bodies, regardless of whether a performance analysis is omitted from the Performance Report. Disclosure may include cross referencing separate publications that contain such information, or provision of information regarding:* ○ *how the entity has had due regard to the aims of the public sector equality duty where applicable;* ○ *information on environmental matters, including the impact of the entity's business on the environment. Reporting entities may reference to a standalone report and when it will be published.* • *Performance on other matters raised during the year (for example, in Treasury PES papers) these will be separately notified to bodies.* • *Reference all key themes of the Health and Care Standards and the range of measures across the NHS Wales Delivery Framework.*	Greg Dix, Executive Director of Nursing & Debbie Bennion/ Richard Hughes, Deputy Director of Nursing Dom Hurford, Executive Medical Director & Sallie Davies, Deputy Medical Director Director of Corporate Governance & Hywel Daniel, Executive Director for People & Helen Watkins, Deputy Director for People, Karen Wright, Assistant Director, Workforce	**DRAFTING**	**Submissions by 12noon 9th March 2023**	Draft to Senior Draft to Leadership Group Meeting for comment **12th April 2023 for return by 19th April 2023** Circulate out of Committee to Planning, Performance and Finance Committee/IMs **on 25th April 2023** to gain endorsement for submission of draft to **WG by Fri 5th May 2023.**	Draft to Welsh Government / Audit Wales as part of draft Annual Report by **Friday 5th May 2023 – request comments by the 15th May 2023.**	Amendments made so that final version can be submitted for approval to Extra ordinary Audit & Risk Committee & Health Board **Mon 12th June 2023** FINAL version to be included within as part of Annual Report submission to Welsh Government /Audit Wales by **Wed 14th June 2023** Welsh Translation **15th June 2023– 14th July 2023**	**AGM 27th July 2023**

Main Tasks		Lead	February 2023	March 2023	April 2023	May 2023	June 2023	July 2023
	• *An explanation of the adoption of the going concern basis where this might be called into doubt (expected in extremely limited circumstances).* *The focus should be presentation of information which is of* ***relevance to the organisation's resident population/stakeholders.*** *It should provide an opportunity to let the public know, in an open and honest way, how it is doing to ensure its services are safe and of high quality and are meeting local need. It will also summarise how regulatory requirements have been discharged.* *It is important that the* ***body presents information on concerns*** *to assure the public that they are taken seriously, dealt with in an open and honest way and lessons learned and acted upon. It will bring together a summary highlighting* ***what has been done to deliver and improve the quality of services*** *the organisation provides and commissions, to drive further improvements in population health and care.* ***Quality should be the thread running through the report*** *demonstrating an organisation's planning and provision of services to improve the quality of care provided leading to improved patient outcomes. The information provided will continue to vary from that required prior to the pandemic, with the need to acknowledge the ongoing impact of COVID-19 on service provision and the action taken to ensure essential services have been maintained and other services have been maintained/re-instated. In developing the report it should enable organisations to:* • *provide an assessment of how well they are doing across all services along the patient pathway from community, primary care and those where other sectors are engaged in providing services, including the third sector through to social care;* • *promote good and innovative practice to share and spread more widely;* • *confirm any areas which need improvement and actions planned; and* • *reference all key themes of the Health and Care Standards and the range of measures across the NHS Wales Delivery Framework* • *an explanation of the adoption of the going concern basis where this might be called into doubt (expected in extremely limited circumstances).* *The report should set the context, describing the population needs of the organisation which have been identified and how these will be met. Summarising the steps being taken to engage with its population and users and the improvement priorities set last year and any in-year challenges including unexpected events which may have influenced this. Further detail on items to include is reported in Annex 7.*		**DRAFTING**	**Submissions by 12noon 9th March 2023**	Circulate to Senior Leadership Group Meeting for comment **12th April 2023 for return by 19th April 2023** Circulate out of Committee to Planning, Performance and Finance Committee/IMs **on 25th April 2023** to gain endorsement for submission of draft to **WG by Fri 5th May 2023.**	Draft to Welsh Government / Audit Wales as part of draft Annual Report by **Friday 5th May 2023 – request comments by the 15th May 2023.**	Amendments made so that final version can be submitted for approval to Extra ordinary Audit & Risk Committee & Health Board **Mon 12th June 2023** FINAL version to be included within as part of Annual Report submission to Welsh Government /Audit Wales by **Wed 14th June 2023** Welsh Translation **15th June 2023– 14th July 2023**	**AGM 27th July 2023**

Main Tasks		Lead	February 2023	March 2023	April 2023	May 2023	June 2023	July 2023
	The Six Goals for Urgent and Emergency Care policy handbook sets out our expectations for health, social care, independent and third sector partners for the delivery of the right care, in the right place, first time for physical and mental health. *The national Six Goals for Urgent and Emergency Care Programme has also been established with senior clinical leadership to enable local teams to deliver the goals and improve experience and outcome for service users.* *The National Programme Board has set two priorities for Health Boards:* • *to develop a safe and effective 24/7 urgent care model to help signpost people to care as close to home as possible to optimise experience and outcomes. This should include development of 'urgent primary care centres'; and* • *to deliver seven day a week same day emergency care services that help people who may have ordinarily been admitted to hospital to return home to sleep in their own bed on the same day.* *Organisations should include a summary of how they are currently performing against these priorities.*							
Wellbeing of Future Generations (Wales) Act 2015 (within Annual Report)	Public bodies must **publish a statement when setting their well-being objectives** explaining why they believe the objective will help them achieve the goals and how it has applied the sustainable development principle. They must also make sure that they involve people interested in achieving the goals and that those people reflect the diversity of their area. Annex 11 provides detail taken from the HFMA report on Integrated Reporting and the Well-being of Future Generations Act (Wales) 2015 which summarises the well-being goals and how NHS Wales can contribute to them for context and to aid considerations. Annex 12 contains guidance on the level of disclosure bodies should report in 2022-23. NHS Wales bodies may choose to insert a link to a published statement the organisation may have made regarding their well-being objectives and ensure that these objectives are reflected upon in their Performance Report.	Sara Thomas, Interim Deputy Director of Public Health	**DRAFTING**	**Submissions by 12noon 9th March 2023**	Circulate to Senior Leadership Group Meeting for comment **12th April 2023 for return by 19th April 2023** Circulate out of Committee to Planning, Performance and Finance Committee/IMs **on 25th April 2023** to gain endorsement for submission of draft to **WG by Fri 5th May 2023.**	Draft to Welsh Government / Audit Wales as part of draft Annual Report by **Friday 5th May 2023 – request comments by the 15th May 2023.**	Amendments made so that final version can be submitted for approval to Extra ordinary Audit & Risk Committee & Health Board **Mon 12th June 2023** FINAL version to be included within as part of Annual Report submission to Welsh Government /Audit Wales by **Wed 14th June 2023** Welsh Translation **15th June 2023– 14th July 2023**	**AGM 27th July 2023**

Welsh Language Regulations (within Annual Report)	You must publish your Welsh Language Annual Report no later than 6 months following the end of the financial year to which the report relates and make this available on your website. NHS health boards **may choose to refer to their work in the report on improving services to Welsh language speakers in the Annual Reports and Accounts and insert a link to relevant published information.** *Each organisation must produce an annual report in relation to each financial year, which deals with the way in which you have complied with the Welsh Language standards with which you were under a duty to comply during that year. This must include the following information (where relevant, to the extent you are under a duty to comply with the standards referred to)—* • *A **the number of complaints** that you received during the year in question which related to compliance with the standards with which you were under a duty to comply (on the basis of the records you kept in accordance with standard 60);* • *The **number of employees who have Welsh language skills** at the end of the year in question (on the basis of the records you kept in accordance with standard 62);* • *The **number (on the basis of the records you kept in accordance with standard 63) of new and vacant posts that you advertised** during the year which were categorised as posts where—* ○ *Welsh language skills were essential;* ○ *Welsh language skills needed to be learnt when appointed to the post;* ○ *Welsh language skills were desirable; or* ○ *Welsh language skills were not necessary.* *You must publish the annual report no later than 6 months following the end of the financial year to which the report relates.*	Hywel Daniel, Executive Director for People / Ben Screen, Welsh Language Manager	**DRAFTING**	**Submissions by 12noon 9th March 2023**	Circulate to Senior Leadership Group Meeting for comment **12th April 2023 for return by 19th April 2023** Circulate out of Committee to Planning, Performance and Finance Committee/IMs **on 25th April 2023** to gain endorsement for submission of draft to **WG by Fri 5th May 2023.**	Draft to Welsh Government / Audit Wales as part of draft Annual Report by **Friday 5th May 2023 – request comments by the 15th May 2023.**	Amendments made so that final version can be submitted for approval to Extra ordinary Audit & Risk Committee & Health Board **Mon 12th June 2023** FINAL version to be included within as part of Annual Report submission to Welsh Government /Audit Wales by **Wed 14th June 2023** Welsh Translation **15th June 2023– 14th July 2023**	**AGM 27th July 2023**

Main Tasks		Lead	February 2023	March 2023	April 2023	May 2023	June 2023	July 2023
Accountability Report	• **Corporate Governance Report** consisting of Director's Report, A statement of Accounting Officer's Responsibility and Governance Statement • **Remuneration and Staff Report** (Reference Annex 13) • **Senedd Cymru/Welsh Parliament Accountability and Audit Report** The Accountability Report will contain an annual slavery and human trafficking statement setting out the steps taken by the organisation during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains or in any part of its business.	Cally Hamblyn, Assistant Director of Governance & Risk and Wendy Penrhyn-Jones, Head of Corporate Governance and Board Business Owen James, Head of Corporate Finance and Elisabeth Williams, Finance Manager Karen Wright, Assistant Director of Workforce & Compliance and Claire Nicholas, Head of Workforce Improvement & Efficiency	**DRAFTING**	**Submissions by 12noon 9th March 2023**	Circulate to Senior Leadership Group Meeting for comment **12th April 2023 for return by 19th April 2023** Circulate out of Committee to Planning, Performance and Finance Committee/IMs **on 25th April 2023** to gain endorsement for submission of draft to **WG by Fri 5th May 2023.**	Draft to Welsh Government / Audit Wales as part of draft Annual Report by **Friday 5th May 2023 – request comments by the 15th May 2023.**	Amendments made so that final version can be submitted for approval to Extra ordinary Audit & Risk Committee & Health Board **Mon 12th June 2023** FINAL version to be included within as part of Annual Report submission to Welsh Government /Audit Wales by **Wed 14th June 2023** Welsh Translation **15th June 2023– 14th July 2023**	**AGM 27th July 2023**
Annual Quality Statement								
(No obligation to provide this separately for 2022-2023)								
Annual Sustainability Report (No obligation to provide for 2022-2023 – signpost where available as a standalone document on CTM Website)								

Agenda Item Number: 3.1

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) Audit & Risk Committee held on the 12 December 2022 as a Virtual Meeting via Microsoft Teams

Members Present:

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

In Attendance:

Sara Utley	Audit Wales
Mark Jones	Audit Wales
Paul Dalton	NWSSP – Internal Audit & Assurance
Emma Samways	NWSSP – Internal Audit & Assurance
Eifion Jones	NWSSP – Internal Audit & Assurance (In Part)
Sally May	Executive Director of Finance
Hywel Daniel	Executive Director for People
Cally Hamblyn	Assistant Director of Governance & Risk
Owen James	Head of Corporate Finance
Matthew Evans	Head of Local Counter Fraud
Alison Williams	Local Counter Fraud Specialist
Nerys Conway	Assistant Medical Director, Medical Workforce
Emma Walters	Corporate Governance Manager (Secretariat)

Unconfirmed

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:

- Dom Hurford, Medical Director

J Sadgrove advised that she would need to leave the meeting at 4pm.

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 24 October 2022

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

2.1.2 Declarations of Interest and Gifts & Hospitality Report

Resolution: The Report was **ENDORSED** for Board approval**.**

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**.

2.2.3 Audit & Risk Committee Effectiveness Self-Assessment

P Roseblade advised that there were a few areas highlighted within the self-assessment which required further action and advised that she had asked Internal Audit and Counter Fraud colleagues to provide Members with more detail in relation to their responsibilities and the reasons why they have to report against certain areas.

Resolution: The report was **NOTED.**

2.2.4 Clinical Audit Annual Report

Resolution: The report was **NOTED.**

3.0.0 MAIN AGENDA

GOVERNANCE

3.1 Audit & Risk Committee Action Log

Unconfirmed

C Hamblyn presented Members with the action log. The following updates were discussed:

- Action 5.3.5 – It was confirmed that an update had not been included in the Chief Operating Officers report to Quality & Safety Committee in relation to the Patient Pathway Appointment Management Process. Members noted that a discussion would be held with G Hughes outside the meeting;
- Action 5.4.5 – Reminder to be sent to H Daniel in relation to providing a response to Committee Members regarding this action;
- Action 5.2 – Members noted that this action would remain in progress and the recommendation would remain on the audit tracker until Audit Wales colleagues were comfortable that processes were in place;
- Action 5.3.2 and 5.3.3 – Members noted that a discussion would be held at the Digital & Data Committee on Monday 19 December 2022 regarding the two Committee referrals.

I Wells made reference to action 18/099 and advised that he hoped that a report would be received at the February 2023 meeting of the Committee.

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

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 and highlighted the key matters for Members attention.

J Sadgrove made reference to the number of days spent against each area of work and noted that roughly 50% of the days had been used in relation to Inform and Involve in comparison to roughly two thirds of the days being used against the other areas. J Sadgrove noted that M Evans planned to present a report on this matter at a future meeting of the Committee. M Evans advised that requests for Counter Fraud Awareness training had been received and in a future report he will capture data in respect of the awareness work being undertaken within the organisation.

In response to a question raised by P Roseblade in relation to the referral rate for CTM being significantly higher than the previous year and higher than the All Wales average, M Evans advised that Whilst more referrals had been received, more cases were being closed earlier due to a pragmatic view being taken on progression. M Evans provide assurance that case closures were reviewed by third parties independent from the investigation which meant that the team were maintaining a manageable case load as a result.

Unconfirmed

A Williams presented Members with the outcome of the proactive review that had been undertaken in relation to salary overpayments to temporary staff that had been recruited during the Covid-19 pandemic. Members noted that 1240 cases were reviewed which identified a small number of non-compliant cases which resulted in overpayments.

P Roseblade welcomed the robust and comprehensive update received. . P Roseblade questioned whether there was a requirement for further training to be provided to managers to prevent further salary overpayments occurring in future. Members noted that the Counter Fraud Team were in the process of developing a risk assessment which should hopefully address the position moving forwards. S May noted that this is an area of concern which had been identified which required addressing as a whole system issue.

Resolution: The report was **NOTED.**

4.2 The National Fraud Initiative in Wales 2020 – 2021: National Fraud Initiative Self-Appraisal Checklist

M Evans presented the report which was a reflection of the work that had been undertaken as part of the National Fraud Initiative. Members noted that a report would be presented to the Committee in June 2023 in relation to National Fraud Initiative progress and outcomes.

S Utley confirmed that discussions had been held in relation to the Management Response provided and added that Audit Wales appreciated the completion of the self-appraisal checklist.

Resolution: The report was **NOTED**.

4.3 Procurements and Scheme of Delegation Report

S May presented Members with the report.

In response to a comment made by P Roseblade in relation to the waiver of the Engagement and Communication Single Tender Action, S May advised that a discussion was held with the Communications Team regarding this matter and advised that further discussions would need to take place with the Assistant Director of Engagement and Communication to ensure appropriate engagement is undertaken moving forward.

Resolution: The report was **APPROVED**.

4.4 Losses and Special Payments Report

S May presented Members with the report.

Unconfirmed

In response to a query raised by C Donoghue, S May confirmed that references being made to Integrated Locality Group Governance Teams would now be changed to Care Groups.

In response to a comment made by C Donoghue regarding the statement made in section 2.10 that the submission of Learning From Events reports was progressing well, S May advised that whilst good progress had been made, further work was required to ensure that fully completed reports were being submitted as opposed to high level reports. Members noted that the Health Board were working closely with the Welsh Risk Pool who were understanding of the process being followed.

C Donoghue made reference to the statement made within the key risks section which stated that sustainable improvements would be made once the new Quality Governance Operating Model was in place and sought clarity as to the timescales as to when the new model would be implemented. Members noted that the Director of Nursing had initiated the Consultation on the proposed new structure for Quality Governance which was due to close in January 2023. Members noted that it was hoped that the new structure would be implemented quickly once the consultation had closed. C Hamblyn advised that there should be greater clarity on the position at the February Audit & Risk Committee. J Sadgrove advised that a discussion was held at the Quality & Safety Committee where concerns were raised as to whether sufficient resource had been allocated to the processing of Learning From Events reports to enable improvements to be made in a timely manner and learning identified and shared.

In response to a question raised by P Roseblade as to whether any claims had been rejected by the Welsh Risk Pool and if so what the total value of the losses were, O James advised that to date no claims had been rejected and written off as a loss.

In response to a question raised by P Roseblade as to whether the submission of blank LFER forms would achieve anything, S May advised that the former Director of Corporate Governance had discussed this with the Welsh Risk Pool prior to her departure and there was a shared understanding in place of the process being followed.

In response to a query raised by P Roseblade as to why the permanent injury benefit seemed high compared to previous years and whether there was anything in particular that was driving the increase, O James advised that he would need to review the position and would provide a response outside the meeting.

Resolution: The report was **NOTED**.

Action: Review to be undertaken of the reasons behind the increase in permanent injury benefits compared to previous years.

Unconfirmed

4.5 Consultant Job Planning

N Conway presented Members with the report which provided an update on progress being made in relation to Consultant Job Planning. Members noted that to date 35% of job plans had been signed off.

J Sadgrove advised that this was an area where the Committee had expressed concern against over recent years and added that she was pleased to see that the issues were being addressed with vigour. J Sadgrove advised that she welcomed the work being undertaken to ensure consistency across the Health Board and added that she looked forward to further progress being made in this area. N Conway confirmed that the Care Groups had been challenged to achieve a target of 50% in relation to completed job plans.

H Daniel advised that a broader piece of work was being undertaken in relation to medical workforce productivity in its entirety and added that support was being received from an external organisation to develop a coherent plan for medical workforce moving forwards.

In response to a question raised by P Roseblade as to whether the work being undertaken to develop a rate card included a rate card for GP's, H Daniel advised that this had not been included in the first phase but would need to be considered moving forwards.

Resolution: The report was **NOTED.**

4.6 Medical Rostering

N Conway presented report providing Members with an update on progress achieved in relation to the recommendations contained within the Internal Audit Review of Medical Rostering.

P Roseblade made reference to recommendation 1.1 which had been marked as completed and advised that she was under the impression that the Health Roster system was not being used within Anaesthetics and the Emergency Department. N Conway advised that she understood that the Health Roster system did not support the Anaesthetics and Emergency Department rota's which had resulted in them using an alternative system for their rostering arrangements. H Daniel advised that a further review of the position would need to be undertaken to determine where this decision was made and whether testing of the system had been undertaken within these areas. H Daniel advised that he would discuss this further with the Medical Director.

C Donoghue made reference to recommendation 5.1 which had been marked as completed and advised that it seemed premature to mark this as completed when the update advises that training had been offered. C Donoghue also advised that it would be helpful if timescales for completion could be included against the recommendations which remained in progress. P Dalton advised that correlation would need to be undertaken in relation to the updates included

Unconfirmed

within this report compared to the updates contained within the Audit Recommendations Tracker.

In response to a comment made by I Wells in relation to Recommendation 3.1 where he queried which group was now responsible for approving the draft Medics Rostering Policy, N Conway confirmed that this policy would now need to be considered by the Policy Review Group initially prior to being received at the Local Negotiating Committee for approval.

The report was **NOTED.**

Resolution:

Action: Discussion to be held with the Medical Director outside the meeting in relation to the decision to not use the Health Roster System within Anaesthetics and the Emergency Department. Discussion also required as to whether the system had been tested within these areas.

Action: Correlation to be undertaken in relation to the updates included within the Medical Rostering report compared to the updates contained within the Audit Recommendations Tracker.

5.0.0 IMPROVING CARE

5.1 Organisational Risk Register

C Hamblyn presented the report and provided an update against the key matters for Members attention.

I Wells made reference to the emerging risk relating to Digital and Data contained on page 4 of the cover report and advised that he was unsure what this was referring to. C Hamblyn agreed to confirm the position outside the meeting.

I Wells made reference to risk 4664 and advised that he had concerns about the wording contained within the update. It was suggested that a further discussion on this risk was held during the In Committee session and it was agreed that any risks of this nature would need to be discussed In Committee moving forwards.

C Donoghue advised that there were some key themes within the risk register which did not seem to change, for example, number of references made to submission of business cases, staff appointments being made and a number of risks which did not have timescales set against them. C Donoghue advised that it would be helpful if these points could be shared with the Executive Team at the risk workshop being held in January 2023. P Roseblade reiterated the need to ensure any new updates were clearly identified in red.

Resolution: The report was **REVIEWED**.

Unconfirmed

Action: Confirmation to be provided outside the meeting as to the nature of the emerging risks relating aligned to the Digital and Data function.

Action: Feedback identified by C Donoghue in relation to the risk register to be discussed with the Executive Team at the Risk Workshop being held in January 2023.

5.2 Audit Recommendations Tracker

C Hamblyn presented the report and highlighted the key matters for the attention of the Committee.

S Utley advised that some recommendations relating to the Audit of the Accounts Addendum seemed to have been removed from the External Audit Recommendations tracker and asked for a review to be undertaken as to why they had been removed. M Jones added that for consistency it would be helpful if future iterations of the cover report could outline any key commentary for External Audit as well as Internal Audit.

Resolution: The report was **NOTED**.

Action: Review to be undertaken of the External Audit Recommendations Tracker to determine why five recommendations relating to the Audit of the Accounts Addendum had been removed from the tracker.

Action: Future iterations of the cover report to include commentary for External Audit to ensure consistency with Internal Audit entries.

5.3 INTERNAL AUDIT

5.3.1 Internal Audit Review Progress Report

P Dalton presented the report.

Resolution: The report was **NOTED**.

5.3.2. Internal Audit Review – Decarbonisation

E Jones presented the report. Members noted that 11 recommendations had been made, some of which did not have target dates set against them, with some recommendations being jointly owned between the Health Board and Welsh Government.

Resolution The report was **NOTED**.

5.3.3 Internal Audit Review – iCTM Improvement Team Discussion

P Dalton presented the report which had been allocated a reasonable assurance rating. P Roseblade welcomed the management response provided which she had found to be comprehensive.

Unconfirmed

Resolution The report was **NOTED**.

5.3.4 Internal Audit Review – Clinical Service Group – Radiology Discussion

E Samways presented the report.

C Donoghue advised that there was a significant amount of detail contained within the report and drew attention to the statement that staff would be encouraged to enter their annual leave onto ESR. C Donoghue queried whether this process should be mandated rather than voluntary. In response, H Daniel confirmed that there was an expectation for staff to be enter their annual leave onto ESR as the agreed system for annual leave management.

Resolution: The report was **NOTED**.

5.3.5 Internal Audit Review – Wellbeing

E Samways presented the report and advised that a reasonable assurance rating had been allocated.

H Daniel advised that the Team had felt disappointed with the outcome of the audit and felt that there were some areas which could have been reflected on slightly differently.

S May expressed concerns with regards the focus of the report findings recognising the significant activity led by the Wellbeing Function and in particular the reference to the need for a group to be established in recommendation 5. In response, E Samways advised that the findings in relation to recommendation 5 related to a number of groups being in place in the past who were monitoring the wellbeing agenda and the gap that this may now present.

P Roseblade sought clarity as to whether the recommendations were achievable. H Daniel advised that whilst the recommendations would be addressed, it was considered that they would not add significant value to the wellbeing agenda offered by the Health Board and added that the Team had asked Internal Audit to review the quality of the Health Board's wellbeing offer.

I Wells queried whether this report should be paused in light of the concerns expressed by Executive Colleagues. In response, P Dalton advised that a number of discussions had been held with Executive Colleagues regarding this review prior to Committee, but welcomed a further opportunity to discuss with S May outside the meeting in acknowledgement of the feedback received at the meeting.

Following discussion, it was agreed that this review would not be added to the audit recommendations tracker until a further conversation had taken place outside the meeting. It was agreed that a verbal update would be provided to

Unconfirmed

the February meeting regarding the outcome of the discussions that had taken place.

Resolution: The report was **NOTED**.

Action: Further discussion to take place outside the meeting in relation to the outcome of the review. Verbal update to be provided to the February Audit & Risk Committee regarding the outcome of the discussions held.

5.4 AUDIT WALES

5.4.1 Audit Wales Audit & Risk Committee Update

S Utley presented the report

Resolution: The report was **NOTED**.

5.4.2 Audit Wales Review - Making Equality Impact Assessments more than just a tick box exercise

S Utley presented the report. P Roseblade requested that the report was shared with all Independent Members for information and awareness.

Resolution: The report was **NOTED.**

Action: Report to be shared with all Independent Members via the Independent Members portal on Admincontrol.

5.4.3 Audit Wales - Review of Commissioning and Contracting Arrangements (CTM & Swansea Bay)

S Utley presented the report and advised that the management response was in the process of being finalised and would be presented to the February Audit & Risk Committee. Members noted that four recommendations had been made which had been accepted by Management.

I Wells made reference to the suggestion made within the report that all service level agreements would be temporary and added that he understood following discussion amongst the Executive Team that there would be some Service Level Agreements that would remain in place. S Utley advised that there would always be some elements of Service Level Agreements in place between organisations and added that the programme would need to identify which agreements needed to remain in place. S May advised that a Memorandum of Understanding had been developed to underpin this which would be discussed further at the Joint Executive Group.

Resolution: The report was **NOTED.**

Unconfirmed

5.4.4 Audit Wales Review - Transforming Leadership Partnership Board Baseline Governance Review

S Utley presented the report and advised that seven recommendations had been made which had all been accepted by Management.

Resolution: The report was **NOTED.**

6.0.0 ANY OTHER BUSINESS

7.0.0 COMMITTEE HIGHLIGHT REPORT

8.0.0 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.

9.0.0 DATE AND TIME OF NEXT MEETING
The next meeting would take place on Monday 13 February 2023.

8.0.0 CLOSE

Unconfirmed

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item 3.2

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 where circulated)
18/099	8/10/2018	Endoscopy JAG Accreditation Closure report to be presented to a future meeting.	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 Now April 2023	**In progress** The Chief Operating Officer has requested some further work be undertaken on this matter during February 2023 and has therefore requested that this item is deferred from the February to the April 2023 meeting of the Audit & Risk Committee Forward Work Programme updated to April 2023.
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** The Medical Director has agreed to discuss this matter further with the Director for People. An update on the outcome of the discussions held will be provided to Committee members in due course.

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 April 2023**	**In Progress** Recommendation has been added back onto the tracker and would not be removed until Audit Wales colleagues were comfortable that processes were in place. Audit Wales to meet with the Director of Digital to discuss this matter further. Meeting to take place following February meeting and therefore outcome will be reported to April 2023.
4.6	12/12/2022	Medical Rostering - Discussion to be held with the Medical Director outside the meeting in relation to when and who made the decision to not use the Health Roster System within Anaesthetics and the Emergency Department. Discussion also required as to whether the system had been tested within these areas.	Director for People	April 2023	**In progress** Discussion has not yet taken place due to winter pressures. Update to be provided at the April 2023 meeting.
5.3.5	12/12/2022	Internal Audit Review – Wellbeing - Further discussion to take place outside the meeting in relation to the outcome of the review. Verbal update to be provided to the February Audit & Risk	Head of Internal Audit/Director of Finance	February 2023	**On agenda** Director of Finance and Head of Internal Audit met to discuss the outcome of the review. Revised report being presented to the

		Committee regarding the outcome of the discussions held.			February 2023 meeting of the Committee
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)**
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	**Completed** Update included in the Chief Operating Officers report presented to the Quality & Safety Committee held on 24 January 2023.
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	**Completed** Report discussed at the December meeting of the Digital & Data Committee and the Management Responses were considered to be appropriate and had been refined to ensure they would address the

					improvements recognised within the Internal Audit Review. Progress being made against the recommendations to continue to be monitored by the Audit & Risk Committee.
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	**Completed** Report discussed at the December meeting of the Digital & Data Committee and the Management Responses were considered to be appropriate and had been refined to ensure they would address the improvements recognised within the Internal Audit Review. Progress being made against the recommendations to continue to be monitored by the Audit & Risk Committee.
4.4	12/12/2022	Losses and Special Payment Report - Review to be undertaken of the reasons	Head of Corporate Finance	February 2023	**Completed**

		behind the increase in permanent injury benefits compared to previous years.			Response shared with Members by email on 14 December 2022
5.1	12/12/2022	Organisational Risk Register - Confirmation to be provided outside the meeting as to the nature of the emerging risk relating to Digital and Data and what this was referring to.	Assistant Director of Governance & Risk	February 2023	**Completed** A detailed update was provided at the Digital & Data Committee on the 19th December, on the emerging risks in relation to: • Microsoft Sustainability • Unsupported server operating systems The minutes of the Digital & Data Committee can be shared upon request.
5.1	12/12/2022	Organisational Risk Register - Number of generic issues identified by C Donoghue in relation to the risk register to be discussed with the Executive Team at the Risk Workshop being held in January 2023.	Assistant Director of Governance & Risk	February 2023	**Completed** The following feedback has been incorporated into the slides for the workshop with Executive Leads in January 2023 and will continue to be raised with risk leads in updating and reviewing risks and in training sessions. Repeating Themes: • Reference to Business Cases to be supported

					with other mitigating action should business cases not be supported. • Where appointments to roles are referenced include timeframes. • Review dates updated • Actions updated with robust progress – avoid repeating previous action updates. • Target Scores revisited to ensure consistent approach to risk scoring.
5.2	12/12/2022	Audit Recommendations Tracker - Review to be undertaken of the External Audit Recommendations Tracker to determine why five recommendations relating to the Audit of the Accounts Addendum had been removed from the tracker.	Corporate Governance Manager	February 2023	**Completed** Review undertaken. Confirmation provided to Audit Wales that recommendations had been removed from the tracker as they had been marked as completed. Audit Wales confirmed that progress would be checked as part of the 2022/2023 audit which takes place in 2023.
5.4.2	12/12/2022	Audit Wales Review - Making Equality Impact Assessments more than just a tick box exercise - Report to be shared with all Independent Members	Corporate Governance Manager	December 2022	**Completed** Report uploaded to the IM Portal on Admincontrol

		via the Independent Members portal on Admincontrol.			
4.6	12/12/2022	Medical Rostering - Correlation to be undertaken in relation to the updates included within the Medical Rostering report compared to the updates contained within the Audit Recommendations Tracker.	Corporate Governance Manager	February 2023	**Completed** The Medical Rostering Report largely correlated with the Audit Recommendations Tracker with the exception of recommendation 4.1 where the update differed. The audit tracker has now been amended to reflect the update included within the report. A further update on progress has been included in the latest iteration of the tracker.
5.2	12/12/2022	Audit Recommendations Tracker - Future iterations of the cover report to include the same commentary provided for Internal Audit for External Audit also.	Corporate Governance Manager	February 2023	**Completed** Same commentary has now been included within the report.

AGENDA ITEM
4.1

AUDIT & RISK COMMITTEE

LOCAL COUNTER FRAUD UPDATE REPORT

Date of meeting	13 February 2023
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 outined 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.

Agenda Item 4.1

Cwm Taf Morgannwg University Health Board

Audit & Risk Committee – 13 February 2023

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	80
Prevent and Deter Discouraging those who may want to commit crimes against the NHS and ensure that such opportunities are minimised.	125	126
Hold to Account Detecting and investigating crime, prosecuting those who have committed crimes and seeking redress as a result.	321	267
TOTAL	616	512

4. STRATEGIC GOVERNANCE

The Counter Fraud Team have attended a 2-day training and development session delivered by the NHS Counter Fraud Authority. The training covered the areas of Criminal Procedure in Investigations Act particularly around evidential disclosure, the function and application of diversionary cautions which are a new out of court disposal introduced by the Police Crime Sentencing and Courts Act replacing conditional cautions this year, and refresher training on investigation skills and the Fraud Investigation Model.

A benchmarking report of key performance indicators has been produced and is attached at Appendix 1 to this report. The report measures Health Board performance

against an all-Wales benchmark average to provide greater context to the information. The report is based on Q1 – Q3 year on year data to allow comparisons to previous performance.

5. INFORM AND INVOLVE

A programme of awareness is now being offered to GP Practices. This extends the existing awareness programme at the Health Board and seeks to harden response to frauds and scams targeted at GP Practices as well as covering learning from a recent prosecution of a Practice Manager in the Swansea area as well as further referrals received relating to alleged fraud within GP Practices.

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

The Counter Fraud Team are undertaking a comprehensive risk assessment around overpayments of salary. The risk assessment is undertaken in line with requirements of the Counter Fraud Standards. The process will involve liaison with Workforce & OD, Finance and Payroll colleagues to measure and assess current controls against perceived fraud risk in this area.

A risk measurement exercise is being undertaken in relation to the offering of free Health Sector conferences/networking events to NHS staff. This follows receipt of local intelligence via the Director of Finance regarding Health Board and other NHS Wales employees attending such events with negative experiences. The measurement exercise will seek to inform the wider NHS via CFS Wales and the NHS Counter Fraud Authority of a so far unknown or unseen risk.

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.

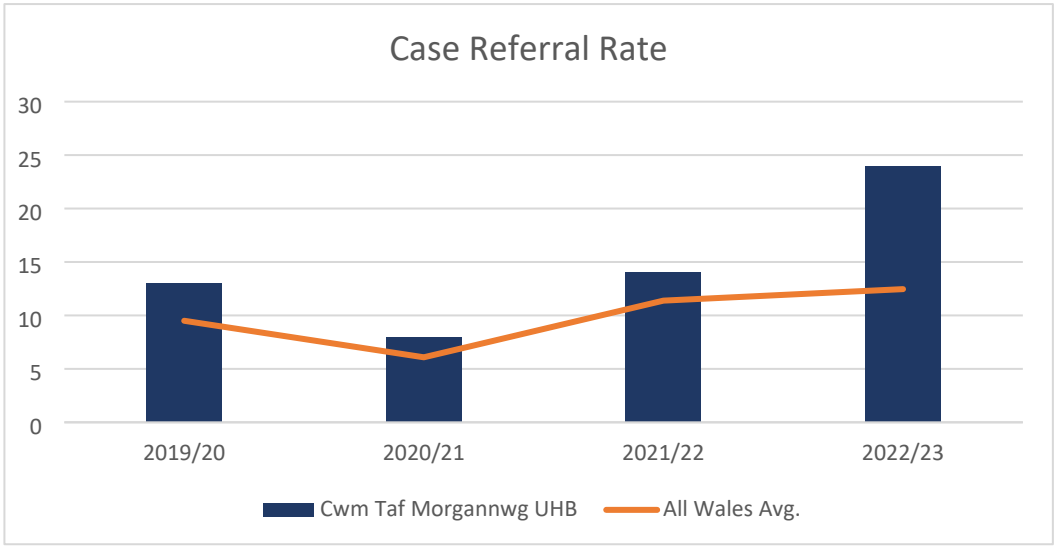
A table of Closed Cases is also presented to review outcomes of investigations.

Item 4.1 – Appendix 1

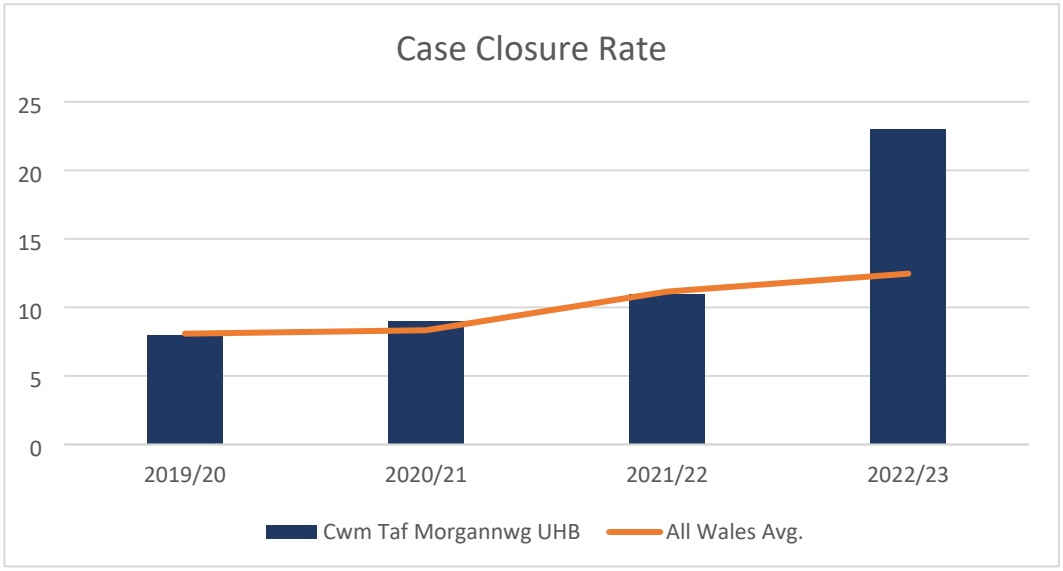
Counter Fraud Benchmark Report

Counter Fraud Benchmarking Statistics – Q1-Q3

Case Referral Rate	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	13	9.5
2020/21	8	6.1
2021/22	14	11.4
2022/23	24	12.5



Case Closure Rate	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	8	8.1
2020/21	9	8.3
2021/22	11	11.2
2022/23	23	12.5



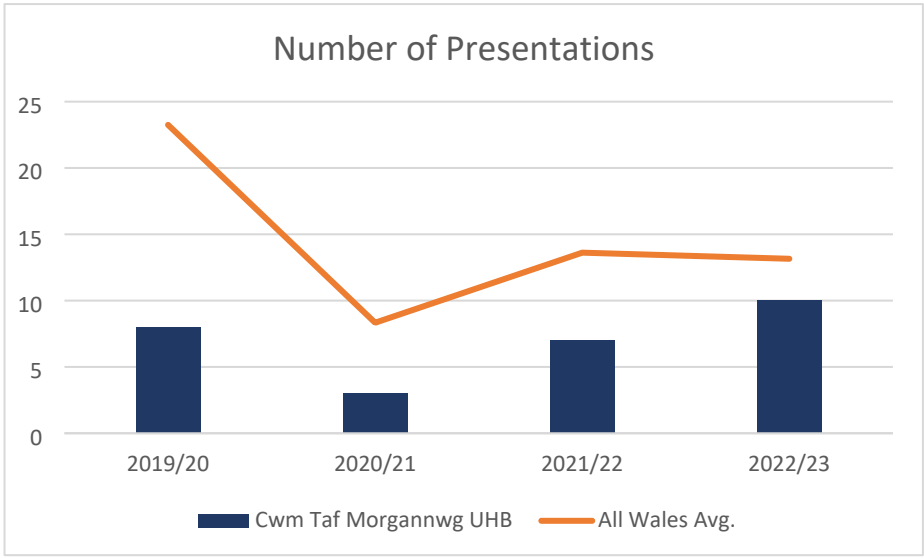
Counter Fraud Benchmarking Statistics – Q1-Q3

Investigation Progression Rate	Cases Open at Start of FY	Referrals Received	Cases Closed	Total Cases Open End of Period
2019/20	11	13	8	16
2020/21	18	8	9	17
2021/22	13	14	11	16
2022/23	11	24	23	12

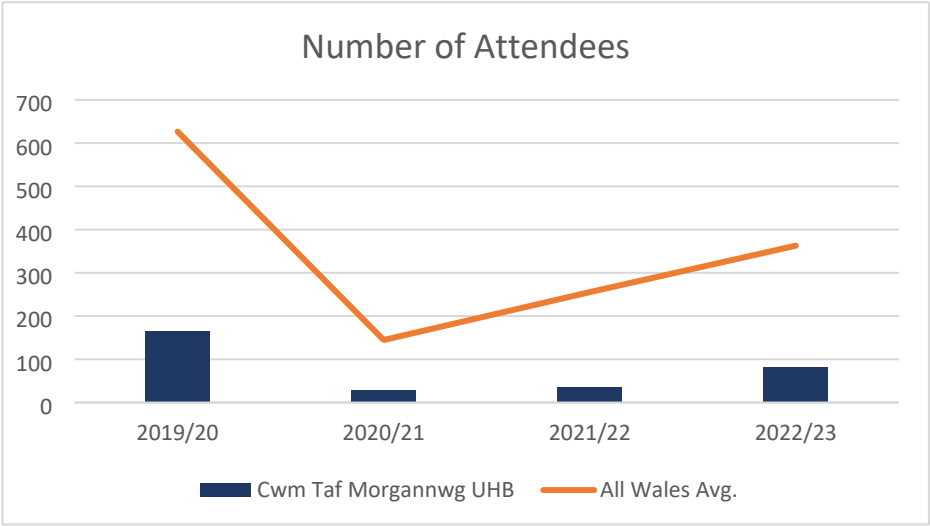
Sanctions	2019/20			2020/21			2021/22			2022/23		
	Criminal	Disp	Civil	Criminal	Disp	Civil	Criminal	Disp	Civil	Criminal	Disp	Civil
Cwm Taf Morgannwg UHB	0	1	1	0	1	1	1	0	6	0	1	4
All Wales Avg.	0.9	1.9	2.5	0.7	1.8	1.3	0.4	3.2	2.2	0.6	2.1	2.9
All Wales Total	11	23	30	8	21	15	5	41	28	8	27	38

Counter Fraud Benchmarking Statistics – Q1-Q3

Number of Presentations	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	8	23
2020/21	3	8
2021/22	7	14
2022/23	10	13

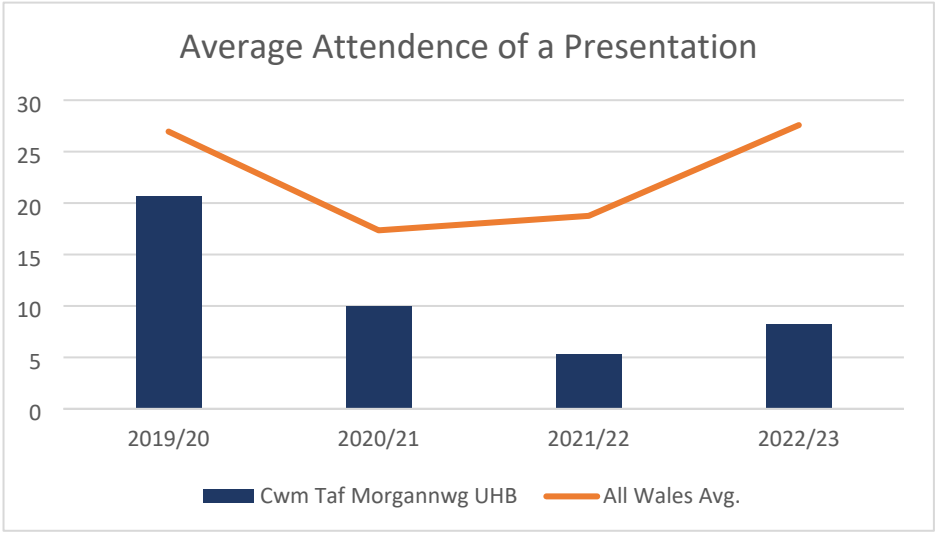


Number of Attendees	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	165	627
2020/21	30	145
2021/22	37	255
2022/23	82	363

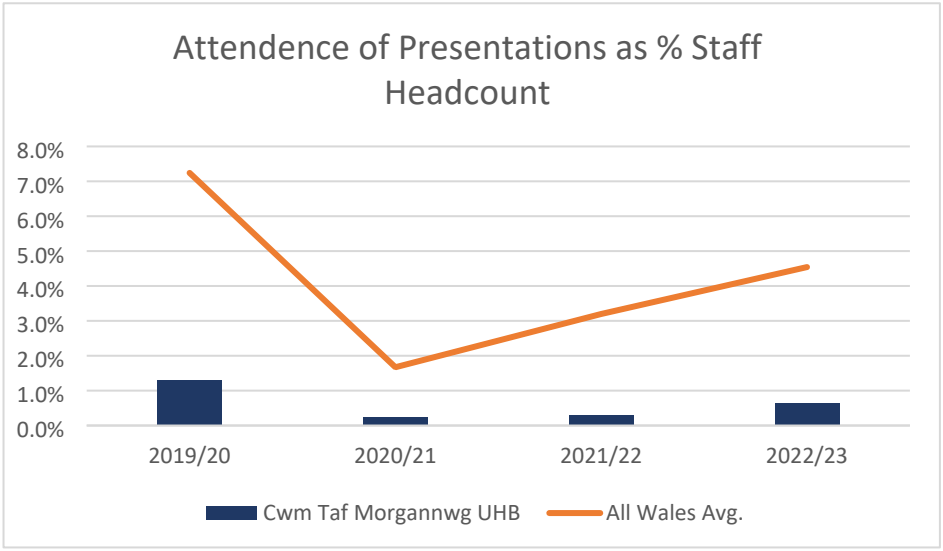


Counter Fraud Benchmarking Statistics – Q1-Q3

Average Attendance of a Presentation	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	21	27
2020/21	10	17
2021/22	5	19
2022/23	8	28

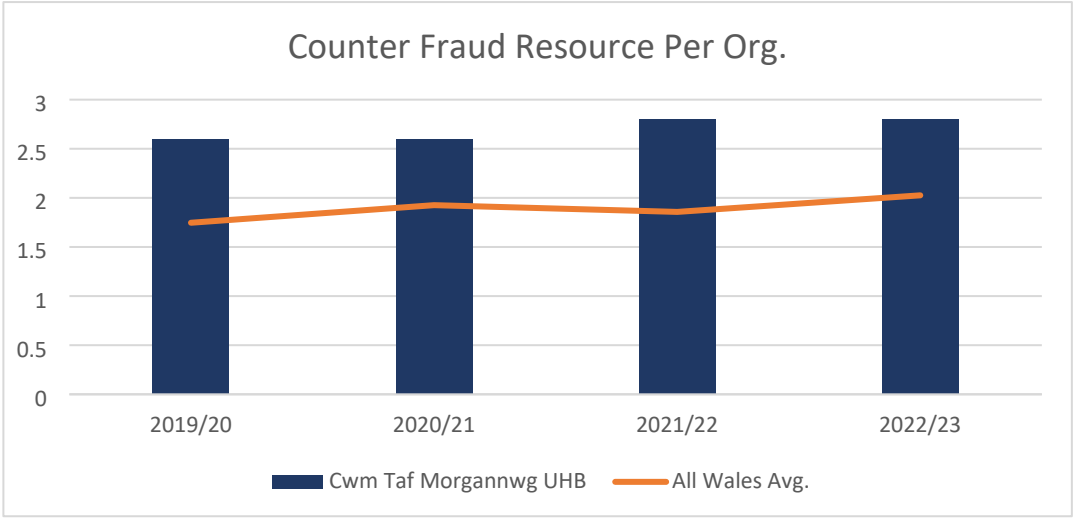


Attendance of Presentations as % Staff Headcount	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	1.3%	7%
2020/21	0.2%	1.7%
2021/22	0.3%	3.2%
2022/23	0.6%	5%

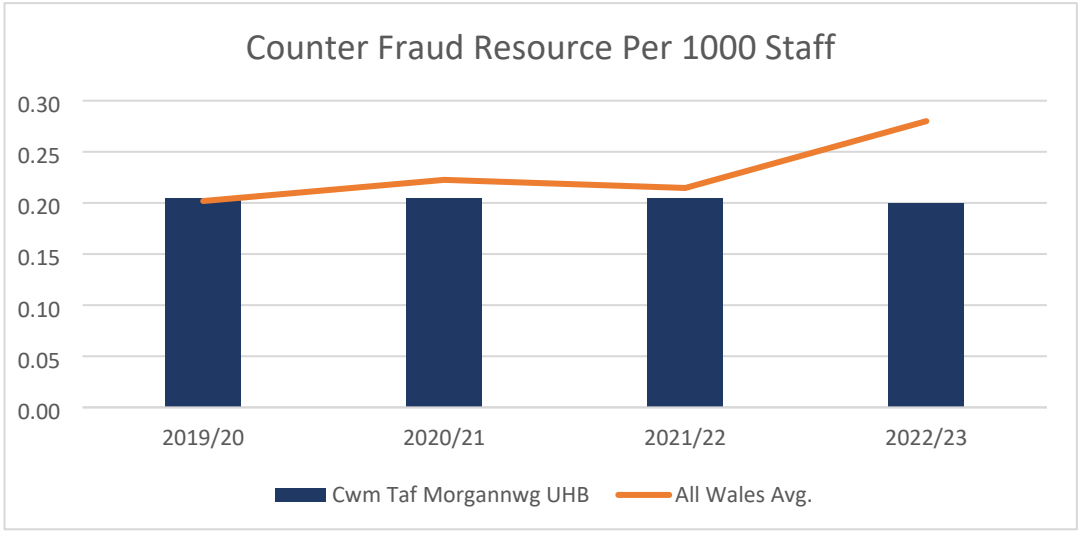


Counter Fraud Benchmarking Statistics – Q1-Q3

Counter Fraud Resource Per Org.	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	2.6	1.7
2020/21	2.6	1.9
2021/22	2.8	1.9
2022/23	2.8	2.0



Counter Fraud Resource Per 1000 Staff	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	0.20	0.20
2020/21	0.20	0.22
2021/22	0.20	0.21
2022/23	0.20	0.28



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

Item 4.1 – Appendix 2

Counter Fraud Investigations Update Report

13 February 2023

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
12	0	22

Case Rates

Referrals Received 2022/23	Cases Under Investigation for Over 12 Months
26	2

Sanctions/Outcomes

Criminal Sanctions	Civil Sanctions (Inc. Financial Recovery)	Disciplinary Sanctions
1	4	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 has been undertaken by CPS and LCFS investigators will meet with Prosecutors in February to discuss strategy. 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/22/00707	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/22/01137	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 undertaken to gain account from subject. The subject attended interview and gave full admission of having knowledge of payments and spending money when not entitled to. The subject has provided mitigation of conduct and bank account activity is being reviewed to corroborate.
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 undertaken and account gained from subject. Follow up enquiries are being pursued.
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.

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/23/00117	16/01/2023	Prescription Fraud	Patient presented falsified prescription for controlled drugs at a community pharmacy. Prescription found to be a genuine blank NHS script which was stolen from an independent prescriber at another pharmacy believed to have been handwritten by the person presenting. Police are investigating, LCFS is supporting via the drugs liaison officer and reviewing risk.

Closed Cases			
Reference Number	**Date Opened**	**Allegation**	**Outcome**
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 has been completed and funds recovered.
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.
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. A further Med3 Fitness for Work Certificate was issued by the subject's doctor stating long covid. The doctor subsequently confirmed that the terms were referring to the same condition. Although a certificate has been altered there is no loss to the Health Board and therefore no fraud offence established.
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 established that an amended reference has been supplied to another organisation but original unamended reference was received by the Health Board.
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.

AGENDA ITEM
4.2

AUDIT & RISK COMMITTEE

Losses and Special Payments 01.10.22 to 31.12.22

Date of meeting	13/02/2023
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

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

CMR	Claims Management Report
LFER	Learning From Events Report
ILG	Integrated Locality Group
CSG	Clinical Service Group
SOP	Standard Operating Procedure
GMPI	General Medical Practice Indemnity
HSE	Health and Safety Executive
AMD	Assistant Medical Director

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 October 2022 to 31 December 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 31 December 2022

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

Table 1

	31.12.22	30.09.22	31.03.22	31.03.21	31.03.20
	£000	£000	£000	£000	£000
	Cumulative	Cumulative	Cumulative	Cumulative	Cumulative
Medical Negligence claims/costs	59,617	65,994	65,127	86,029	85,516
Redress Medical Negligence claims/costs	575	538	235	269	382
Personal Injury claims/costs	859	618	611	436	680
Recoverable from Welsh Risk Pool	(73,232)	(84,441)	(93,074)	(114,863)	(115,161)
Net claim provision (Note 1)	**(12,181)**	**(17,291)**	**(27,101)**	**(28,129)**	**(28,583)**
Permanent Injury Benefit	5,951	6,018	6,201	6,320	6,252
Net Provision	**(6,230)**	**(11,273)**	**(20,900)**	**(21,809)**	**(22,331)**
Number of live cases on losses system (LaSPaR)					
	31.12.22	**30.09.22**	**31.03.22**	**31.03.21**	**31.03.20**
Medical Negligence claims (Note 2)	339	326	299	309	279
Redress Medical Negligence claims (Note 2)	247	243	213	168	202
GP Indemnity claims	13	7	7	0	0
Personal Injury claims	130	129	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 this financial year as noted in the table above. However, a systems reconciliation process is being completed currently and updated number of open cases will be provided to the next Audit & Risk Committee.

b) Expenditure incurred for the year to 31 December 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 (12.12.2022).

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 ended	Year ended	Year ended
	31.12.22	**30.09.22**	**31.03.22**	**31.03.21**	**31.03.20**
	£000	**£000**	**£000**	**£000**	**£000**
Medical Negligence claims/costs	(282)	3,749	1,945	13,110	18,455
Redress Medical Negligence claims/costs	645	431	170	305	367
GP Indemnity	3	0	1	0	0
Personal Injury claims/costs	763	262	772	316	557
Recoverable from Welsh Risk Pool	190	(3,782)	(1,210)	(12,449)	(18,225)
Net claim expenditure (Note 3)	**1,319**	**660**	**1,678**	**1,282**	**1,154**
Permanent Injury Benefit	(42)	(80)	286	470	2,075
Other	1,232	1,210	570	609	407
Total expenditure	**2,509**	**1,790**	**2,534**	**2,361**	**3,636**

Note 3: The annual budget for net claim expenditure for 2022-23 is £1,785k (year to date £1,338k), there is therefore a very small underspend of £19k.

c) Cash Write-Offs made for the period 1 October 2022 to the 31 December 2022

Table 3 shows the cash impact to 31 December 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

	01.10.22 - 31.12.22 £000	Previously Reported £000	Total 2022-23 £000
Medical Negligence (Appendix 1)			
Claims	1,432	1,262	2,694
Costs	756	1,424	2,180
Defence Fees	159	194	353
Medical Negligence Totals	2,347	2,880	5,227
Redress Medical Negligence (Appendix 2)			
Claims	110	95	205
Costs	20	20	40
Defence Fees	46	15	61
Redress Medical Negligence Totals	176	130	306
GP Indemnity (Appendix 3)			
Defence Fees	3	0	3
GP Indemnity Totals	3	0	3
Personal Injury (Appendix 4)			
Claims	23	111	134
Costs	193	63	256
Defence Fees	45	80	125
Personal Injury Totals	261	254	515
Permanent Injury Benefit (Appendix 5)	103	103	206
Permanent Injury Benefit Totals	103	103	206
Other (Appendix 6)			
Ex-Gratia	16	61	77
Debt Write Off	4	0	4
Loss of Cash	0	861	861
Ombudsman	2	3	5
Employment Matter	0	285	285
Other Totals	22	1,210	1,232
Total	2,912	4,577	7,489
Recovered from Welsh Risk Pool	(7,236)	(12,414)	(19,650)
Net Cash Write-Off	(4,324)	(7,837)	(12,161)

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
- 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
- AMD engagement to assist with the LFER process
- Reconciliation of WRP data and CTM Datix Cymru data.

2.10 Submissions are reviewed by WRP and either deferred or approved at panel and final approval for reimbursement given 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
January -	£5,867,563.53

Circa £18.2 million

2.11 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.

2.12 RCA training includes the importance of the completion of LFERs in a timely manner, with the financial implications highlighted to staff.

Status

2.13 There are currently 83 Red/Amber deferred cases recorded on the Welsh Risk Pool system, of those 20 have gone over the 6 months extension deadline date and can be at risk of permanent deferral. With a further 42 due to hit the 6 month deadline.

2.14 The Legal Services team are working closely with Heads of Quality & Safety and governance teams to address these cases.

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 The Health Board is now beginning to realise the risk of submitting blank LFERs, as the number of Amber/Red deferred cases are increasing, with a risk of them eventually breaching the 6 months extension and becoming a risk of permanent deferral.

3.2 The new operating model for quality, safety and governance has built learning from events reports facilitation into the patient safety team. It is felt that sustainable improvements will be made in this area, when the new operating model is implemented.

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 October 2022 to 31 December 2022.
- **NOTE** the update in respect of the matter relating to the late submission of the WRP reimbursement claims.

Medical Negligence Payments 01/10/2022 - 31/12/2022							Appendix 1
Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimbursement £000	Total £000	Previous Write Offs £000	Cumulative £000
05RVEMN0022	0	0	0	-438	-438	463	25
10RYLMN0014	0	3	0	0	3	45	49
10RYLMN0078	103	1	0	0	104	335	440
12RYLMN0035	0	0	75	0	75	81	156
12RYLMN0037	0	1	0	0	1	230	231
12RYLMN0070	0	0	0	-56	-56	106	50
13RYLMN0005	0	-3	0	0	-3	22	20
14RYLMN0127	0	0	0	-1,391	-1,391	1,416	25
14RYLMN0200	0	0	32	-3,550	-3,518	3,575	57
15RYLMN0040	0	0	0	-20	-20	45	25
15RYLMN0109	0	0	0	0	0	25	25
15RYLMN0130	0	2	0	0	2	100	102
16RYLMN0040	0	0	0	-77	-77	102	25
16RYLMN0073	0	0	0	0	0	453	453
16RYLMN0089	20	0	0	0	20	397	417
16RYLMN0203	1	0	0	0	1	111	112
16RYLMN0205	0	2	0	-54	-52	1,356	1,304
17RYLMN0012	0	0	0	-74	-74	99	25
17RYLMN0115	0	0	0	-212	-212	237	25
17RYLMN0120	0	0	0	-169	-169	194	25
17RYLMN0122	0	0	350	0	350	41	391
18RYLMN0056	-7	0	0	0	-7	158	152
18RYLMN0076	0	0	0	0	0	25	25
18RYLMN0078	0	2	0	0	2	6	8
18RYLMN0085	65	2	0	0	67	128	195
18RYLMN0106	0	4	0	0	4	7	11
18RYLMN0109	0	0	0	-100	-100	125	25
18RYLMN0114	2	5	0	0	7	2	9
19RYLMN0006	0	0	0	-429	-429	454	25
19RYLMN0021	0	2	0	0	2	6	9
19RYLMN0024	9	1	0	0	11	43	54
19RYLMN0030	0	0	51	0	51	10	61
19RYLMN0056	0	0	0	-191	-191	301	110
19RYLMN0079	0	1	0	0	1	0	1
19RYLMN0083	13	0	48	0	61	59	120
19RYLMN0087	30	0	24	0	54	1	55
20RYLMN0005	45	3	0	0	48	354	401
20RYLMN0008	0	0	0	-341	-341	366	25
20RYLMN0009	42	1	-23	0	20	85	106
20RYLMN0014	0	0	52	0	52	0	52
20RYLMN0023	0	0	32	0	32	0	32
20RYLMN0030	0	0	7	0	7	47	54
20RYLMN0035	125	13	0	0	138	2,781	2,919
20RYLMN0037	0	3	0	0	3	0	3
20RYLMN0112	0	1	0	0	1	3	4
20RYLMN0116	10	0	20	0	30	56	86
20RYLMN0119	4	0	0	0	4	15	19
20RYLMN0121	50	3	450	0	503	6	508
20RYLMN0129	0	7	15	0	22	194	216
20RYLMN0163	23	0	0	0	23	47	70
20RYLMN0164	0	0	0	0	0	7	7
20RYLMN0170	0	2	0	0	2	7	9
20RYLMN0198	0	1	0	0	1	16	17

Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimbursement £000	Total £000	Previous Write Offs £000	Cumulative £000
21RYLMN0010	0	0	0	0	0	3	3
21RYLMN0024	0	0	0	0	0	37	37
21RYLMN0025	0	0	0	-13	-13	38	25
21RYLMN0028	0	3	0	0	3	0	3
21RYLMN0032	49	0	0	0	49	46	95
21RYLMN0034	0	3	0	0	3	0	3
21RYLMN0060	0	2	0	0	2	0	2
21RYLMN0077	50	2	100	0	152	1	154
21RYLMN0080	15	0	15	0	30	11	41
21RYLMN0090	2	0	0	0	2	17	18
21RYLMN0098	0	2	0	0	2	9	10
21RYLMN0099	0	1	0	0	1	74	75
21RYLMN0100	26	0	15	0	41	1	42
21RYLMN0115	0	0	15	0	15	1	16
21RYLMN0118	0	1	0	0	1	86	88
21RYLMN0119	0	14	0	0	14	3	17
21RYLMN0135	26	1	0	0	26	45	72
21RYLMN0147	0	0	0	0	0	5	5
22RYLMN0007	0	1	0	0	1	3	4
22RYLMN0008	0	3	0	0	3	3	6
22RYLMN0012	0	1	0	0	1	2	3
22RYLMN0036	0	5	55	0	60	6	67
22RYLMN0069	8	1	0	0	9	36	44
22RYLMN0073	0	1	0	0	1	4	4
22RYLMN0094	0	0	7	0	7	3	10
22RYLMN0111	0	1	0	0	1	1	2
22RYLMN0112	0	2	0	0	2	0	2
22RYLMN0113	0	2	0	0	2	14	16
22RYLMN0152	0	1	0	0	1	0	1
22RYLMN0154	0	2	0	0	2	0	2
22RYLMN0157	0	1	0	0	1	3	4
22RYLMN0161	0	5	0	0	5	0	5
22RYLMN0166	18	4	13	0	34	3	38
22RYLMN0168	0	11	0	0	11	0	11
22RYLMN0169	10	2	60	0	72	2	74
22RYLMN0172	0	2	0	0	2	0	2
22RYLMN0183	0	2	0	0	2	1	3
22RYLMN0188	9	0	0	0	9	2	11
23RYLMN0034	0	2	0	0	2	0	2
23RYLMN0040	0	1	0	0	1	0	1
23RYLMN0042	0	2	0	0	2	0	2
23RYLMN0048	0	5	0	0	5	0	5
23RYLMN0049	0	3	0	0	3	0	3
23RYLMN0051	0	5	0	0	5	0	5
23RYLMN0052	0	2	0	0	2	0	2
23RYLMN0061	0	3	0	0	3	0	3
23RYLMN0071	0	1	0	0	1	0	1
23RYLMN0072	10	0	20	0	30	0	30
23RYLMN0075	0	2	0	0	2	0	2
23RYLMN0103	0	0	0	0	0	0	0
23RYLMN0128	0	1	0	0	1	0	1
Total 01/10/2022 - 31/12/2022	**756**	**159**	**1,432**	**- 7,115**	**- 4,768**		
Total						**15,204**	**10,436**

Redress Payments 01/10/2022 - 31/12/2022							Appendix 2
Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimbursement £000	Total £000	Previous Write Offs £000	Cumulative £000
18RYLMN0124	0	9	0	0	9	4	12
19RYLMN0018	0	0	0	-21	-21	24	2
19RYLMN0090	0	2	0	0	2	1	3
19RYLMN0105	0	3	0	0	3	0	3
19RYLMN0124	2	0	0	0	2	24	26
20RYLMN0051	0	0	0	0	0	1	1
20RYLMN0065	2	0	0	0	2	8	10
20RYLMN0070	0	0	0	-14	-14	17	4
20RYLMN0077	0	0	0	-12	-12	14	2
20RYLMN0096	0	0	11	0	11	0	11
20RYLMN0146	2	4	0	0	5	0	5
20RYLMN0150	0	0	0	-0	-0	0	0
20RYLMN0159	0	0	0	-8	-8	10	2
20RYLMN0160	2	3	0	0	4	0	4
20RYLMN0161	2	0	14	0	16	1	17
20RYLMN0176	0	1	18	0	19	1	19
20RYLMN0187	0	3	0	0	3	1	4
20RYLMN0189	0	0	6	0	6	0	6
20RYLMN0206	2	0	5	0	7	0	7
20RYLMN0209	0	0	0	-6	-6	8	2
21RYLMN0001	2	2	15	0	19	0	19
21RYLMN0037	0	2	0	0	2	0	2
21RYLMN0042	0	0	7	0	7	0	7
21RYLMN0046	2	0	0	0	2	2	4
21RYLMN0053	0	1	0	0	1	1	2
21RYLMN0069	0	2	0	0	2	0	2
21RYLMN0070	0	0	0	-1	-1	3	2
21RYLMN0091	3	1	0	0	4	4	8
21RYLMN0102	0	0	-1	0	-1	1	0
21RYLMN0126	0	0	0	-1	-1	1	0
21RYLMN0142	0	0	0	-2	-2	4	2
21RYLMN0153	0	0	0	-3	-3	5	2
22RYLMN0026	0	4	0	0	4	0	4
22RYLMN0030	0	0	0	0	0	0	0
22RYLMN0080	0	0	0	-2	-2	2	0
22RYLMN0082	0	0	0	0	0	0	0
22RYLMN0087	0	0	0	-5	-5	6	2
22RYLMN0107	2	5	0	0	6	0	6
22RYLMN0118	2	0	25	0	27	0	27
22RYLMN0134	0	0	0	0	0	11	11
22RYLMN0179	0	1	0	0	1	0	1
22RYLMN0194	0	0	0	0	0	0	0
22RYLMN0196	2	0	0	0	2	1	2
23RYLMN0018	0	0	0	-1	-1	1	0
23RYLMN0026	0	2	0	0	2	0	2
23RYLMN0060	0	0	4	0	4	0	4
23RYLMN0092	0	0	1	0	1	0	1

23RYLMN0111	0	0	2	0	2	0	2
23RYLMN0130	0	0	0	0	0	0	0
23RYLMN0132	0	0	0	0	0	0	0
23RYLMN0145	0	0	5	0	5	0	5
Total 01/10/2022 - 31/12/2022	**20**	**46**	**110**	**-75**	**101**		
Total						**156**	**258**

GP Indemnity Payments 01/10/2022 - 31/12/2022							Appendix 3
Case Reference	**Costs £000**	**Defence Fee £000**	**Claims £000**	**WRP reimbursement £000**	**Total £000**	**Previous Write Offs £000**	**Cumulative £000**
22RYLMN0192		3			3	0	3
Total 01/10/2022 - 31/12/2022	**0**	**3**	**0**	**0**	**3**		
Total						**0**	**3**

Personal Injury Payments 01/10/2022 - 31/12/2022

Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimbursement £000	Total £000	Previous Write Offs £000
15RYLPI0047	0	0	0	-47	-47	72
18RYLPI0010	0	0	0	0	0	44
18RYLPI0031	10	0	0	0	10	11
19RYLPI0009	9	7	0	0	16	5
19RYLPI0030	0	1	0	0	1	1
20RYLPI0006	0	5	0	0	5	14
20RYLPI0008	0	2	0	0	2	0
20RYLPI0016	0	1	0	0	1	0
20RYLPI0022	0	0	6	0	6	1
20RYLPI0024	0	4	0	0	4	22
20RYLPI0029	0	2	0	0	2	0
20RYLPI0050	0	0	7	0	7	0
21RYLPI0009	19	2	0	0	21	9
21RYLPI0011	0	5	0	0	5	30
21RYLPI0015	0	3	0	0	3	0
21RYLPI0017	7	0	4	0	11	2
21RYLPI0021	0	2	0	0	2	3
21RYLPI0028	0	3	0	0	3	16
21RYLPI0034	0	0	0	0	0	6
21RYLPI0036	0	0	0	0	0	1
21RYLPI0041	0	0	0	0	0	2
21RYLPI0042	60	2	0	0	62	30
21RYLPI0046	5	1	1	0	7	1
22RYLPI0003	0	0	0	0	0	3
22RYLPI0004	0	0	0	0	0	12
22RYLPI0005	0	0	0	0	0	1
22RYLPI0014	0	0	0	0	0	0
22RYLPI0017	0	0	0	0	0	1
22RYLPI0019	2	1	4	0	7	1
22RYLPI0022	0	0	0	0	0	1
22RYLPI0024	1	0	1	0	3	0
22RYLPI0025	0	0	0	0	0	1
22RYLPI0027	0	0	0	0	0	0
22RYLPI0028	0	0	1	0	1	1
22RYLPI0030	5	0	0	0	5	1
22RYLPI0034	0	0	0	0	0	0
22RYLPI0035	0	1	0	0	1	5
22RYLPI0037	0	0	0	0	0	0
22RYLPI0038	0	0	0	0	0	0
22RYLPI0040	0	0	0	0	0	0
22RYLPI0041	0	1	0	0	1	1
22RYLPI0042	0	0	0	0	0	0
22RYLPI0043	0	0	0	0	0	0
22RYLPI0044	0	0	0	0	0	0
23RYLPI0002	0	1	0	0	1	0
23RYLPI0003	0	0	0	0	0	0
23RYLPI0004	0	0	0	0	0	0

23RYLPI0005	0	0	0	0	0	0
23RYLPI0006	0	0	0	0	0	0
23RYLPI0007	0	0	0	0	0	0
23RYLPI0008	0	0	0	0	0	0
23RYLPI0010	0	0	0	0	0	0
23RYLPI0011	0	1	0	0	1	0
23RYLPI0013	0	0	0	0	0	0
23RYLPI0014	0	0	0	0	0	0
23RYLPI0016	0	0	0	0	0	0
23RYLPI0017	0	0	0	0	0	0
23RYLPI0019	0	0	0	0	0	0
23RYLPI0020	0	0	0	0	0	0
23RYLPI0021	0	0	0	0	0	0
23RYLPI0023	0	-12	0	0	-12	12
23RYLPI0024	0	0	0	0	0	0
23RYLPI0026	0	1	0	0	1	0
23RYLPI0027	0	0	0	0	0	0
23RYLPI0028	0	0	0	0	0	0
23RYLPI0029	0	0	0	0	0	0
23RYLPI0030	0	0	0	0	0	0
23RYLPI0031	0	0	0	0	0	0
23RYLPI0037	75	0	0	0	75	0
Total 01/10/2022 - 31/12/2022	**193**	**45**	**23**	**-47**	**214**	
Total						**311**

Appendix 4
Cumulative £000
25
44
21
21
2
19
2
1
6
26
2
7
30
35
3
12
5
18
6
1
2
92
8
4
12
1
1
1
8
1
3
1
1
1
6
1
6
1
1
1
2
1
1
1
1
1
1

0
0
1
1
1
1
1
0
0
0
0
0
0
0
0
0
1
0
0
0
0
0
75
525

Permanent Injury Benefit 01/10/2022 - 31/12/2022

Appendix 5

Laspar Number	In period Payments £000	Previous Write-Offs £000	Cumulative £000
01RRSPI0020	4	234	238
02RVEPI0001	2	64	66
02RVEPI0003	3	171	174
02RVEPI0004	2	117	119
03RRSPI0020	12	838	851
03RVEPI0028	3	258	261
04RRSPI0009	4	227	230
04RRSPI0024	3	157	160
05RRSPI0020	1	77	79
05RRSPI0021	3	187	191
05RVEPI0033	5	287	292
05RVEPI0034	1	84	86
08RVEPI0009	3	185	189
10RYLPI0070	2	105	107
11RYLPI0065	5	238	244
12RYLPI0059	2	71	73
13RYLPI0020	1	37	38
13RYLPI0050	3	139	142
98RVEPI0005	0	7	7
19RYLPI0022	11	296	307
20RYLPI0032	3	34	37
20RYLPI0033	1	15	16
20RYLPI0034	2	23	25
20RYLPI0035	5	69	74
20RYLPI0036	4	47	51
20RYLPI0037	1	16	17
20RYLPI0038	3	39	42
20RYLPI0039	2	29	31
20RYLPI0040	6	72	78
20RYLPI0041	4	48	52
20RYLPI0042	2	23	25
Total 01/10/2022 - 31/12/2022	**103**		
Total		**4,196**	**4,300**

Other Payments 01/10/2022 - 31/12/2022			Appendix 6
Case Reference	**Type**	**Details**	**Amount £000**
23RYLEG0181	Ex-Gratia	Damages to Personal Effects	0.70
23RYLEG0182	Ex-Gratia	Damages to Personal Effects	0.50
23RYLEG0183	Ex-Gratia	Loss of Personal Effects	0.90
23RYLEG0204	Ex-Gratia	Loss of Personal Effects	2.50
22RYLEG0061	Ex-Gratia	Retirement Gratuity	-0.31
22RYLEG0128	Ex-Gratia	Retirement Gratuity	-0.40
22RYLEG0140	Ex-Gratia	Retirement Gratuity	-0.38
22RYLEG0250	Ex-Gratia	Retirement Gratuity	0.06
23RYLEG0037	Ex-Gratia	Retirement Gratuity	-0.33
23RYLEG0184	Ex-Gratia	Retirement Gratuity	0.35
23RYLEG0185	Ex-Gratia	Retirement Gratuity	0.37
23RYLEG0186	Ex-Gratia	Retirement Gratuity	0.25
23RYLEG0187	Ex-Gratia	Retirement Gratuity	0.33
23RYLEG0188	Ex-Gratia	Retirement Gratuity	0.28
23RYLEG0189	Ex-Gratia	Retirement Gratuity	0.26
23RYLEG0190	Ex-Gratia	Retirement Gratuity	0.48
23RYLEG0190	Ex-Gratia	Retirement Gratuity	-0.48
23RYLEG0191	Ex-Gratia	Retirement Gratuity	0.25
23RYLEG0192	Ex-Gratia	Retirement Gratuity	0.31
23RYLEG0193	Ex-Gratia	Retirement Gratuity	0.36
23RYLEG0194	Ex-Gratia	Retirement Gratuity	0.26
23RYLEG0195	Ex-Gratia	Retirement Gratuity	0.33
23RYLEG0196	Ex-Gratia	Retirement Gratuity	0.37
23RYLEG0197	Ex-Gratia	Retirement Gratuity	0.42
23RYLEG0198	Ex-Gratia	Retirement Gratuity	0.23
23RYLEG0199	Ex-Gratia	Retirement Gratuity	0.42
23RYLEG0200	Ex-Gratia	Retirement Gratuity	0.39
23RYLEG0201	Ex-Gratia	Retirement Gratuity	0.24
23RYLEG0202	Ex-Gratia	Retirement Gratuity	0.20
23RYLEG0203	Ex-Gratia	Retirement Gratuity	0.39
23RYLEG0205	Ex-Gratia	Retirement Gratuity	0.33
23RYLEG0206	Ex-Gratia	Retirement Gratuity	0.20
23RYLEG0207	Ex-Gratia	Retirement Gratuity	0.36
23RYLEG0208	Ex-Gratia	Retirement Gratuity	0.40
23RYLEG0209	Ex-Gratia	Retirement Gratuity	0.35
23RYLEG0210	Ex-Gratia	Retirement Gratuity	0.41
23RYLEG0211	Ex-Gratia	Retirement Gratuity	0.37
23RYLEG0212	Ex-Gratia	Retirement Gratuity	0.31
23RYLEG0213	Ex-Gratia	Retirement Gratuity	0.24
23RYLEG0214	Ex-Gratia	Retirement Gratuity	0.26
23RYLEG0215	Ex-Gratia	Retirement Gratuity	0.25
23RYLEG0216	Ex-Gratia	Retirement Gratuity	0.38
23RYLEG0217	Ex-Gratia	Retirement Gratuity	0.29
23RYLEG0218	Ex-Gratia	Retirement Gratuity	0.35
23RYLEG0219	Ex-Gratia	Retirement Gratuity	0.22
23RYLEG0220	Ex-Gratia	Retirement Gratuity	0.39
23RYLEG0221	Ex-Gratia	Retirement Gratuity	0.44

23RYLEG0222	Ex-Gratia	Retirement Gratuity	0.48
23RYLEG0223	Ex-Gratia	Retirement Gratuity	0.35
23RYLEG0224	Ex-Gratia	Retirement Gratuity	0.34
23RYLEG0225	Ex-Gratia	Retirement Gratuity	0.35
23RYLMN0146	Ombudsman	Damages	0.50
23RYLMN0149	Ombudsman	Damages	0.50
23RYLMN0151	Ombudsman	Damages	0.05
23RYLMN0171	Ombudsman	Damages	0.82
23RYLMN0187	Ombudsman	Damages	0.25
23RYLBD0001	Bad Debts	Inv 99232	0.48
23RYLBD0002	Bad Debts	Inv 15324	1.21
23RYLBD0003	Bad Debts	Inv 23723	2.31
Total 01/10/2022 - 31/12/2022			**22.43**

AGENDA ITEM
4.3

AUDIT & RISK COMMITTEE

PROCUREMENT & SCHEME OF DELEGATION REPORT

Date of meeting	13/02/2023
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	FOR NOTING

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 01.11.22 to 31.12.22.

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 01.11.22 to 31.12.22.

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 01.11.22 to 31.12.22

Table A – Single Tender Actions 01.11.22 to 31.12.22

STA	Revenue / Capital	Division	Contract description	Supplier	Contract Value Exc. VAT	Reason for approval	Date Returned
1631	Revenue	Primary Care	Psychosocial Substance Misuse Services Adult and Child	Dyfodol	£305,946	d)	14/12/22
1633	Revenue	Continuing Health Care	D2RA Assessment beds	Hafod	£99,000	c)	23/12/22
1634	Revenue	Facilities	Provision of 4x4 Vehicles	Vale Car and Van Rental	£48,356	a)	14/12/22

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 1631- Psychosocial substance misuse service for adult and children at HMP & YOI Parc

Cwm Taf Morgannwg is taking over the healthcare arrangements for Parc Prison. The responsibility for the provision of psychosocial substance misuse service within HMP & YOI Parc is transferring to the health board on 15th December 2022. G4S Care & Justice Ltd are the current service providers. To ensure continuity of services and safety of patients, a contract is required for a 6-month period until June 2023. Due to the timescales required to run a competitive tender exercise, putting a contract in place with the current service provider is the safest option to ensure continuity of service. A full competitive tender process will be undertaken in the next 6 months.

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

T820 - Dental Services Bridgend, supplier - BDS Dentist Ltd, contract value £5,670,000, approval received 06.12.22

2.2 Purchase to Pay (P2P)

The PSPP figures are reported to 31 December 2022.

The Health Board has seen an improvement in the PSPP figures and has now met its 95% target of paying non-NHS invoices within 30 days to Month 9 2022-23 achieving 95% (value 94.7%). This compares to 95.1% (value 93.7%) to Month 10 2021-22.

For the month of December 98.2% was achieved. This is a vast improvement on September and October and if the value was to continue would achieve the target at the end of the year.

	0 - 30 Days		Total		%	
	Number	Value	Number	Value	Number	Value
Apr-22	20,647	46,892,657	21,591	49,645,760	95.63	94.45
May-22	19,164	43,532,576	19743	46,362,084	97.1	93.9
Jun-22	25,837	43,403,990	26,643	45,600,115	97.0	95.2
Jul-22	17,575	36,530,389	18,763	39,107,080	93.7	93.4
Aug-22	25,146	40,095,837	26,158	41,905,798	96.1	95.7
Sept-22	15,918	39,219,002	18,482	42,990,714	86.1	91.2
Oct-22	15,351	38,682,833	17,368	41,866,683	88.4	92.4

Nov-22	27,922	61,257,428	28,615	63,769,737	97.6	96.1
Dec-22	28,547	67,160,694	29,076	68,973,282	98.2	97.4
YTD	196,107	416,775,406	206,439	440,221,253	95.0	94.7

The NHS invoice position continues to be challenging and shows that 84.7% (number) and 75.9% (value) of invoices were paid within 30 days to month 10 2022-23. (78.4% (number) and 70.4% (value) for the same period in 2021-22).

Scheme of Delegation and Financial Control Procedures

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

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

3.1 N/A

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined 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

The Audit & Risk Committee is asked to:

a) **NOTE** the position on procurement matters for the period 01.11.22 to 31.12.22;

b) **NOTE** the update regarding Purchase to Pay and achievement of PSPP target.

AGENDA ITEM
5.1

AUDIT & RISK COMMITTEE

ORGANISATIONAL RISK REGISTER

Date of meeting	13 February 2023

FOI Status	Open

If closed please indicate reason	Not a applicable public meeting

Prepared by	Cally Hamblyn, Assistant Director of Governance & Risk
Presented by	Cally Hamblyn, Assistant Director of Governance & Risk
Approving Executive Sponsor	Paul Mears, 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	December 2022 / January 2023	RISKS REVIEWED
Executive Leadership Group	16.1.2023	RISKS REVIEWED AND MANAGEMENT SIGN OFF RECEIVED
Quality & Safety Committee	24.1.2023	ASSIGNED RISKS REVIEWED
Health, Safety & Fire Sub Committee	7.2.2023	ASSIGNED 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 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: Realignment to complete by 31.1.2023. Assistant Director of Governance and Risk and COO Team met with each Care Group Leadership Group to review and agree assigned risks on the Organisational Risk Register.

2.2 Care Group Directors have undertaken the initial alignment of risks on the Organisational Risk Register to the new Care Group model and are in the process of undertaking detailed reviews on risks assigned to their areas.

2.3 Service / Winter pressures along with planning to respond to the impact of Industrial Action has posed significant challenges which should be recognised in light of the ability to keep pace with the timeframes to undertake this review and update risks this period.

2.4 The Assistant Director of Governance & Risk and Chief Operating Officer are holding a workshop with Executive Leads in January 2023 to review the Organisational Risk Register in terms of consistency of risk scoring, robustness of narrative and review of actions being taken to mitigate risks.

2.5 Monthly Risk Management Awareness Sessions (Virtually via Teams). The monthly sessions are set in the calendar until the end of 2023. 369 members of staff trained to date.

2.6 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

Diagnostics, Therapies and Specialties Care Group

- Datix ID 3131 - Mortuary Capacity. Risk scored at a 20.
- Datix ID 2721 - Capacity to deliver POCT training to Health Board Nursing Staff. Risk scored at a 16.
- Datix ID 5323 - Fluoroscopy Room has become Obsolete. Risk scored at a 15.

3.2 CHANGES TO RISKs

a) Risks where the risk rating INCREASED during the period

Patient Care & Safety

- Datix ID 5267 - There is a risk to the delivery of quality patient care due to difficulty recruiting & retaining sufficient numbers of nurses. 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 16 to a 9.

Rationale is captured in Appendix 1.

3.3 CLOSED RISKS FROM THE ORGANISATIONAL RISK REGISTER

People and Culture Directorate

- Datix ID 4679 - Absence of a TB vaccination programme for staff. Target score reached and risk closed.

All Care Groups

- Datix ID 4253 – Ligature Points – Inpatient Services.

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

3.4 DISCUSSION POINTS

Changes to Risks

The Executive Medical Director is initiating a review of Datix Risk ID 4590 - Critical Care Pharmacist Resource and Datix Risk ID 5214 - Critical Care Medical Cover, with the view to amalgamate these two risks.

Emerging Risks

As part of the review of current risks following alignment to the new Operating Model new risks and changes to risks are in development to come forward to a future iteration of the Organisational Risk Register.

Cyber Risks
Due to the potential vulnerabilities of publishing detail on the cyber risks facing the Health Board these risks have been removed from the public report and will be considered in the private "In Committee" meeting.

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

Consequence						
	5			3337 4768 4772 2987 3993 5323	5254 4080 3826 4887 5214	
	4				4149 4458 4148 4337 3008 4743 4798 4906 4908 4809 5014 4722 4753 4152 3585 3133 2787 1133 4752 4922 4479 4940 4315 4417 2721	4491 4632 4071 4721 4103 4841 4827 5153 5154 5036 4907 4780 4922 5267 3131
	3					3638 4691 4732 4920 5207 4971 4699 4672 4512 4590 4691 2808 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
3131	Chief Operating Officer	Diagnostics, Therapies and Specialties Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Mortuary Capacity	**IF:** There is insufficient Mortuary capacity across the Health Board, including bariatric capacity **THEN**: the Health Board will be unable to accommodate any increases in deaths (due to seasonal pressures, pandemics, general increases in service demand), and may exceed capacity in the event of Mortuary closure or refrigeration failure, or funeral directors/undertakers being unable to collect bodies or move bodies between sites due to adverse weather. **RESULTING IN:** bodies not being placed in storage that is in compliance with HTA licencing standards, No capacity for bariatric bodies, leading to HTA reportable incidents, complaints and reputational damage.	Mortuary capacity log is in operation and informs the pathology scorecard for monthly reporting (average, max and min). Business continuity plan is in place to move bodies around the sites to ensure capacity is maintained within the HB. This relies on the Health Boards contracted funeral director to move the bodies in an appropriate and dignified manner. Mortuary staff are trained to complete the mortuary capacity log on a daily basis and to ensure the business continuity plan is executed in the event of likely capacity issues. Nutwell units in use at Royal Glamorgan Hospital (RGH) and Prince Charles Hospital (PCH) "Real time" capacity white board installed in both mortuaries so porters/APTs can visualise quickly capacity issues. Private ambulance with a dedicated driver, now in use between sites. 4X4 vehicle so can be used during inclement weather (within reason). Can transport up to 4 deceased per journey, in a dignified manner.	Long Term Mortuary Capacity Plan. (5 year lease of additional capacity based at PCH has been approved by Executive leadership team in November 2022. Additional unit delivered and preparation and equipping underway to go live by the end of January.) Ongoing discussions with the Coroner have resulted in a 1 year reprieve of post mortems by CTM staff but continuing use of Mortuary space at PCH for external Medical examiners to use from January 2023. SLA being drawn up. Plan to implement electronic white boards for mortuaries in 2023-24.	Quality & Safety Committee	20	C4xL5	C3xL2	New risk escalated to the Org Risk Register in January 2023	05.03.2018	05.1.2023	5.2.2023
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:** the new Laboratory Information Management System (LIMS) service is not fully deployed before the contract for the current LIMS expires in June 2025. **THEN:** operational delivery of pathology services may be severely impacted. **RESULTING IN** potential delays in treatments, affecting the quality and safety of a broad spectrum of clinical services and the potential for financial and workforce impact.	Currently LINC Programme reports progress against timeline to LINC Programme Board and Chief Executive Group. Business continuity options are being explored including extending the contract for the current LIMS to cover any short term gap in provisions. An expert stock take review of the LINC programme has been completed with findings presented to Collaborative Executive Group (CEG) to inform next steps.	A provision will be added to the current legacy contract for a short-term extension until September 2025; this has been agreed in principle but not yet been formally implemented. A set of additional contract milestones to the new system supplier will be included in the contract change notice (CCN) for hosting; the hosting CCN has been agreed subject to Ministerial approval. The LINC programme is working with Health Boards and Trusts to review the new system suppliers revised delivery plan. There has been several meetings between Health Boards, LINC Programme and Commercial Providers. At a meeting held on the 13th December it was agreed by NHS that deployment would be sequential and in the original running order. Health Board configuration meeting scheduled with Commercial supplier for 10th January 2023.	Digital & Data Committee Quality & Safety Committee	20	C5xL4	5 (C5xL1)	↔	26.10.2022	03.01.2023	31.01.2023
5254	Executive Director of Nursing.	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. Update December 2022: Invest to save bid unsuccessful, therefore alternative options for funding being explored. National impact assessment is being developed, which will be reviewed and localised for CTM. New operating model, should give some limited capacity, however, focus will be to target the backlogs within the department.	Quality & Safety Committee	20	C4xL5	8 (C4xL2)	↔	07.10.2022	19.12.2022	31.01.2023
4922	Director of Corporate Governance Interim - Executive Director of Nursing	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 or 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. Update December 2022 - The Covid-19 Information Manager position was re-advertised in December for shortlisting in the New Year. Whilst the success of this latest recruitment exercise is unknown the risk score will remain unchanged. Review 31.1.2023.	Quality & Safety Committee	20	C4xL5	8 (C4xL2)	↔	23.11.2021	20.12.2022	31.01.2023
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 Tontegi 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. Next review scheduled for the 31.01.2023.	Health Safety & Fire Sub Committee	20	C4 x L5	4 C2xL2	↔	06.08.2021	30.11.2022	31.01.2023
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	Retrieval and filing of case notes in the POW Medical Records Library	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 failing 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. Timeframe 31.07.2023 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. Update January 2023 - Relocation of Case Notes Action: 30,000 case notes relocated to Glanrhyd. This action was closed 16.12.2022.	Digital & Data Committee & Quality & Safety Committee	20	C5xL4	10 C5xL2	↔	27.10.2021	16.12.2022	30.01.2023

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
4827	Executive Director for People	Central Support - Health, Safety & Fire Safety Function	Head of Health, Safety & Fire	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	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 e.g. 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. Next review due 31.1.2023.	Health Safety & Fire Sub Committee	20	C4xL5	9 C3xL3	↔	01.02.2021	30.11.2022	31.01.2023
4491	Chief Operating Officer	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	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. Update 3rd Jan 2023. The funding position for 22/23 in relation to Exceptional items and ongoing Covid -19 response costs has now been clarified by WG. The forecast Core plan overspend for 22/23 at M8 is still £26.5m and there is no change to the risk score.	Planning, Performance & Finance Committee	20	C4 x L5	12 C4 x L3	↔	8.7.22	3.1.2023	01.3.2023
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. Update 3rd Jan 2023 - The M8 YTD position is a £18.0m deficit. This represents a £0.3m adverse variance compared to 8/12th of the £26.5m Core plan deficit (£17.7m). The M8 Savings position is forecasting £17.5m of Savings in 22/23 but only £10.6m on a Recurrent basis. (Savings target for 22/23 = £17.3m). The forecast underlying recurrent deficit at 31/3/23 is now £47.6m. This position represents a £19.6m deterioration from the planned recurrent deficit of £28.0m and includes: forecast shortfalls in recurrent savings delivery in 22/23 (£6.7m) and forecast recurrent overspends in Care Groups and directorates (£11.0m). The key actions are to further develop the savings planning/recovery planning processes via the Value and Efficiency programme and the Financial Plan for 2023/24.	Planning, Performance & Finance Committee	20	C4 x L5	12 C4 x L3	↔	8.7.22	3.1.2023	01.3.2023
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 Impact on the safety – Physical and/or Psychological harm	Failure to sustain services as currently configured to meet cancer targets.	**IF:** The Health Board fails to sustain services as currently configured to meet cancer targets. **Then:** The Health Boards ability to provide safe high quality care will be reduced. **Resulting in**: Compromised safety of patients, potential avoidable harm due to waiting time delays for treatment.	• Tight management processes to manage individual cases on the cancer Pathway. • Regular reviews of patients who are paused on the pathway as a result of diagnostics or treatment not being available. To ensure patients receive care as soon as it becomes available. • Regular Quality impact assessments with the MDTs, to understand areas of challenge and risk • Harm review process to identify patients with waits of over 104 days and potential pathway improvements. • Initiatives to protect surgical capacity at the Vale hospital for ASA 1+2 level patients until alternatives become available. • All three 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 rigours 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.	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. Update December 2022 - Score remains unchanged. Health Board is now in targeted intervention for cancer. Additional assurance meeting with WG, WCN and DU underway. New cancer assurance cycle from November 2022 embedding. 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. Referral rates are higher than pre Covid, but reducing from their highest levels. Challenges remain with diagnostic capacity, short term outsourcing has improved wait times, but longer term solution needed. The mobile endoscopy unit is also providing additional capacity, and reducing waiting times, but a longer term solution is required for after this. 104+ day harm review panels are paused on two sites, recruitment underway for administration support to recommence.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4 x L5	12 (C4 x L3)	↔	01/04/2014	23.12.2022	31.1.2023

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 Impact on the safety – Physical and/or Psychological harm	Failure to recruit sufficient medical and dental staff	**If:** the CTMUHB fails to recruit sufficient medical and dental staff. **Then:** the CTMUHB's ability to provide high quality care may be reduced. **Resulting in:** a reliance on agency staff, disrupting the continuity of care for patients and potentially effecting team communication. This may effect patient safety and patient experience. It also can impact on staff wellbeing and staff experience.	• Associate Medical Director for workforce appointed July 2020 • Recruitment strategy for CTMUHB being drafted • Establishment of medical workforce productivity programme • Work to understand workforce establishment vs need • Development of 'medical bank' • Developing and supporting other roles including physicians' associates, ANPs .Improving induction and development of new doctors	In terms of recruitment the following actions are underway over the next 6-12 months: • Meeting with Executive Director for People held on 24.11.2022 to discuss Medical Workforce (MWF) recruitment (including PAs, Specialist's) • Liaising with Care Group Medical Directors regarding their Care Group workforce planning and strategy • Once the Health Board identifies the gaps from the Medical Workforce Productivity Programme group on the establishment work stream it can then target specific areas with either Consultant, Specialist, MG cover • A report is also being prepared on British Association of Physicians of Indian Origin (BAPIO) for international recruitment.	Quality & Safety Committee People & Culture Committee	20	C5 x L4	15 (C5xL3)	↔	01.08.2013	24.11.2022	31.1.2023
4103	Chief Operating Officer	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Sustainability of a safe and effective Ophthalmology service	**IF**: The Health Board fails to sustain a safe and effective ophthalmology service. **Then:** The Health Boards ability to provide safe high quality care will be reduced. **Resulting in:** Sustainability of a safe and effective Ophthalmology service	Measure and ODTC DU reviews nationally. . Clinical staffing structure stabilised and absence reduced (new consultant, nurse injectors, ODTC's, weekend clinics). . On going monitoring in place with regards RTT impact of Ophthalmology. . In line with other services, to meet the RTT requirement services are being outsourced - maintaining this level of performance will be challenging going forward. . Additional funding for follow up appointments provided and significant outsourcing undertaken (6,500 cases) with harm review piloting to assess all potential harms. . Additional services to be provided in Community settings through ODTC (January 2020 start date). . Intravitreal injection room x2 established with nurse injectors trained. Follow up appointments not booked being closely monitored and outsourcing enactioned. Regular updates re follow up appointments not booked being monitored by Management Board / Q&SR (patient safety issues) and Finance, Performance and Workforce Committee (performance issues). Reviewing UHB Action Plan in light of more recent WAO follow up review of progress. Primary and Secondary Care working Groups in place. Ophthalmology Planned care recovery group established overseeing a number of service developments: WLI clinics, outsourcing of Cataract patients, development of an ODTC in Maesteg Hospital, implementation of Glaucoma shared care pathway, implementation of Diabetic Retinopathy shared care pathway, regional work streams, trial of new Glaucoma procedure (IMS), streamlining pathways. Quality and Performance Improvement Manager post created to provide dedicated focus, detailed demand and capacity analysis being undertaken. All patients graded according to the WG risk stratification R1, R2, R3. Additionally, several specific waiting lists are further risk stratified to ensure that the highest risk patients are prioritised.	November 2022 update: WLI activity commenced W/C 11th November in an attempt to clear the >104 week backlog, primarily for stage 1 long waiting cataracts. Ongoing clinical and non-clinical validation work is being carried out on all pathway stages with a number of patients being removed as treated or no longer requiring treatment. An application has been made to the Governance Board to appoint an extended nursing team specifically for harm reviews - awaiting outcome. Nursing review is being carried out to measure utilisation and productivity. Ongoing discussion with Cardiff &Vale in relation to using the Vanguard theatres between January and March 2023. Revised SOP shared with community optometrist to consider carrying out new patient glaucoma referrals - awaiting SEWROC outcome. COO and MD met with the Ophthalmologist to outline future plans and expectations. Update December 2022 - There has been a significant decrease in >104 week stage 1 waiting list subsequent to additional weekend activity. At the beginning of November 2022 we were reporting 1869 RTT cases >104 weeks, The Health Board has carried out 66 additional sessions, primarily addressing cataracts and General Ophthalmology. Scheme extended into January. Consequent to this piece of work, all stage 1 cataract conversions will be sent to C&V during February and March for assessment and procedure. C&V are providing capacity for 500 stage 4 patients, CTM currently have 228 stage 4 conversions >104 weeks and this number will increase whilst we continue with the weekend activity. Validation work is being carried out in tandem with the booking of weekend work and RTT rules. Progress has been made with the regional programme, an Option Appraisal presentation has been circulated to all HB's to include 6 delivery models for local preference ranking. All options are being explored and evaluated against a set of agreed criteria.	Quality & Safety Committee	20	C4 x L5	12 C4 x L3	↔	01/04/2014	23.12.2022	30.1.2023
4632	Executive Director of Therapies and Health Sciences.	Unscheduled Care Group	Head of Strategic Planning and Commissioning	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Provision of an effective and comprehensive stroke service across CTM (encompassing prevention, early intervention, acute care and rehabilitation)	**IF:** changes are not made to improve and align stroke prevention initiatives, early intervention campaigns, and acute and rehabilitation stroke care pathways across CTM **THEN:** avoidable strokes may not be prevented, patients who suffer a stroke may miss the time-window for specialist treatments (thrombolysis, thrombectomy), and patients may not receive timely, high-quality, evidence-based stroke care **RESULTING In:** higher than necessary demand for stroke services, poorer patient outcomes/increased disability, increased length of stay, and poor patient/carer experience. Impact will extend to the need for increased packages of care, increased demand for community health services, and increased carer burden when discharged to the community.	• Executive-led Stroke Strategy Group in place, with targeted task and finish under development. • 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 3.1.2023 -** Recruitment process ongoing as part of CTM Consultant Recruitment Drive. The CSGs continue to work with medical staffing agencies to aid the recruitment of a Locum Consultant following the resignation of Consultant Stroke Physician at Prince Charles Hospital. Development of a CTM stroke consultant rota, with joint working between PCH and POW consultants to enable a more stable rota. Continued dialogue with Cardiff and Vale UHB to look at long term solutions, feeding into the South Wales Central Regional Programme Board. •Regional developments with Cardiff and Vale UHB continue, with a further meeting of the regional programme board held on 22nd November. Key links being established to the National Stroke Programme Board to ensure congruence between the national stroke programme and the South Wales Central stroke network programme. •Fortnightly Stroke Pathway Task and Finish Group meetings continue. Review of priorities and risks undertaken within the Task & Finish meetings, nominated leads identified and priority actions are 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. •CTM Stroke Strategy Group established to drive forward the strategic development of stroke services across CTM UHB, with work streams for acute stroke and rehabilitation care pathways and early intervention/prevention. First meeting of strategy group took place 8th December and moving forward will receive updates and assurance from Task and Finish Groups. •Work is underway in CTM UHB in preparation for forthcoming 24/7 access to Thrombectomy at Bristol. This includes plans to get radiographer approved CT angiograms at same time as plain CT scans, to minimise delays in suitable patients, and CT reports (including out of hours) within 30 minutes, together with planned additional training for middle grade doctors. •National relaunch of FAST campaign planned by the Stroke Association. Local plans to raise awareness amongst those at high risk of stroke in primary care being developed by Public Health Wales in conjunction with primary care colleagues.	Quality & Safety Committee	20	C4 x L5	12 (C4 x L3)	↔	05.07.2021	3.1.2023	31.1.2023
4743	Chief Operating Officer	All Care Groups	Deputy COO (Acute Services)	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	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 Ty Llidiard 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
5036 Link to RTE 5155	Chief Operating Officer	Diagnostics, Therapies and Specialties Care Group	Service Director - Diagnostics, Therapies and Specialties Care Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	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. 10. Suboptimal care for Haematology cancer patients	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 19.10.2022: Outsourcing continues to LDPath - incidents/complaints regarding delays have been received POCT training room is now being used for IHC Some new equipment has been Recruitment drive and capacity planning continues. Update 30.12.2022 Outsourcing to continue in Q4, backlog clearance has helped reduce internal turnaround time for cancer diagnostics to around 10 days (with exception of complex sampling) some serious incidents have been reported through from what was expected to be routine samples but have returned and confirmed cancer samples (gynaecology). Macmillan have supported a 3 year post for haematology. Service Director awaiting response from Executive colleagues regarding sustainable funding post 2026 from SLA repatriation. Bid to continue use of LD Path outsourcing being prepared for 2023-2024 while regional collaboration discussions progress in tandem. Improvement team have been approached to undertake a process mapping exercise to see if we can "lean out" the processes in cellular pathology and haematology. In addition Wales Cancer Network has been approached to support Demand and capacity as internal resource are not adequate to assist in a timely fashion.	Quality & Safety Committee	20	C4 x L5	6 (C3xL2)	↔	02.03.2022	30.12.2022	31.01.2023

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3826 Linked to 4839 and 4841 in Bridgend Linked to 4462	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director - Unscheduled Care.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Emergency Department (ED) Overcrowding	**If:** As a result of exit block due to hospital capacity and process issues patients spend excess amounts of time within the Emergency Department. This is manifested by, but not limited, to significant 12 hour breaches currently in excess of 400 per month. There are also large numbers of patients spending longer than 24hrs and 48hrs within the ED (please see attached information). **Then:** patients are therefore placed in non-clinical areas. **Resulting In:** Poor patient experience, compromising dignity, confidentiality and quality of care. The ability for timely ambulance handover with extensive delays for patients requiring assessment and treatment. Filling assessment spaces compromised the ability to provide timely rapid assessment of majors cases; ambulance arrivals and self presenters. Filling the last resus space compromises the ability to manage an immediate life threatening emergency. Clinicians taking increasing personal risk in management of clinical cases. Environmental issues e.g. limited toilet facilities, limited paediatric space and lack of dedicated space to assess mental health patients. Some of the resulting impact such as limited space has been exacerbated by the impact of the Covid-19 pandemic and the need to ensure appropriate social distancing.	Increased number of nursing staff being rostered over and above establishment. Additional repose mattresses have been purchased with associated equipment. Additional catering and supplies. Incidents generated and attached to this risk. Weekly report highlighting level of above risk being generated. All patients are triaged, assessed and treatment started while waiting to offload. - Escalation of delays to site manager and Director of Operations to support actions to allow ambulance crews to be released. - Rapid test capacity in the POW hot lab has recently increased with a reduction in swab turnaround times. - Expansion of the bed capacity in YS to mitigate against the loss of bed capacity in the care home sector and Maesteg community hospital. - Daily site wide safety meeting to ensure flow and site safety is maintained. - There is now a daily WAST led call (including weekends) with a senior identified leader from the Health Board representing CTM and talking daily through the plans to reduce offload delays across the 3 DGH sites. ·Twice weekly meetings with BCBC colleagues to ensure that any delays in discharge are escalated at a senior level to maximise the use of limited care packages/ care home capacity. ·Appointment of Clinical Lead and Lead Nurse for Flow appointed Feb 21 - Operational Performance is now monitored through the monthly performance review. Performance review process has been restructured to bring more rigour with a focus on specific operational improvements. - Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board.	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	Executive Director of Nursing	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 Redress cases efficiently and effectively	**If**: The Health Board is unable to meet the demand for the predicted influx of Covid19 related, FUNB Ophthalmology Redress/Claim cases **Then:** the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. **Resulting in:** Risk to quality and safety of patient care, resulting from poor management of cases. Financial impact to the Health Board from Redress cases which have been poorly managed and consequently proceed to claim.	Controls are in place and include: • Regular reports run on all Redress cases, with monitoring by the Head of Legal Services & Legal Services Manager	The 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. Update December 2022 - A considerable redress backlog remains, with CTM realising the risk of cases being transferred out of redress into claims, therefore having inability to recoup full costs. This continues to pose a significant reputational and financial impact on the Health Board. Invest to save bid has been unsuccessful therefore other funding options are being explored. Some limited capacity has been identified through the operating model review in respect of quality, safety and governance, however, more resource will be required to begin to manage cases in a timely manner.	Quality & Safety Committee	20	C4xL5	8 (C4xL2)	↔	02.11.2021	19.12.2022	31.01.2023
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 Impact on the safety – Physical and/or Psychological harm	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 The HCSW agency shift requests will follow the same type of forms and sign off from December 2022. Nurse Roster Policy now approved, ratified and implemented in December 2023. This includes KPIs which will allow monitoring of effective roster management. 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 Nursing Productivity Group actions are progressing well through this forum. Registered Nurse Off contract agency in hours and out of hours forms have been in place for two months – there has been a noticeable reduction in usage and thus spend on off contract Registered Nurses. Workforce and finance teams are working together to provide joint metrics and monitoring of agency usage and cost progress monitored via Nursing Productivity group who report into the Value & Effectiveness portfolio group. SAFER CARE Roll out continues on all sites. ENHANCED SUPERVISION Corporate nursing team are due to undertake focused work on areas who have a high number of HCSW agency requests to understand the demand in terms of whether HCSW's are required to support the supervision of an individual or group of patients, whether the requests are related to the increase acuity or due to high sickness/vacancy rates and/ or poor fill rate from bank HCSW requests. The risk score for this risk has been increased to 20 in January 2023 due to the fact that severe operational pressures in the clinical areas, including the opening of several different areas of unfunded beds and frequent "boarding" of additional patients on some wards mean the frequency of the likelihood which was scoring 4 ((Frequency: At least weekly) is now scored at 5 (Frequency: At least daily). This score will be reviewed in March 2023	Quality & Safety Committee	20	C4xL5	C4xL3	↑ Increased in January 2023	25.10.2022	04.01.2023	04.02.2023
2721	Chief Operating Officer	Diagnostics, Therapies and Specialties Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Capacity to deliver POCT training to Health Board Nursing Staff	Currently there is insufficient POCT staff resource to effectively deliver essential training to Nursing/Medical/HCSW staff across the HB. In addition there is no training facility to deliver this training to large cohorts of staff, this is an issue across the HB. The POCT testing repertoire has significantly increased, and will continue to increase across the HB as the drive for near patient testing increases.	POCT have worked with L&D to move POCT glucose e-learning refresher training to ESR (this can prove troublesome and the training dept. have removed their support). Issue has been previously escalated to HoN. Temporary staff from Covid funding has alleviated some of the pressure (post currently vacant). Working with training dept. to try an block book training rooms, but this is difficult as there are no definitive timescales. Some cascade training in place (also a risk of dilution of scientific knowledge)	SBAR in progress to describe current issues with delivery of POCT training and recommendations on how this can be improved moving forward. Covid funding has been agreed previously for POCT (Band 4) until March 23. This post is currently vacant, therefore we need to recruit into this post 30.12.22: Discussion of risk and options to be discussed at Improving Care Board in January 2023.	Quality & Safety Committee	16	C4xL4	C2xL2	New risk escalated to the Org Risk Register in January 2023	27.02.2017	31.10.2022	31.01.2023
4149	Chief Operating Officer	Mental Health Care Group	Clinical Service Group Manager - CAMHS.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	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 Llidiard 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 CAHMS 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 CAHMS 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 Llidiard 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	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 Update 29.11.2022 - Improvement in compliance for SB CAMHS for MHM Part 1a 83% in October and backlog addressed. Slight improvement for CTM CAMHS in MHM Part 1a but waiting list has increased due to increased demand in October. SB meeting Part 2 compliance but numbers reported low. Improvement plan in place for CTM Part 2 compliance. Continued improvements being made in Ty Llidiard, NCCU attended in November and reviewed clinical notes and positive feedback. Awaiting formal feedback via WHSSC escalation meeting on 5th December. Weekly audit reviewing clinical records in place using QI methodology and demonstrating improvement. Ty Llidiard Away Day planned in December to focus on developing the team approach. New therapies lead starting in December, FACTs service - consultant appointed awaiting start date. Ongoing recruitment to vacancies in service. Plan to advertise clinical lead role once consultant has been appointed	Planning, Performance & Finance Committee & Quality & Safety Committee	16	C4xL4	8 C4xL2	↔	01/01/2015	29.11.2022	31.01.2023

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
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 Impact on the safety – Physical and/or Psychological harm	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 is 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.	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 Update 6.1.2023 - actions as reported in August 2022 currently on track. Next review scheduled for January 2023.	Quality & Safety Committee	16	C4xL4	2 C1xL1	↔	30.12.2020	6.1.2023	31.01.2023
1133	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	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	12.10.2022	07.03.2023
2787	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	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	30.11.2022	31.01.2023
3008	Chief Operating Officer	Children and Families Care Group	Raised by Obstetrics in PCH.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	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	30.11.2022
3133	Chief Operating Officer	Central Support Function -Facilities	Governance and compliance manager, Facilities	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	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: December 2022 Medical Device Training is in constant communication with clinical leads to create and adapt solutions to increase Medical Gas Training compliance across the Health Board. As of December 2022 the current Medical Gas training details for CTMUHB are as follows: Total Staff Requiring Training - 2287, Staff Trained - 168, Compliance Percentage - 7.34%, Untrained Staff - 2119. The current risk rating will remain unchanged until Medical Gas Training Compliance increases significantly. As this remains at high risk, a review will be completed in 3 months (DG DW 21/11/2022). Review Date: 28/02/2023	Quality & Safety Committee.	16	C4 x L4	8 (C4xL2)	↔	01/05/2018	8.12.2022	28.02.2023
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

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
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 Impact on the safety – Physical and/or Psychological harm	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 Impact on the safety – Physical and/or Psychological harm	Back log for Imaging in all modalities / areas and reduced capacity	**If:** there is a backlog of imaging and reduced capacity **Then:** waiting lists will continue to increase. **Resulting in** delay and diagnosis and treatment. Due to the Covid-19 outbreak, all routine imaging has stopped and there is reduced capacity for imaging of USC sand Urgent patients.	Due to the Covid-19 outbreak, all routine imaging was curtailed in line with recommendation for the lockdown periods, resulting in reduced capacity for imaging of Urgent Suspected Cancer (USC) and Urgent patients. It is likely to take many months or even years to get back to a pre-Covid state without additional planned care recovery financial support. However, the Welsh Government (WG) target is to return within the 8-week standard for all patients by March 2024. Cancer waits have been prioritised and are now being undertaken within around 2 weeks with the exception of CT scans which are still around 4 weeks at present.	WLIs are being undertaken by consultants to reduce reporting backlogs, this is part of the work agreed via Planned Care Recovery (PCR) funding. Use of fixed term locum staff to help relieve pressure from vacancies. Overtime payments have been made in line with agreed PCR schemes for sessions to help reduce backlogs. Weekend scanning sessions being provided and added lunchtime lists as overtime being run. Re-vetting of referrals against BMUS guidance, review of pathways/criteria, increased productivity per scanner. Close monitoring of USC waiting times and working collaboratively with Cancer Business Unit and other colleagues. There is an ongoing review of capacity plans for the whole service but without additional investment the WG target will not be met. 30.12.22: Cancer waits have reduced significantly and are getting towards the 10 day internal target with exception of CT. CTC pathway work has identified overuse of this test and pathway redesign will help realign the demand to optimal pathway reducing inappropriate testing. CTM Improvement team have undertaken a process mapping exercise showing variation and some opportunities for streamlining processes. Wales Cancer Network are supporting a demand and capacity exercise in Radiology as internal support is stretched and unable to support in a timely fashion. Consideration for additional sessions to reduce backlog quicker through Planned care recovery board have been declined. Further bids will be submitted for 2023-2024 as diagnostics are key to planned care recover pathways.	Quality & Safety Committee	16	C4 x L4	4	↔	01/06/2020	05.01.2023	01.02.2023
4315	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	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. **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(RRFSO. **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. Learning & Development is currently working with the Health Board Fire Officers to reinstated the fire element of Corporate Orientation, so progress is being made to address those who have had no CTMUHB fire training at all. Fire Officers in conjunction with the Nurse Education Lead continue to provide face to face training for these staff.	Recruit additional 2 Fire Officers to support the existing provision and assist in providing training across all sites/ILG. Timeframe 31.5.2022. New Fire Officer appointed 1.9.2021 on 12 month fixed term contract. Business case will be presented to extend funding to substantial appointment. Due to long term sickness and 1 x FO retiring in March 2022, this risk remains. 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 Update 30.11.2022 - No Change to risk mitigation and scoring.	Health Safety & Fire Sub Committee	16	C4 x L4	8 C4xL2	↔	05.10.2020	30.11.2022	28.02.2023
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** 1. SBUHB Service Level Agreement 2. Bridgend disaggregation and the one-CTM aggregation plan 3. NHS Wales Control Agreement and data sharing agreements 4. Numerous national service management boards and Technical oversight groups providing strategic, tactical and operation governance. 5. National ePR programme and systems **Gaps in Control** The full business case for the Bridgend / old-CT integration remains unfunded. There are currently a number of CTM systems that are not compatible with Bridgend systems. 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 Myrddin 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 Impact on the safety – Physical and/or Psychological harm	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
4798	Executive Director of Therapies & Health Sciences Therapies hosted by Merthyr & Cynon Integrated Locality Group	Diagnostics, Therapies and Specialties Care Group	Clinical Director of Allied Health Professionals - Therapies	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	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	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. 21/12/22 update: - Recent formation of critical care project group with a remit to produce recommendations to the ELG end Jan/early Feb 23 in response to the Hackwell report 2022 regarding the future of critical care configuration in CTM. The CD for AHPs will be a key stakeholder in these weekly Jan 2023 meetings to ensure that the AHP requirements are fed in. We continue to not meet GPICS standards across all therapy professions. The current critical care AHP workforce situation as at 21 Dec 2022 is steady but limited Physio services across all 3 units. No OT service. Limited Dietetic service in PCH and RGH with no dietetic service in POW ITU. There is currently no critical care SLT service across CTM due to delays in future critical care planning. SLT have only 1 funded session which can give limited support to level 1 patients at ward level only. With no investment there will be no SLT critical care service in CTM causing continued delays in weaning, increased pressure on MDT, reduced pt experience and outcomes and potential disruption to repatriation pathway from UHW.	Quality & Safety Committee	16	C4xL4	8 C4xL2	↔	21.2.2023	22.12.2022	21.02.2023

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
4809	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	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 a lack of training resource within the Health Safety and Fire Team. If the training is not delivered, then the organisation will not be compliant with mandatory Violence and Aggression Training. Restraint training is mandatory for inpatient acute services for Mental Health and CAMHS. Training is delivered by inpatient staff and the Health Safety and Fire Personal Safety Advisor. If there is insufficient training resource available then the organisation will be unable to maintain compliance on annual refreshers. If the PSA is unable to deliver key aspects of their role due to the high demand for violence and aggression training delivery then advice to clinical areas is greatly reduced. Resulting in non compliance of mandatory training and a risk of injuries to both staff and patients and possible claims.	Personal Safety Advisor delivers training modules with some support from part time trainers within Mental Health and CAMHS. However there is insufficient resource to ensure compliance within the entire organisation. Trained tutors available from clinical areas. The PSA regularly has to support training due to ward based trainers unable to be released to deliver. This role is not currently included in their job description which has resulted in some trainers resigning from delivering, hence compounding the lack of training resource. The availability of the PSA to offer personal advice to clinical areas is greatly reduced due to the excessive training requirement.	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. Update 30.11.2022 - No change to mitigation and risk score. Meetings still ongoing with the Mental Health Care Group.	Health Safety & Fire Sub Committee	16	C4 x L4	9 C3xL3	↔	31.08.2021	30.11.2022	31.01.2023
4906	Executive Director of Nursing	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. Update December 2022: - The new operational model review in respect of quality, safety & governance has ensured that the facilitation of LFERs sits within the Care Group Governance Teams. LFER status is regularly reviewed in the weekly Patient Safety, Complaints and Legal Services data meeting, weekly Executive Patient Safety Meeting and Quality & Safety Committee. LFER reports are now available per care group, ensuring better monitoring.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	02.11.2021	19.12.2022	19.2.2023
4908	Executive Director of Nursing	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	The Health Board are developing an action plan in response to the Welsh Risk Pool review, which includes the reviewing structures and workloads The Health Board are reviewing the Covid funding in respect of the recruitment Covid19 specific Redress Handlers. Meetings with Care Groups to be established in respect of complaint responses to ensure legal aspects have been reviewed and validated.	The Health Board have developed an action plan in response to the 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. Update December 2022: - Invest to save bid was unsuccessful, therefore alternative funding options being explored. Some limited capacity will be realised in the new operating model for quality, safety and governance. CTM commissioned Legal and Risk to provide assistance and direction on the historic redress cases, however L&R have no capacity to take these over. Therefore, will have to be dealt with in turn, as part of the backlog.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	02.11.2021	19.12.2022	19.02.2023
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, 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. 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 prems. 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. SBUHB, HDUHB, ABUHB, BCUHB. 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. December 2022 Update- The information team have automated 8 patient experience surveys within Civica which is also aligned to the PROMs conducted as part of the VBHC portfolio. However 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. The number of responses seen are low when compared to other HB who are actively using the SMS component. As a consequence of not having the automated SMS component up and running across CTM it has resulted in an increase of paper copies which require resource to manually input the responses into Civica- This resource currently does not exist as only 1x PM is working on the system part time. Update 5.1.2023 - Project Manager is exploring how the Health Board can slowly integrate within specialised surveys as this work is specific within the ask of IT, however the Health Board cannot implement the automatic SMS for all appointments/inpatient interaction with the Health Board at present.	Quality & Safety Committee	16	C4 x L4	12 (C4xL3)	↔	09.12.2021	5.1.2023	14.02.2023
4417 (Linked to Risk IDs 4706 and 4703)	Chief Operating Officer	All Care Groups	Deputy COO (Acute Services & Primary, Community & Mental Health)	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm & Statutory Duty / Legislation	Management of Security Doors in All Hospital Settings	Following several serious incidents following patients absconding from clinical areas, the HSE have issue an Improvement Notice on Bridgend Integrated Locality Group (see Documents) outlining the following actions: In consultation with employees and involving competent persons: 1. Identify the units, wards and premises where in-patients may be at risk from wandering, absconding or escaping. 2. For each of these, undertake a suitable and sufficient risk assessment of physical and procedural measures to prevent in-patients from wandering, absconding or escaping. 3. Identify the measures needed to protect patients at risk 4. Record the significant findings. Any lessons learned from the above should be formally shared with the other 2 Integrated Locality Groups for action. IF: the Health Board do not comply with the notice. THEN: the Health Board may be subject to prosecution by the HSE RESULTING IN: Large Fines and poor publicity.	Clinical areas across the Health Board should have in place local arrangements/procedures to prevent patients from absconding. A document has been circulated from Estates which outlines procedures around how and where staff should be reporting failures in doors.	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

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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
4722	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	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 weak. 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 Impact on the safety – Physical and/or Psychological harm	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 Ewm 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. Update Dec 22 - Phase 3 Update - The need for further capital investment is recognised and is on the Health Board list of schemes. Phase 3 FBC funding request has been submitted to WG (approval pending) with the intention plans are drawn up in a timely fashion so the project can be progressed when the funding becomes available and capacity to accommodate the works is possible later into Phase 2.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	15	C5xL3	6	↔	29.11.2017	08.12.2022	28.02.2023
2808	Chief Operating Officer	Children and Families Care Group	Clinical Service Group Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Waiting Times/Performance: ND Team	IF: The Neurodevelopment service does not have capacity to achieve the WG assessment target (80% of assessments to commence within 26 weeks of referral) and to follow up patients in a timely way, due to demand exceeding capacity Then: Patients will wait excessive periods to reach a diagnosis and children on medication that require titration and monitoring may not be able to be seen within the appropriate timeframes Resulting in: Delays in appropriate treatments being commenced, delays in accessing support e.g. in school following a diagnosis, delay in being effectively titrated, risks associated with delays in medication monitoring	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. Next review scheduled for 1.3.2023 regarding mitigating action - Consideration required for further investment in service.	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	14.07.2017	03.1.2023	01.03.2023
3638	Executive Medical Director	Diagnostics, Therapies and Specialties Care Group	Chief Pharmacist	Inspiring People	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	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.	This CTM Pharmacy issue that has stalled at various times in the past which has added to delay. Initially started in 2018 as an SBAR propose increase training capacity in order to meet the demand. Included in IMTP and prioritised as number one priority, 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. As such is in place and continues to run. Funding approved for primary care lead pharmacist - commenced in post April 2019.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. SECONDARY CARE elements were not supported in the IMTP prioritisation process	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. September 2022 - New Chief Pharmacist in post. Aware of the risk and need to address. This is forming part of their plans in addressing a number of issues within Pharmacy service. December 2022 - risk remains as little change in mitigation. Actions are being updated as risk is reliant on HEIW continuing funding. Similar position recognised in other Health Boards.	People & Culture Committee	15	C3 x L5	6 (C3xL2)	↔	02.01.2018	20.12.2022	20.02.2023
3993	Executive Director of Strategy & Transformation	Central Function - Planning Project Risk	Head of Capital, Strategic and Operational Planning	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Fire Enforcement Notice - POW Theatres.	**IF:** The Health Board fails to meet fire standards required in this area. **Then:** the safety of patients, staff, contractors/visitors etc. and the protection of the buildings could be compromised. **Resulting in:** potential harm, risk of fire. Possible further enforcement in the form of prosecution.	Storage room obtained on ward 16 to store theatre equipment to ensure evacuation corridor is kept free for evacuation. Staff training on lift evacuation. Closed storage cupboards purchased for safe storage of equipment. "safe" areas identified with Senior Fire officer for storage of equipment in corridors. Weekly meetings to discuss and plan building work necessary to meet requirements of the enforcement notice. Enforcement notice has been extended to December 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. Updated Dec 22 - WG and SWFRS meetings deferred until January due to potential crossover of enabling and decant options with the planned procurement of the BA site in Llantrisant. Clinical engagement and option appraisal session planned for the 11th January to confirm preferred options for provision of decant theatres to support the main works taking place. Mobile theatres (revised design) have been visited and are being reconsidered as an option.	Quality & Safety Committee Health, Safety & Fire Committee	15	C5xL3	8	↔	31.01.2020	31.12.2022	28.02.2023

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
4512	Chief Operating Officer	Mental Health Care Group	Deputy COO - Primary, Community and Mental Health	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	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 Specialties Care Group	Chief Pharmacist	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	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. INCLUDED in the Reconfiguration Group work for sustainable model. New Chief Pharmacist aware o f issue and forming part of their evaluation of Pharmacy model across CTM. SBAR included in Medicines management and advised to include in ACT directorate IMTPs. 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. UPDATE DECEMBER 22 - new Reconfiguration Group to address all workforce shortfall issues (inc Pharmacy), also part of new CP plans to establish changes across CTM.	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	05.04.2021	20.12.2022	20.02.2023
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 onotology server, WCP & E-forms etc. **Tactical controls:** Digital element of the strategic programme - Culture to digitise the EPR, our communications, how we do business National Architecture Review - encompassing (NDR /CDR & Sharing arrangements) Coding transformation programme . **Gaps in controls** Scanning time of outpatient activity to digitise the record is at 51 days cf maximum clinically safe time of 24-48 hours Quality of paper record and its filing is very poor with audits identifying over 70% of paper records are not maintained to acceptable standards Digital solutions not yet using snomed-CT/ structurally coded data Information and Technical Standards not being followed with national body favouring document rather than data exchange Vast amounts of clinical information stored in disparate spreadsheets not visible to central medical record or available to patients or system leaders (including value based healthcare) Digital transcription programme unsupported & unsupported from march 23	Update 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 Impact on the safety - Physical and/or Psychological harm	Lack of orthogeriatrician as NICE guidance and KPI1 NHFD	IF: If we do not have this specialist service THEN: our patients will receive suboptimal care than others in the UK and across Wales with potential for non achievement of KPIs set by the Welsh Government, increased length of stay, increased complications such as delirium and pressure ulcers and increased mortality. RESULTING IN: The inability to achieve good outcomes and care appropriately for our patients has a detrimental effect on staff wellbeing too.	The already stretched on call medical team are contacted for ad hoc advice. There is no 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
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 on actions December 2022 SON to be submitted and if successful replacement software purchased and installed. Timescale: 31/03/2023. 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. The 13 stage press is due to have the update to software data. Since the last review there have been constant breakdowns within the laundry which has kept putting the upgrade back. As a contingency the 13 stage press is being monitored and the Health Board hopes to complete the software upgrade before March 31st 2023. Based on this update the risk remains as a high risk and will be reviewed in 3 months time or once the software has been installed (DW 11/11/2022). Review Date: 28/02/2023	Quality & Safety Committee Planning, Performance & Finance Committee	15	15 (C5xL3)	5 (C5xL1)	↔	27.07.2021	08.12.2022	28.02.2023
4920	Executive Director of Therapies & Health Sciences	Diagnostics, Therapies and Specialties 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. Update 28.12.2022 - two vacancies are anticipated to be recruited to March 2023 following the return of maternity leave and retire and return employee. Ongoing discussion with staff member temporarily re deployed due to Long COVID regarding returning to substantive post. Review 31.3.2023	Quality & Safety Committee	15	C3 x L5	12 (C3xL4)	↔	27.11.2021	28.12.2022	31.3.2023

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
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. Risk likelihood reduced, rationale being sought prior to de-escalation from Organisational Risk Register.	Quality & Safety Committee	15	C3xL5	3 C1xL3	↔	04.01.2022	31.10.2022	31.01.2023
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 Myrddin strategic programme group has been established, chaired by the CEO of DHCW to map out how the constraints can be overcome SLAs are in place between DHCW and NHS Wales organisations, however their futility has been exposed by demand pushing the waiting times for developments to start (not complete) to over 12 months Gaps in controls: WG have agreed some funding for the PAS element, however the DHCW IMTP continues to be a top down decision process rather than one being based on HB (user / customer) needs - driven in part by demand overwhelming their capacity (much of which is either Covid born or results from the significant overrun in establishing a minimum viable product to replace CanISC) and numerous critical constraints not continuing to be observed in the system whilst the architecture remains closed. HB carrying vacancies in critical areas with no capacity to cover the work from within. As a consequence programme to digitise the Emergency Department processes and records has been suspended. Data acquisition from DHCW products is a curates egg, some new APIs are being made available to standards, however latest PAS offering is via csv download, presenting challenges to adoption of standards within certain areas. UHB still awaiting availability of access to key HB data such as radiology and tests results.	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 date 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	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
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.	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. RTE CG - 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 ensuites on ward admissions/21/22 and PICU being upgraded. M&C CG - SRU/Pinewood – ligature work has been completed. Update 31.12.2022 Bridgend All works have been completed at: Ward 14 PICU Angelton. RTE Ward 21 - Completed Ward 22– Completed Admissions – Completed PICU – 1 Bedroom still to complete All wards scheduled to have returned to their home location and works fully completed by 13th January 2023	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. 6. 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 to take place early 2023. 7. Recruitment has taken place for 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. Updated - 31.12.2022 with no change to risk rating	Quality & Safety Committee	15	15 (C3xL5)	6 (C3xL2)	↔	15.06.2021	31.12.2022	5.3.2023
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. Update December 2022 - Working with Care Inspectorate Wales (CIW) to understand how the Health Board can become a registered provider of care if appropriate.	Quality & Safety Committee Planning, Performance & Finance Committee	15	C5xL3	10 C5xL2	↔	19.8.2022	30.12.2022	28.02.2023
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 if 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 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

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
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. Update 6.1.2023 - The scoping work has been delayed due to the increased respiratory viruses circulating/ number of outbreaks which the IPC department have had to respond to. This will be reviewed at the end of January 2023.	Quality & Safety Committee	15	C3xL5	6 C3xL2	↔	16/07/2020	06.01.2023	31.1.2023
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
5323	Chief Operating Officer	Diagnostics, Therapies and Specialties Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Fluoroscopy Room has become Obsolete	IF room 3 in POW is not replaced THEN there will be situations where there is no interventional Radiology service at POW (during maintenance and potential break down of Room 6) RESULTING IN having to transfer very unwell patients to other hospitals, pressure on staff and services at other sites to accommodate. Overall poorer patient experience and potentially outcomes.	Utilising Room 6 to its full capacity Some Barium lists being performed at RGH when possible	Completion of SON to support replacement of Room3 - Timeframe 27.1.2023	Quality & Safety Committee	15	C5xL3	C5xL1	New risk escalated to the Org Risk Register in January 2023	23.12.2022	23.12.2022	01.02.2023

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
4356	Executive Director for People Health, Safety & Fire Function	Central Support - Health, Safety & Fire Safety Function	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	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	9 ↓ 12	C2xL3	30/11/2022 Fire Officers have reviewed current building responsibilities and have made a concerted effort to ensure all FRAs are up to date. Whilst 100% compliance is challenging due to workplace changes, the team compliance is approx. 95% and therefore the likelihood of this risk has been reduced.

Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Month Closed on Org RR	Closure Rationale
4679	Executive Director for People (Executive Lead for Occupational Health)	Central Support Function - Occupational Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	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	Jan-23	Update Jan 2023 - Training is now arranged 16th and 18th January for Occupational Health Nurses and a support group via Cardiff & Vale is being implemented to provide peer support going forward. The likelihood score was reduced to a 2 as a result achieving the target score of 8. This risk can now be closed.
4253	Chief Operating Officer	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 ant-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 Heath 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	Jan-23	Risk Closed 13.1.2023 - Health Board Capital works department have signed off all of the schemes connected to the anti ligature work.

AGENDA ITEM
5.2

AUDIT & RISK COMMITTEE

AUDIT RECOMMENDATIONS TRACKER UPDATE REPORT

Date of meeting	13/02/2023
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.

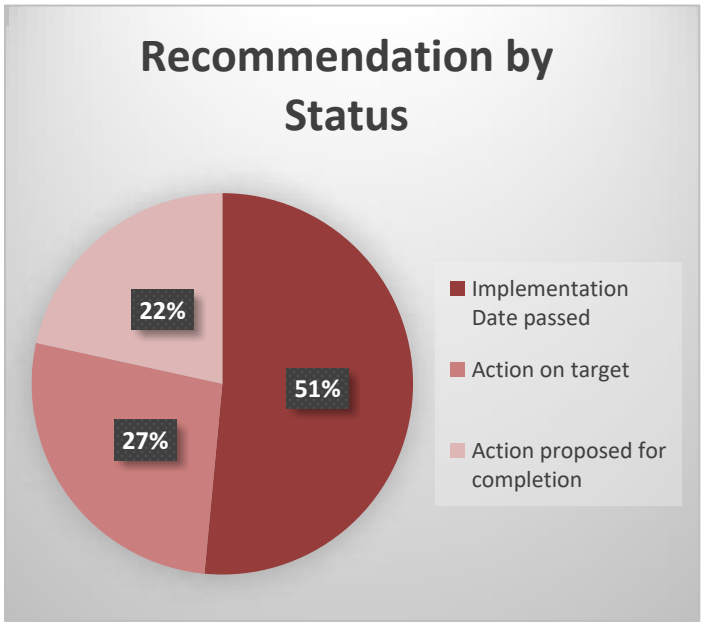
1.2 This report relates to both internal and external audit review recommendations.

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 36 internal audit recommendations have been completed/closed and are proposed for removal from the tracker, together with 4 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 improved slightly to 51% compared to the December position which was at 53%.



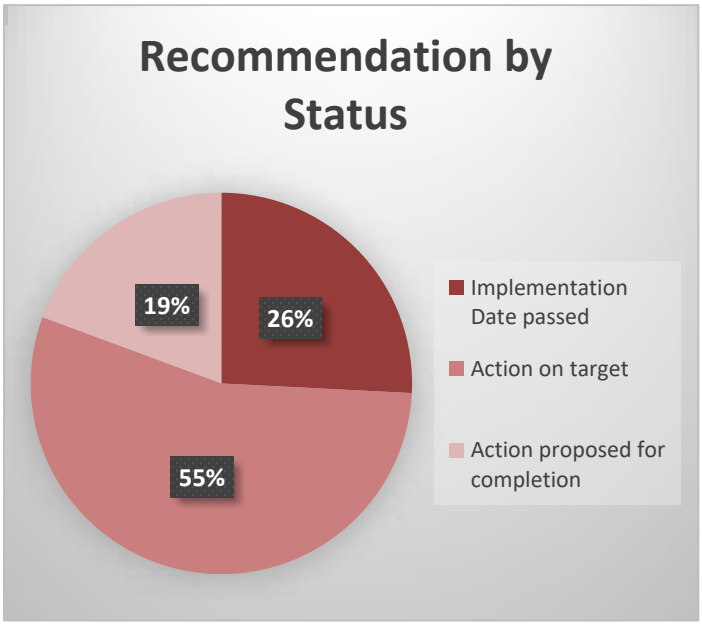
Recommendations by Priority & Status				
Priority	**TOTAL**	Implementation Date passed	Action on target	Actions Completed
High	**43**	21	12	10
Medium	**109**	58	28	23
Low	**15**	7	5	3

Recommendations by Executive Lead & Status				
Executive Lead	**Total**	Implementation Date passed	Action on target	Actions Completed
Director of Corporate Governance	**3**	1	1	1
Director of Finance	**27**	3	20	4
Chief Operating Officer	**44**	21	12	11
Director of Nursing	**38**	25	4	9
Director of Digital	**16**	4	6	6
Director for People	**20**	15	2	3
Director of Strategy & Transformation	**15**	15	0	0
Medical Director	**4**	2	0	2

Implementation Date Extended by					
Priority	**TOTAL**	More than 24 Months	18-24 Months	12-18 Months	6-12 Months
High	**20**	3	2	1	14
Medium	**48**	4	7	11	26
Low	**6**	1	1	2	2

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 has improved slightly to 26% compared to the 33% reported to the December 2022 meeting.



Recommendations by Priority & Status				
Priority	TOTAL	Implementation Date passed	Action on target	Actions Completed
High/Medium/Low	**31**	9	18	4

Recommendations by Executive Lead & Status				
Executive Lead	**Total**	Implementation Date passed	Action on target	Actions Completed
Director of Corporate Governance	**2**	0	2	0
Director of Strategy & Transformation	**7**	2	4	1
Chief Operating Officer	**1**	1	0	0
Director of Finance	**7**	1	4	2
Director of Digital	**2**	2	0	0
Director of Nursing	**9**	4	4	1
Director for People	**2**	0	2	0
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	3

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.
	Not required
Legal implications / impact	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.

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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
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 Now March 2023		In progress	February 2023 Update - each area has devised a local index list of SOPs and where required policies, and working through the drafts. Agreed approach for sign off and monitoring via revised Quality Safety and Patient Experience Meeting	March 2021 Update - Update will be available in May 2021. May 2021 Update - 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. 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.
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 though 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 Now February 2023		In progress	February 2023 update - Reviews are well in hand, some changes to the proposed operating model will have an effect on some of the SOPs, however these can be changed and ready in line with implementation of the new quality governance structure.	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. 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.
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 Now February 2023		In progress	February 2023 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. CTM attends the All Wales Duty of Candour Education and Training network. A raft of education and training materials are being developed at an All Wales level. These will be rolled out alongside a complaints training programme. 3.1b - Training Needs analysis will be undertaken on completion of prospectus with the newly formed care groups.	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 Now February 2023		In progress	February 2023 Update 6.1a - A new quality assurance SOP has been developed, an audit programme will commence in February 2023. 6.1b - The QA document contained within Appendix 4, is being revised in line with the new organisational Concerns Policy.	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
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		Completed	February 2023 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. Learning newsletters are shared across the organisation	9.1a April 2022 Update - Learning Framework has been developed and is in DRAFT form at present. This may need to be revisited following changes to the Operating model. 9.1b April 2022 Update - Learning Framework has been developed and is in DRAFT form at present. This may need to be revisited following changes to the Operating model. June 2022 9.1a - Reports are provided on themes and trends following incidents/complaints and claims. These are presented at various committees. A review of these will be undertaken to ensure that they are fit for purpose and are used to drive improvements 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 9.1a 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

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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 Now February 2023		In progress	February 2023 Update: In the interim and whilst waiting for NWSSP Facilities and Estates Services to address the All Wales Fire System, summary data is now available and will be presented to the forthcoming February 2023 Health Safety & Fire sub-committee.	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. December 2022 Update - Despite chasing them, 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		Completed	February 2023 Update - While the ILG structure is to be disbanded, required elements of reporting were individually evidenced by enhanced reporting addressing other recommendations.	April 2022 Update - Ongoing. August 2022 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. December 2022 Update - no further update provided against this recommendation as new Care Group Operating model is still not available.
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 Now April 2023		In progress	February 2023 Update - a list of the officers on the circulation list has been produced and will be circulated to Service Group Managers in the next month to ensure that the right names are included. This will then be sent back to Performance colleagues.	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. December 2022 Update - date for completion remains 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	February 2023 Update - a list of the areas where data is not being updated has been produced and some initial conclusions drawn. Once sense checked with colleagues in Performance, this will be reported to Service Groups for training needs to be established and resolved.	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. December 2022 Update - progress slow as a consequence of activity on sites. Meeting in diaries to resolve way ahead.
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	February 2023 Update - no further action to report here. This will be the next area of consideration when the circulation and training is addressed as above.	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. December 2022 Update - progress slow as a consequence of activity on sites. Meeting in diaries to resolve way ahead.
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	February 2023 Update - as with 1.1 above, a list of the officers on the circulation list will be produced and will be circulated to Service Group Managers in the next month to ensure that the right names are included. This will then be sent back to Performance colleagues when agreed.	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. December 2022 Update - progress slow as a consequence of activity on sites. Meeting in diaries to resolve way ahead.

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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	February 2023 Update - this will be undertaken in line with the actions planned above.	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. December 2022 Update - progress slow as a consequence of activity on sites. Meeting in diaries to resolve way ahead.
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	February 2023 Update - this will be undertaken in line with the actions planned under 1.3 above.	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. December 2022 Update - progress slow as a consequence of activity on sites. Meeting in diaries to resolve way ahead.
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	February 2023 Update - initial conversations being undertaken as part of this work - some of which is outlined above - indicate that this is happening but a more formal response will be sourced in the next month.	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. December 2022 Update - progress slow as a consequence of activity on sites. Meeting in diaries to resolve way ahead.
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 Now March 2023		In progress	February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then	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. 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.
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	Propose Qtr 2 2023/2024		In progress	February 2023 Update - Work ongoing re: operational management of digital & data services in alignment with the Care Group model	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	Propose Qtr 2 2023/2024		In progress	February 2023 Update - Work ongoing - new Digital & Data Structure is being finalised	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 Operating 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	February 2023 Update - Strategic Leadership structure will be finalised in this Qtr as proposed	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 Operating 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	February 2023 Update - Costs for various schemes have now been identified. Prioritisation of programmes of work to be undertaken during February 2023	December 2022 Update - IMTP development will propose required capital and revenue funding to support digital requirements
Radiology Service Review 6.1	Dec-22	Limited	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	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.	Chief Operating Officer	Site Superintendent Radiographers	31st December 2022	Now February 2023		In progress	February 2023 Update - Sickness Training Updates are currently being arranged with People's Services for staff on all 3 DGH sites.	
Radiology Service Review 9.1	Dec-22	Limited	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	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.	Chief Operating Officer	Clinical Service Manager Super intendent Radiographer	Jan-23	Now March 2023		In progress	February 2023 Update - The site leads have developed a programme to undertake PDRs. POW are 100% compliant. RGH/PCH staff are working to pay progression dates. The new admin manager is currently undertaking a programme of PDRs. Ongoing due to clinical commitments.	
Radiology Service Review 10.1	Dec-22	Limited	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	High	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 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.	Chief Operating Officer	Clinical Service Manager Super intendent Radiographers	Mar-23			In progress	February 2023 Update - The Learning & Development Team have been contacted around core competencies. The matter is ongoing with corporate team.	
Radiology Service Review 10.2	Dec-22	Limited	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	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.	Chief Operating Officer	Clinical Service Manager Super intendent Radiographers	Mar-23			In progress	February 2023 Update - Ongoing work is underway to drive core compliance. Unfortunately there are some classroom based courses which are unavailable. Time is being allotted to staff balancing clinical commitments. A Module of the Month is sent to encourage staff to complete training. Ongoing	

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Radiology Service Review 11.1	Dec-22	Limited	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	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	Chief Operating Officer	Clinical Director Clinical Service Manager	Jan-23	Now March 2023		In progress	February 2023 Update - A programme of Job Planning is nearing completion with only 2 outstanding Consultant Job Plans.	
Concerns 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 Now February 2023		In progress	February 2023 update - Policy has been reviewed and amended however, some minor 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. 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.
Concerns 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 Now February 2023		Part Completed	February 2023 Update - ESR have confirmed training can be captured on ESR, however resource to update ESR would have to be considered. In the interim period the Central complaints team will be retaining training records.	3.3a April 2022 Update - Discussions ongoing. 3.3b April 2022 Update - Email to ESR team to query whether PTR and further concerns management training records can be stored on ESR. 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. Consideration for inclusion in PTR training as part of induction. August 2022 Update 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. 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.
Concerns 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 Now February 2023		In progress	February 2023 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. With complaints moving to a centrally managed service, consistency and uniformity will be achievable. 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. Policies and procedures are in the process of being reviewed.	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
Concerns 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 Now February 2023		Part Completed	February 2023 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.	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. 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
Concerns 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 Now February 2023		In progress	February 2023 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 has been developed and will commence in February 2023, after quality governance model is 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 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 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. 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

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Concerns 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 Now February 2023		In progress	February 2023 Update - This has been included into the Quality Assurance and Audit Programme, which commences in February 2023.	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. 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.
Concerns 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		Completed	February 2023 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. More consistent, uniform and empathetic letters will be achievable with a centrally managed service.	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 compliant 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. 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
Concerns 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 Now February 2023		In progress	February 2023 Update - This has been included in the review of Policies and Procedures. This will be incorporated into the training needs analysis and 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. 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.
Concerns 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 Now February 2023		In progress	February 2023 Update - This has been included in the review of Policies and Procedures. This will be incorporated into the training needs analysis and will be undertaken in conjunction with the central care group governance teams and a training plan will be developed and implemented. The new triage model will support this requirement.	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. Rationale for reopening of complaints is space on Datix, however, this will be regularly monitored. When the new triage process is implemented, with a view to increasing early resolutions and decreasing formal complaints, a balancing measure will be the number of early resolutions moving onto formal complaints. This will be incorporated into the rolling audit programme. 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. 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. 3.1b - Training Needs analysis will be undertaken on completion of prospectus with the newly formed care groups.
Concerns 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		Completed	February 2023 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. A consistent approach to the management of historic concerns will be more achievable in a centrally managed service. Open complaints are regularly monitored via Patient Safety Executive	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. The importance of recording regular updates on Datix will be included as part of 3.1a training programme. 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. 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.
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 Now February 2023		In progress	February 2023 Update - The revised policies and procedures captures this requirement. The quality assurance new checklist monitors this. Management of this going forward will be more achievable in a centrally managed service.	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 Polices 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. 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.

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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		Completed	February 2023 Update - 10.1/10.b/10.c - Various reports are already available and presented at various committees. The Datix team have produced 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 week 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. 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 October 2022
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			In progress	February 2023 Update - Risks are reported and profiled to Welsh Government at both the Fire Safety Risk Register, and Estates Facilities Performance and Condition report. However, this does not represent a time-phased strategy to address e.g. for expert resource to drive certain actions, or co-ordination with building works. Management comment - Agreed - however, due to limited All Wales capital finance, this has not been prioritised over the last year.	April 2022 Update - Work ongoing. August 2022 Update - no further update provided on this occasion October 2022 - No further update provided on this occasion. 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.
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		Completed	February 2023 Update - Management confirmed that the former CTMUHB Senior Fire Officer has been re-employed within the Estates & Capital Department to carry out a review of all Fire Orientation/Compartmentation plans across the HB and feed info into the HB CAD operator for updating if required. Timelines were confirmed as: • Work already underway at the Royal Glamorgan Hospital - to be completed by end of January 2023. • Survey work commenced in Princess of Wales Hospital (POW) in November 2022 and will be finalised in March 2023. • POW to be followed by Prince Charles Hospital which will take a further 4 months to complete. • Work to Community Hospitals to commence on completion of the District General Hospital sites, with a revised completion target date of September 2023. Management comment - This work will allow the Health Board to have centralised base line fire plans for all the District General Hospital sites that will be utilised for all Passive and Active fire information such as Dampers; cause & effect etc. as well as any other services or operational needs.	April 2022 Update - Work ongoing by the Capital and Estates Team. 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. 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. 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.
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		Completed	February 2023 Update - Amendment to procedures has been agreed by the Head of Health, Safety & Fire to ensure that high-risk issues identified at risk assessments, are addressed by local procedures.	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. 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.
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	February 2023 Update - This item will be considered as part of the process for this audit set out above.	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. December 2022 Update - progress slow as a consequence of activity on sites. Meeting in diaries to resolve way ahead.

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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 Now March 2023		In progress	February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then	October 2022 Update - Whilst appointments and structures are confirmed this remains outstanding. 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.
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 Now March 2023		In progress	February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then	October 2022 Update - Until a way forward is agreed with WG this will not be required as no new contracts will be let. 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.
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 Now March 2023		In progress	February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then	October 2022 Update - This is a future recommendation at such a time post business case approval. 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.
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 Now March 2023		In progress	February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then	October 2022 Update - This will be reviewed at the letting of a contract for construction stage post business case approval in 2023. 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.
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 Now March 2023		In progress	February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then	October 2022 Update - This will be addressed on letting the contract post business case approval in 2023. 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.
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 Now March 2023		In progress	February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then	October 2022 Update - This will be addressed on letting the contract post business case approval in 2023. 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.

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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 Now March 2023		In progress	February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then	October 2022 Update - This will be addressed on letting the contract post business case approval in 2023. 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.
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 Now March 2023		In progress	February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then	October 2022 Update - This will be addressed on letting the contract post business case approval in 2023. 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.
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 Now March 2023		In progress	February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then	October 2022 Update - This will be developed and included at business case stage once a preferred option is identified in November. 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.
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 Now March 2023		In progress	February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then	October 2022 Update - This will be addressed on letting the contract post business case approval in 2023. 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.
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 Now March 2023		In progress	February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then	October 2022 Update - This will be developed and included at business case stage once a preferred option is identified in November. 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.
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 Now March 2023		In progress	February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then	October 2022 Update - This will be addressed on letting the contract post business case approval in 2023. 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.

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Digital Operating 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	February 2023 Update - Ongoing and will be factored into the subsequent structure design for the Digital & Data team	December 2022 Update - Digital development resources will be aligned to the requirements of the IMTP from Care Groups
Digital Operating 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	February 2023 Update - Work Ongoing	December 2022 Update - Activity to be undertaken once Strategic Leadership roles are finalised
Digital Operating 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	February 2023 Update - Ongoing in alignment with the IMTP	December 2022 Update - Digital Literacy and training initiatives to be outlined within the IMTP
Digital Operating 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	February 2023 Update - Work ongoing	December 2022 Update - New Digital Service Desk launched in November 2022. Work ongoing to complete how to guides …
Radiology Service Review 6.2	Dec-22	Limited	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	All superintendents will be advised of the need to maintain accurate documentation of all decision taken including those outside of the Managing Attendance Policy.	Chief Operating Officer	Superintendent Radiographers	31st December 2022	Now February 2023		In progress	February 2023 Update - All Superintendents have been informed of their responsibilities in terms of sickness management. A training update session is in the progress of being arranged with People's Services.	
Radiology Service Review 6.3	Dec-22	Limited	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	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.	Chief Operating Officer	Clinical Services Manager	31st January 2023	Now March 2023		In progress	February 2023 Update - An electronic staff Personnel File has already been implemented for new staff at RGH and PCH. There is a hybrid system for established staff and a system to scan in legacy documents. Work is underway at POW but the current sickness absence in admin team has delayed progress.	

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Radiology Service Review 7.1	Dec-22	Limited	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	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.	Chief Operating Officer	Clinical Service Group Manager Superintendent Radiographers	30th November 2022			Completed	February 2023 Update - The team at POW have now transitioned over to ESR from paper recording. All leave requests and sickness absence is recorded through ESR and Health Roster. Completed action.	
Radiology Service Review 8.1	Dec-22	Limited	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	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.	Chief Operating Officer	Clinical Service Manager Site Superintendent Radiographers	Feb-23	Now March 2023		In progress	February 2023 Update - The team have met to review the current HB policy and will implement across Radiology on the 3 sites.	
Radiology Service Review 8.2	Dec-22	Limited	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	A review of the current systems to record TOIL will be undertaken to establish which system is most effective and applied across the localities.	Chief Operating Officer	Clinical Service Manager Site Super intendent Radiographers	Feb-23			Completed	February 2023 Update - All staff members have been informed to complete the appropriate TOIL form and request permission to build up TOIL in the absence of the Heath Roster being implemented across the 3 sites.	
Radiology Service Review 11.2	Dec-22	Limited	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	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.	Chief Operating Officer	Clinical Director Clinical Service Manager	Jan-23	Now March 2023		In progress	February 2023 Update - The relevant house keeping has been undertaken with the Allocate Team and all current consultant staff are assigned accordingly. There appears to be an issue with the system where the relevant notification is not being received for sign off by clinician. To be addressed through Allocate Support Team.	
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 Now March 2023		In progress	February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then	October 2022 Update - This will be addressed on letting the contract post business case approval in 2023. 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.
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 Now March 2023		In progress	February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then	October 2022 Update - This will be addressed on letting the contract post business case approval in 2023. 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.

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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
Radiology Service Review 8.3	Dec-22	Limited	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	A review of the current systems to record TOIL will be undertaken to establish which system is most effective and applied across the localities.	Chief Operating Officer	Clinical Service Manager Site Super intendent Radiographers	Feb-23	Now March 2023		In progress	February 2023 Update - All staff members have been informed to complete the appropriate TOIL form and request permission to build up TOIL in the absence of the Heath Roster being implemented across the 3 sites.	
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 Now March 2023		In progress	February 2023 Update - The Bank Policy went to Policy Review Group and was shared for final comment. There were comments on the policy received, that are now being amended in the document to allow it to be re-submitted for the Feb-23 meeting. The actions required in this recommendation have been addressed and included in the policy.	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 Heath 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 Now March 2023		In progress	February 2023 Update - The Bank Policy went to Policy Review Group and was shared for final comment. There were comments on the policy received, that are now being amended in the document to allow it to be re-submitted for the Feb-23 meeting. The actions required in this recommendation have been addressed and included in the policy.	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 had to be stalled due to changes needed to the agency booking process required by the Nurse Productivity
Directorate 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	February 2023 Update - position is unchanged from last report.	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. March 2021 Update - This will be an area 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. July 2021 Update - no change for RTE and MC ILGs at present however this remains on the agenda. 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. December 2022 Update - position remains the same in RTE area.
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	January 2023 update - A Band 7 post was advertised until 23rd January. Interviews are scheduled for 6th February. The Deputy Lead Infection Prevention Control Nurse and Decontamination Officer continues to work with 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. 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.

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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 Now March 2023		In progress	February 2023 Update - Met with the Exec Dir for People on 30 Jan 2023 to plan and confirm meeting dates for 2023/24 Welsh Language Steering Group. First meeting of the Steering Group will take place on the 15 March 2023 and a programme of dates have been agreed for the rest of the 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. 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.
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		Completed	February 2023 Update - Following a recent report that was presented to Quality & Safety Committee it has been agreed that going forward an Annual Report will be submitted to this Committee. Also, all Escalating Concerns will be reported through the Primary Community Care Group Highlight Report and all MH Hospitals on AWF that are receiving additional monitoring will be reported through the MHLD Care Group Highlight Report.	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. 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.
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 Now March 2023		In progress	February 2023 Update - The revised draft Overtime Policy incorporates the management actions agreed. The required system settings to ensure Working Time Regulations compliance are activated as required by the audit.	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. December 2022 update - Work has commenced on reviewing the policy and will be taken to the January 2023 People Policy Review Group.
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		Completed	February 2023 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. 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. December 2022 Update - Training is taking place in respect of Datix Cymru and the training which has support the launch of the Incident
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 Now March 2023		In progress	February 2023 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 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, identifying further areas as part of No PO review (Top 3 monthly with systems). 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. 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.

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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		Completed	February 2023 Update - Propose to close - routine report now in place	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
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			Completed	February 2023 Update - Medical Records action plan and monitoring activities now in place	December 2022 Update - As part of Medical Records review in November 2022, SOP for reporting quality issues has been identified and in development
ICTM Quality Improvement Team 1.2a and 1.2b	Dec-22	Reasonable	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. 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.	High	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.	Director of Nursing	Assistant Director Improvement Culture, Capability & Delivery	Dec-22	Now January 2023		Part Completed	February 2023 Update - 1.2a Completed - plan on a page has been reviewed and a version produced that can be integrated into the LifeQI record. 1.2b Procedural guidance is in draft form for completion in January 2023.	
iCTM – Quality Improvement Team 1.4	Dec-22	Reasonable	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	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.	Director of Nursing	Assistant Director Improvement Culture, Capability & Delivery	Dec-22	Now January 2023		In progress	February 2023 Update - Procedural guidance is in draft form for completion in January 2023. The new form is being used to asses new pieces of work as described. The Project Workbook is being used for the Community Acquired Pressure Ulcer collaborative and is under review to assess its suitability for other projects.	
iCTM – Quality Improvement Team 5.1	Dec-22	Reasonable	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	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.	Director of Nursing	Assistant Director Improvement Culture, Capability & Delivery/ Assistant Director of Governance & Risk	Dec-22			Completed	February 2023 Update - Risk management training has been held with the Corporate Risk Management Team and risk management process agreed. Risk will be a monthly agenda item on management team meetings and Datix will be used to generate a risk log as per organisation guidance.	
iCTM – Quality Improvement Team 5.2	Dec-22	Reasonable	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	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.	Director of Nursing	Assistant Director Improvement Culture, Capability & Delivery/ Assistant Director of Governance & Risk	Dec-22			Completed	February 2023 Update - Risk management training has been held with the Corporate Risk Management Team and risk management process agreed. Risk will be a monthly agenda item on management team meetings and Datix will be used to generate a risk log as per organisation guidance.	

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Radiology Service Review 3.1	Dec-22	Reasonable	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	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 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.	Chief Operating Officer	Senior Superintendents Clinical Leads Superintendent Radiographers Clinical Leads Health & Safety Leads	June 30th 2023			In progress	February 2023 Update - a) A review of all policies and procedures is an ongoing programme of work. A formal circulation list for review of any policies / procedures has been developed. A Radiology adapted Policy for the Management and Authorisation of Radiology documents has been drafted for ratification on 1 December 2022.	
Radiology Service Review 5.2	Dec-22	Reasonable	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	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.	Chief Operating Officer	Clinical Lead for Quality and Governance Senior Superintendents	31st December 2022			Completed	February 2023 Update - Risk Managing is a standard item on the Radiology Business meeting agenda. The service has implemented a monthly Risk Management meeting following the Business Meeting. All departmental risks are also discussed or escalated via the Radiology Quality, Improvement and Governance Meeting quarterly. Completed.	
Radiology Service Review 12.1	Dec-22	Reasonable	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	The Service Group now sits in the Diagnostic and Therapies Care Group since September 2022 and the Care Group Director and Medical Director will work with the teams to advise of the workforce plan required for the IMTP/Annual Plan for 2023/24. On receipt of this advice the Service Group will work with the Workforce Business Partners to articulate the current workforce issues and medium and longer term plans.	Chief Operating Officer	Care Group Service Director Care Group Medical Director	30th November 2022	To be confirmed		In progress	February 2023 Update - Work has been developed within the IMTP framework to address this. Draft IMTP submitted December 2022.	
Radiology Service Review 15.1	Dec-22	Reasonable	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	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.	Chief Operating Officer	N/A				Completed		
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		Completed	February 2023 Update - Recommendation has now been superseded as a result of the Radiology Service Review	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. 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.

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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 to be undertaken.	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 Now July 2023		Part Completed	February 2023 Update - There are continued issues with network connectivity on the POW site which remains unresolved and is therefore holding up progress on POW site. K1 to K2 migration project initiated 18/01/2023 for utilising the existing passive system and transfer medical equipment over to the newer platform. DG has discussed options for utilising new active tags with the new platform and establish if current Wi-Fi infrastructure can support the new tag technology. This would simplify expansion UHB wide. (Still awaiting confirmation of specs required) DG developing a new SON in anticipation of the technology being a possibility to use as it could reduce the capital request. Based on the above update, the target date has been moved to 31/07/2023 (WG 25/01/2023).	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 recirculated 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 Now March 2023		In progress	February 2023 Update - The Bank Policy went to Policy Review Group and was shared for final comment. There were comments on the policy received, that are now being amended in the document to allow it to be re-submitted for the Feb-23 meeting. The actions required in this recommendation have been addressed and included in the policy.	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. 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.
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 Now March 2023		In progress	February 2023 Update - The Bank Policy went to Policy Review Group and was shared for final comment. There were comments on the policy received, that are now being amended in the document to allow it to be re-submitted for the Feb-23 meeting. The actions required in this recommendation have been addressed and included in the policy.	Appendix 5 has been sent through to the workforce policy review group for the change to be made to the roster policy it is in the agenda for the aug meeting. 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. 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
Directorate 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	February 2023 Update - position remains unchanged.	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. December 2022 Update - no change within the RTE area as a result of inadequate resources to complete this piece of work.

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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	February 2023 Update - A small cohort of the OFW Task and Finish Group met with the OFW Datix Team on the 6th December to receive an update on progress. Suggestions on further improvements were put forward and a further update meeting is scheduled for 2023. In the meantime monthly training continues with sessions booked throughout 2023. The revised Risk Assessment Procedure was approved in December 2022 which mandates the use of Datix for all risks irrespective of scoring. This has been promoted through the Staff Newsletter along with the training.	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 Now April 2023		In progress	February 2023 Update - FCP has now been updated and will be circulated for review and comment ready for April Audit & Risk Committee.	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 improve current processes. December 2022 Update - Awaiting update from ICT on the change in process for
Sunnyside Health & Wellbeing 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	February 2023 Update - position remains unchanged.	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 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 know 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 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
Sunnyside Health & Wellbeing 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	February 2023 Update - position remains unchanged.	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. 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
Sunnyside 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	February 2023 Update - position remains unchanged.	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

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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
Sunnyside 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 31 March 2022 Now July 2022 Now December 2022 Now March 2023		In progress	February 2023 Update - position remains unchanged.	September 2021 Update - There have been delays in obtaining all of this due to the priority being the completion contract works these are in hand to be provided by the time of the next meeting. November 2021 Update - Remains in progress to be provided by 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. 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 - Awaiting to ensure that the tender will proceed in current format or whether separate continuation arrangements and contracts will be made. 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. 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
Sunnyside 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	February 2023 Update - position remains unchanged.	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
Sunnyside 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	February 2023 Update - position remains unchanged.	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. 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
Sunnyside 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	February 2023 Update - position remains unchanged.	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. 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
Sunnyside 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	February 2023 Update - position remains unchanged.	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. 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
Sunnyside 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	February 2023 Update - position remains unchanged.	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. 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
Sunnyside 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	February 2023 Update - position remains unchanged.	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. December 2022 Update - no change as there will not be an update until the new contractor is
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	February 2023 Update - position remains unchanged.	September 2021 Update - Ongoing. November 2021 Update - Ongoing. January 2022 Update - 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

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Red -
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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
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	February 2023 Update - position remains unchanged.	September 2021 Update - Ongoing. November 2021 Update - Ongoing. 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. 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
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	February 2023 Update - position remains unchanged.	September 2021 Update - Ongoing. November 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. 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
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 Now March 2023		In progress	February 2023 Update - Met with the Executive Director for People on 30th Jan 2023 to plan and confirm meeting dates for 2023/24 Welsh Language Steering Group. First meeting of the Steering Group will take place on the 15 March 2023 and a programme of dates have been agreed for the rest of the 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. 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. 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.
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		Completed	February 2023 Update - All existing documentation and assessment forms have been reviewed and updated to reflect the revised WG CHC Framework. 1.1b Dedicated CHC Page on CTMUHB Intranet has been set up and will continue to be updated throughout 2023 as necessary. CHC Page on CTMUHB Internet site also set up.	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. 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.
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 Now March 2023		In progress	February 2023 Update - ToR still in draft will be finalised by March 2023.	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. December 2022 Update - Await new operating model. Terms to be reviewed in light of this once received.
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 Now April 2023		In progress	February 2023 Update - CHC Finance Team are currently drafting Financial Control Procedure and will liaise with CHC Team to confirm when completed. Should be within the month.	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. December 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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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	Now Qrtr 4 2022/2023		In progress	February 2023 Update - Structure will be finalised by end of Qtr 4 2022/2023. 12 month post will be appointed to support service change and benefits realisation under a new Assistant Director of Digital Transformation	June 2022 Update - Operating model phase 1 nearing completion, 2nd stage yet to commence. August 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. 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
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 Now March 2023		In progress	February 2023 Update - First draft of policy complete, seeking clarification on NWSSP recording process in respect of overtime worked which is not recorded in Health Roster. The guidance to support managers with NWSSP process needs to be written to form an appendix of policy. The policy will go out for consultation to be brought back to Feb 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. December 2022 - Work has commenced on reviewing the policy and will be taken to the January 2023 Employment Policy Review Group.
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 Heath 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 Now March 2023		In progress	February 2023 Update - The revised draft Overtime Policy incorporates the management actions agreed.	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. December 2022 update - Work has commenced on reviewing the policy and will be taken to the January 2023 Employment Policy Review Group.
Overtime & Additional Hours 2.1	May-22	Reasonable	The value and practicality of using the overtime authorisation checklist should be reviewed. 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 Now March 2023		In progress	February 2023 Update - The revised draft Overtime Policy incorporates the management actions agreed.	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. December 2022 update - Work has commenced on reviewing the policy and will be taken to the January 2023 Employment Policy Review Group.
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 development 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 Now March 2023		In progress	February 2023 Update - The revised draft Overtime Policy incorporates the management actions agreed. Overtime booked via the eSystems team (Health Roster) captures the reason for why the shift has been booked, when and who authorised it. This is the case for every shift undertaken, such as 'sickness'.	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. December 2022 update - Work has commenced on reviewing the policy and will be taken to the January 2023 Employment Policy Review Group.
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 Now March 2023		In progress	February 2023 Update - As part of the policy development we are developing a standardised claim form using NWSSP payroll template to be used when overtime is not recorded on Health Roster.	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. December 2022 update - Work has commenced on reviewing the policy and will be taken to the January 2023 Employment Policy Review Group.

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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
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 Now March 2023		In progress	February 2023 Update - The revised draft policy now confirms that all overtime and enhanced payments will only be paid in accordance with A4C and any deviation must be approved by the Exec Director for People. Payroll will only process enhanced payments if prior approval has been given by the UHB. Health Roster can only allow enhanced payments if this is turned on for areas. This can only be allowed centrally and at the instruction of the Director for People.	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. December 2022 update - Work has commenced on reviewing the policy and will be taken to the January 2023 People Policy Review Group.
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		Completed	February 2023 Update - The SPA document has been approved between Medical Workforce, the BMA and the Local Negotiating Committee (LNC). It has been distributed to the Consultant workforce and relevant managers. A Job Planning workshop is planned for the 26th January to discuss the SPA document and job planning.	June 2022 Update - In progress - on target for September 2022 completion. July 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. December 2022 Update – The BMA representatives have now withdrawn approval for the previous documentation shared, wanting further changes.
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	Now April 2023		In progress	February 2023 Update - An all Wales approach has now developed a rate card. The work is now in its final stages, with all the Health Boards undertaking a cost assessment based on the proposed ADH rates for Wales. There is a meeting scheduled for the 1st week of February where the implementation date will be discussed and set. The implementation date has been estimated as 1st of April 2023, however this will be revised after the meeting in Feb-23.	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. 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.
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	Now February 2023		In progress	February 2023 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 meetings. 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. December 2022 Update - 1.1a Some Legal Services SOPs have been reviewed and updated. Some are still in progress of being reviewed.
Welsh Risk Pool Claims 2.1	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 Now February 2023		In progress	February 2023 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 December 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		Completed	February 2023 Update - Discussions have taken place with the management accounts team and an updated process note is being implemented.	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. December 2022 Update - Process still being reviewed

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Yellow - Action
Green - Action
Blue - Action

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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		Completed	February 2023 Update - Discussions have taken place with the management accounts team and an updated process note is being implemented.	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. December 2022 Update - Process still being reviewed.
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	February 2023 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. 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
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	February 2023 Update - Refer to the update provided for 7.1. Retrospective review being undertaken as part of AW P2P T&F group, and further training needs will be identified by March 2023 No PO policy and exemption list being progressed through AW P2P and Finance academy. NO PO policy letters issued to HB in December 2022.	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. 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
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	February 2023 Update - Documentation and information will be available through the development of the CTM SharePoint page which will be linked to the NWSSP SharePoint page with all relevant P2P information including virtual training guides 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. 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.
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	February 2023 Update - as per December update.	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. 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
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		Completed	February 2023 Update - The revised Risk Assessment Procedure was approved in December 2022 which clearly articulates the system and processes for the Management of Risk within the Health Board. Training continues throughout 2023 via monthly risk awareness sessions where messaging in terms of these themes are reiterated. A workshop is scheduled with the Executive Team in January 2023 to review the risks on the Organisational Risk Register and address the common feedback themes. In the call for risk updates common feedback themes are raised with risk leads.	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. 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.

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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	February 2023 Update - no update provided on this occasion	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. 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
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	February 2023 Update - no update provided on this occasion	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. 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.
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	February 2023 Update - no update provided on this occasion	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. December 2022 Update - PCH Surgery CSG are actively participating in the Planned Care Quality & Safety meeting which has met for the first time.
Medical & Dental Rostering 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 Now March 2023		In progress	February 2023 Update - The policy is awaiting review at the LNC. The next LNC is not until March 2023, so the policy will not be ratified until after this. This is however reliant on it passing the committee with no alteration required.	October 2022 Update - no update provided against this recommendation on this occasion. 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.
Medical & Dental Rostering 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			Completed	February 2023 Update - In terms of the Health Roster Systems, Allocate do provide guides and there is a tutorial in the system; we also train multiple people in the areas so that any issues like absence are less disruptive, In terms of the other systems by ACT and ED, they have local connections with their providers so we do not have any guides or control other these,	October 2022 Update - no update provided against this recommendation on this occasion. December 2022 Update - How to guides are yet to be developed or shared by Anaesthetics or Emergency Department (ED) colleagues.

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Medical & Dental Rostering 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 Now March 2023		In progress	February 2023 Update - Further meeting to be scheduled with BMA to discuss approach and confirm agreement	October 2022 Update - On track for completion November 2022. December 2022 update - 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.
CAMHS Workforce 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 Now March 2023		In progress	February 2023 Update - SOP has been drafted and circulated for comment prior to sign off.	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. 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.
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	February 2023 Update: Ongoing - will be aligned to the next iteration of the Care Group structure	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		Completed	February 2023 Update: Records have been identified and process underway / Propose to close	December 2022 Update - Work underway - plan to complete by end of QTR4 2022/2023
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			Completed	February 2023 Update - Underlying causes identified / resources required to rectify some of the key issues / decisions will need to be made in alignment of priorities for the Health Board. Actual action complete - propose to close	December 2022 Update - To be completed with the Medical Records review report from November 2022

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ICTM Quality Improvement Team 1.1	Dec-22	Reasonable	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	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.	Director of Nursing	Assistant Director Improvement Culture, Capability & Delivery	Jan-23			In progress	February 2023 Update - Procedural guidance is in draft form for completion in January 2023. Project approval will be incorporated as an agenda item in the monthly project group.	
iCTM – Quality Improvement Team 1.3a, 1.3b and 1.3c	Dec-22	Reasonable	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. 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.	Medium	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.	Director of Nursing	Assistant Director Improvement Culture, Capability & Delivery	Mar-23			Completed	February 2023 Update - Use of LIFEQI has been reviewed. Projects will be monitored at the monthly 'Project Review' group. Reference numbers will be used as requested.	
iCTM – Quality Improvement Team 2.1	Dec-22	Reasonable	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	We are developing a solution which will be based either on use of the existing LifeQI system or a new centrally held database.	Director of Nursing	Assistant Director Improvement Culture, Capability & Delivery	Jan-23	Now February 2023		In progress	February 2023 Update - All improvement projects will be captured on LifeQI.	
iCTM – Quality Improvement Team 2.2	Dec-22	Reasonable	All Improvement projects should be aligned to the organisation's strategic aims and objectives, and this should be captured within project documentation.	Medium	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.	Director of Nursing	Assistant Director Improvement Culture, Capability & Delivery	Jan-23			In progress	February 2023 Update - We are aligning all projects either to the goals of CTM 2030 - the LHBs long term strategy, or toward the goals of the national Safe Care Collaborative. In addition, scrutiny at the monthly project group will allow us to ensure projects are aligned to organisation goals.	
iCTM – Quality Improvement Team 3.1	Dec-22	Reasonable	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	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.	Director of Nursing	Assistant Director Improvement Culture, Capability & Delivery	Jan-23	Now February 2023		In progress	February 2023 Update - Faculty Framework has been reviewed and a new model in development.	

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iCTM – Quality Improvement Team 4.1	Dec-22	Reasonable	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	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.	Director of Nursing	Assistant Director Improvement Culture, Capability & Delivery	Jan-23			In progress	February 2023 Update - Procedural guidance is in draft form for completion in January 2023.	
iCTM – Quality Improvement Team 4.2	Dec-22	Reasonable	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 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.	Medium	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.	Director of Nursing	Assistant Director Improvement Culture, Capability & Delivery	Jan-23			In progress	February 2023 Update - Procedural guidance is in draft form for completion in January 2023.	
iCTM – Quality Improvement Team 4.3	Dec-22	Reasonable	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	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 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.	Director of Nursing	Assistant Director Improvement Culture, Capability & Delivery	Jan-23			Completed	February 2023 Update - Projects will be monitored monthly at the Project Review Group.	
Radiology Service Review 1.1	Dec-22	Reasonable	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	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. 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.	Chief Operating Officer	Executive Office Clinical Service Manager Senior Superintendents Clinical Lead for Quality and Governance Health and Safety Leads	31 December 2022 9 November 2022	Now March 2023		In progress	February 2023 Update - A standardised ToR is in the process of being implemented for all meeting groups. The Radiology Quality, Improvement and Governance Chair and management have met to finalise the ToR for QI&G and the first new meeting took place on 25/01/23, with vice chair appointed.	
Radiology Service Review 2.1	Dec-22	Reasonable	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	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.	Chief Operating Officer	Clinical Service Manager Clinical Lead for Quality and Governance Senior Superintendents Health and Safety Leads	30-Nov-22	Now March 2023		In progress	February 2023 Update - A standardised ToR is in the process of being implemented for all meeting groups. The Radiology Quality, Improvement and Governance Chair and management have met to finalise the ToR and the first new meeting took place on 25/01/23. A Vice Chair has been appointed to oversee meetings in absence of Chair. March 2023.	

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Radiology Service Review 2.2	Dec-22	Reasonable	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	The Terms of Reference for all existing groups will be reviewed to ensure that there is a standardised approach.	Chief Operating Officer	Clinical Service Manager	Dec-22	Now March 2023		In progress	February 2023 Update - A standardised ToR is in the process of being implemented for all meeting groups.	
Radiology Service Review 2.3	Dec-22	Reasonable	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	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.	Chief Operating Officer	Clinical Service Manager Executive Office	Completed			Completed		
Radiology Service Review 3.2	Dec-22	Reasonable	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	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.	Chief Operating Officer	Clinical Services Manager	Completed			Completed		
Radiology Service Review 4.1	Dec-22	Reasonable	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	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.	Chief Operating Officer	Corporate Services Manager/Clinical Service Manager	31st December 2022			In progress	February 2023 Update - no update provided on this occasion	
Radiology Service Review 5.1	Dec-22	Reasonable	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	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.	Chief Operating Officer	Superintendent Radiographers Clinical Service Manager Care Group Service Director	30th November 2022			Completed	February 2023 Update - Risk Management is a standard item on the Radiology Business meeting agenda. The service has implemented a monthly Risk Management meeting following the Business Meeting. All departmental risks are also discussed or escalated via the Radiology Quality, Improvement and Governance Meeting quarterly. Completed.	

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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
Radiology Service Review 13.1	Dec-22	Reasonable	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	Medium	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.	Chief Operating Officer	Care Group Director	31st December 2022	Now March 2023		In progress	February 2023 Update - There is no formal agenda for the monthly performance meeting. Following receipt of the ToR, this will enable the department to follow an agenda or inform expectations for reporting consistently. Ongoing.	
Radiology Service Review 14.1	Dec-22	Reasonable	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	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.	Chief Operating Officer	Finance Business Partner Clinical Service Manager	31st December 2022	To be confirmed		In progress	February 2023 Update - The current Performance Meeting does not cover CRES. CRES discussions are held at Care Group level with Director of Finance and Care Group senior team.	
Radiology Service Review 15.2	Dec-22	Reasonable	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 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.	Medium	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.	Chief Operating Officer	N/A				Completed		
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 Now 31 May 2022	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	February 2023 Update - The Health Safety and Fire Team have completed their second Organisational Audit and results will be provided to the 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 so 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. 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.
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	February 2023 Update - no update provided on this occasion	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 quinnquennial 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. December 2022 Update - A draft version has been completed and is being checked through, this will now be completed during December 2022.
Sunnysi de Health & Wellbeing Centre 09	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	February 2023 Update - position remains unchanged.	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. 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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Sunnyside Health & Wellbeing Centre 17	Aug-21	Reasonable	Management should instigate a process for formal review and sign-off of any further design changes with relevant parties.	Low	The Health Board already has in places processes for sign off of design by users and this process will be used in this scheme moving forward (also to be detailed in the Project Execution Plan).	Director of Finance	Senior Project Manager	Nov-21	Now 31 March 2022 Now July 2022 Now December 2022 Now March 2023		In progress	February 2023 Update - position remains unchanged.	September 2021 Update - Ongoing. November 2021 Update - to be completed this month. January 2022 Update - although technically this has been agreed it can not be fully implemented until the new contractor is back on site and appointed which will be at least March. 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. 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
Financial Systems 6.1	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		Completed	February 2023 Update - Discussions have taken place with the management accounts team and an updated process note is being implemented.	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. December 2022 Update - Process still being reviewed alongside Ref 1.1 and 6.2
Risk Management 2022 05	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	February 2023 Update - A small cohort of the OFW Task and Finish Group met with the OFW Datix Team on the 6th December to receive an update on progress. Suggestions on further improvements were put forward and a further update meeting is scheduled for 2023. In the meantime monthly training continues with sessions booked throughout 2023. The revised Risk Assessment Procedure was approved in December 2022 which mandates the use of Datix for all risks irrespective of scoring. This has been promoted through the Staff Newsletter along with the training.	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. 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 mandating the use of Datix for risk
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	February 2023 Update - no update provided on this occasion	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. December 2022 Update - Quality & Safety Framework first draft expected 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	February 2023 Update - no update provided on this occasion	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. To date approx. 70 people have been trained to maximise patient safety, understand putting things right legislation and undertake investigations. Sessions will continue to run monthly from November. As the organisational change takes place, the vision is for the all governance teams across the care groups to support with delivering this training. 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.
CSG & ILG Quality Assurance 5.0	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	February 2023 Update - no update provided on this occasion	October 2022 update-This has been responded to within earlier updates in relation to the new Quality & Safety Framework. December 2022 Update - Quality & Safety Framework first draft expected December 2022
iCTM – Quality Improvement Team 3.2	Dec-22	Reasonable	The updated faculty framework document should be formally approved with the date of approval and issue recorded on the document.	Low	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.	Director of Nursing	Assistant Director Improvement Culture, Capability & Delivery	Mar-23			In progress	February 2023 Update - Procedural guidance is in draft form for completion in January 2023.	
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		Completed	January 2023 update - Since the time of making the recommendation the majority of sub-contractor accounts have been formally acknowledged as signed off. Those remaining constitute a small risk in monetary terms and are largely for service or supply contracts rather than works. This information has been shared with NWSSP Audit Service, who are content that this risk can be closed.	December 2022 Update - Statements of final account are being sought for the outstanding accounts.

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R2 Follow Up Outpatients 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 though 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	February 2023 Update - nothing further to add. Verbal update will be sought for meeting of Audit Committee.	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. 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.
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 (eg SOS / PIFU projects, Attend Ane). Our work has found that there continues to be issues with the quality of medical records within the Heath Board. In 2018, NWIS 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	February 2023 Update - Action plan now in place for Medical Records - Action Plan in place until October 2023. Propose to close.	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 mandate 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 digitisation, which have been delayed due to COVID-19 until 20/21. 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 20/21. 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 NWIS 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 CITO 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 month. Pressure of work at present is significant. June 2022 - Update Will be available for August 2022. August 2022 - nothing further to report. October 2022 Update: 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.
Clinical Coding Furlow 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 NWIS 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	February 2023 Update - Regular audits and reporting of the quality of the medical record are now in place - propose to close.	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 AMaT (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. 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.
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	February 2023 Update – Discussions are currently taking place with the Employee Experience Lead and the Head of Nursing Professional Standards and Education, regarding how this policy work can be integrated into the retention / Itchy Feet work which is currently being progressed, to ensure the processes align with the new Flexible Retirement Policy.	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 employee 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. 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.

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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/HIW 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 sight; 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 CSG/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	February 2023 Update - no update provided on this occasion	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. December 2022 Update - The Quality & Safety Framework first draft will be available end of December 2022. Quality Strategy update as in R1.
Audit Wales/HIW 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	February 2023 Update - no update provided on this occasion	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 PREMS 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 the system is increasing and deep in sessions for staff are planned for June/July across acute sites to demonstrate
Audit Wales/HIW 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	February 2023 Update - no update provided on this occasion	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
Audit Wales/HIW 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	February 2023 Update - no update provided on this occasion	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 services and the experience of our workforce.
Audit Wales/HIW 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	February 2023 Update - A small cohort of the OFW Task and Finish Group met with the OFW Datix Team on the 6th December to receive an update on progress. Suggestions on further improvements were put forward and a further update meeting is scheduled for 2023. In the meantime monthly training continues with sessions booked throughout 2023. The revised Risk Assessment Procedure was approved in December 2022 strengthening the process for risk and training opportunities. This has been promoted through the Staff Newsletter along with the training.	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 - 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
Audit Wales/HIW Quality Governance Follow Up Review R10.4	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	An efficient risk management process which is seen as efficient and not cumbersome – linked to the new Once For Wales Risk Management System.	Director of Corporate Governance	Assistant Director of Governance & Risk	Apr-22	Now October 2022 Now 31 December 2022 Now 31 March 2023		In Progress	February 2023 Update - Please see update for recommendation R10.1. The Risk Management System is clearly defined but will require alignment to the new OFW Risk Management Module once available.	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. November 2021 - No further update provided. 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 Datix Cymru Risk Module to ensure that any training modules

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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/HIW 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	February 2023 Update - no update provided on this occasion	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. December 2022 Update - There are no incidents within the holding area of the Health Board's legacy system. A small number remain
Audit Wales/HIW 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		Completed	January 2023 Update - The consultation for the new quality governance central model to support the Care Groups has closed. An implementation plan is being developed. Complaints policies and procedures are in the process of being reviewed. 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. A training needs analysis is being developed which will be circulated to Care Groups for identification of staff. Complaints handling training has commenced. 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. Learning newsletters are shared across the organisation	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. Polices 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/HIW 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	February 2023 Update - no update provided on this occasion	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 wales 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, 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- 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/HIW 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	February 2023 Update - no update provided on this occasion	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/department 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. January 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 • Continue the CTM Ward Assurance project group to provide a governance framework regarding the development and implementation of new audits, ensuring consistency and validation • Implementation of the Safe care digital platform across CTM
Audit Wales/HIW Quality Governance Follow Up Review R7.7h		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	February 2023 Update - no update provided on this occasion	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. December 2022 Update - On track for July 2024 completion
Structured Assessment 2021 Phase 2 R5	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	February 2023 Update - no update provided on this occasion	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 post
Audit of Account 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	February 2023 Update - Will be implemented at year end	October 2022 Update - Will be completed when draft accounts prepared in April 2023. December 2022 Update - On track for April 2023 completion
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	February 2023 Update - Will be implemented at year end	October 2022 Update - Will be completed when draft accounts prepared in April 2023. December 2022 Update - On track for April 2023 completion
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	February 2023 Update - Will be implemented at year end	October 2022 Update - Will be completed when draft accounts prepared in April 2023. December 2022 Update - On track for April 2023 completion

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 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	February 2023 Update - Will be implemented at year end	October 2022 Update - Will be completed when draft accounts prepared in April 2023. December 2022 Update - On track for April 2023 completion
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 Now April 2023		In Progress	February 2023 Update - Awaiting the completion of an internal audit review of the area prior to updating the FCP. The review has been completed and the report is currently in draft stage, and should be finalised shortly. We will then work with the workforce team to update the FCPs accordingly.	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. December 2022 Update - Out for comment and review. On track for December 2022 completion.
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	February 2023 Update - The working group met on 12/01/23 to process map the current process and identify slippage and pressure points. The Improvement and Innovation Team are currently mapping a reviewed process and initial conversations are underway to explore the digitisation of EIA forms.	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.
National Fraud Initiative in Wales 2020-21 R1	Dec-22	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.	Director of Finance	Head of Local Counter Fraud	Completed			Completed		
National Fraud Initiative in Wales 2020-21 R3	Dec-22	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.	Director of Finance	Head of Local Counter Fraud	Completed			Completed		
Transformational Leadership Programme Board – Baseline Governance Review R1	Dec-22	Strategic planning and applying the sustainable development principle Our work found opportunities for the TLPB to strengthen its planning arrangements and demonstrate how it is acting in accordance with the sustainable development principle (as set out in the Well-being of Future Generations (Wales) Act). The principle should be integral to the TLPB's thinking and genuinely shaping what it does by: a) taking a longer-term approach to its planning beyond five years, b) ensuring greater integration between the long-term plans of the four statutory bodies of the TLPB, and c) improving involvement of all members of the TLPB to ensure an increased voice for non-statutory partners and a better understanding of the purpose of the RPB more generally.		Agreed. Although the sustainable development principle is a fundamental consideration in all decision making, this will be made more explicit in reports to TLPB and RPB going forward. Transition to a new delivery plan has been completed and work will continue to integrate the long term plans of the four statutory bodies improve involvement of non-statutory partners	Director of Strategy & Transformation	Head of Regional Collaborative Unit	31 March 2023			In Progress	February 2023 - No further update. Ongoing action	
Transformational Leadership Programme Board – Baseline Governance Review R2	Dec-22	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	Director of Strategy & Transformation	Chair of the TLPB	30-Jul-22			Completed	February 2023 Update - this is now established and has been in place since end of summer 2022	
Transformational Leadership Programme Board – Baseline Governance Review R3	Dec-22	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	Director of Strategy & Transformation	Head of RCU	30 September 2022			In Progress	February 2023 Update - the outcomes and performance framework is still being finalised	
Transformational Leadership Programme Board – Baseline Governance Review R4	Dec-22	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.	Director of Strategy & Transformation	Chair TLPB	31 March 2023			In Progress	February 2023 Update - no update provided on this occasion	
Transformational Leadership Programme Board – Baseline Governance Review R5	Dec-22	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.	Director of Strategy & Transformation	Head of RCU	31 December 2022			In Progress	February 2023 Update - no further update, ongoing action	
Transformational Leadership Programme Board – Baseline Governance Review R6	Dec-22	Use of Resources Improving the health and social care outcomes of the region will require efficient and effective use of combined resources. Our work found that there had been some limited examples of pooled budgets and other arrangements for sharing resources. The TLPB needs to explore more innovative ways of sharing and pooling core		Agreed. The development of the RIF delivery plan is only one funding stream and TLPB recognises that we will need to align core budgets, for example around children with complex needs. This will be addressed through the planning cycle in advance of 2023/24	Director of Strategy & Transformation	Chair TLPB	31 March 2023			In Progress	February 2023 Update - ongoing action as currently in the planning cycle so this work is being taken forward.	
Transformational Leadership Programme Board – Baseline Governance Review R7	Dec-22	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	Director of Strategy & Transformation	Chair TLPB	31 March 2023			In Progress	February 2023 Update - needs to be established as part of agenda/working arrangements under the ILB	

Cwm Taf Morgannwg University Health Board

Audit & Risk Committee
Internal Audit Progress Report

February 2023

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 **31 January 2023**. This report provides information on the status of progress of our reviews.

1.2 We report the progress made to date against individual assignments along with details regarding the delivery of the plans and any required updates.

2 Reports Issued

2.1 Since the December meeting of the Committee three reports have been finalised, two reports have been issued in draft, and we have ongoing fieldwork in relation to ten 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
Wellbeing	-	1	4	5	Substantial
Medical variable pay – agency costs	4	2	-	-	Limited
Follow up – Fire safety	-	2	-	-	Reasonable

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	93% (13/14)	80%	v>20%	10%<v <20%	v<10%
Report turnaround: time taken for management response to draft report [15 days per Internal Audit Charter]	Amber	67% (8/12)	80%	v>20%	10%<v <20%	v<10%
Report turnaround: time from management response to issue of final report [10 days]	Green	100% (12/12)	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 six responses to date.

5 Other activity

Meetings

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

Planning for 2023/24

5.2 We have started our planning and will meet with directors and independent members over the next few weeks. We aim to present the plan at the next meeting of the Committee.

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	~~1~~ 2	Final	December Committee
26	Follow up - Fire safety	Reasonable	-	Final	February Committee

Plan Ref.	Review	Rating	Review period	Status	Notes
8	Board awareness of digital	Reasonable	2	Draft	Planned February Committee
12	Medical variable pay	Limited	2	Draft	February Committee
4	Reasonable offer	-	~~1~~ 2	WIP	Planned February Committee, but fieldwork has taken longer to complete.
28	Follow up - Bridgend transfer of IT	-	4	WIP	Fieldwork ongoing
N/A	Follow up - Facilities governance	-	3	WIP	Fieldwork started 16.01.23
14	Risk management	-	~~3~~ 4	WIP	Move to Q4 as prior year was delayed to 21/22 Q4. Fieldwork started 21.12.23
15	Performance monitoring and management	-	3	WIP	Fieldwork started 12.01.23
17	SLA arrangements	-	3	WIP	Fieldwork started 16.01.23
N/A	Follow up - Patient pathway appointment management process	-	4	WIP	Fieldwork ongoing

Plan Ref.	Review	Rating	Review period	Status	Notes
5	National incident framework	-	~~1~~ 4	WIP	Moved to Q4 new framework needs time to embed. Fieldwork started 23.01.23
24	Welsh Risk Pool	-	4	Planned	Brief agreed
29	Follow up - Concerns	-	4	Planned	Brief agreed
7	Financial systems (financial savings)	-	~~2~~ 4	Planning	Request move to Q4 for implementation of OM. Brief issued 26.01.23
18	Health system	-	3	Planning	Initial planning meeting held on 22.11.22
13	Recruitment and retention	-	~~2~~ 4	Planning	Planning meeting 11.07.22. Management request to move to Q4
10	Service configuration to meet cancer targets	-	~~2~~ 4	Planning	Management request to move to Q4. Discussed with COO 01.12.22. Awaiting information.
25	Decontamination	-	4	Planning	Planning meeting 21.12.22 and second 19.01.23

Plan Ref.	Review	Rating	Review period	Status	Notes
11	Interventions Not Normally Undertaken (INNU)	-	~~2~~ 4	Planning	Discussed with COO 01.12.22. Awaiting information.

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	-	Audit work a little behind. Will go to April Committee.
Governance	WIP	-	Audit work a little behind. Will go to April 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	Draft brief issued 16.01.23
35	WHSSC – Mental health	-	Defer	Defer to next year as mental health strategy yet to be finalised.

Staff Wellbeing

Final Internal Audit Report

January 2023

Cwm Taf Morgannwg University Health Board

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Review reference:	CTMUHB-2223-09
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Final report issued:	6 December 2022 updated 23 January 2023
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
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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:

- 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

Few matters require attention and are compliance or advisory in nature.

Low impact on residual risk exposure.

Assurance summary[1]

Objectives		Assurance
1	An appropriate framework and governance arrangements are in place.	Substantial
2	Engagement with staff has taken place to identify issues or gaps in provision.	Substantial
3	Appropriate training and resources are available.	Substantial
4	The effectiveness of wellbeing initiatives is regularly monitored.	Reasonable

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
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. We note that these proactive priorities have been captured and monitored by an overarching Wellbeing Priorities workplan that includes the wellbeing objectives, actions and outputs, key dates and a progress RAG rating. Periodically refreshing this workplan appears to be a helpful way for the service to plan its forward work, while being mindful that it needs to maintain flexibility to meet reactive demands. **(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. Periodically refreshing the workplan to help the process of prioritising forward work 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 substantial 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 In 2021 the Health Board undertook an innovative staff wellbeing survey. There is an opportunity to increase the coverage of future wellbeing surveys by analysing the data to identify areas of the Health Board where uptake was low. 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. The Staff Wellbeing Survey can be a key tool to identify staff wellbeing perceptions and needs. The Health Board can build on the learning from previous surveys to improve completion rates of future surveys. We have provided substantial 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 been 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**	**Responsible Officer**
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	Head of Policy, Compliance and Agenda for Change for LPF Strategic Lead for Employee Experience and Wellbeing.
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.		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**
The Wellbeing Service has to be both proactive and reactive in nature, and at times may have competing priorities. To help prioritise its work the team has used a workplan, although the workplan for July to December 2022 was not refreshed before the start of the six-month period that it covered.	Negative impact on service delivery if priorities due for delivery are delayed and not monitored.

	Recommendation	**Priority**
2.1	For the proactive elements of the Wellbeing service provided we would encourage the use of the forward looking workplan, while acknowledging that it should remain flexible to accommodate the reactive nature of more immediate priorities.	**Low**

	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**
In 2021 the Health Board undertook a Wellbeing Staff Survey, the findings of which are a key source of information for the Wellbeing Service in determining its future service provision. In 2021, 21% of the Health Board staff completed the survey. There is an opportunity to analyse 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, which may be as some staff working in small teams wanted 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.	**Low**

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

Follow-up: Fire Safety Management
Final Internal Audit Report

January 2023

Cwm Taf Morgannwg University Health Board

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

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

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Auditors:	NWSSP Audit & Assurance: Specialist Services Unit
Executive sign-off:	Hywel Daniel, Executive Director for People
Distribution:	Tim Burns, Assistant Director of Strategic & Operational Planning Chris Beadle, Head of Health, Safety & Fire Carl Edwards – Senior Fire Safety Officer
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

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Executive Summary

Purpose

The Health Board is required to comply with the Regulatory Reform (Fire Safety) Order 2005 as applied in Wales by Welsh Health Technical Memorandum 05-02 (WHTM 05-02) ('the Firecode').

The audit sought to determine the status of agreed recommendations arising from the 2021/22 Fire Safety Management audit. That report determined a limited assurance rating, with several significant matters identified, placing the Health Board at risk of non-compliance with Firecode.

Overview of findings

Agreed actions from the prior review have been largely implemented, with 12 of the 15 recommendations now implemented (including 4 high priority matters).

Two Medium priority matters remained outstanding:

- on-going update of site-specific procedures; and
- the need for an investment strategy (this was not prioritised due to funding constraints).

The remaining high priority matter was in progress i.e.:

- the need for summary reporting of risk assessment completion status (now compiled & awaiting publication).

These matters remaining are further detailed below.

Actions taken over the last year have therefore addressed most former recommendations. While also recognising the significance of outstanding / on-going issues, a **reasonable** assurance is determined in relation to management action.

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

Assurance Summary

	High	Medium	Low	**Total**
Closed	4	7	1	**12**
Partially Implemented	1	-	-	**1**
Outstanding	-	2	-	**2**
Total	**5**	**9**	**1**	**15**

Key Matters Remaining		Control Design or Operation	Recommendation Priority
Site specific procedures Rec. **2.1**	Local procedures will be reviewed and updated within specified review periods - and associated uniform approval arrangements applied.	Operation	**Medium**
Strategy Rec. **4.1**	Management should develop an appropriate medium-term strategy to demonstrate co-ordination of efforts in managing the fire risk.	Operation	**Medium**
Risk assessment completion status Rec. **5.1**	Appropriate systems should be developed to allow the production of basic management information in relation to risk assessments.	*Operation*	**High**

*Full details of recommendations requiring further action are provided in the **Management Action Plan** in **Appendix A**.*

1. Introduction

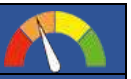
1.1 This review was undertaken in accordance with the 2022/23 Internal Audit Plan agreed with the University Health Board (the UHB).

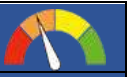
1.2 The overall objective of the audit was to evaluate the adequacy and timeliness of management action to address previously agreed recommendations included at the February 2022 Fire Safety Management audit report (providing limited assurance).

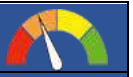
1.3 The potential risks considered in the review were that:

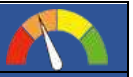
- management control frameworks continued to exhibit weaknesses;
- management did not have processes in place to review and action agreed audit recommendations; and
- management action had not been tailored to reflect emerging risks.

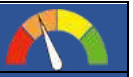
Appendix A: Management Action Plan Status

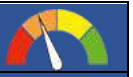
Fire Safety Management (February 2022)				Previously providing 	
Ref	**Area**	**Previously agreed action**	**Updated position**	**Updated Responsibility & Timescale**	**Priority Rating**
1.1	Policy	The Fire Safety Policy should be appropriately updated/ ratified.	**Implemented** An updated Fire Safety Policy was ratified by the Quality & Safety Committee on 1st September 2021.	N/A	**Medium**
2.1	Site specific procedures	Local procedures will be reviewed and updated within specified review periods - and associated uniform approval arrangements applied.	**Outstanding** WHTM 05-01 states that: *"NHS organisations in Wales will have a clearly defined fire safety policy covering all buildings they occupy."* At the original audit, three hospital site procedures were selected for review (Princess of Wales; Prince Charles; and Ysbyty Cwm Rhondda hospitals), and found to be out-dated. No further update was provided at this audit in respect of these three sites. **Management comment** The Health Board has both area / ward based procedures and overall site procedures. This does not present a major risk, as these are background information utilised for training, rather than being the emergency procedures. These also represent best practice rather than being a legislative requirement, being additional to the area specific procedures.	30/06/2024 Head of Health Safety & Fire	**Medium**

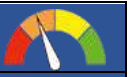
Fire Safety Management (February 2022)				Previously providing 	
Ref	**Area**	**Previously agreed action**	**Updated position**	**Updated Responsibility & Timescale**	**Priority Rating**
			The site procedures are comprehensive procedures, and will be updated over an 18 month period following the recent appointment of a new Senior Fire Safety Officer. The initial priority had been to put in place site procedures for Bridgend, as when this was transferred to CTMUHB it lacked site procedures.		
3.1	Terms of reference	Terms of reference of relevant committees should be updated, as required, to reflect revised monitoring and reporting arrangements in respect of fire safety.	**Implemented** Fire Safety was confirmed to be included at the Terms of Reference of relevant committees and groups.	N/A	**Medium**
4.1	Strategy	Management should develop an appropriate medium-term strategy to demonstrate co-ordination of efforts in managing the fire risk.	**Outstanding** The Chief Executive of NHS Wales wrote to all NHS organisations on 13th February 2020 emphasising: *"organisations assess and provide appropriate levels of investment in relation to fire safety measures."* with direction to *"discuss.. implications with organisations via the regular Capital review meetings."* i.e. investment sources should be confirmed, including the need to submit capital business cases to Welsh Government. This recommendation was made and agreed in context of the Fire Safety Management audit (the subject of this follow-up) forming	31/3/23 Head of Health, Safety and Fire Head of Capital and Estates	**Medium**

Fire Safety Management (February 2022)				Previously providing 	
Ref	**Area**	**Previously agreed action**	**Updated position**	**Updated Responsibility & Timescale**	**Priority Rating**
			part of an All Wales review, and was to be consistent across Health Boards. Risks are reported and profiled to Welsh Government at both the Fire Safety Risk Register, and Estates Facilities Performance and Condition report. However, this does not represent a time-phased strategy to address e.g. for expert resource to drive certain actions, or co-ordination with building works. **Management comment** Agreed - however, due to limited All Wales capital finance, this has not been prioritised over the last year.		
5.1	Risk Assessment	Appropriate systems should be developed to allow the production of basic management information in relation to risk assessments.	**Ongoing** Summary data is now available and will be presented to the forthcoming February 2023 Health Safety & Fire sub-committee.	28/02/2023 Head of Health Safety & Fire	**High**
5.2		Risk assessments should be completed within stipulated review periods, including refresh for ward reconfigurations.	**Implemented** "Firecode" requires that "*Fire risk assessments are maintained up-to-date and are reviewed as appropriate."* At the time of prior audit, circa 35 – 49% of risk assessments were over-due. Data now shows only 4.2% of Risk Assessments overdue i.e. 17 of 405 assessments i.e. substantial compliance, with on-going	N/A	**High**

Fire Safety Management (February 2022)				Previously providing 	
Ref	**Area**	**Previously agreed action**	**Updated position**	**Updated Responsibility & Timescale**	**Priority Rating**
			monitoring and accountability being put in place by publication of this data to meetings of the Health Safety & Fire sub-committee. Noting that Risk Assessments would not be revised ahead of time, this number, as now reported for scrutiny, is now deemed acceptable.		
6.1	Risk actions	Reporting to the Health, Safety & Fire Sub-committee should be enhanced to include action taken to address risks identified in risk assessments and risks still to be actioned.	**Implemented** Outstanding risks with assigned priority ratings were reported to the Health, Safety & Fire sub-committee, including a "deep dive" into 21 high priority fire risks from Datix. The report was presented to the October 2022 sub-committee.	N/A	**High**
6.2		High priority Integrated Locality Group (ILG) risk actions will be appropriately summarised / reported in accordance with request of the Executive Director of Operations at the August 2020 Health, Safety & Fire Sub-committee.	**Implemented** High priority matters were profiled and reported to the Health, Safety & Fire sub-committee.	N/A	**Medium**
7.1	Building alterations	Users should be reminded that Fire Build forms are to	**Implemented**	N/A	**Medium**

Fire Safety Management (February 2022)				Previously providing 	
Ref	**Area**	**Previously agreed action**	**Updated position**	**Updated Responsibility & Timescale**	**Priority Rating**
		be utilised in accordance with the Fire Safety Policy.	Audit sample showed that "*Fire Build Request for Change of Use / Alteration*" forms were being utilised as required.		
8.1	Maintenance	Management will confirm that GAP analysis has been concluded to ensure comprehensive appliance checks.	**Implemented** Comprehensive appliance checks informed by GAP analysis have been evidenced.	N/A	**Low**
9.1	ILG reporting	ILG reporting could be improved by the inclusion of the issues raised at the observation.	**Implemented** While the ILG structure is to be disbanded, required elements of reporting were individually evidenced by enhanced reporting addressing other recommendations.	N/A	**High**
9.2		As per the requirement of the Health Safety & Fire Sub-committee, minutes of the ILG H&S Meetings will be tabled for information.	**Implemented** Minutes were provided to Health Safety & Fire sub-committee.	N/A	**Medium**
10.1	Training	ILGs will be required to regularly report on fire training compliance (including specialist training) against predefined performance indicators,	**Implemented** ILG fire safety training performance was found to be reported to the Fire, Health & Safety sub-committee against predefined performance indicators, identifying appropriate strategies to improve compliance.	N/A	**High**

Fire Safety Management (February 2022)				Previously providing 	
Ref	**Area**	**Previously agreed action**	**Updated position**	**Updated Responsibility & Timescale**	**Priority Rating**
		identifying appropriate strategies to improve compliance.			
11.1	Drawings / compartmentation	Management should confirm an appropriate timeline to update drawings in respect of compartmentation for all sites.	**Implemented** Management confirmed that the former CTMUHB Senior Fire Officer has been re-employed within the Estates & Capital Department to carry out a review of all Fire Orientation/Compartmentation plans across the HB and feed info into the HB CAD operator for updating if required. Timelines were confirmed as: • Work already underway at the Royal Glamorgan Hospital - to be completed by end of January 2023. • Survey work commenced in Princess of Wales Hospital (POW) in November 2022 and will be finalised in March 2023. • POW to be followed by Prince Charles Hospital which will take a further 4 months to complete. • Work to Community Hospitals to commence on completion of the District General Hospital sites, with a revised completion target date of September 2023. **Management comment** This work will allow the Health Board to have centralised base line fire plans for all the District General Hospital sites that will be	N/A	**Medium**

Fire Safety Management (February 2022)				Previously providing 	
Ref	**Area**	**Previously agreed action**	**Updated position**	**Updated Responsibility & Timescale**	**Priority Rating**
			utilised for all Passive and Active fire information such as Dampers; cause & effect etc. as well as any other services or operational needs.		
12.1	High risk actions	Management should confirm a process of review of local procedures in respect of each high-risk action addressed.	**Implemented** Amendment to procedures has been agreed by the Head of Health, Safety & Fire to ensure that high-risk issues identified at risk assessments, are addressed by local procedures.	N/A	**Medium**

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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

Medical Variable Pay – Agency Costs
Final Internal Audit Report

February 2023

Cwm Taf Morgannwg University Health Board

Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

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Executive sign-off:	Dom Hurford, Medical Director
Distribution:	Sallie Davies, Deputy Medical Director Paul Harrison, Head of Workforce Productivity and e-systems
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 evaluate and determine the adequacy of the systems and controls in place within the Health Board for the payments made to medical agency staff.

Overview

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

Whilst the policies and procedures set out the controls and process that staff should follow, these were not up to date, not always followed and some staff were not aware of them. Our testing has identified issues in relation to:

- A lack of evidence to support higher rate payments to agency staff. Leading to an inability to confirm rates paid were what was agreed.
- Lack of evidence to support longer-term and extended placements.
- Increasing use of non-direct engaged locums.

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

Report Opinion

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Objectives		Assurance
1	Policies and procedures in relation to medical agency staff are in place.	Reasonable
2	Appropriate authorisation is sought to engage agency staff dependant of their rate of pay.	Limited
3	Appropriate authorisation for longer term placements.	Limited
4	Correct rates actually paid.	Limited
5	Monitoring and scrutiny of spend.	Reasonable

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Design and use of policies and procedures	1	Design	High
2	Use of directly engaged locums	2	Operation	Medium
3	Authorisation of higher value payments	2 & 4	Operation	High
4	Authorisation for longer-term cover	3	Operation	High
5	Monitoring medical agency spend	5	Operation	Medium
6	Formal approval of the use of agency staff	2	Operation	High

1. Introduction

1.1 Our review of Medical Variable Pay – Agency Costs was completed in line with the 2022/23 Internal Audit plan for Cwm Taf Morgannwg University Health Board (the 'Health Board').

1.2 The Health Board has a number of options available to fill shifts when short and long-term gaps in rosters are identified, which includes using agency staff. Agency staff are either directly engaged (paid through payroll), or non-directly engaged (paid through accounts payable). The Health Board's preferred approach is to use directly engaged agency staff as there are greater costs to the Health Board when using non-direct engaged staff. In the first four months of 2022/23, the Health Board spent on average over £1m per month on medical agency costs. By November 2022, £9.7m had been spent, with the estimated full year spend being £16.7m.

1.3 Since November 2018 the Health Board has had a contract with a provider, Retinue Solutions, who act as an agent on behalf of the Health Board to source all medical agency staff.

1.4 In 2017 the Welsh Government (WG) established a control framework to help facilitate a reduction in medical and dental agency and locum spend across Wales, and to have a more equitable and transparent reward system with reduced internal wage competition, which included the introduction of price cap. The rates set in 2017 have not changed since that date. The Health Board's Medical Variable Pay Financial Control Procedure sets out the process to be followed when engaging medical agency staff, and the authorisation requirements should payments above the price cap be requested.

1.5 We looked at three Clinical Service Groups (CSGs), one in each of the Integrated Locality Groups (ILGs). These were:

- Acute Medicine, Bridgend ILG;
- Acute Surgery, Rhondda Taff Ely ILG; and
- Women and Children, Merthyr Cynon ILG.

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

- Additional costs and pressures on the Health Board where medical agency workers are used unnecessarily.
- Inconsistent approaches to the engagement of medical agency workers and their rates of pay.
- Inappropriate or unauthorised payments made at higher rates.

2. Detailed Audit Findings

Objective 1: The policy and procedure in place for the use of medical agency staff provides clear guidance on the process to apply. The policy is available to staff and is subject to regular review.

2.1 A Medical Variable Pay Financial Control Procedure (FCP) is in place that sets out the high-level controls in relation to the engagement and payment of medical locums. The FCP also covers the use of Additional Duty Hours (ADH) and Waiting List Initiatives, however those areas were not covered as part of this review.

2.2 There is a Medical Agency Locums Standard Operating Procedure (SOP), and a number of other procedures to support the use of the Retinue agency booking system and process. The documents are available to staff via the Health Board's intranet site.

2.3 At the time of our fieldwork the FCP had passed its review date, although we acknowledge that management's ongoing review was paused while they awaited the findings of our audit. (**Matter Arising 1**)

2.4 As part of our fieldwork within the CSGs, we met with key staff who are responsible for the preparation of the medical work rosters and for booking medical agency staff to fill roster gaps. We note that none were aware of the FCP and there was limited awareness of the SOP. (**Matter Arising 1**)

2.5 Our testing identified instances where the FCP and SOP were not followed, with different practices in place and where terminology between the documents varied. For example, forms were not completed, so we saw no appropriate approval for longer term placements, placement extensions and the use of non-directly engaged locums. We also noted instances where staff were not clear which of the cost elements paid to Retinue should be considered when determining if a rate breaches the WG cap rates, again having a potential impact on obtaining appropriate authorisation. (**Matter Arising 1**)

Conclusion:

2.6 The Health Board's FCP and SOP set out the processes and controls to manage medial agency staff, although both now need to be reviewed. We also identified that better awareness of the policies is needed. We have provided Reasonable Assurance in relation to this objective.

Objective 2: Appropriate authorisation is sought from budget holders to engage agency staff, and where necessary, further authorisation is sought to agree rates of pay above the WG pay cap.

2.7 In the CSGs where we undertook testing, the 'on call' rosters were created using the Health Roster system. This allows for staffing gaps to be identified, with ADH shifts offered to existing staff before using agency cover. To ensure agency staff are only used to cover existing funded posts, the FCP requires CSG managers approval before seeking agency cover. However, in all of the CSGs that we tested, while roster gaps may be discussed with the CSG or Deputy CSG Manager, they

considered 'formal approval' was unnecessary, as the roster gaps were within agreed establishment for their department. (**Matter Arising 6**)

2.8 The Health Board has a target of only using DE locums for all agency use, however, their use has fluctuated throughout the year. Over the period February to October 2022 the average use was 77%. At points this dipped to 66% but was also as high as 87% in February 2022.

2.9 We identified that staff were not aware of the SOP requirement to obtain approval to use non-DE locums. Furthermore, staff absence pressures within the central Workforce Efficiency team has meant that scrutiny, challenge and support to switch locums to DE, has been limited. (**Matter Arising 2**)

2.10 The Welsh Government agency price cap rates include cost elements such as basic pay, NI, and agency fees. Our testing confirmed that departments were aware of the WG rates and the need to obtain authorisation to pay agency staff above these rates. However, staff appeared unclear which cost elements should be included when determining if the use of proposed agency staff would breach the WG cap rates. Awareness and training of the FCP and SOP may help address this matter. (**Matter Arising 1**)

2.11 Our testing of agency usage identified that nearly all were paid rates that exceeded the WG pay cap, and 62% of our sample were paid rates that exceeded the WG cap by more than 25%.

2.12 The process described in the FCP and SOP of obtaining ILG Director approval for rates that are less than 25% above WG cap is not in place. Instead, we understand that the Medical Director authorises all payments above the WG cap rate. However, the supporting evidence is not held in an organised format that would allow retrospective scrutiny. As such we were unable to confirm if the appropriate authorisation of our sample. (**Matter Arising 3**)

Conclusion:

2.13 Whilst the FCP and SOP set out the processes for authorising the use of agency locums and higher payments, these processes are not clearly followed. In relation to higher payments, we acknowledge that the Medical Director is sighted on these cases. However, this may not be the most efficient use of their time and due to retention methods, we were unable to evidence the Medical Director's approval. We have provided Limited Assurance in relation to this objective.

Objective 3: Appropriate authorisation processes are in place for longer term placements (over six-months).

2.14 The FCP and SOP provide guidance on the approval process for placements longer than six months or where ongoing extensions to a placement make it longer than six months. However, we did not see evidence of the process being followed for the 12 long term placements that we reviewed.

2.15 Furthermore, the process for extending existing bookings with Retinue is not robust. We could not be provided with any evidence to confirm relevant challenge or approval when a booking is extended. (**Matter Arising 4**)

2.16 We did question with the CSG staff the reasons behind the longer-term bookings and tried to determine if, where applicable, had there been any attempts to recruit into these posts. In relation to our sample, we only received a response from one CSG manager who confirmed that there had been ongoing recruitment attempts, with some posts recently recruited to. (**Matter Arising 4**)

Conclusion:

2.17 Whilst the FCP and SOP set out the processes to be followed for authorising the use of longer-term placements, these processes were not followed. Furthermore, we had a limited response when attempting to confirm recruitment attempts. We have provided limited assurance against this objective.

Objective 4: The rates paid to agency staff are in line with the rates authorised.

2.18 We note that when Retinue are instructed to seek an agency locum, there will often been negotiation around the hourly rate of pay, with Retinue updating the system to reflect the rates. Our testing confirmed that the last rate recorded on the Retinue booking system agreed to the rate paid to the agency staff in our sample.

2.19 However, as set out in paragraph 2.12 we were unable to confirm that hourly rates had been appropriately authorised. As such, we were unable to been able to perform any testing to confirm if the agreed rate was the actual paid rate and that there had been no subsequent adjustments post approval by the Medical Director. (**Matter Arising 3**)

Conclusion:

2.20 While we have confirmed that rates recorded on Retinue were the rates paid, we were unable to confirm if these were the rates that had been approved. As such we have provide limited assurance against this objective.

Objective 5: Monitoring and scrutiny of medical agency spend data takes place at various levels within the Health Board.

2.21 Monitoring of medical agency spend takes place as part of the routine budget monitoring process. Each CSG receives a monthly finance pack of their spend, with supporting narrative provided to the CSG Managers via email, or as part of regular finance meetings. We understand that material medical agency spend would be highlighted in the finance packs. The QlikView reporting system also provides details of pay spend, so budget holders can review their medical agency spend further. In addition, finance reports are discussed with the Care Group leads in monthly meetings with the Chief Operating Officer.

2.22 The FCP states that ILGs should receive weekly reports summarising all authorised WG cap breaches, and monthly reports on overall spend, DE rates, higher earners and long serving individuals. However, we understand that these reports are not received by ILGs. Furthermore, we have been unable to determine where overall medical agency spend is monitored.

2.23 During 2022 a Medical Productivity project board was established as part of the Health Board wide value and efficiency portfolio. The main aims of the project are:

to reduce projected medical temporary staffing spend; to improve medical staff productivity and value and effectiveness, whilst also improving workforce sustainability and reducing premium rate temporary cover costs. As such, while the project is live medical agency spend data is scrutinised. When the project concludes Health Board wide spending monitoring may end. (**Matter Arising 5**)

Conclusion:

2.24 Monitoring of medical agency spend currently takes place at a CSG level as part of routine budget monitoring arrangements. The current Medical Productivity project also means that medical agency spend across the Health Board is taking place in order to help inform the actions required as part of the project. We are able to provide reasonable assurance against this objective.

Appendix A: Management Action Plan

Matter Arising 1: Policy and procedure need updating (Design)	**Potential Impact**
At the time of our audit fieldwork the Medical Variable Pay FCP had passed its review date and the Medical Agency Locums SOP review was imminent. We are aware that work to update the FCP was paused while management awaited our audit findings. We have identified a number of inaccuracies within the FCP and SOP, and a number of areas where the guidance is not clear, or no longer being followed. These include: • There is different terminology in the FCP compared to the Retinue booking system in relation to the cost elements that make up the client charge. The lack of clarity makes it difficult for staff to determine if the cap rate has been breached and therefore if approval is required. • Reference is made in the FCP to a 'WhatsApp' group for the approval of urgent bookings. However, staff were not aware of there being a WhatsApp group in place, or what the approval process is for urgent bookings. Furthermore, there is no definition of what is deemed an 'urgent' booking. • The guidance differs between the FCP and SOP with regard to non-direct engaged agency staff and whether they are paid via payroll or accounts payable. • The FCP refers to CSG managers giving prior approval for agency use to ensure requests are for posts within the agreed funded establishment. However, approval for this reason is not deemed necessary by the CSGs, as gaps in rosters are part of the agreed establishment. Template forms in the SOP for extending an agency placement, and for using non-direct engagement staff are not used, and the email address that the forms should be sent to is not active. Monthly reporting required by the procedures was not done and reports to the Audit and Risk committee have stopped. Each CSG has staff that generate rosters, identify gaps, and set up requests for agency staff on the Retinue system. We met with four roster 'approvers' and note that three were not aware of the SOP, and none were aware of the FCP. As such, some aspects of the SOP were not being followed. For example, the scrutiny and seeking approval for employing non-direct engagement locums and approvals for booking longer term placements or placement extensions.	Inconsistent approaches to the engagement of medical agency workers and their rates of pay. Inappropriate or unauthorised payments at higher rates.

Recommendations		Priority
1.1a	A review of the Medical Variable Pay Financial Control Procedure and the Medical Agency Locums Standard Operating Procedure should be undertaken. From considering the findings from the audit report and reviewing current processes, both documents should be updated to reflect the processes and controls that staff should be adhering to when engaging medical agency staff.	**High**
1.1b	Updated copies of the updated FCP and SOP should be accessible to all staff and staff should be made aware of their existence.	
1.1c	Consideration should be given to providing training to relevant staff to raise awareness of the FCP and SOP and ensure staff are clear on the correct processes to be followed.	

Agreed Management Action		Target Date	Responsible Officer
1.1a	The Financial Control Procedure (FCP) and Standard Operating Procedure (SOP) will be reviewed immediately and updated in line with recommendations within this report. They will then go through a ratification process to ensure this is also compliant with the Health Board's scheme of delegation and in place policy and procedures. Both the FCP and SOP were due to be reviewed at the start of this audit, however this was delayed to ensure the recommendations contained in this audit could be incorporated into both documents. The June target date is used as the FCP will have to go through a ratification process.	June 2023	Nerys Conway, Assistant Medical Director. Paul Harrison, Head of Workforce Productivity & eSystems.
1.1b	Both the FCP and SOP will be hosted on the agency intranet page, also available from the People Directorate on request and issued by Retinue to current users. Every time a new area is added to the system, all staff with access to book agency workers will be issued with the documents, along with training on how to use the system.	June 2023	
1.1c	All areas using the agency booking system will be provided with refresher training. A training plan will be developed and provided to all existing users, once the new	August 2023	

	FCP and SOP are in place. A record will be kept of what areas have had this training and when.		

Matter Arising 2: Limited challenge when using non-direct engagement agency staff (Operation)	**Potential Impact**
Through a review of the performance reports taken to the Planning, Performance and Finance Committee we note that the use of Direct Engagement (DE) agency locums fluctuated throughout 2022. There is a target of 100% DE use, and over the nine-month period February to October 2022, the average use was 77%. At points this dipped to 66% but was also as high as 87% in February 2022. Through our discussions with staff in the CSGs it was clear that the overarching reason for selection of an agency employee was quality of their CV, NHS experience and references, though rates of pay were a consideration. However, as identified in objective one, most of the staff we met were not aware of the SOP for Medical Variable Pay. As such, they were not aware of the requirement to complete the non-DE form and seek approval from their ILG Director ahead of non-DE use. This has resulted in the challenging of use of non-DE locums not happening at an early stage in the booking process. Furthermore, it would appear that the absence of the Workforce Efficiency Co-ordinator has also had an impact on the use of non-DE locums, as there is no longer anyone actively encouraging agency staff to switch to DE. We acknowledge that some scrutiny of non-DE engagement is taking place by the Medical Director at the same time as reviewing and approving rates that are above WG cap. However, this is relatively late in the booking process and could not be evidenced.	Additional financial costs to the Health Board.

Recommendations		**Priority**
2.1a 2.1b	The process for using non-direct engaged medical locums should be reviewed to ensure suitable controls, scrutiny, challenge and authorisation is in place going forward. The FCP and SOP should be updated to reflect the correct process to be followed, and staff should be made aware of the correct processes and the additional cost implications of using non-direct engaged staff.	**Medium**
2.2	The Health Board should resume previous work undertaken with Retinue to encourage agency locums to switch to being directly engaged.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
2.1a 2.1b	The process around non-direct engagement booking will be fully reviewed. Any identified shortcomings, along with the recommendations of this audit, will be rectified and added to the SOP and FCP. Staff will be provided with the new FCP and SOP. They will also be provided with training on how to apply these to this particular part of the audit. The training will be recorded centrally, to ensure every area using the system is up to date with their responsibilities relating to it. Part of this training will be conveying the importance of direct engagement (DE) bookings and the financial benefit to the Health Board.	June 2023	Nerys Conway, Assistant Medical Director. Paul Harrison, Head of Workforce Productivity & eSystems.
2.2	All current agency workers being used by the organisation will be reviewed for their DE status. Any that are not being engaged through DE will be approached to switch. Retinue will be required to offer up DE candidates in the first instance if available, as well as encourage non-DE agency workers seeking to work in Cwm Taf Morgannwg to switch to DE. This will become a constant process of analysis and identification of non-DE workers in the Health board, which will allow the organisation to target and reduce DE use.	June 2023	Nerys Conway, Assistant Medical Director. Paul Harrison, Head of Workforce Productivity & eSystems.

Matter Arising 3: Payments above WG cap (Operation)	**Potential Impact**
The agency costs at each medical staffing grade comprises of elements such as basic pay, holiday pay, national insurance and agency and management fees. The WG cap rates are based on a number of these elements. Our discussions with staff identified that they were sometimes unclear which cost elements needed to be considered to calculate the overall cost, to determine if WG cap rates had been breached, and if authorisation was required. Furthermore, the Health Board's procedures and the Retinue system used different terminology in relation to the cost elements, potentially causing greater confusion. We tested a sample of 26 payments. 25/26 of our sample of payments were above WG cap rates, with 16 paid more than 25% above the cap rate. This is shown in the table below: **% above WG cap rate** / **Number** 25% - 34% / 8 35% - 44% / 3 45% - 54% / 2 55% - 64% / - 65% - 74% / - 75% - 84% / 1 85% - 94% / 1 95% + / 1 **Total** / **16** The FCP requires approval by the ILG Director for rates less than 25% above cap, although we did not see evidence of this. For rates more than 25% above cap the Medical Director should give approval. While we understand that the Medical Director authorises all payments above the WG cap rate, the supporting evidence is not held in an organised format that would allow retrospective scrutiny. As such we were unable to confirm the appropriate authorisation of our sample.	Inappropriate or unauthorised payments at higher rates.

Recommendations		Priority
3.1a 3.1b	The process for authorising payments that exceed the WG cap rates should be reviewed, with suitable authorisation taking place to approve higher value payments. The FCP and SOP should be updated to reflect the correct process to be followed and should provide greater clarity on the cost elements that need to be included when determining if a rate exceeds guidance rates. There should be consistent use of terminology across the FCP, SOP and Retinue system.	**High**
3.2	Approval of higher rate payments should be retained in a suitable format that allows future reference if needed.	**High**

Agreed Management Action		Target Date	Responsible Officer
3.1a 3.1b	The process for payments exceeding the WG cap rates will be fully reviewed as part of the development of the new FCP and SOP. The recommendations of this audit will be incorporated into the FCP and SOP. The new FCP and SOP will fully address and unify the inconsistent terminology used currently, to reduce any confusion going forwards. The documents will also clearly set out the authorisation process required for rates that exceed WG cap rates. The process for requesting above WG cap rates will also be included in the refresher training to all areas using agency workers.	June 2023	Nerys Conway, Assistant Medical Director. Paul Harrison, Head of Workforce Productivity & eSystems.
3.2	All authorisation of higher rates payments will be recorded fully and provided on request. The way this is captured and accessible for audit will be included in the FCP and SOP for future reference.	June 2023	Nerys Conway, Assistant Medical Director. Paul Harrison, Head of Workforce Productivity & eSystems.

Matter Arising 4: Authorisation of longer-term placements (Operation)	**Potential Impact**
We selected a sample of 12 medical agency staff that had been in place for more than six months and requested the approval forms that should be completed ahead of longer-term placements or extensions taking place. As none could be provided, we could not establish the reason for the longer placement, confirm if the cost had been considered, or if the appropriate approval had been sought. We did see alternative forms being completed for some of the sample in Women and Children's, but the forms did not contain any of the approval or authorisations sections. For the same sample of long-term placements, we attempted to confirm if, where relevant, attempts to recruit into these posts had been made, in accordance with the policy. We received responses from one CSG for 3/12, who confirmed efforts to recruit had been made, with two of the posts recently filled. Through our conversations with CSG staff we established that as longer-term placements drawn near their completion date, Retinue will contact the relevant CSG lead to see if there needs to be an extension. The approvers will discuss possible extensions with their CSG managers either verbally or by email and if they wish to extend, Retinue will be informed of the revised time-frame. However, we saw no evidence of these conversations or emails being maintained to support the decision and demonstrate any scrutiny or challenge. Whilst there are continuity benefits of retaining the same agency staff in a department, we were unable to determine if all options had been considered before extending and if the CSG had looked at alternative candidates, that are possibly better suited or at a lower hourly rate.	Additional costs and pressures on the Health Board where medical agency workers are used unnecessarily.

	Recommendations	**Priority**
4.1	It should be ensured that suitable processes are in place and adhered for engaging agency staff on a longer-term basis, or for extending any placements thus making them longer term. Prior to authorising longer-term placements, it should be confirmed that recent efforts to recruit into the post have been made and that plans for future recruitment attempts are in place, to prevent ongoing reliance on the agency locum. Where there is a need to extend existing placements, it should be ensured that a review of the current post holder and any alternative agency staff is carried out to ensure the Health Board is achieving value for money and the best fit person is used.	**High**

Agreed Management Action		Target Date	Responsible Officer
4.1	The recommendations of this action will be included in the FCP and SOP. Setting out a clear process for extending agency workers placements, that ensure the recommended considerations are taken and recorded, before offering an extension. Training will be provided to all areas on how and when this process is to be used, to ensure the Health Board gets the correct balance between value for money and the correct person for the role.	August 2023	Nerys Conway, Assistant Medical Director. Paul Harrison, Head of Workforce Productivity & eSystems.

Matter Arising 5: Monitoring Medical Agency spend (Operation)	**Potential Impact**
The FCP sets out the approach to regular monitoring and reporting with reports to be provided to ILG Directors and workforce leads. However, we have not seen evidence that this is happening. We understand that as part of the medical productivity efficiency project, scrutiny of medical agency spend, including DE engagement, is now taking place. Whilst the current project work mitigates against the previous lack of monitoring, it is our concern that when work in relation to the medical efficiency project ceases, monitoring will also cease.	Actions not taken to address issues in relation to medical agency spend.

	Recommendations	**Priority**
5.1	Following the implementation of any actions arising from the Medical Productivity Board, the future reporting and monitoring requirements, in relation to medical variable pay, should be agreed and the FCP updated accordingly.	**Medium**

	Agreed Management Action	**Target Date**	**Responsible Officer**
5.1	Finance currently provide comprehensive reports to the Care Groups detailing medical spend. This reporting will continue to happen and any additional requirements recommended by the Medical Productivity Board (MPB) will be added to this financial dataset. The FCP will be updated to reflect the recommendations from the MPB as soon as they are communicated.	June 2023	Sue Holroyd, Assistant Director of Finance. Nerys Conway, Assistant Medical Director. Paul Harrison, Head of Workforce Productivity & eSystems.

Matter Arising 6: Formal approval of the use of agency staff (Operation)	**Potential Impact**
The Health Board's health roster system allows for staff roster gaps to be identified. To ensure agency staff are only used to cover existing funded posts, the procedure requires CSG Managers to approve the need for cover before seeking agency staff. As the roster creators are working to fill the gaps within the agreed establishment for their areas, 'formal approval' was not always being obtained. We tested 26 cases where agency locums had been used. We understand that CSG Managers and local Clinical Directors were involved in the process of choosing suitable agency staff. However, the approvals were either verbal, or via email and we could not be provided with any information to support our sample. Without formal approval it appears that additional agency staff could be used within a department without appropriate authorisation.	Additional costs and pressures on the Health Board where medical agency workers are used unnecessarily.

Recommendations		**Priority**
6.1a	The process for seeking CSG Manager approval to use agency staff to cover roster gaps should be reviewed to ensure that agency use is appropriate.	**High**
6.1b	The FCP and SOP should be updated to reflect the correct process to be followed.	

Agreed Management Action		**Target Date**	**Responsible Officer**
6.1a	A process for authorisation will be clearly defined and communicated via the new FCP and SOP. How to undertake this process and ensure authorisation is gained, will be incorporated into the training provided to all areas using agency staff.	August 2023	Nerys Conway, Assistant Medical Director. Paul Harrison, Head of Workforce Productivity & eSystems.
6.1b	The recommendations and subsequent processes developed will be included in the FCP and SOP.		

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

Archwilio Cymru
Audit Wales

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

Date issued: February 2023

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

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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	The Auditor General certified the statements on 27 January, with an unqualified (positive) audit opinion. We made three recommendations for improvement.
Audit of the Health Board's 2022-23 Performance Report, Accountability Report and Financial Statements	We have recently commenced our audit planning.

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
Review of the temporary closure of the Ysbty Cwm Cynon Minor Injuries Unit (Local work 2022)	The report and Management Response will be considered by the committee in February 2023.

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.	We are preparing an all-Wales summary report, and considering preparation of a discrete Annex for each Health Board.

Topic and relevant Executive Lead	Focus of the work	Current status and Audit and Risk Committee consideration
	Our findings will be summarised into a single national report with supplementary outputs setting out the local position for each health board.	Planned date for consideration: April 2023
Structured Assessment 2022 Executive Lead – Director of Corporate Governance	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 Planned date for consideration: April 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 March 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 The most recent events were held during October 2022, focussing on Tackling Poverty in Wales (resources are available here). Details of future events are available on the GPX website.

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
A Missed Opportunity – Social Enterprises	December 2022
Time for Change – Poverty in Wales and Poverty in Wales Data Tool	November 2022

8 The Audit and Risk Committee might also be interested to know that we have recently published our **Fee Scheme for 2023-24**. The document is available on our website.

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

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Cwm Taf Morgannwg University Health Board – Review of the temporary closure of the Ysbyty Cwm Cynon Minor Injuries Unit

Audit year: 2022

Date issued: February 2023

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

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We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

This document is also available in Welsh.

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Introduction

1 Minor injuries services are part of a range of urgent care services provided by Cwm Taf Morgannwg University Health Board (the Health Board). The Health Board delivers its minor injuries services from two dedicated Minor Injury Units, which are located at Ysbyty Cwm Rhondda and Ysbyty Cwm Cynon (YCC).

2 The Minor Injuries Units, which are led by Emergency Nurse Practitioners[1] (ENPs), are designed to enable residents to access medical treatment for minor injuries in a more timely and accessible way, thereby enabling the Health Board's main emergency departments to focus on treating more urgent cases.

3 In September 2021, the Health Board decided to temporarily close the Minor Injuries Unit (the MIU) at YCC due to concerns relating to the fragility of the service and competency-based training compliance. Prior to its closure, the service operated between 9.00am and 4.30pm from Monday to Friday, excluding Bank Holidays.

4 The Health Board reopened the MIU, albeit on a phased basis, in May 2022[2].

About this report

5 In November 2021, we decided to undertake a high-level review to examine the issues surrounding the temporary closure of the MIU at YCC. We interviewed senior managers within the Health Board and reviewed the relevant documents. This report sets out the key findings and recommendations arising from our review.

Main conclusions

6 We found that the MIU closed at short notice largely due to shortcomings in the managerial oversight arrangements of the MIU, which led to:

- the unit operating with staff whose competence to work autonomously had not been adequately assessed, despite concerns over staff training and supervision being raised as far back as 2018-19;
- a fragile unit that was operating sub-optimally due a lack of investment in support staff to enable ENPs to manage workload demands efficiently; and
- staff not having up-to-date performance appraisals; however, this situation is not unique to the MIU.

[1] Emergency Nurse Practitioners are registered nurses who have completed further training in the management of minor injuries and who practice without consultant supervision to see, treat, and discharge patients.

[2] https://ctmuhb.nhs.wales/news/latest-news/the-minor-injuries-unit-at-ysbyty-cwm-cynon-to-reopen-its-doors-next-week/

7 We found that the closure of the MIU led to reduced service options available to residents and increased the number of individuals attending the Emergency Department at Prince Charles Hospital (PCH), which was already operating under significant pressure.

8 Although the Health Board determined that the risk of harm to patients of being seen at YCC was minimal, we found that this was not formally reported to the Quality and Safety Committee, thus limiting opportunities to enable full scrutiny and provide assurance. Furthermore, we found that the Health Board has not assessed or reported on the impact on the patient experience, or the quality of the care provided to residents required to attend the Emergency Department at PCH following the closure of the MIU.

9 More positively, we found that the Health Board's arrangements for communicating the closure to patients, the Quality and Safety Committee, and other key stakeholders as well as its arrangements for redeploying MIU staff were effective.

Key findings

Managerial oversight of the MIU

The closure of the MIU could have been avoided if action had been taken sooner to strengthen managerial oversight of the unit as well as to address the concerns raised in 2018/19 around staff training and qualifications.

10 In September 2021, the Health Board decided to close the MIU at YCC at short notice due to concerns raised by the Integrated Locality Group (ILG) that:

- MIU staff did not have the appropriate training and competencies in place to work autonomously with no medical supervision on site; and
- the MIU was fragile and operating sub-optimally due a lack of investment in support staff to enable ENPs to manage workload demands efficiently.

11 In order to practice autonomously, ENPs in Wales are required to complete the Agored Cymru[3] Level 7 Diploma in the Autonomous Management of Minor Injuries. This is the nationally recognised programme of development for Emergency Practitioners. The MIU was closed by the Health Board due to concerns that the relevant staff did not have this qualification in place. Similar concerns were raised as far back as 2018/19, but no action or follow-up was taken at the time.

12 However, a review undertaken by the Health Board following the closure of the MIU found that two of the ENPs had completed a Cardiff University accredited

[3] Agored Cymru is an education provider that creates nationally recognised, quality assured qualifications and units across a diverse range of subjects in Wales.

course for Emergency Nurse Practitioners prior to the launch of the Agored Cymru Level 7 Diploma in 2016. It continues to be a recognised course for ENPs, providing they continue to maintain evidence of their advanced practice via the Agored Cymru portfolio.

13 The Health Board also found that staff had commenced the Agored Cymru Level 7 Diploma and had portfolios of evidence in place for the study days they had completed, which had been assessed and signed-off by PCH Emergency Department Consultants. However, they were unable to practice autonomously until they completed all of the study days and had their portfolios of evidence assessed and signed-off by Registered Agored Cymru Assessors. None of the PCH Emergency Consultants are Registered Agored Cymru Assessors.

14 Furthermore, our review found that MIU staff did not have up-to-date performance appraisals in place, thus highlighting further weaknesses in the Health Board's arrangements for oversight and professional development of staff.

15 The Health Board's review also highlighted other concerns relating to the fragility and efficiency of the service due a lack of investment in support staff to enable ENPs to manage workload demands efficiently, as well as concerns about the lack of appropriate oversight and supervision of the MIU.

16 In order to address these issues, the Health Board has:

- established a Clinical Education Forum, as a sub-committee of the Quality and Safety Committee, to oversee educational governance and leadership;
- created a new Band 8a Senior Nurse post with responsibility for practice development;
- plans in place to support the relevant MIU staff to complete the Level 7 Diploma and maintain their ongoing evidence of practice;
- plans in place to support Emergency Medicine Consultants and Advanced Practitioners to become Registered Agored Cymru Assessors;
- established new oversight and management arrangements for MIU staff via a new Clinical Director; and
- plans in place to review MIU staffing arrangements, including the skill mix.

17 Despite the positive steps taken by the Health Board to address the situation, it is reasonable to conclude that the closure of MIU could have been avoided if action had to been taken sooner to strengthen managerial oversight of the unit as well as to address the concerns raised in 2018/19 around staff training and qualifications.

Impact of the MIU closure

Although the Health Board has indicated that the impact was minimal, the closure of the MIU increased footfall to an already pressured Emergency Department, and no assessment of the impact on patients has been undertaken.

18 By closing the MIU, the Health Board reduced the service options available to its population, and increased the number of individuals attending the Emergency Department at Prince Charles Hospital (PCH) by around 30 each day. According to the Health Board, the impact on the Emergency Department at PCH has been minimal. However, at the time of our work, the Emergency Department at PCH was operating under considerable pressure. It is reasonable to conclude, therefore, that the closure of the MIU – a service designed to reduce demand on emergency departments – contributed to this pressure.

19 We found that the Health Board has not assessed or reported on the impact on the patient experience, or the quality of the care received by patients redirected to the Emergency Department at PCH following the closure of the MIU.

Communication and redeployment arrangements

Arrangements to communicate the closure to stakeholders and to redeploy staff were effective.

20 The arrangements for communicating the closure of the MIU were effective:

- a full initial disclosure was presented to the Health Board's Quality and Safety Committee in September 2021;
- Welsh Government was formally informed of the closure;
- the closure was discussed with Community Health Council and Local Authority partners; and
- information for patients was published on the Health Board's website.

21 In terms of redeployment arrangements, the ENPs were relocated to the PCH Emergency Department until their competencies could be fully assessed. The movement of this cohort of staff enabled the Health Board to establish a minor injuries pathway within the main Emergency Department, which has proved successful. In January 2022, the Health Board moved its Trauma Clinic Service into the vacant MIU at YCC.

22 At the time of our work, the Health Board was unable to reopen the MIU as this would destabilise the minor injuries pathway at Prince Charles Hospital. As a result, the Health Board agreed to recruit an additional 4.8 WTE Band 7 ENPs to provide a dedicated MIU at both PCH and YCC. At the time of our work, the recruitment was in progress but not yet complete.

Quality and Safety Committee oversight

There have been gaps in the reporting the ongoing position regarding the closure of the MIU to the Quality and Safety Committee.

23 As noted previously, a full initial disclosure was presented to the Health Board's Quality and Safety Committee in September 2021.

24 At the time, the Health Board informed the Quality and Safety Committee that it would seek to establish if any harm had come to patients seen at the MIU. Following a review of patient files, the Health Board concluded an assessment of harm was not required as the risk of harm was minimal due to the patient cohort having low levels of acuity. However, the outcome of this work was not formally reported to the Quality and Safety Committee.

25 Furthermore, we found that there has been no further reporting to the Quality and Safety Committee on the situation since the initial report in September 2021. Independent Members, therefore, have not been given opportunities to fully scrutinise the actions taken by the Health Board to remedy the situation, and subsequently provide assurance to the Board that the concerns relating to the MIU are being adequately addressed.

Recommendations

26 Whilst the Health Board has identified a series of actions to address these shortcomings and reopen the MIU on a phased basis, we believe there are important and wider lessons to be learned. Our recommendations, which are detailed in **Exhibit 1**, are designed to support this learning, and to reduce the risk of similar incidents occurring in the future. The Health Board's management response to these recommendations will be summarised in **Appendix 1** once considered by the relevant committee.

Exhibit 1: recommendations

Recommendations
Reviewing managerial oversight arrangements of remotely operating services R1 Our work has found shortcomings in the managerial oversight arrangements of the MIU at YCC. In order to assure itself that these issues are not widespread across the organisation, the Health Board should review the managerial oversight arrangements of services which are staffed by the Health Board but operate remotely to ensure they are sufficiently robust and effective. The findings of the review should be reported to the Quality and Safety Committee to provide the required assurances.

Improving oversight of competency-based training arrangements at the MIU and across the wider organisation

R2 Our work has highlighted concerns with the Health Board's competency-based training arrangements at the MIU. In order to assure itself that these issues are not widespread across the organisation, the Health Board should undertake a review of its competency-based training arrangements (at the MIU and across the wider organisation) to ensure:

a) effective policies and procedures are in place to support staff to complete all relevant competency-based training in a timely manner;
b) competencies requiring assessment are assessed by qualified assessors in a timely manner; and
c) evidence of competency-based training completed by staff is recorded appropriately; and
d) competency-based training completion rates are monitored and reviewed on a regular basis by the relevant management teams.
e) the findings of the review should be reported to the Quality and Safety Committee to provide the required assurances.

Improving performance appraisal compliance rates

R3 Our work has found that staff in the MIU did not have up-to-date performance appraisals. However, there is also a similar picture across the Health Board. The Health Board, therefore, need to agree a range of appropriate actions to improve compliance rates across the organisation. The People and Culture Committee should continue to monitor compliance rates and provide effective challenge when the Health Board is failing to demonstrate ongoing improvement.

Enhancing Quality and Safety Committee oversight

R4 Our work has found that despite the full initial disclosure to the Quality and Safety Committee in September 2021, there was no further reporting on any assessment of potential harm, and lessons learned. The Health Board, therefore, should provide an update report to the committee outlining the lessons learned, and confirmation of any outcomes from the work to assess harm.

Appendix 1

Management response to audit recommendations

Exhibit 2: management response

Recommendation	Management response	Completion date	Responsible officer
Reviewing managerial oversight arrangements of remotely operating services R1 Our work has found shortcomings in the managerial oversight arrangements of the MIU at YCC. In order to assure itself that these issues are not widespread across the organisation, the Health Board should review the managerial oversight arrangements of services which are staffed by the Health Board but operate remotely to ensure they are sufficiently robust and effective. The findings of the review	The Health Board (HB) has now completed the initial phase of operational restructure resulting in a care group model encompassing services delivered across the HB. As a result, services delivered outside of the three acute sites have been incorporated to care groups relevant to the speciality and service being delivered.	Complete	Chief Operating Officer

Recommendation	Management response	Completion date	Responsible officer
should be reported to the Quality and Safety Committee to provide the required assurances.	Structural adjustment to the service reporting lines such as the Minor Injury service across the HB being managed by and reporting to the Unscheduled Care Group. It is through this reporting method; the care groups will seek to monitor and respond to operational and clinical governance matters whilst also providing the organisation and the Board with the appropriate assurances.		

Recommendation	Management response	Completion date	Responsible officer
Improving oversight of competency-based training arrangements at the MIU and across the wider organisation R2 Our work has highlighted concerns with the Health Board's competency-based training arrangements at the MIU. In order to assure itself that these issues are not widespread across the organisation, the Health Board should undertake a review of its competency-based training arrangements (at the MIU and across the wider organisation) to ensure: a) effective policies and procedures are in place to support staff to complete all relevant competency-based training in a timely manner; b) competencies requiring assessment are assessed by qualified assessors in a timely manner; and c) evidence of competency-based training completed by staff is recorded appropriately; and	a) Competency based training has been established against the national training arrangements for minor injury practitioner utilising the framework provided through Agored Cymru. Current and new practitioners now practice on a rotation basis across the community hospital and acute hospital sites to ensure adequate supervision and maximum training opportunities. This process is being led by the Senior Nurse and Advanced Nurse Practitioner for Professional Development. b) The HB has now established the appropriate number of appropriately trained assessors across minor injury units and hospital sites. This has been further enabled through the	Complete Complete	Unscheduled Care Director of Nursing

Recommendation	Management response	Completion date	Responsible officer
d) competency-based training completion rates are monitored and reviewed on a regular basis by the relevant management teams: and e) The findings of the review should be reported to the Quality and Safety Committee to provide the required assurances.	adjustment in the educational leadership model as well as the implementation of the HB wide care group structure. c) Through the leadership of the Senior Nurse for professional development, the management teams can monitor the progress of training of new trainee practitioners as well as the continued development of established practitioners. d) With the formation of the Unscheduled Care Group (USCG), urgent care service leaders are currently reviewing a model of	Complete April 2023	Unscheduled Care Director of Nursing & Medical Director

Recommendation	Management response	Completion date	Responsible officer
	assurance and learning on all aspects of emergency care innovation and education across the HB. During this transitional phase, each local leadership team now has dedicated Practice Development Nurses working with the Senior Nurse for Professional Development to ensure local compliance and escalations where required. e) As part of an overall appraisal in the quality, safety, and patient experience within emergency care services across the HB, the USCG is preparing a report/presentation for the Quality and Safety Committee in March 2023.	March 2023	Unscheduled Care Director of Nursing & Medical Director
Improving performance appraisal compliance rates	The Health Board recognises the importance of PADR and	Completed	Executive Director for People / Deputy

Recommendation	Management response	Completion date	Responsible officer
R3 Our work has found that staff in the MIU did not have up-to-date performance appraisals. However, there is also a similar picture across the Health Board. The Health Board, therefore, need to agree a range of appropriate actions to improve compliance rates across the organisation. The People and Culture Committee should continue to monitor compliance rates and provide effective challenge when the Health Board is failing to demonstrate ongoing improvement.	the impact it has on employee development, performance and wellbeing. The Health Board has revised its Appraisal process and through the introduction of 'PDR: Your Conversation' it has placed increased emphasis on the importance of values and Behaviours and staff wellbeing at the heart of the conversation. PADR compliance is included in the suite of metrics that is reported to People and Culture Committee as a regular agenda item and provides an opportunity to		Director of People – Health Board Wide leads.

Recommendation	Management response	Completion date	Responsible officer
	scrutinise the trend data and performance. The data is also shared with Care Groups and Corporate Directorates to enable improvement plans to be developed and monitored.		
	A Communications and Engagement plan is being launched in February by the Learning and Development department which will include a mix of written guidance and video presentations to reinvigorate PDR and other core learning and improve performance. Bespoke training is also available for teams.	February 2023	Executive Director For People / Deputy Director of People
	Current and new practitioners now practice on a rotation basis across the community hospital and acute hospital	March 2023	Unscheduled Care Group Directors (Operations, Nursing and Medicine)

Recommendation	Management response	Completion date	Responsible officer
	sites to ensure adequate supervision and maximum training opportunities. In reporting to the USCG, each local acute site emergency department leadership team is responsible for the support and development of staff and practitioners across the department and respective unit.		
	The USCG Director of Nursing is to present to the People and Culture Committee this financial year on the current arrangement and feedback as well as future care group plans	February 2023	Unscheduled Care Group Director of Nursing

Recommendation	Management response	Completion date	Responsible officer
	attending to the development and wellbeing of the team.		
Enhancing Quality and Safety Committee oversight R4 Our work has found that despite the full initial disclosure to the Quality and Safety Committee in September 2021, there was no further reporting on any assessment of potential harm, and lessons learned. The Health Board, therefore, should provide an update report to the committee outlining the lessons learned, and confirmation of any outcomes from the work to assess harm.	As part of an overall appraisal in the quality, safety, and patient experience within emergency care services across the HB, the USCG is preparing a report/presentation for the Quality and Safety Committee this financial year. Furthermore, as part of the ongoing service delivery reviews within the newly established care group model, the USCG will seek to provide a report to the Quality and Safety Committee in full on the Minor Injury Service provision across the HB early in 2023/24.	March 2023 May 2023	Unscheduled Care Group Director of Nursing Unscheduled Care Group Directors (Operations, Nursing and Medicine)

Exhibit source: Audit Wales

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

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Commissioning and Contracting Arrangements Post Bridgend Boundary Change – Swansea Bay and Cwm Taf Morgannwg University Health Boards

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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 was 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 1 April 2019.

3 However, while most Bridgend services transferred to CTMUHB on 1 April 2019, it was not possible to transfer all of them. 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 90 clinical or service specific Service Level Agreements (SLAs), and 21 corporate SLAs[1]. 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 three and five years. Individual service lines relate to the provision of specific clinical services.

Key messages

6 Overall, we found **that the contract arrangements are sound and 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 need 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 are currently being finalised, and will be presented once finalised to the February 2023 committee.

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 was 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.

Recommendations

Risk management

R4 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 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 need 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 12 workstreams. These workstreams covered a range of areas including capital and estates, information technology, and finance.

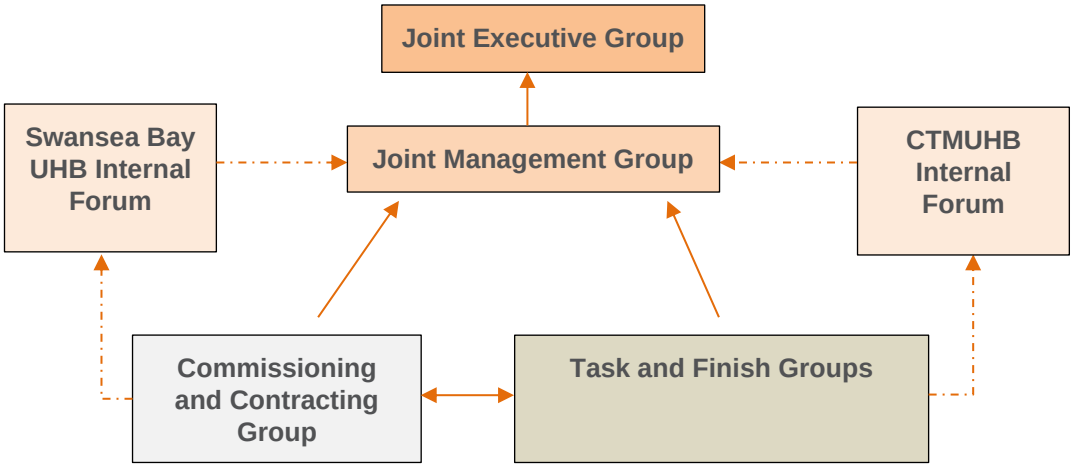
15 These arrangements were established to operate until the transition date of 1 April 2019 and were both stood down on 23 April 2019. It was clear from the handover and legacy statements at the time that the disaggregation of services both clinically and corporately was significantly complex, and many 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 management representatives from the 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 JEG[4] 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 the 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 200 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 LTAs and SLAs 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 are 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 spending 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 32 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 21 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 are 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 the 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 boards' 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 six-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 2019-2022, 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
	Number	32	24	↓ 8

		2019-20	2022-23	Change
Provision of services by CTMUHB to Swansea Bay UHB	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, ie 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 was having to take a tactical approach to the transfer. COVID-19 has affected the pace of this, but CTMUHB has 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.

Appendix 1

Management response to audit recommendations

Recommendation	Management response	Completion date	Responsible officer
Commissioning and Contracting Group R1 We observed good scrutiny by the commissioning and contracting group. However, there was a significant agenda which was challenging to cover in the allotted meeting time and there was a lack of operational and clinical representation. The health boards should: • Review the time allotted to meetings, or review the content of the agenda 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.	At the time the review was undertaken there was a significant amount of disaggregation's being worked through as well as operational/ contractual issues. The frequency of the meetings was increased from monthly to three weekly in order to accommodate the large agenda. This appears to have stabilised meaning that the agenda is more manageable and at the meeting on 11/10/22 the group considered reverting back to monthly meetings or keep to three weekly but	November 2022	Head of Strategic Commissioning (SB) & Assistant Director of Transformation (CTMUHB)

Recommendation	Management response	Completion date	Responsible officer
	reduce the meeting to 1 hour. Services are invited to attend the C&C meetings to discuss cessations or operational issues. At least 30 minutes of the meeting is dedicated to the service discussion. The last service to attend a C&C meeting was Pathology in August 2022. C&C members also attend the service to service meetings and report back to C&C on the outcomes of the meetings. Due to the significant amount of SLAs in place which covers numerous services, it would be extremely challenging to gain operational/ clinical representation at every		

Recommendation	Management response	Completion date	Responsible officer
	C&C meeting and attending the meetings is not a good use of colleague's clinical time. All service to service meetings include both operational and clinical staff and this arrangement appears to be working.		
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	The disaggregation plan for 2022-23 incorporates a plan into the next financial year as it is recognised that most cessations are still in the planning stage and that cessation dates are still to be agreed once the due diligence has been completed. • Exercise to be undertaken with all services to categories SLAs into the following	January 2023	Head of Strategic Commissioning (SB)

Recommendation	Management response	Completion date	Responsible officer
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 of the disaggregation programme through the relevant Board and Committee structures within both health boards.	categories as this will inform work plan over the next few years: • Short term disaggregation before end of March 2024 • Plan to medium term disaggregation between 2 and maximum of 5 years • Long term service and contractual relationships to be maintained between the two Health Boards on a partnership basis with no intent of disaggregating • Revised disaggregation plan to be signed off by Joint Management Group which includes a 5 year work programme	March 2023 March 2023	& Assistant Director of Transformation (CTMUHB) Assistant Director of Strategy (SB) & Assistant Director of Transformation (CTMUHB)

Recommendation	Management response	Completion date	Responsible officer
	• Progress against the work plan to be reported through SBU's Performance & Finance Committee and through CTMUHB's Planning Performance and Finance Committee and Board. This is in place – the PPF committee received a full progress update on 25th October 2022 and will continue to receive reports at 6 monthly intervals.		
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	Changes in patient flows and impact on patients is addressed in the cessation paperwork and is always discussed as part of the disaggregation discussions. Equality Impact	November 2022	Assistant Director of Strategy (SB) & Assistant Director of Transformation (CTMUHB)

Recommendation	Management response	Completion date	Responsible officer
boards should implement a process for conducting impact assessments when making changes to the way in which services are delivered for the Bridgend population.	Assessments have started to be completed for the cessation of the Clinical Capacity SLAs in NPTH as the changes will impact on patient flow and access to services. However, there is not enough corporate resource to complete a detailed impact assessment for each SLA cessation and in most cases the impact is not necessary as there is no change in patient flow. The Community Health Councils are kept up to date on all cessations and detailed engagement is undertaken where changes will affect patient flow.		
Risk management	Clinical risk matrix has been developed and is completed	March 2023	Head of Strategic Commissioning (SB)

Recommendation		Management response	Completion date	Responsible officer
R4	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 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.	as part of the disaggregation process. The risk score is highlighted to Joint Management Group and Joint Executive Group through the slidedeck. However, the risk register for the programme needs to be reviewed and there needs to be a stronger link between the risk register for the programme and the corporate risk registers. Process to be developed outlining how service risks are linked with the CTMU and SBU risk registers.		& Assistant Director of Transformation (CTMUHB)

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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