



| 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 |
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| Data Quality 01 | Oct-19 | Limited | 1. Directorate Managers need to: □ Remind consultant, medical and nursing staff of the need to complete outcome forms for all patients seen. □ Remind outpatient receptionists of the importance of inputting outcome forms on WPAS in a timely manner. □ Remind Medical Secretaries to check that outcomes that have been input on WPAS align to outcomes as per dictated letters. Where necessary additional training should be requested to ensure that all staff are aware of their responsibilities in completing the above steps correctly. 2. Management should engage with the two directorates where the electronic outcome form was trialled to understand why it has been adopted in one area and not in the other. Following the conclusion of this engagement the Health Board should consider trialling the electronic outcome forms within all Directorates. 3. Consideration should be given as to how data can be captured to allow the calculation and monitoring of the proportion of patients whose outcome is not recorded on WPAS. Updated Recommendation - 1. Clinical Service Group Managers need to: □ Remind consultant, medical and nursing staff of the need to complete outcome forms for all patients seen. □ Remind outpatient receptionists of the importance of inputting outcome forms on WPAS in a timely manner. □ Remind Medical Secretaries to check that outcomes that have been input on WPAS align to outcomes as per dictated letters. All staff need to be made fully aware of the implications of not recording the outcome for a patient and their responsibilities in ensuring the correct process is adhered to. 2. The reports received by the Clinical Service Groups of patients with no outcome recorded, should be analysed to determine if there are certain departments or clinics who are repeatedly failing to record outcomes. Where necessary additional training should be requested. 3. Given the ongoing problem of outcomes not recorded and the apparent success of the use of electronic outcome forms within ENT, the use of electronic forms should be reviewed again, for piloting in other areas. 4. If the 'Planned Patient Flow Project' remains a live project, its action plan should be updated to fully incorporate the internal audit findings in relation to patient pathways. | High | We fully agree with all the recommendations and will incorporate this into our action plan. We intend to secure additional resource to assist in the monitoring and implementation of this action plan. A forum will be set up to oversee this work stream and detailed action plan. A process of 'cashing up' at the end of every clinic is required to ensure clinic and administration staff have processed the patients using the outcome form and WPAS. This process needs to include the initiation of diagnostic tests and request forms being processed to cut down on 'dead time' waits for diagnostics. This process needs to be mandated and managed by the clinic manager. Temporary administration and nursing staff need to undertake mandatory training in cashing up clinics. The Assistant Director of Scheduled Care together with the Assistant Director of Performance and Information will engage with the two directorates where the electronic outcome form was trialled to understand why it has been adopted in one area and not in the other. Following the conclusion of this engagement the Health Board will consider trialling the electronic outcome forms within all Directorates. An appointment with no outcome registered report needs to be circulated in order that administration managers can act on patients who have no outcome, validating the patient's position on the pathway. All staff need to understand the implications of failure to comply. Weekly reports need to be circulated to services including consultants with non-compliance addressed by relevant professional leads. Updated Management Response - These recommendations are accepted, though the ownership at ILG level will be through the Hospital Service Managers. Regular performance meetings have been set up in two of the three ILGs, where this will be a regular performance/compliance agenda item. These two ILGs also have a senior Performance & Information lead taking up post in January, a key appointment that will help drive forward this agenda. The equivalent post in the third ILG is out to advert. No other specialty has been as enthusiastic as ENT in the deployment of JAYEX, with some openly hostile. Whilst attempts will be made to reinvigorate this deployment, the lack of a dedicated resource, but more so given the alternative digital solutions for non-face to face consultation means that this may not be a desirable longer term objective. The Planned Patient Flow Project stopped in March 2020 and given the turnover of key staff, together with a new operating model, an alternative mechanism is to be found to take this work forward. With bed pressures and mass vaccination the key priorities for January, reinforcing the recording of outcomes, together with providing any refresher training required is targeted for the end of February 2021. With individual ILGs taking on UHB wide responsibility for certain specialties, the ongoing challenge of having to utilise two instances of WPAS becomes even more challenging e.g. for Bridgend ILG, who are continuing to use the Swansea Bay UHB WPAS instance, but will now additionally need to utilise the CTM instance for Ophthalmology and for RTE ILG, who will now need to also utilise the Swansea Bay instance for Urology services. This ongoing risk requires resourcing to ensure that services are transferred over to single instances of core operational systems on an incremental basis during this calendar year and beyond. | Chief Operating Officer | ILG Acute Service Managers/Assistant Director of Performance & Information | Mar-20 | 01/02/2021 Now November 2021 Now December 2021 Now March 2022 Now June 2022 Now October 2022 | Part Completed in two ILG's | August 2022 Update. Nothing further to report for this month - anticipate it will be at the next meeting. | December 2020 Update - There has been limited progress in taking action to address the previous recommendations. The onset of Covid-19 clearly impacted on the UHB's ability to deliver elective activity, as it concentrated all its efforts in responding to the pandemic. As a consequence, the UHB lost the momentum it had built up through the establishment of a Planned Patient Flow Project to take forward both the recommendations of the Internal Audit report, as well as the those of the Delivery Unit report arising from their supportive intervention on waiting list management. As has been rightly pointed out by our Internal Audit colleagues, the PID did not make reference explicitly to two of the actions from their report (Findings 4 & 5) and whilst the PPF Project may not have been the right forum for aspects of Finding 4 (temporary secretaries), it should have made explicit reference to the action, especially given the focus on training. Finding 5 (watch list functionality) is not something that the UHB can amend and whilst we were seeking a response from NWIS regarding what might be feasible and over what timescale (current thinking is that this may well not be technically feasible), it is not documented within the PID as it should. IA colleagues have noted that a number of changes have occurred within the Health Board, as a result of turnover and ownership of the agreed actions within the report has not been clearly transferred to individuals now responsible for this area, which is accepted. My WPAS Team are still sending out regular reports to relevant departments requesting errors to be rectified and whilst the volume of errors reduced, this was linked to reduced activity during Covid-19, as opposed to any improvement, as noted by IA colleagues. We have not been able to focus on this over the last ten months and now have to restart our work through the new operating model, working with our ILG colleagues. On the positive side, much of the groundwork is in place, though the follow-up report from our IA colleagues is a timely reminder of just how much work remains. 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. May 2021 Update - Operational pressures have meant that an update has not been possible this month - a full update will be available at the next meeting. Nothing further to report this month. July 2021 Update. Additional information received from Information colleagues to be escalated the ILGs immediately. September 2021 Update. Nothing further to add - target date now December 2021. November 2021 Update - limited discussion with colleagues from ILGs indicates that the main aims of this recommendation are being undertaken, though this assurance has not been possible across the UHB given the other operational issues which continue to be ongoing. A final review will be undertaken by the time of the next meeting. February 2022 Update. | |
| Data Quality 02 | October 2019 | Limited | 1. Directorate Managers and their teams should review the report of patients recorded as being on a closed pathway to ensure that they are on the correct pathway. Day-case and inpatients should be moved back to an open pathway so that they receive the required treatment on a timely basis. 2. Analysis should be undertaken of the cases where the pathway has been incorrectly closed to identify if they are common to one directorate, department or person. Where necessary, further investigation should be undertaken to why these errors are routinely occurring and further training provided. 3. Consideration should be given to escalating the incorrectly closed pathway reports to ensure Service Group Managers and more senior staff within the Health Board are made aware of the ongoing issue. UPDATED RECOMMENDATION - We have re-raised our original recommendations: 1. Within each of the Directorates/ Clinical Service Groups, analysis should be undertaken of the cases where the pathway has been incorrectly closed to identify if they are common to one department or person. Further training should be provided within the respective areas. 2. The incorrectly closed pathway reports should be escalated to ensure that Service Group Managers and more senior staff within the Health Board are made aware of the ongoing issue. | High | We are fully in agreement with the recommendations and will incorporate this into the action plan response (see above). Recommend clinic outcome letters are an opportunity to validate patient outcomes, a SOP will detail the actions to be taken to achieve this. Where staff are unable to achieve the required standards, a performance monitoring process will be instigated. Agree there is a need for a regular monitoring report to be tabled at Directorate meetings for improvement purposes. UPDATED MANAGEMENT RESPONSE - We agree with the recommendations, noting that the draft Data Quality Assurance Framework and the additional training material developed offer an opportunity to ensure staff are accountable for their actions and this will need to be reinforced through the new operating model. The Performance & Information Directorate will regularly carry out analyses to target additional training towards specific Directorates and/or individuals and escalate concerns to the ILG Hospital Service Managers. This will commence in the new year, with a regular process in place by the end of January 2021. The same risk regarding two instances of core operational systems having to be used by all ILGs applies. | Chief Operating Officer | ILG Acute Service Managers/Assistant Director of Performance & Information | Mar-20 | 01/01/2021 Now November 2021 Now December 2021 Now March 2022 Now June 2022 Now October 2022 | Part Completed in two ILG's | August 2022 Update - Nothing further to report for this month - anticipate it will be at the next meeting. | ILGs have been asked about progress in these areas specifically and the following responses have been received / discussed: December 2020 Update - See above response. 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. May 2021 - nothing further to report this month. July 2021 Update. Additional information received from Information colleagues to be escalated the ILGs immediately. November 2021 Update - limited discussion with colleagues from ILGs indicates that the main aims of this recommendation are being undertaken, though this assurance has not been possible across the UHB given the other operational issues which continue to be ongoing. A final review will be undertaken by the time of the next meeting. February 2022 Update. ILGs have been asked to comment on progress in these areas specifically - M&C and RTE have indicated that the actions are undertaken - formal response expected from Bridgend ILG imminently. April 2022 Update - Nothing further to report for this month - anticipate it will be at the next meeting. June 2022 Update - weekly reports are received for action at CSG level. Management actions have been undertaken. Work continues as trends and repeat issues are identified within the CSGs. Final confirmation needed from one of the ILGs | |
| Head & Neck Management Arrangements 06 | Aug-20 | Limited | 1. All episodes of sickness should be recorded on ESR. Comprehensive and accurate documentation in relation to each episode of sickness should be maintained to allow the proper management of sickness within the directorate and accurate reporting. 2. It should be ensured that self-certification and return to work forms are fully completed. 3. All information contained on self-certification forms, RTW forms and ESR should correspond. 4. Absence management prompts should be monitored and where periods of absence result in a prompt being breached, the appropriate action should be taken. | High | Working with colleagues in WOD the Directorate will start an education programme for all staff management issues - with joint workshops as has happened in other areas (for example, Mental Health). This will start a journey for the Directorate towards compliance. Since receipt of the report the detail has been shared with the Heads of Service and improvements have been made which will be qualified if a re-review takes place. Further, this issue will be highlighted to the Bridgend ILG when it takes over management responsibility for this service. | Chief Operating Officer | Service Group Manager | Oct-20 | March 2021 April 2021 September 2021 November 2021 December 2021 Now March 2022 Now June 2022 Now October 2022 | Part Completed in two ILG's | August 2022 Update. Nothing further to report for this month - anticipate that there will be at the next meeting. | January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. An update will be provided in March 2021. March 2021 Update - Covid 19 has hampered progress in this area. Limited action can be proved to have taken place. An update on progress will be available by the end of April 2021 -this recommendation open and progress will be monitored. May 2021. The Head & Neck Directorate no longer exists and a proposal around how this is handled will be made to Auditors. In the meantime, a check has been made on the arrangements where these services are now held. Colleagues from WOD work closely within all CSGs and provide important support where it is needed. These issues are monitored via internal ILG processes and then via the Performance Review with the COO. At present issues with ESR and Health Roster are the focus of work and as a result the date will be September 2021. July 2021 Update - In RTE and MC ILGs, this action is complete. In BILG, training is underway for action 1, for action 2 it is in place for clerical and medical staff and for the other two work is complete. September 2021. Work remains ongoing - date is still December 2021. November 2021 Update - for BILG, PDRs will be scheduled by the operational team to take place from January 22 and all staff aim to be completed in month, undertaking ESR training will be a common objective for all. February 2022 Update - Staff are still completing ESR training in Surgery, ESR structures have now been correctly aligned to reflect the structure. Progress will be reported at the next meeting. April 2022 Update - Nothing further to report for this month - anticipate that there will be at the next meeting. June 2022 Update. No further action reported - best efforts for the next meeting. This issue has been a focus for all ILGs but there are | |
| Head & Neck Management Arrangements 07 | Aug-20 | Limited | 1. In line with Health Board targets, all staff should be subject to a PDR on an annual basis. 2. PDR documentation should be fully completed, with meaningful objectives agreed by the manager and employee. The document should be signed by both parties and ESR with the date the PDR took place. 3. Copies of PDRs can be accessed to be undertaken in Manager's absence. | High | The report has been shared with all Heads of Services and improvements have been made in the specialty area of Dental Services. The new management arrangements for the RTE ILG are in the process of being resolved and in line with the new workforce performance management ILG structure, the detailed improvements will be made. Further, this issue will be highlighted to the Bridgend and RTE ILG when it takes over management responsibility for this service. | Chief Operating Officer | Service Group Manager | Oct-20 | March 2021 April 2021 August 2021 November 2021 December 2021 Now March 2022 Now June 2022 | Completed | August 2022 Update - now completed in Bridgend ILG. | 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 - Covid 19 has hampered progress in this area. Limited action can be proved to have taken place. An update on progress will be available by the end of April 2021 -this recommendation open and progress will be monitored. 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 risk given the size of the challenge and is monitored through internal ILG Meetings and the ILG Performance Review with the COO. July 2021 Update - For RTE ILG and BILG, this is an aim but not achieved across both areas given the implications of covid. There is a plan with WOD colleagues and intent for this to be improved. This is monitored in ILG Performance Review meetings monthly. In both areas the information is readily available if needed. No response from MC. For MC ILG (OMFS) this is complete. September 2021. Work remains ongoing - date is still December 2021. November 2021 Update - for BILG, PDRs will be scheduled by the operational team to take place from January 22 and all staff aim to be completed in month, undertaking ESR training will be a common objective for all. Nothing further from other ILGs this month. February 2022 Update - the Bridgend ILG will aim to complete all PDRs by March 2022. The issue has been held back due to operational pressures across all services. April 2022 Update - A further update will be available at the next meeting - no further information at this time. June 2022 Update. No further action reported - best efforts for the next meeting. This issue has been a focus for all ILGs but there are | |



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| 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 | | In progress | 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. | 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 13/6/22. |
| Single Cancer Pathway Data Quality Integrity 02 | Oct-21 | Limited | 1. Management should ensure robust processes are put in place that safeguards the integrity of the SCP data prior to it being published and reported on, including accurate input of dates and outcome data onto the clinical portal. 2. Referral letters and other key documents that support the 'start the clock' and 'stop the clock' dates should be added to the clinical portal. Note: Management added to this part of the recommendation: Once we deploy WPRS for Cancer specialities, this data is captured and present in WCP. | High | Acknowledging the later recommendation around the need for a planned approach to improving data quality across CTM, the operating model is being amended to improve ownership of the data integrity issue. Previously, the Cancer Business Unit has held responsibility for the data aspects of Cancer service delivery. In Q3 2021/22, each ILG will take accountability for their Cancer MDTs, trackers and information analysts which will allow each CSC to own the data for their smaller group of patients. The CBU will oversee the roll out of robust data capture through the use of Cancer MDT e-forms in line with the Cancer Informatics plan and CANISC replacement (commencing Q3 2021/22) Wider issues around discrepancies between the paper and digital record have been identified and added to the corporate risk register. The Cancer Business Unit will develop and implement interim safeguards to mitigate risk whilst we transition from paper to digital ways of working through the HB digital strategy. This will include frequent improvement cycles and audit undertaken by clinical coding and the care teams. There are also wider issues around the PAS and WCP not conforming to information and technical standards and applications being design which do not readily enable the clinical data to be stored digitally at a data item level in a manner which it is clinically interpretable and re-usable. Business cases have been submitted collaboratively with NWIS to improve compliance with standards at the application and data storage layers to address these fundamental requirements. Operationally the UHB are committed to prioritising resources to strategically aligned initiatives, such as electronic referral through the WPRS and electronic test requesting for pathology and radiology and through digitising the patient record which including scanning documents, such as the referral letter, using CITO. We see the full implementation of standards and digital applications and the safe, clinically and cost effective methods required to enable our strategy and meet the need for accurate reporting data. In the short term, existent processes whereby referral information is transcribed on to the PAS will be re-affirmed, thereby ensuring key tracking data is available for a myriad of uses including, but not limited to, cancer information. These interim actions will be superseded by the development of the overarching health board strategy (CTM 2030: Our Health Our Future). This will set out the design principles for clinical services and other activities and will include specific ambitions for the digital agenda. This will be supported with the appointment of a new Digital Director taking up post this autumn. This will help support the acceleration of the digital plans to support the overall HB strategy. There is an urgent requirement to reaffirm referral management processes and accuracy of recording of PoS when referrals are received, and uploading on to WPAS. Clinical service group managers are required to take ownership over the validation, cancer waiting times and their cancer waiting lists (See newly devised cancer operating framework). Cancer business unit to undertake quarterly audits on data accuracy of patients that are active on cancer tracker. A WPAS cancer tracker 7 training manual has been developed for all staff using this system. This has been made available online. A training record has been developed and is being updated following individuals completion of training and competency of the WPAS cancer tracker. Clinical Service Group & Operational Managers to ensure uoarde / downgrade SOP is followed along with diligent management of information services to support with validation. Any errors are raised with the information reporting team and any SQL script errors are reported as bugs and corrected. 2. A newly developed SOP has been developed for both weekly and monthly validation of all treated patients within that given month. This is awaiting approval. Validation of all treated patients both in and out of target is undertaken at month end in accordance with the validation SOP. This document is currently awaiting approval. 3. An issues log has been devised which logs all month end validation discrepancies in data identified, with the actions undertaken to resolve them. The discrepancies are sent to the appropriate service group managers. Discrepancies identified during validation of the treated confirmed cancer patients, with the appropriate action taken to resolve the discrepancy, is sent to the appropriate service group managers to discuss with the team responsible and take as a learning opportunity. | Chief Operating Officer | Various | Various | Now March 2022 Now June 2022 | | Completed | August 2022- discussion with Cancer Unit indicate that appropriate action has been taken, that this is now complete and discussed with colleagues in Audit. | November 2021 Update - Devolvement of MDT Coordinators and information assistants still outstanding whilst managerial issues are worked through. CANISC replacement and Wrapper roll out deferred until May 2022 nationally. CTM have established an implementation group to tackle each tumour site in turn. Lung is the first tumour site and work has started. Funding via WCN has been had to develop BI tools. Two pronged approach; integration of endoscopy and radiology feeds into cancer tracker and development / enhancement of Qlik app. February 2022 Update - no further update received. Response will be sought from ICT colleagues - as redirected. April 2022 Update - Nothing further to report in this reporting period - responses will be pursued for the next meeting. June 2022 update - Following discussion - agreed that the MDT Coordinators and Information Assistants are centralised within the CBU. Engagement session being held 13/6/22 with planned integration from Sept 2022. Phase 1 Qlik insights, a cancer BI tool specifically designed for clinicians and service group managers to assist them with managing and delivering their respective cancer services has been completed and went live on 1/6/22. Automated feeds from Radis, EMS and LIMS into cancer tracker has been developed, completed and gone live on 1/5/22. Canisc replacement is ongoing and has been further delayed until Sept 2022. Concern from clinicians raised regarding the impact it will have on current resources. An initial meeting was established via the CBU with lead MDTs and cancer leads for ILG in May but was cancelled due to numerous apologies. This is currently being re-booked. Additionally a working group is planned with the lead MDTs to identify specifically issues / resource implications etc for each individual MDM. |
| Single Cancer Pathway Data Quality Integrity 03 | Oct-21 | Limited | 1. While error rates remain high, senior management quality assurance checks should be undertaken to ensure reliability of the SCP data. Consideration should be given to including these checks as part of the data validation SOP that is being drafted. 2. Validation checks of both breached and achieved cases should commence in line with the draft SOP. 3. An issues log should be maintained to record discrepancies in the data identified during the validation and quality checking process to help identify any trends in errors. | High | 1. Monthly validation reports are sent to the cancer service supervisors via information services to support with validation. Any errors are raised with the information reporting team and any SQL script errors are reported as bugs and corrected. 2. A newly developed SOP has been developed for both weekly and monthly validation of all treated patients within that given month. This is awaiting approval. Validation of all treated patients both in and out of target is undertaken at month end in accordance with the validation SOP. This document is currently awaiting approval. 3. An issues log has been devised which logs all month end validation discrepancies in data identified, with the actions undertaken to resolve them. The discrepancies are sent to the appropriate service group managers. Discrepancies identified during validation of the treated confirmed cancer patients, with the appropriate action taken to resolve the discrepancy, is sent to the appropriate service group managers to discuss with the team responsible and take as a learning opportunity. | Chief Operating Officer | Various | May 2021/Quarter 2 2021 | Now March 2022 Now June 2022 | | Completed | August 2022- discussion with Cancer Unit indicate that appropriate action has been taken, that this is now complete and discussed with colleagues in Audit. | November 2021 Update - Both weekly and monthly validation undertaken. SOP approved. Reaudit mirroring that undertaken by the internal audit department has revealed an improvement of 29% in data accuracy. February 2022 Update - Issue 1. This will be confirmed at the next meeting of the committee. Issue 2. Monthly validation completed checking PoS and FDT. Re audit of internal audit criteria undertaken identifying 79% accuracy (29%) improvement - Complete. Issue 3. Established and maintained monthly following validation. Discrepancies identified sent to the respective individuals for learning - Complete. April 2022 Update - Nothing further to report in this reporting period - responses will be pursued for the next meeting. June 2022 update - Internal CBU monthly validation continues. Internal audit scheduled to revisit mid to end of June 2022 - specific date yet to be confirmed. Engagement with audit department to develop a rolling audit programme has taken place but Covid had prevented development of this due to deployment of staff during that time and greater priorities. Funding for the development of the dashboard to monitor compliance against the national cancer audits re started. |
| CAMHS Follow Up Workforce 1.1 | Dec-21 | Limited | The outstanding issue in relation to accessing the job plans of CAMHS staff within the Allocate system should be resolved with immediate effect so that the updated Consultant Job plans can be uploaded on to the system. | High | Access to Allocate requested for all relevant staff. Appointments made with all Doctors with outstanding job plans to update. The CAMHS folder on Allocate has been reviewed and organised to align with recent organisational changes. Consultant/SAS lists were updated with new appointments added and legacy names removed (Krishna Menon, July 2021) A clear system of delegation has been established whereby Clinical Leads in each service are responsible for creating/ updating job plans for doctors in their areas jointly with the CSG Manager who will be the 1st sign off, with the Clinical Director reviewing the finished job plans for assurance before completing 2nd sign off. Training on Allocate is being organised to support Clinical leads in this regard. Clinical Leads will continue to be job planned jointly by the CSG Manager and CSG Director. Clinical Leads have been approached on several occasions (July 2021) in order to undertake job plans in their areas but progress has been slower than anticipated due to clinical pressures and lack of operational support. It is anticipated that this will be resolved at pace with the new CAMHS CSG Manager taking up her post in February 2022 but the Deputy CSG Manager will be requested to progress this in the interim with support from the Director of Operations. | Chief Operating Officer | Clinical Director | Dec-21 | Now June 2022 Now August 2022 | | Completed | August 2022 Service was reaudited in July and audit report identified that the issue around accessing the job plans of CAMHS staff with the allocate system has been closed. | February 2022 Update - no permanent CSG Manager in post. Update will be available for the next meeting. April 2022- Due to clinical pressures; vacancies in consultant posts and the gap in CSG Manager progress has been limited. Deputy Directorate Manager has completed the training. CSG Manager will meet with Clinical Leads and Clinical Director in April 2022 to review and make a plan to progress this area. June 2022 Update - meets have taken place and request for action in this area, there are 4 job plans awaiting sign off by clinicians and a further 9 in discussion. For those awaiting sign off, CSGM and CD will follow the CTM UHB User guide around presumed sign off to make progress in this area. Plans to progress those in discussion are underway with the relevant Clinical Leads. Further training will also be provided on the new system |
| CAMHS Follow Up Workforce 1.2 | Dec-21 | 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 and any disputes resolved ahead of the job plan start period. | High | A clear dispute process to be followed: Where issues are raised in relation to the job plans created, prompt discussions should take place between the individual, the Clinical Service Group Manager and Clinical Director in order to resolve any problems in a timely manner and ensure plans get signed off. System to provide assurance that the sessions agreed on the job plan are what are being delivered by the Consultants. The Clinical Director will review and complete 2nd sign off of all job plans to provide assurance that they accurately reflect the consultant/SAS doctor's commitments are aligned to the service needs. A process has been agreed to escalate any disputes to the ILG Group Director. | Chief Operating Officer | Clinical Director | Dec-21 | Now August 2022 Now September 2022 | | In progress | August 2022 Service was reaudited in July 2022 with findings that 18 out of 20 of the job plans were either complete or in the process of being completed. The recommendation was to ensure that the process should be started for the two members of staff who are yet to have a plan in place. We have commenced the process for 1 member of staff and due to upload agreed job plan. The second member of staff works on a term time contract so is back to work in September and will be agreed then. | February 2022 Update - no permanent CSG Manager in post. Update will be available for the next meeting. April 2022- Due to clinical pressures; vacancies in consultant posts and the gap in CSG Manager progress has been limited. CSG Manager will meet with Clinical Leads and Clinical Director in April 2022 to review and make a plan to progress this area. June 2022 Update - Meetings have taken place with Clinical Director and Clinical Leads to get remaining job plans in discussion or due to need review progressed to sign off. A plan for following the CTM UHB user guide to progress timely sign off |



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| CAMHS Follow Up Workforce 2.1 | Dec-21 | Limited | Staff personal records should be stored electronically and in such a way that allows other relevant managers to have access to them should an employee's direct line manager be absent from work for a period. This will also enable line managers to access files wherever they are based and will reduce the risk of files being mislaid. | High | The Health Board agrees with the recommendation that staff electronic records are ideal. This will be explored and progressed with IT with regards to the governance & security of IT records for all CAMHS staff. | Chief Operating Officer | Deputy Directorate Manager | Nov-21 | Now August 2022 Now December 2022 | In progress | August 2022 Service was reaudited in July 2022 and reported 1. The use of electronic personal records is being trialled within one area of CAMHS and a Standard Operating Procedure (SOP) is being produced to ensure consistent practices when the process is rolled out to other CAMHS teams. The set-up of the electronic files has allowed shared access at the appropriate level. Further work is now needed to finalise the SOP, fully populate existing files and roll out to the rest of the CAMHS CSG. As such this finding is partially implemented. We have confirmed that the SOP will be drafted and taken to the QPSE in October for review and discussion prior to sign off. Once Swansea Bay have implemented this will be rolled out to CTM towards the end of 2022. | February 2022 Update - no permanent CSG Manager in post. Update will be available for the next meeting. April 2022 - Information has been provided by ICT regarding the approach to setting up secured folders on the shared drives. New admin post will be appointed to as support for the Senior Management Team by June 2022 and will provide support to the Locality Management Team to request and establish secure folders and scan existing files. June 2022 Update - Progress has been made with one of the Localities starting this process and setting up the shared folders. Plan for this area to implement first with some guidance around approach in June and then consider roll out to other areas from July. | |
| CAMHS Follow Up Workforce 2.4 | Dec-21 | Limited | It should be ensured that: • Comprehensive and accurate documentation in relation to each episode of sickness should be maintained. • 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. • Where periods of absence result in a prompt being breached, appropriate action in line with the Managing Attendance Policy should be taken. The roll out of the Line Management Training package should assist in making staff aware of the absence management processes they need to follow. | High | The Line Management training will continue to be delivered across CAMHS to all staff with line management responsibilities as a rolling programme. A line management check list will be rolled out & used by all staff during line management supervision to ensure consistency with issues discussed. This checklist (currently in use in a different directorate) will be updated and reviewed to ensure it is comprehensive and meets the requirements for CAMHS. A monthly audit will be undertaken to provide assurance regarding the quality of line management supervision delivered. | Chief Operating Officer | Senior Nurse/Improvement Manager/Lead Nurse | Nov-21 | Now June 2022 | Completed | August 2022 The service was reaudited in July 2022 and since the last audit, confirmation that the Line Management Training package has been updated and improved. The audit identified some areas of the training package that would benefit from further updates such as including information about mandatory training requirements, annual leave carry over rules and relevant forms and documentation in relation to flexi time and TOIL. This has been addressed in the package. The auditors found evidence of the Line Management Training Package having been delivered to a number of key staff within the CAMHS CSG. We are rolling out some further training sessions and on the basis of the feedback updating the checklist. Monthly audits are in place | February 2022 Update - no permanent CSG Manager in post. Update will be available for the next meeting. April 2022 - line management training has been delivered to staff and information shared with each area. Checklist has also been rolled out and used locally. Senior nursing team will complete audits in May 2022 to review compliance and provide assurance. June 2022 Update - Line management training has been updated to reflect new policies and feedback from HR and L&D colleagues. It has been shared with Internal Audit for review and they have provided some feedback which we will incorporate in June. Plan to provide some further sessions in next few months and then approach for Senior Nurses in each locality to take a lead and this to be included in induction. Audit has taken place in May which demonstrates compliance with sickness management. Internal Audit are also planning to sample 5 staff records to test as well. Following this and the internal audit recommendations potential to close this action | |
| Concerns 1.2 | Feb-22 | Limited | A comprehensive set of Standard Operating Procedures should be developed setting out the process to follow from the point a concern or complaint is received through to the provision of a response. The SOP should include concerns from all sources such as those received via the dedicated email accounts, those made in person or issues raised via local MPs or MSs. The responsibilities of the Corporate Concerns Team and the ILGs should be clearly set out. | High | Review the PTR Guidance alongside the CTM structures to identify what Standard Operating Procedures are required and develop and implement to support the new process. | Director of Corporate Governance/ Board Secretary | Interim Head of Concerns, Redress & Legal | Jun-22 | Now September 2022 Now January 2023 | In progress | 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. | April 2022 Update - On hold until changes to the operating model. - 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. June 2022 | |
| 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 Corporate Governance/ Board Secretary | 3.1a Interim Head of Concerns, Redress & Legal 3.1b Interim Head of Concerns, Redress & Legal/ILG Heads of Quality & Safety | 3.1a April 2022 3.1b June 2022 | Now January 2023 | In progress | 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. | 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. | |
| 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 developed | Director of Corporate Governance/ Board Secretary | Interim Head of Concerns, Redress & Legal | Apr-22 | Now September 2022 Now January 2023 | In progress | 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. | 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. | |



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| Concern s 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 order 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 Corporate Governance/ Board Secretary | 9.1a Datix Manager 9.1b AD Nursing & Patient Safety and Interim Head of Concerns, Redress & Legal AD Nursing & Patient Safety and Interim Head of Concerns, Redress & Legal | Jan-22 | Now September 2022 Now January 2023 | In progress | 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 intelligence tool. The Listening and Learning Framework has been developed and is in DRAFT form at present, this is due to be launched at the end of September in the inaugural Learning from Events day. 9.1b The new operating model in respect of quality and safety being central and aligned to care groups will ensure consistent use of data and how and where it is shared throughout 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. | |
| 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 | In progress | 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. | 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. | |
| Fire Safety Management 5.2 | Feb-22 | Limited | Risk assessments should be completed within stipulated review periods, including refresh for ward reconfigurations. | High | An additional Fire Officer has been appointed on a fixed term basis to support the completion of Fire Risk Assessments following the backlog created during the Covid pandemic. This role will be reviewed alongside the capacity of Fire Safety Team to maintain all the Health Board's Fire Risk Assessments. A Strategic Leadership Group paper will be presented on the outcome of this review and prior to the end of the fixed term appointment. | Director for People | Head of Health, Safety and Fire | Jun-22 | | In progress | August 2022 Update - The Health Board has replaced one of the vacancies for a Fire Officer in the Merthyr/Cynon area but sadly the Temp post and one substantive Fire Officer post had to be provided as a cost saving initiative. Prior to these changes, the majority of Fire Risk Assessments were updated. | April 2022 Update - Whilst the additional temporary post was helpful in managing the backlog of outstanding fire risk assessments following the pandemic, subsequently 2 Fire Officers have retired and a further is due to retire in June 2022. Vacancies for replacement are currently on hold due to financial constraints within the Health, Safety and Fire Team Budget. | |
| 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 | | In progress | August 2022 Update - This recommendation will have to be reviewed further as a result of changes to the Health Board's Operating Model. | April 2022 Update - Ongoing | |
| Facilities Systems 2.1 | Jun-22 | Limited | Management should ensure that staff that have responsibility for managing contracts and for approving requisitions and approving purchase orders in relation to those contracts are following the procurement process set out in the Requisition of Goods and Services Financial Control Procedure and the All-Wales No PO No Pay policy. | High | We have worked with procurement and finance colleagues to co-produce an agreed process compliant with All Wales No PO No Pay Policy. In addition to this piece of work we have worked with our procurement business partners and with our contractors/suppliers to ensure they are fully aware of their obligations under the P2P process. The hierarchy for approval of requisitions has also been agreed with finance and procurement colleagues and is being rolled out. | Director of Finance/Chief Operating Officer | Head of Technical Services | Completed | | Completed | | | |



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| Facilities Systems 2.4 | Jun-22 | Limited | Documentation to support all orders should be retained and made available if required. | High | A process is being developed to ensure all documentation in relation to orders for goods/services are available in the Oracle financial system. | Director of Finance/Chief Operating Officer | Head of Technical Services | Jun-22 | | Completed | Completed | August 2022 Update - Action Card in place agreed with procurement | |
| Facilities Systems 3.1 | Jun-22 | Limited | In liaison with Procurement, a review exercise should be undertaken by those managers with responsibility for overseeing contracts to ensure that the arrangements with existing suppliers are appropriate and that the Health Board can demonstrate best value for money. | High | An initial review meeting has now been set up with Facilities procurement business partner and all managers responsible for overseeing contracts to ensure that the arrangements with existing suppliers are appropriate and that the Health Board can demonstrate best value for money. Monthly contract meetings with procurement business partners have also now been set up to ensure a rolling review of all Facilities contracts is in place. | Director of Finance/Chief Operating Officer | Assistant Director OSS (Facilities) | Completed | | Completed | Completed | | |
| Facilities Systems 6.1 | Jun-22 | Limited | For those issues that have been identified management should review the circumstances and take appropriate action to ensure that there is no recurrence of the issue. Management should also consider providing further information and guidance that clarifies purchasing responsibilities for the Central Facilities Hub and the ILGs Facilities Teams. Management should also consider reviewing the original schedules drawn up as part of the revised operating model to see if the details are still applicable or whether any changes are required. Where changes are required, management should ensure that they are approved by an appropriate forum. The changes should then be communicated to all relevant staff and the Oracle purchasing hierarchy and | High | Work programme has been initiated with finance colleagues to identify where ILG generate demand that the Facilities Hub have no managerial control over. Processes have been developed to capture spend against activity and demand generated by the ILG's with initiatives to mitigate and reduce this spend where possible. | Director of Finance/Chief Operating Officer | Head of Technical Services | Completed | | Completed | Completed | | |
| Facilities Systems 7.1 | Jun-22 | Limited | The approval hierarchy for the department should be reviewed as soon as possible to ensure the details and approval limits of staff listed are correct. Where discrepancies are identified management should investigate and take appropriate action. | High | CTM Financial Systems were contacted 12th May 2022 to provide the details - approval limits and staff listed for each cost code within Facilities Hub. This list was circulated to the senior management team (16th May 2022) to review for accuracies. Finance business partners were provided with a list of cost centres in May 2022 requesting to enable any hierarchy approval corrections for all of the Facilities cost centres. | Director of Finance/Chief Operating Officer | Technical Services Manager | Completed | | Completed | Completed | | |
| 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 | In progress | In progress | August 2022 Update - No formal feedback received from ILGs. To ensure progress, meeting planned for Thursday 25 August 2022 to discuss this audit. | |



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| Patient Pathway Appointment Management Process Follow Up 1.2 | Jun-22 | Limited | Management should ensure that outcome reports are being sent to the correct staff within each of the Clinical Service Groups to ensure that they action the outcomes recorded. The WPAS team should liaise with senior managers in each ILG to identify who is the most appropriate person in each CSG to receive the monthly reports. | High | Each ILG will work with colleagues in the WPAS team to identify the correct staff members. | Chief Operating Officer | ILG Directors of Operations / Head of Information | Aug-22 | Now December 2022 | | In progress | August 2022 Update - No formal feedback received from ILGs. To ensure progress, meeting planned for Thursday 25 August 2022 to discuss this audit. | |
| 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 | | In progress | August 2022 Update - No formal feedback received from ILGs. To ensure progress, meeting planned for Thursday 25 August 2022 to discuss this audit. | |
| Patient Pathway Appointment Management Process Follow Up 1.4 | 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 ensure that the reports produced are suitable to allow the appropriate monitoring to take place. | Chief Operating Officer | ILG Directors of Operations / Head of Information | Aug-22 | Now December 2022 | | In progress | August 2022 Update - No formal feedback received from ILGs. To ensure progress, meeting planned for Thursday 25 August 2022 to discuss this audit. | |
| 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 | | | In progress | August 2022 Update - Date remains September 2022. | |
| 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 | | In progress | August 2022 Update - No formal feedback received from ILGs. To ensure progress, meeting planned for Thursday 25 August 2022 to discuss this audit. | |



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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 | | In progress | August 2022 Update - No formal feedback received from ILGs. To ensure progress, meeting planned for Thursday 25 August 2022 to discuss this audit. | |
| Patient Pathway Appointment Management Process Follow Up 2.3 | Jun-22 | Limited | On receipt of the reports, management within the CSGs should ensure that they analyse the data to identify any trends such as those staff or departments that are continually making the errors and closing pathways incorrectly. Appropriate action should be taken including the provision of additional training on the WPAS. | High | ILGs will ensure that they undertake this action | Chief Operating Officer | ILG Acute Services General Managers | Aug-22 | Now December 2022 | | In progress | August 2022 Update - No formal feedback received from ILGs. To ensure progress, meeting planned for Thursday 25 August 2022 to discuss this audit. | |
| 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 | | | In progress | August 2022 Update - Date remains September 2022. | |
| Data Quality 05 | October 2019 | Limited | The process for monitoring patients who are awaiting diagnostic investigation results should be reviewed to ensure all Medical Secretaries are utilising a standard approach that is user friendly and does not restrict access, thus allowing visibility to other staff members. UPDATED RECOMMENDATION - 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 | A review of this process and guidance will be carried out, potentially with external support to assist and add pace to the review. Consistent guidance and emphasis on use will then be provided. Management teams will ensure that locally held spreadsheets are not replacing the mandatory addition to the formally report QL. Request internal audit re-assessment of this in next year's audit plan. UPDATED MANAGEMENT RESPONSE - A technical assessment on the potential upgrading of watch list functionality to facilitate performance management of Medical Secretaries will be commissioned. | Chief Operating Officer | Assistant Director of Performance & Information/ Assistant Director ICT | March/April/May 2020 | February 2021 March 2021 August 2021 Now October 2021 Now December 2021 Now March 2022 Now June 2022 Now September 2022 | | In progress | August 2022 Update. Operational pressures have made this difficult to assess. Nothing further to add this month - anticipate that a response will be ready at the next meeting. | December 2020 Update - See above response 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. May 2021 Update - Nothing further to report this month. July 2021 Update. No change reported. September 2021 Update. Nothing further to add - target date now December 2021. Informal discussion with SGMs suggests strongly that Medical Secretaries are provided with support with training. November 2021 Update - limited discussion with colleagues from ILGs indicates that the main aims of this recommendation are being undertaken, though this assurance has not been possible across the UHB given the other operational issues which continue to be ongoing. A final review will be undertaken by the time of the next meeting. February 2022 Update - limited discussion with colleagues from ILGs indicates that the main aims of this recommendation are being undertaken, though this assurance has not been possible across the UHB given the other operational issues which continue to be ongoing. A final review will be undertaken by the time of the next meeting. April 2022 Update - Nothing further to add this month - anticipate that a response will be ready at the next meeting. June 2022 Update - Colleagues in RTE confirm that limited progress continues with work ongoing with the functionality of the watchlist and governance process. Diagnostic reporting and waiting lists are a priority within all recovery plans and will progress the watch list process for tracking and formal QL use. Anticipate similar responses from colleagues from MC and BILG at the next meeting. |
| Head & Neck Management Arrangements 09 | Aug-20 | Limited | The Directorate should ensure that all staff record their mandatory training in ESR and all staff are provided with the opportunity to undertake their mandatory training. Monitoring at a departmental level should take place to identify any problem areas and to establish reasons for non-compliance with a view to providing support where necessary. | Medium | This has been raised with the Heads of Service. The new management arrangements for RTE ILG are in the process of being resolved and in line with the new workforce performance management ILG structure, the detailed improvements will be made. Further, this issue will be highlighted to the Bridgend ILG when it takes over management responsibility for this service. | Chief Operating Officer | Service Group Manager | Oct-20 | March 2021 April 2021 August 2021 Now December 2021 Now March 2022 Now August 2022 Now October 2022 | | Part Completed | August 2022 - final confirmation awaited from one ILG. | 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 - Covid 19 has hampered progress in this area. Limited action can be proved to have taken place. An update on progress will be available by the end of April 2021 - this recommendation open and progress will be monitored. May 2021. The Head & Neck Directorate no longer exists and a proposal around how this is handled will be made to Auditors. In the meantime, a check has been made on the arrangements where these services are now held. These issues are monitored via internal ILG processes and then via the Performance Review with the COO. July 2021 Update - In RTE ILG (for ENT), all staff are aware that this is mandatory and so the action is complete. In BILG (for Ophthalmology), ESR is not used and so training is underway, so not yet complete. For MC ILG, this is complete and happening across all areas of the Clinical Service Group. September 2021. Work remains ongoing - date is still December 2021. November 2021 Update - for BILG, ESR training hasn't been rolled out across the whole service yet. With the new management team in place it is anticipated that there will be progress in this area into quarter 4 of 2021 - 2022. February 2022 Update - the ESR training has started and structures have now been correctly aligned to reflect the structure. April 2022 Update - Nothing further at present. June 2022 - no further update this month. Will be a priority for the next meeting. |



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| Head & Neck Management Arrangements 10 | Aug-20 | Limited | 1 Consultant job plans should be reviewed and agreed on an annual basis, with planning discussions commencing in enough time to get the plan signed off ahead of the job plan start period. 2 Where issues are raised in relation to the job plans created, prompt discussions should take place between the individual, the Directorate Manager and Clinical Director to resolve any problems in a timely manner and ensure plans get signed off. | Medium | The management team agree with this recommendation, and the lack of compliance has been as a result of COVID restrictions. The Clinical Director and the Service General Manager will work to complete this work by the end of September 2020. | Chief Operating Officer | Clinical Director/Service General Manager | Sep-20 | 01/03/2021 August 2021 Now October 2021 Now March 2022 Now June 2022 Now August 2022 Now October 2022 | Red - | Part Completed | August 2022 Update - In Bridgend ILG, all appropriate job planning has now been undertaken and is complete. RTE final confirmation awaited | January 2021 Update The CSG Manager and Director are undertaking job planning across their areas. Issues are discussed and agreed as part of CSG normal business - the status has been changed to yellow to reflect this. 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 - As a result of the lack of a Deputy SGM (since at least October 2019) this work has not progressed as fast as would have been liked. The SGM has instigated a process to speed up the process of carrying out job planning, any urgent matters are managed by the SGM and the Clinical Director. May 2021. The Head & Neck Directorate no longer exists and a proposal around how this is handled will be made to Auditors. In the meantime, a check has been made on the arrangements where these services are now held. These issues are monitored via internal ILG processes and then via the Performance Review with the COO. July 2021 Update - In RTE ILG, the aim is to complete plans annually and there has been an improvement with a plan in place. For action 2 this does take place. In BILG, job planning is underway and should be completed by September 2021, so this is almost complete. In MC ILG, this was complete pre-COVID-19. Unfortunately as a consequence of the response, job plans are still fluid and in a state of flux. However, Job plans for all specialities of the Clinical Service Group are being planned for September 2021. September 2021. Work remains ongoing - date is still October 2021. November 2021 Update - within OMFS in MC ILG, a new CSG manager and CD have started in post and continue to work through and updating all Job Plan. This is currently slow to progress due to operational demands and reduced CSG support. April 2022 Update - Nothing further to add this month - anticipate that it a response will be ready at the next meeting. June 2022 Update. Final confirmation required - will be chased for the next meeting. November 2021 Update continued - within Ophthalmology, the CSGM, CD and Assistant CD took post in Mid-September. Job planning starts on 19th November with CD and all consultants have a date booked for job planning, aim is to complete the consultant body on 10th December 2021. February 2022 Update - Bridgend ILG. Job plans in Ophthalmology have been held up by a disputed job plan in December that was escalated to the Medical Director, this has now been completed and the remaining consultants and SAS medics will be completed in February 2022. In MC, job planning is still on target to be complete by March 2022 with three undertaken this month and a further four planned for the coming month. |
| CAMHS Follow Up Workforce 1.3 | Dec-21 | Limited | Once all job plans have been brought up to date, the Clinical Service Group should be able to assure itself that the sessions agreed on the job plan are what are actually worked by the consultants. | Medium | The annual job plan review will provide assurance, ensuring sessions agreed reflect the work undertaken. | Chief Operating Officer | Clinical Director | Dec-21 | Now September 2022 | Green - Action | Completed | August 2022 - The reaudit in July 2022 reported that the monitoring of job plan sessions to actual hours worked is undertaken as part of the annual planning review process and more frequently during the year as part of activity monitoring within the service area. The report confirmed that this action is now closed | February 2022 Update - no permanent CSG Manager in post. Update will be available for the next meeting. April 2022- Due to clinical pressures; vacancies in consultant posts and the gap in CSG Manager progress has been limited. CSG Manager will meet with Clinical Leads and Clinical Director in April 2022 to make a plan to get current job plans uploaded and signed off. Once this is done CSG Manager will work with Clinical Director to put in place annual review of job plan and activity. June 2022 - Meetings have taken place with Clinical Director and Clinical Leads to get remaining job plans in discussion or due to need review progressed to sign off. A plan for following the CTM UHB user guide to progress timely sign off. |
| 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 Corporate Governance/ Board Secretary | Interim Head of Concerns, Redress & Legal | Jun-22 | Now September 2022 Now January 2023 | Red - | In progress | 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. | 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. |
| Concerns 2.1 | Feb-22 | Limited | To ensure consistency, a more simplified approach to receiving concerns and complaints into the Health Board should be developed. The Health Board should ensure that relevant and up to date information is available across their respective areas to ensure that it is clear who and how patients, carers and families contact, should they have a concern or complaint to report. | Medium | Review the Health Board website and any other documentation i.e. (posters, leaflets) in respect of how to raise a concern, to ensure there is a single point of access. This will reflect a new process for the management of concerns as per 1.1 above. | Director of Corporate Governance/ Board Secretary | Interim Head of Concerns, Redress & Legal | Jun-22 | Now September 2022 | Green - Action | Completed | August 2022 Update A single point of entry is available on the Health Board website. However there is PALS telephone numbers for each ILG. This will be reviewed following Operational model restructure. | April 2022 Update - Single point of access is on website for central concerns team telephone and email address. However there is PALS telephone numbers for each ILG. This may need to be reviewed following Operational model restructure. June 2022 - A single point of entry is available on the Health Board website. However there is PALS telephone numbers for each ILG. This may need to be reviewed following Operational model restructure |
| Concerns 3.2 | Feb-22 | Limited | Those staff who may have received training previously or are experienced in the role of investigator or quality assurance, should receive "refresher" training to ensure awareness of current processes and the application of consistent practices across the Health Board. | Medium | This will be picked up as part of the Training Needs Analysis in 3.1b and where relevant, training will be provided as part of the training programme. | Director of Corporate Governance/ Board Secretary | Interim Head of Concerns, Redress & Legal | Jun-22 | Now September 2022 | Green - Action | Completed | August 2022 Update 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, PTR, breach of duty, causation, redress, claims and learning from events reports, sharing of learning. | April 2022 Update - To be developed once training package has been completed. June 2022 - to be picked up as part of 3.1 training programme and training needs analysis. |
| 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 Corporate Governance/ Board Secretary | Interim Head of Concerns, Redress & Legal | Feb-22 | Now December 2022 | Yellow - Action | Part Completed | 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. | 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. |



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| Concern s 4.1 | Feb-22 | Limited | A review should be carried out to establish why Bridgend ILG is closing fewer concerns at an early resolution stage in comparison to the other ILGs. The review should include identifying if there is a link between concerns closed at early resolution stage and concerns re-opened. Any learning identified from the review should be shared across the ILGs and where necessary processes followed should be captured in a Standard Operating Procedure. | Medium | Audit of Complaints Management to be reintroduced looking at all aspects of complaints management. Audit will commence with BILG to address this risk and will then be conducted across the other sites. A programme of on-going audit will be re-introduced. | Director of Corporate Governance/ Board Secretary | Complaints Manager | Apr-22 | Now December 2022 | Completed | Completed | August 2022 Update Staff vacancies have had a bearing on the number of concerns closed at ER stage within Bridgend. The recording of re-opened complaints has no correlation with ERs. | April 2022 Update - Complaints Manager not in post. 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. June 2022 |
| Concern s 4.2 | Feb-22 | Limited | 4.2a Management should understand why RTE has not been re-categorising early resolution concerns that were not resolved in the timeframe and take appropriate action to resolve and accurately record in Datix. 4.2b To ensure consistency, a Standard Operating Procedure (SOP) should be in place outlining the process for re-categorising concerns, including who is responsible for performing this task. Training should be provided where necessary. | Medium | 4.2a As 4.1 above 4.2b Standard Operating procedure to be developed as part of a suite of SOPs outlined in 1.2 above. | Director of Corporate Governance/ Board Secretary | 4.2a Complaints Manager 4.2b Interim Head of Concerns, Redress & Legal | Apr-22 | Now December 2022 Now January 2023 | In progress | In progress | 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. | 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. |
| Concern s 5.1 | Feb-22 | Limited | For each concerns investigation undertaken, in the absence of detailed Standing Operating Procedures, the process outlined in the Concerns Policy and Procedure documents should be followed. Comprehensive notes and evidence should be added to Datix in a timely manner to support the process followed, the investigation carried out and the lessons learnt. Where aspects of the policy are not being undertaken at all, it should be established if this is due to staff not being aware of this aspect of the process or if the policy is in fact out of date and in relation to current practices. | Medium | To be included in training programme as per 3.1a and 3.1b above | Director of Corporate Governance/ Board Secretary | Interim Head of Concerns, Redress & Legal | Apr-22 | Now December 2022 | Part Completed | Part Completed | 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. | 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. |
| Concern s 6.2 | Feb-22 | Limited | Evidence should be retained of CSG management's contribution to the quality checking process of review and oversight of the investigation's outcomes and the draft PTR Concerns Response letters prior to their submission to an ILG Director for sign-off. | Medium | Standard Operating procedure to be developed as part of a suite of SOPs outlined in 1.2 above | Director of Corporate Governance/ Board Secretary | Interim Head of Concerns, Redress & Legal | Jun-22 | Now October 2022 | In progress | In progress | 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. | 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. |
| Concern s 6.3 | Feb-22 | Limited | A process of retrospectively reviewing the quality assurance processes applied in ILG should be introduced at a corporate level to ensure oversight, challenge and facilitate learning. | Medium | To form part of the rolling corporate concerns management audit programme | Director of Corporate Governance/ Board Secretary | Interim Head of Concerns, Redress & Legal | Apr-22 | Now December 2022 | In progress | In progress | 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. | 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. |
| Concern s 6.4 | Feb-22 | Limited | All ILGs should ensure that the content of their PTR Concerns Response Letters are empathetic, showing concern and explaining with clarity the outcomes and lessons learned arising from the reported complaint. Letters should be independently reviewed and signed by an ILG Director in a timely manner. | Medium | This recommendation should be achieved following development of SOPs, Training and the QA process. | Director of Corporate Governance/ Board Secretary | Interim Head of Concerns, Redress & Legal | End of June 2022 | Now September 2022 | In progress | In progress | August 2022 Update A review of complaint response letters has been undertaken in conjunction with the Communications department and the CEO. The review has focussed on the empathy of letters whilst ensuring they are informative and cover the necessary legislative requirements. Regular QA reviews will take place as part of the audit programme. | 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. |



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| Concern s 7.1 | Feb-22 | Limited | Clarity should be sought, and information documented with a SOP as to when a case should be closed on Datix and the circumstances for when it can be re-opened. To avoid any confusion, information contained in a SOP and the Concerns Policy should align. | Medium | To be included in the development of SOPs as per 1.2 above | Director of Corporate Governance/ Board Secretary | Interim Head of Concerns, Redress & Legal | Apr-22 | Now September 2022 Now January 2023 | In progress | In progress | 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. | 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. |
| Concern s 7.2 | Feb-22 | Limited | Prior to closing concerns at early resolution stage, some form of quality assurance process should be followed that ensures all aspects of the concern raised by the complainant have been adequately addressed, thus preventing the case being potentially re-opened at a later date. This process should be documented. | Medium | To be included in the development of SOPs and training as per 1.2, 3.1a and 3.1b above | Director of Corporate Governance/ Board Secretary | Interim Head of Concerns, Redress & Legal | Jun-22 | Now September 2022 Now January 2023 | In progress | In progress | 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. | 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 sparse 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. |
| Concern s 8.1 | Feb-22 | Limited | In relation to aged open concerns, it should be ensured comprehensive Datix records are maintained including recording the reason / justification for why the case has remained open and that relevant management are aware of it remaining open. | Medium | Process already in place which includes dashboards, and is monitored via Patient Safety Executive Meeting. The importance of recording regular updates on Datix will be included as part of 3.1a training programme. | Director of Corporate Governance/ Board Secretary | Interim Head of Concerns, Redress & Legal | Apr-22 | Now December 2022 | Part Completed | Part Completed | 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. | 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. |
| Concern s 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 Corporate Governance/ Board Secretary | Interim Head of Concerns, Redress & Legal | Apr-22 | Now September 2022 | In progress | In progress | 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/famils 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. | 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. |
| Concern s 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 Corporate Governance/ Board Secretary | ILG Heads of Quality & Safety | Immediatley | Now December 2022 | Part Completed | Part Completed | August 2022 Update 10.1/10.1b/10.1c - Various reports are already available and presented at various committees. The Datix team and OWVMS 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 OW National Team in respect of the Business Intelligence tool which is due to be rolled out as part of Phase 2 of the OWVMS (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 | 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 |



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| 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 | | | | August 2022 Update - no further update provided on this occasion | April 2022 Update - Work ongoing |
| 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 | | | In progress | August 2022 Update - no further update provided on this occasion | April 2022 Update - Work ongoing by the Capital and Estates Team |
| 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 | | | In progress | August 2022 Update - no further update provided on this occasion | April 2022 Update - Work ongoing by the Capital and Estates Team. Current Procedure to be reviewed and revised where necessary. |
| Facilities Systems 1.1 | Jun-22 | Limited | While the lunch and learn sessions should improve the knowledge of staff, management should ensure that there are structured training arrangements in place for the Oracle I-Procurement module for all staff responsible for, and involved with, the delivery of the purchase to pay process. | Medium | Arrangements have been made for structured training on the Oracle I-Procurement module for all staff responsible for, and involved with, the delivery of the purchase to pay process. | Director of Finance/Chief Operating Officer | Head of Technical Services | Completed | | | Completed | | |
| Facilities Systems 2.2 | Jun-22 | Limited | 2.2a Those members of staff with responsibility for managing contracts should work with colleagues in Procurement to identify the contracts where it would be appropriate to have alternative mechanisms for raising orders and paying invoices, for example the use of 'call off / open' orders. 2.2b In liaison with Procurement, clear guidance should be developed around when it may be acceptable to utilise 'call off / open' orders and the process staff need to follow to ensure appropriate controls are in place. The FCP should also be updated accordingly. | Medium | 2.2a We have worked with procurement and finance business partners to co-produce an agreed process compliant with All Wales No PO No Pay Policy. There is also an agreement that allows us to raise retrospective orders against Emergency PO's for specific contracts. | Director of Finance/Chief Operating Officer | Head of Technical Services | Completed | | | Completed | | |
| Facilities Systems 2.3 | Jun-22 | Limited | Where a retrospective order is deemed appropriate staff should be encouraged to complete the notes section in Oracle explaining the reason for the use of a retrospective order, including details of who requested the goods and services to be procured. | Medium | Noted and agreed staff have been advised. | Director of Finance/Chief Operating Officer | Head of Technical Services | Completed | | | Completed | | |



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| Facilities Systems 3.2 | Jun-22 | Limited | Management should remind staff that procurement guidance requires three quotations to be obtained where expenditure for goods or services to be procured are expected to exceed £5k. Consideration should be given to providing refresher training in relation to this. | Medium | All staff have been reminded that procurement guidance requires three quotations are to be obtained where expenditure for goods or services to be procured are expected to exceed £5k. Procurement P2P initial training has now been provided for Facilities Central Services staff in relation to this. | Director of Finance/Chief Operating Officer | Assistant Director OSS (Facilities) | Completed | | Completed | | | |
| Facilities Systems 4.1 | Jun-22 | Limited | Management should liaise with Finance and Procurement colleagues to ensure ongoing regular receipt of details of any invoices on hold for Facilities and then review and take appropriate action to 'release' the hold. When reviewing the reason for the 'holds' management should note the issues, such as use of retrospective orders and take appropriate action, including arranging further training of staff if necessary, to ensure that the issues do not recur. | Medium | Weekly (invoices on hold) lists are now shared with the Facilities Hub for review and action. | Director of Finance/Chief Operating Officer | Head of Technical Services | Completed | | Completed | | | |
| Facilities Systems 5.1 | Jun-22 | Limited | A training needs assessment of all budget holders within the Facilities directorate should be carried out to identify those that need training on the QlikView system and those that need general budgetary control training. In liaison with the Finance Business Partners, a consistent approach to training delivery should be adopted across the directorate. | Medium | A training needs assessment has been completed of all budget holders within Facilities. In liaison with Procurement staff, general budgetary control training and guidance through Procurement P2P training has now been provided for Facilities Central Services staff. Facilities Governance Manager has met with Finance Systems team to discuss and arrange a QlikView training plan and an accompanying training guide for those staff identified in the training needs assessment. | Director of Finance/Chief Operating Officer | Governance & Compliance Manager | Completed | | Completed | | | |
| Facilities Systems 7.2 | Jun-22 | Limited | The Financial Systems Team should issue copies of the Oracle approval hierarchy to all departments of the Health Board on a regular basis for scrutiny and conformation that details are correct. | Medium | An electronic diary note has been set up for 27th June and quarterly thereafter to repeat the process detailed in 7.1 to ensure continued accuracy. | Director of Finance/Chief Operating Officer | Facilities Manager | Completed | | Completed | | | |
| 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 | | In progress | August 2022 Update - Date remains September 2022. | | |
| Fire Safety Management 8.1 | Feb-22 | Limited | Management will confirm that GAP analysis has been concluded to ensure comprehensive appliance checks. | Low | 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 | Mar-22 | Now May 2022 | Completed | August 2022 Update - A report covering this issue was provided to the last Health, Safety and Fire Sub Committee to provide the Committee with assurance. | April 2022 Update - A report outlining the measures the Health Board has in place in relation to electrical safety compliance is to be submitted by the capital and Estates Team to the next Health, Safety and Fire Sub Committee. | |



| 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 |
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| Facilities Systems 2.5 | Jun-22 | Limited | Staff should be reminded of the importance of checking on the Oracle system for existing open orders when needing to make lease payments, as opposed to raising a new (retrospective) order. | Low | Noted, agreed and actioned | Director of Finance/Chief Operating Officer | Head of Technical Services | Completed | | | Completed | | |
| Facilities Systems 5.2 | Jun-22 | Limited | Consideration should be given to producing a training guide to accompany the training session that would cover accessing the system and also understanding the 'finance dashboard' that the budget holder will access as well as its application. | Low | Cross reference action to 5.1. | Director of Finance/Chief Operating Officer | Governance & Compliance Manager | Completed | | | Completed | | |
| 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 December 2021 Now April 2022 Now July 2022 Now August 2022 Now October 2022 | | In progress | 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. | 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 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 |
| Nurse Agency Usage 02 | Apr-20 | Reasonable | 1. The Bank / Agency Nurse Quality Monitoring Form should be reviewed to ensure it is fit for purpose and provides a suitable means for the routine monitoring of the quality of work provided by agency staff. 2. Ward Managers should be reminded of the need to complete the quality monitoring form and returning it to the Bank office as a means of formally evaluating the performance of agency nurses and aiding and informing any future acceptance or rejection of potential agency nurses in the event of query or concern. 3. The Clinical Incident Reporting for Agency Staff flowchart and the Staff Bank Policy should be reviewed to ensure consistent guidance for managing and monitoring issues relating to the quality of service provided by agency staff. If the flowchart is the Health Boards preferred approach, all Ward Managers should be made aware that in line with the agreed flowchart, incidents are appropriately and consistently recorded on DATIX to allow effective monitoring. 4. Attempts to cross-reference patient experience data and agency usage data should take place with a view to identifying trends. Outcomes should be | 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 | | In progress | 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. | 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 - 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 |
| Head and Neck Compliance 02 | Aug-20 | Reasonable | Heads of Department within the Head & Neck Directorate should be reminded of the requirement to complete and maintain an inventory of non-capital assets in line with Financial Control Procedure 11, where applicable. | High | Action will be: • The Heads of Service who did not complete the inventories will be contacted individually and required by the Service Group Manager to ensure that they understand the importance of this issue and asked to produce a compliant inventory by the end of September 2020. • Issue will be raised in the CSG Governance meeting and an email sent to all senior staff in the Directorate (from band 7 up) outlining the paramount importance of this issue. | Chief Operating Officer | Service Group Manager | Oct-20 | March 2021 May 2021 Now December 2021 Now March 2022 Now June 2022 | | Completed | August 2022 Update - now complete and confirmed with Department Head in April 2022. | 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. Following the changes to the structure connected with the RTE ILG, discussion is ongoing with the new Associate Service Group Director to decide an agreed way to take this matter forward. March 2021 - Management actions have been stalled by the demands of covid 19 but remain valid. The Ophthalmology aspect of Head & Neck Service has moved to the Bridgend ILG and will join the ILG's arrangements. May 2021. The Head and Neck Directorate no longer exists, and so consideration will be given by the next meeting to how to explain this to auditors and propose a change in the management actions. For reassurance in the meantime, CSGs now managing these specialties have been contacted and though actions are sometimes slow as a result of covid 19 implications, the services are being subsumed into new arrangements in each ILG. The actions recommended are usually monitored locally by the CSG meeting with the ILG and then at ILG Performance Review Meetings with the COO. Within RTE, staff have been communicated with recently with a requirement to address this recommendation and in Bridgend the matter is being subsumed into existing management arrangements. July 2021 Update - For RTE ILG (ENT) more work needed here - though likely to be small numbers. Remains red. For Bridgend ILG (Ophthalmology), all staff aware that this should be completed. No response from MC ILG. For MC (OMFS), colleagues are aware that this should happen and are in the process of undertaking an inventory of each surgery that they work in. September 2021 Update. Target date remains December 2021. Work remains ongoing here. November 2021 Update - work remains ongoing and the implementation date remains March 2022. February 2022 Update - nothing further to report. All ILGs have reported minimal progress in this area as a consequence of staffing and operational pressures. In M&C, the Unit Manager has been asked for progress and to link with Procurement colleagues to assess if this will make the establishment of a register possible. April 2022 Update - Nothing further to add this month - anticipate that a response will be ready at the next meeting. June 2022 - nothing further to add this month, will be pursued for August 2022. |
| Director site 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 | | In progress | 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. | 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. September 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 |



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| 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 | | In progress | 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. | 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. 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. 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. 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. 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. |
| 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 ... | 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 | | In progress | 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. | 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-incide 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. |
| CAMHS Follow Up Governance & Risk 5.1 | Dec-21 | Reasonable | A definitive list of all CAMHS policies should be generated and an action plan developed for reviewing and updating them, to ensure consistency across the localities and relevance and alignment to current legislation and expected working practices. | High | A comprehensive single list of policies will be finalised with the Governance team, ensuring there is clarity between existing policies & SOPs by December 2021. The Corporate Governance team will work with CAMHS to assist with the update of policies. | Chief Operating Officer | Lead Nurse | Dec-21 | Now June 2022 Now August 2022 Now October 2022 | | In progress | 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. A register has been developed and agreement to review which are relevant to go through the HB policy group. | 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. |
| CAMHS Follow Up Governance & Risk 5.2 | Dec-21 | Reasonable | 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 | Updated CAMHS policies will be shared with Corporate Policy Group for ratification & then uploaded to CTM intranet with a review date included, as per standard Health Board process. | Chief Operating Officer | Lead Nurse | Apr-22 | Now June 2022 Now August 2022 Now October 2022 | | In progress | 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. A register has been developed and agreement to review which are relevant to go through the HB policy group. We are considering the development of a sharepoint page to hold policies for all staff to access. Currently they are saved in shared folders and circulated to staff | 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 - 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. |
| 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 | | In progress | August 2022 Update - paper to go to Board to progress in September 2022. | 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. 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. |



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| 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 eSystems Assistant Director of Policy, Governance and Compliance | July 2022 November 2022 | | In progress | 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. | | |
| Welsh Risk Pool Claims 1.2 | Jun-22 | Reasonable | Management and the relevant clinical teams should work together to review outstanding legacy claims, in order to help identify learning and allow completed paperwork to be submitted to WRP and reduce the risk of penalties being imposed on the Health Board. | High | LFER improvement plan in place ensuring engagement from relevant clinical areas. | Director of Corporate Governance/ Board Secretary | Executives/ Assistant Director of Concerns & Claims | Jun-22 | | Completed | August 2022 Update Detailed plan in place, with actions undertaken. Various actions have been undertaken in relation to LFERs and their management: * LFER SOP and How to Guide developed. * LFER trackers disseminated * LFER training provided to various specialities * LFER drop in sessions undertaken * Engagement with ILGs and clinical teams to assist with completion of LFERs LFERs are included within the new Incident Management Framework and supportive training. Regular monitoring of LFER status is undertaken via weekly data review meeting and the Executive Patient Safety Meeting. | | |
| 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 Corporate Governance/ Board Secretary | Assistant Director of Patient Safety/Assistant Director of Concerns & Claims/Care Group Leaders | Jun-22 | Now January 2023 | In progress | 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. | | |
| 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 | In progress | 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. | | |
| IT Systems 01 | Feb-19 | Reasonable | The organisation should develop an overarching BCP / DR process. This should consider all the systems and use a business impact analysis to prioritise the systems for recovery. The business (Directorates / Departments) should be involved in the process and should be consulted in order to define appropriate RTO / RPOs. | Medium | The organisation will look to develop an overall BCP/DR plan for ICT services. This would require senior management within ICT and the Civil Contingencies Manager to drive this with the co-operation of the various stakeholders within the Health Board. This should be overseen by the Digital Strategy Group. July 2019 Update: Quotes for two suppliers were solicited and the lower cost supplier has recently been retained to assist with this activity. A detailed plan will be forthcoming once the supplier is on site. We currently estimate to complete this action in October. | Director of Digital | Assistant Director of ICT | Apr-19 | March 2020 December 2020 July 2021 Now December 2021 Now Summer 2022 | Completed | August 2022 Update - Plans are now in the progress of being created. Propose to close Action | October 2019 Update - Senior management are in discussions around BCP/DR plans relating to infrastructure and ICT service affecting systems. Incident process flow diagrams are being drafted to provide visibility on the work flow when an incident occurs. This will be reviewed and completed in readiness for DHSSG. June 2020 Update - No Further Progress - Revised completion date of December 2020. August 2020 Update: Disaster Recovery plans have been created for infrastructure services such as DHCP services, on site mail exchange services and file storage. Initial work has commenced between ICT governance and the Head of Systems to address clinical systems planning. A template has been produced and is to be agreed for all DR plans. The new Cito system has produced a comprehensive DR and BC plans. November 2020 Update - No further progress made since the August update. January 2021 - Progress made in terms of getting individual system recovery plans produced, DHCP, Hyper-V, CITO, all underway or complete. No Overarchign plan as yet, and BIA to be defined in readiness for NISD giving us which order the applications would need to be recovered in March 2021 - Ongoing. Documents for File services, Kaspersky and Solarwinds now also complete with overarching document started. Regular meetings booked for various technology applications. May 2021 - the member of the Cyber Security team responsible for this work has not been available for over a month which has lead to no progress being made. The member of staff is set to return in the second week of May 2021. July 2021 Update - Work has recommenced since return. Solarwinds document ready for review, Pathology at PCH has also been started. In addition a service catalogue template has been developed using SharePoint online which will provide the Health Board one place where ICT systems and software details can be found. This will also assist in providing information required by NHS Wales Cyber Security Unit (CRU) as part of the NIS Regulations. September 2021 - A number of documents are complete, overarching to pull them together will be done once a full list is complete. November 2021 - No further update provided. January 2022 Update - More documents have been completed and we are now over 50% complete for systems and infrastructure. April 2022 - In light of the increased Cyber Threat, department plans are being reviewed further. ICT Disaster Recovery Processes continue to be refined for all core infrastructure across CTM Both these pieces of work will be ongoing for the life of the services, systems and infrastructure. A table top exercise is being planned nationally for the summer of 2022 to test these plans. June 2022 Update - Interim Head of Systems is now leading this activity. Agreement to complete 1x critical systems per week | |



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| IT Systems 02 | Feb-19 | Reasonable | As part of the review process for DR plans, the identified weaknesses should be addressed, with up to date configurations included, along with all relevant contact names and numbers. The plans should also consider the RTO / RPO needed by the user departments and instructions should be complete. Hard copies of the plans should be stored so they are accessible in the event of network loss. | Medium | Management Response: ICT will address the identified weaknesses including contact details and the availability of hardcopy. In addition, ICT will consult with the department regarding their RTO / RPO requirements which will be factored into the updated DR plans. | Director of Digital | Assistant Director of ICT | Apr-19 | January 2020 December 2020 December 2021 Now March 2023 | Completed | August 2022 Update - 20 systems identified as critical. Propose to Close | <p>July 2019 Update: This will be part of the review process in Finding 1. update - Senior management are reviewing contact names and numbers so they are located on hard copy and digital copy in the event of a major incident. Departments are being communicated with Civil Contingency in terms of user based advice and training in the event of their own DR plans in accordance to ICT service delivery. June 2020 Update - No further progress - revised completion date of December 2020.</p> <p>August 2020 Update - work is progressing as per response for IT01.</p> <p>November 2020 Update - No further progress made since the August update.</p> <p>January 2021 - Weaknesses are being noted and also addressed as we find them during this process. As an example, we've recently found DHCP service didn't have certain IP Ranges available in High Availability, so changes have been raised to rectify. Instead of Hard Copies, our plan is to host on Secure Data Vault which we would use in event of DR.</p> <p>March 2021 - Further issues found during production of solarwinds DR document. A number of devices missing from Solarwinds, now added and monitoring enabled for them. SPOF also identified.</p> <p>May 2021 - Although the member of the Cyber Security team has not been available (as stated in IT01), progress has been made on infrastructure systems. A meeting has taken place with Systems Managers responsible for the Pathology system and progress is being made in this area.</p> <p>July 2021 Update - Work has recommenced since return.</p> <p>Solarwinds document ready for review, Pathology at PCH has also been started. In addition a service catalogue template has been developed using SharePoint online which will provide the Health Board one place where ICT systems and software details can be found. This will also assist in providing information required by NHS Wales Cyber Security Unit (CRU) as part of the NIS Regulations.</p> <p>September 2021 - As per previous updates, any issues identified during the creation of the documents are rectified or a plan put in place to do so. November 2021 - No further update provided.</p> <p>January 2022 Update - As per the above, documentation and rectification is continuing as resources allow. April 2022 - Work ongoing in alignment with completion by March 2023.</p> <p>June 2022 Update - Interim Head of Systems is now leading this activity. Agreement to complete 1x critical systems per week minimum to ensure this is completed within the next 6 months</p> <p>October 2019 update - Civil Contingencies Manager has advised that he has asked all Directorates to produce their ICT recovery plans with some Directorates asking for further advice. No completed plans have been received to date. ICT are working with Civil Contingency on meeting with departments to undertake an exercise around their DR plans and to raise awareness on what services ICT deliver in the event of a disaster.</p> <p>June 2020 Update - Due to the current COVID-19 outbreak focus has been placed elsewhere. Within the Datacentres ICT have now had implemented a resilient third room based at PCH to provide resilience for major systems. This is at the PCH Switchroom which although is on the ground floor at PCH it is in a different fire zone to the main datacentre at PCH. Revised completion date of December 2020.</p> <p>August 2020 Update - Work is progressing as described in IT01.</p> <p>November 2020 Update - No further progress made since the August 2020 update.</p> <p>January 2021 - This is being included in each systems DR plan, and will be collated once we have a list list.</p> <p>March 2021 - no further update.</p> <p>May 2021 - no progress has been carried out on this recommendation.</p> <p>July 2021 Update - no update. RTO will be established with the departments and can then be tested against once documents are complete.</p> <p>September 2021 - No further update. November 2021 - No further update provided.</p> <p>February 2022 Update - The Director of Digital will review all outstanding audit actions to validate the progress made and that the management response is still fit for purpose given the length of elapsed time that has taken place. Any proposed changes to the management response will be discussed in a meeting with the Internal Audit Lead on the 15th March and be brought back to the Audit & Risk Committee thereafter for approval. April 2022 - This action is being completed in alignment with IT Systems 01 and</p> | |
| IT Systems 03 | Feb-19 | Reasonable | As part of the process for reviewing IT DR plans, contact should be made with departments to ask them to establish their required RTO (the time for which they could acceptably work without the IT service being considered). This process should then push departments into developing their own plans for service provision without IT. The plans should consider varying scenarios covering lengths of outage. e.g. 1hr, 4hr, 1day etc. and also the different aspects of IT e.g. network loss, system loss etc. | Medium | Management Response: The Civil Contingencies Manager to review the BC plans within each Department and put mitigations in place as required, addressing the varying scenarios as recommended. | Director of Digital | Assistant Director of ICT | Apr-19 | April 2020 December 2021 Now Summer 2022 | Completed | August 2022 Update - Digital cyber incident response plan tested - now part of BAU. Propose to close. | <p>July 2019 Update: ICT, NWIS and the Civil Contingencies Manager ran a half day major incident scenario on 24 June. NWIS are going to provide feedback on the our response which we will use to update the DR plans. Engagement with departments will start in September. Note that the recent loss of a national datacentre has also tested our resilience and the learning from this event will be included in the revised DR plans.</p> <p>October 2019 update - Civil Contingencies Manager has advised that he has asked all Directorates to produce their ICT recovery plans with some Directorates asking for further advice. No completed plans have been received to date. ICT are working with Civil Contingency on meeting with departments to undertake an exercise around their DR plans and to raise awareness on what services ICT deliver in the event of a disaster.</p> <p>June 2020 Update - Due to the current COVID-19 outbreak focus has been placed elsewhere. Within the Datacentres ICT have now had implemented a resilient third room based at PCH to provide resilience for major systems. This is at the PCH Switchroom which although is on the ground floor at PCH it is in a different fire zone to the main datacentre at PCH. Revised completion date of December 2020.</p> <p>August 2020 Update - Work is progressing as described in IT01.</p> <p>November 2020 Update - No further progress made since the August 2020 update.</p> <p>January 2021 - This is being included in each systems DR plan, and will be collated once we have a list list.</p> <p>March 2021 - no further update.</p> <p>May 2021 - no progress has been carried out on this recommendation.</p> <p>July 2021 Update - no update. RTO will be established with the departments and can then be tested against once documents are complete.</p> <p>September 2021 - No further update. November 2021 - No further update provided.</p> <p>February 2022 Update - The Director of Digital will review all outstanding audit actions to validate the progress made and that the management response is still fit for purpose given the length of elapsed time that has taken place. Any proposed changes to the management response will be discussed in a meeting with the Internal Audit Lead on the 15th March and be brought back to the Audit & Risk Committee thereafter for approval. April 2022 - This action is being completed in alignment with IT Systems 01 and</p> | |
| 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 | In progress | 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. | <p>March 2020 Update - Test site created by E-Business team - Awaiting further direction from Directorate.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> | |
| Medical Equipment and Devices Follow Up 03 | Feb-20 | Reasonable | While we understand that currently, the department does not have the resources to undertake a reconciliation of equipment that has been loaned to wards, consideration should be given to undertaking periodic checks between the equipment available in the library and the equipment recorded as being on loan on the system. | Medium | 1. Band 2 Equipment library Job Description is now matched - to be uploaded and advertised on TRAC to appoint staff. This will then enable periodic checks between the equipment available in the library and the equipment recorded as being on loan on the system to be undertaken. 2. Continued use of partial RF-ID system to be utilised with confirmation that data connection to RAM 5000 can be completed. 3. SON to be submitted to Capital for increased RF-ID system coverage for RGH (£244.8K), early indication from Capital is that a more detailed business case will be required as roll out to other sites is also required. | Chief Operating Officer | Assistant Director of Facilities | Apr-20 | September 2020 April 2021 July 2021 Now March 2022 Now September 2022 | Part Completed | August 2022 Update - Band 7 JD completed and documentation completed for job matching submission for July 2022. John Harris (Pharmacy) is leading cylinder tracking pilot, update from him is that there have been issues with Wi-Fi connectivity affecting the pilot on POW site, supplier to be on site 27/07/22 to review with ICT and look at any other operational issues to trouble shoot (WG DW 25/07/2022). | <p>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).</p> <p>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).</p> <p>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).</p> <p>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).</p> <p>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).</p> <p>3rd draft of business case paper to be finalised with various options and costs for funding (WG 16/07/2020).</p> <p>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).</p> <p>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).</p> <p>1. Role now in place. Complete (WG 28/08/2020)</p> <p>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 ECHG in February 2021 for planning of future phase rollout. Total cost is £554K (WG 25/01/2021).</p> <p>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).</p> <p>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).</p> <p>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).</p> <p>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).</p> <p>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).</p> <p>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 submitted to Capital for funding, awaiting decision. (DW WG 20/09/2021).</p> <p>3. November 2021 Update - CITRIX issue resolved at POW. Remote access issue resolved for supplier to install V2 software for BOC cylinder project. Other ICT anti-virus problem now affecting the system and is under investigation by ICT and Clinical Engineering to replicate and resolve to ensure reliable functionality. The additional quote did not get submitted as key member of staff supporting project left organisation, so it would not be viable to submit without the project / technical support to ensure a successful expansion project. There are other capital replacement schemes which have Clinical Engineering involvement and are higher in risk that are being progressed instead pending submission of an updated bid with</p> | |



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| 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: <input type="checkbox"/> The updated 'Booking Bank & Agency Nurses -Procedures for Ward Managers' <input type="checkbox"/> The new Request for Thornbury Nurses proforma. <input type="checkbox"/> The updated e-datix reporting algorithm The following documents will be recirculated to Heads of Nursing. <input type="checkbox"/> The updated 'Booking Bank & Agency Nurses -Procedures for Ward Managers' <input type="checkbox"/> The new Request for Thornbury Nurses proforma. <input type="checkbox"/> 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 | | In progress | 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. | 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. |
| 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 Managers'. Heads of Nursing to ensure the checklist is re-circulated to Ward Managers and Senior Nurses emphasising the importance of the completion of the checklist 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 | | In progress | 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. | Appendix 5 has been sent through to the workforce polict review group for the change to be made to the roster polocu 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 policy has been updated and is progressing through the approval process. |
| Cyber Security Follow Up 03 | Jun-20 | Reasonable | Original Recommendation - A formal patch management procedure should be developed that sets out the mechanisms for patching / updating all items within the Health Board. Updated Recommendation - A formal patching strategy and SOP should be developed for the patching process that sets out the mechanism and processes for this. | Medium | Original Management Response - Formal patching strategy is being put in place and will be submitted to Digital Strategy Steering Group (DSSG) in June. Updated Management Response - A formal patching strategy and SOP are currently being worked on and should be ready to publish by July 2020. | Director of Digital | Assistant Director of ICT | Jun-19 | July 2020 December 2020 May 2021 July 2021 Now September 2021 Now November 2021 Now August 2022 | | In progress | August 2022 Update - no further update provided on this occasion | Current Position - We note that the process for patching has been amended, with a rota in place for patching of servers. We also note that the Health Board has purchased the Ivanti patch management solution to help improve the patching process. However, at present there is no strategy as stated in the initial management response, and no standard operating procedure (SOP) in place for the patching process. Based on the progress made and the evidence that we reviewed we consider the original recommendation to be partially implemented and have reclassified the remaining elements as Medium priority. July 2020 update - DT & AE drafting patching policy, summary of patching completed but yet to be finalised and produced as SOP. Expected to be finalised by end of August 2020. August 2020 Update - Due to the pressures of Covid 19 and the resources required for the roll out and ongoing maintenance of Microsoft 365, the timescale has been reset to December 2020. January 2021 - work is continuing on the patch management procedure. March 2021 - a draft procedure is in progress and will be presented to the RAGCSB to review at the April 2021 meeting. May 2021 - there has been a delay in completing the procedure due to work pressures, date has been extended to July 2021. July 2021 Update - A policy and procedure will be presented to the RAGCSB August meeting. September 2021 - meetings have been organised to commence the policy and procedure, which will be completed by the end of October 2021. November 2021 - No further update provided. January 2022 Update - No update since last time, owing to focus on NIS. D prioritised actions and staff reductions. April 2022 Update - The SOP has still not been created. Director of Digital to review the work plan for the Cyber team and provide a date by which this will be completed. Date to be identified by the end of May 2022. June 2022 Update - Requesting a revised date for completion - Work is underway and planned to be completed by the end July 2022. Cyber Security Manager will draft the document and circulate for approval |
| Cyber Security Follow Up 05 | Jun-20 | Reasonable | Original Recommendation - The organisation should provide additional resource for a minimum defined period to allow for the data communications team to improve network security. Updated Recommendation - Work should continue to improve the network security of the Health Board. Following the firewall audit, the firewall rules should be amended to increase the security position. | Medium | Original Management Response - Data communications security will be addressed by the new posts discussed in finding 2. Updated Management Response - The firewall audit has been received and confirmed as accurate. Work has commenced in addressing the recommendations highlighted in the audit. The Cyber team have received the Cisco Implementing Advanced Cisco ASA Security and will be addressing the firewall rules starting in June 2020. | Director of Digital | Assistant Director of ICT | Jul-19 | June 2020 December 2020 March 2021 July 2021 Now August 2021 Now February 2022 Now November 2022 | | In progress | August 2022 Update - Request to change date to November 2022. Significant progress around the re-configuration of main site firewall rules has been made by the Cyber lead for networks. Ongoing constraints around resourcing rollouts for networking remain though. Plan to complete in the Autumn of 2022. | Current Position - As noted above, resources have been provided for cyber security and one of the posts is within the server team. The current position with the firewall is that the rules have not been changed to restrict access from NHS Wales, however in order to improve the security of the Health Board, a company has been engaged to undertake a firewall audit. The purpose of this is to look at the firewall configuration and rules, which will form the basis of the control moving forward. We note that control over changes to the firewall rules is moving to the cyber security team with training for the cyber security team booked with Cisco in order to do this. The process for changing the firewall rules has been improved with a standard form in place for requests, which are channelled through the cyber team for approval before being discussed and agreed at the Change Advisory Board (CAB). January 2021 - work is continuing on addressing the rules on the Firewalls where the bulk of the work should be completed by the end of February 2021. Additional hardware and software licenses have been procured for the upgrade of the Solarwinds network and performance management environment. A date has been set for the upgrade to be completed by Friday 12 February. Based on the progress made and the evidence that we reviewed we consider the original recommendation to be partially implemented and the remaining elements remain as Medium priority. July 2020 update: Firewall project to restart in August with gradual handover of firewall rules from Data Comms to Cyber Security Team. Training scheduled between Data Comms Team and Cyber Team to begin handover. We have an additional temporary resource within Cyber Security Team also looking at networking areas and Solarwinds. August 2020 Update - work on the updating of software versions on each firewall is now complete along with configuring each firewall as per recommendations. There has been an issue in auditing the rules on each firewall due to a licensing issue with Solarwinds. The ICT Department have requested a quote from the supplier on the cost of increasing the licenses on Solarwinds to address this issue. March 2021 - work is continuing to address the firewall rules with a review audit by SICL currently being procured. Work is still carrying on to get the new Solarwinds environment set up. May 2021 - a meeting has taken place with SICL and the firewall configuration files have been provided as part of the review process. Work on the firewall rules is continuing. In March ICT procured software called Skybox for a one year as a Proof of Concept. Once installed and configured the software will enable ICT to address more complex firewall rules and help manage the administration more effectively. The new Solarwinds environment is now up and running. July 2021 Update - The Skybox server has had to be rebuilt as the configuration ISO was out of date. There has been a few issues with the configuration, however the contract will not commence until the software is up and running. September 2021 - work is continuing on the installation of the Skybox application. Work has been delayed due to the Firewall replacement programme on the FCH and RGH Firewalls which is due to be completed by the end of October 2021. November 2021 - No further update provided. January 2022 Update - End of year resources have been provided to improve network security, however requirements will remain. April 2022 Update - The SOP has still not been created. Director of Digital to review the work plan for the Cyber team and provide a date by which this will be completed. Date to be identified by the end of May 2022. June 2022 Update - Request to change date to November 2022. Significant progress around the re-configuration of main site firewall rules has been made by the Cyber lead for networks. Ongoing constraints around resourcing rollouts for networking remain though. Plan to complete in the Autumn of 2022. |



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| 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 | | Part Completed | 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. | 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. |
| 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 | | In progress | August 2022 Update - As noted in the previous update 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. The OFW Risk Module implementation has been delayed and has yet to be piloted in two sites across NHS Wales (Originally planned for April 2022) and therefore it is possible that the implementation date for the Health Board of October 2022 might be impacted. Further updates are anticipated in July/August. In the meantime, risk management training continues within the Health Board with monthly sessions being held virtually over Teams. From July 2022, the attendance records for the monthly risk training will capture further detail in relation to the service area represented. | 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 July 2021 - Training Needs Analysis completed and will be shared across the Health Board on 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 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 |
| Estates Directorate Management Arrangements 03 | Apr-21 | Reasonable | Management should ensure that the Asbestos Policy and Service Testing of Electrical Equipment Procedure (STEEP) are updated as soon as possible and all P&Ps which are soon due for review are updated in a timely manner. | Medium | The asbestos policy and STEEP will be updated and endorsed at the next meeting of the relevant group. | Director of Finance | Head of Assets, Technical Services and Governance | May 2021/September 2021 | September 2021 for STEEP element. Now January 2022 Now 30 April 2022 Now June 2022 Now July 2022 | | Completed | August 2022 Update - Asbestos Management Policy is updated and published. STEEP procedure has been replaced with a new Portable Appliance Testing (PAT) Testing Policy. All other policies and procedures remain under constant review by the Capital and Estates governance groups that each meet on a quarterly basis. I am content to mark this management action as completed. | July 2021 Update - The Asbestos Policy has been reviewed, updated approved and published to SharePoint, so this item is complete. The Asbestos Management Plan is reviewed annually with the next review due on the 31st January 2022. STEEP is referring to the In Service Testing of Electrical Equipment procedure, which is being actioned by the Electrical Safety Group, led by Jason Williams. This is currently being reviewed and in the process of being completed, and will require approval through the Electrical safety group, for noting at the H&S&R committee, and final approval at the Capital and Estates Governance committee. September 2021 Update - a revised completion date has been provided for the STEEP element of this recommendation. November 2021 Update - STEEP (Portable Appliance Testing PAT) Policy is under review by the Chair of the Electrical Safety Group. January 2022 Update. The Asbestos Policy has been reviewed, approved and published to SharePoint. The STEEP Procedure has been updated and is with the Chair of the Electrical Safety Group awaiting pre-approval. June 2022 Update - Asbestos management plan (policy) is endorsed and published to the Estates Policies section on SharePoint. Prior to publication, the updated STEEP procedure is to be tabled for approval at the Electrical Safety Group on the 27/6/2022 and then subsequently by the Capital and Estates Governance Board on the 7/7/2022. |
| 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 | | In progress | 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. | 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. |
| Sunnysi de 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 | | In progress | 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. | 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 known and this is not likely to be until December 2021 at the earliest. November 2021 Update - the PEP will be drafted however there have been delays in the same due to the administration of the contractor. It was anticipated the 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 necessary 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 |



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| Sunnysi de 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 | In progress | 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. | 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 | |
| Sunnysi de Health & Wellbeing Centre 05 | Aug-21 | Reasonable | Management should ensure provision of project manager and cost adviser reports, in support of the Welsh Government Dashboard return. | Medium | These will be included as required as soon as the project recommences, and a new contractor is appointed. This is likely to take at least a further 3-4 months hence the longer target date. | Director of Finance | Senior Project Manager | Jan-22 | Now March 2022 Now July 2022 Now December 2022 | In progress | 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. | 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. 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 | |
| Sunnysi de Health & Wellbeing Centre 07 | Aug-21 | Reasonable | Management should obtain documentation to which the client is entitled under the contract, including collateral warranties, and a copy of the construction performance bond, and confirm assurances provided at the latter. | Medium | These are available and will be supplied by the developer. | Director of Finance | Senior Project Manager | Sep-21 | Now November 2021 Now January 2022 Now 31 March 2022 Now July 2022 Now December 2022 | In progress | 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. | 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 - Remains in progress to be provided by 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 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 | |
| Sunnysi de Health & Wellbeing Centre 10 | Aug-21 | Reasonable | Management should be provided with proposed contact variations and monitoring to facilitate timely Health Board scrutiny, in accordance with entitlements under the contract. | Medium | This will be provided when the project restarts and all design works are completed. | Director of Finance | Senior Project Manager | No Date Identified | 01/03/2022 Now July 2022 Now December 2022 | In progress | 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. | 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 | |
| Sunnysi de Health & Wellbeing Centre 11 | Aug-21 | Reasonable | The Health Board require the developer to remind the contractor of its contractual obligations to formally notify of any delays (and their associated time/cost impact within the contractual time frames). | Medium | With the original contractor there was confidence that much of the time could be recovered and therefore no formal application had been made. Clearly with the current contractor going into administration there will need to be a new contractor appointment. The Health Board will ensure that the need for a contractual. notification of future delays is communicated to the new contractor. | Director of Finance | Senior Project Manager | Mar-22 | Now July 2022 Now December 2022 | In progress | 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. | 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 | |
| Sunnysi de Health & Wellbeing Centre 12 | Aug-21 | Reasonable | A costed risk register should be regularly maintained and reported to facilitate monitoring of the build. | Medium | A fully costed capital risk register is in existence and will continue to be kept up to date as risks are realised or not throughout the project, however this will be revisited with decision on process for and appointment of a new contractor. | Director of Finance | Head of Capital | Nov-21 | Now March 2022 Now July 2022 Now December 2022 | In progress | 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. | 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 | |
| Sunnysi de Health & Wellbeing Centre 13 | Aug-21 | Reasonable | Management should actively monitor and report the value of residual construction cost risks v remaining contingency. | Medium | This is picked up in the appendix to the standard Highlight Report discussed in action 2. | Director of Finance | Head of Capital | Sep-21 | Now March 2022 Now July 2022 Now December 2022 | In progress | 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. | September 2021 Update - One off exercise done to date but this will not be actively monitored until construction works commence. November 2021 Update - One off exercise done to date but this will not be actively monitored until construction works commence. 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 | |
| Sunnysi de Health & Wellbeing Centre 15 | Aug-21 | Reasonable | The Health Board should obtain engrossed and signed copies of all relevant developer adviser contracts in accordance with entitlements to inform of potential liabilities and costs, and report relevant implications to appropriate groups/committees. | Medium | This cannot be fully achieved without the appointment of a new contractor. The Health Board will ensure that all contracts have been received and filed centrally. The new contractor contract will be provided by the developer on signature . | Director of Finance | Project Leader | Sep-21 | Now January 2022 Now 31 March 2022 Now July 2022 Now December 2022 | In progress | 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. | 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 | |
| Sunnysi de Health & Wellbeing Centre 18 | Aug-21 | Reasonable | Management should obtain signed lease agreements with relevant parties at the earliest opportunity. | Medium | The Primary Care lead will continue to work with NWSSP Specialist Estates Services to ensure that the lease is signed off as soon as possible. | Director of Finance | Primary Care Estates and Development Manager | Jan-22 | Now 31 March 2022 Now July 2022 Now December 2022 | In progress | 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. | 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 | |
| Sunnysi de 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 | In progress | 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. | September 2021 Update - Ongoing. 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 | |
| Sunnysi de 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 | In progress | 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. | September 2021 Update - Ongoing. 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 | |



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| 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 | In progress | In progress | 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. | 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 |
| Integrated Locality Groups Review 03 | Oct-21 | Reasonable | Primary Care, Merthyr Cynon and Bridgend ILGs Management should ensure that all meetings are scheduled and take place in accordance with the terms of reference for that committee or group. If the previously agreed meeting frequency is no longer suitable, then the terms of reference should be amended accordingly and reapproved. | Medium | Governance meeting occurrence and regularity has been reviewed with the ILGs as a result of the issue of the draft Internal Audit. A number of key actions have taken place: • Primary Care and Merthyr Cynon ILG have confirmed that the meetings have re-commenced since the initial audit was carried out. Management capacity within MC ILG remains a risk and specific reporting of meeting occurrence and attendance will be sought through the ILG PR process. • Bridgend ILG – the ILG found that meeting as a 'Board' was duplicating other meetings. Following discussion with the COO and other ILG colleagues there will be a second look at the terms of reference to make the meeting more useful in terms of providing a forum for approval of policies and assurance. This will also review whether the role of the Board could be aligned with the ILG Performance Review. The Chief Operating Officer has also requested that the role of the ILG Board is included within the specification of the Chief of Staff review into the ILG Operating Model with recommendations on its future role to be made as part of that specification of work. | Chief Operating Officer | Chief Of Staff | Quarter 4 2021/2022 | 01/03/2022 Now June 2022 Now August 2022 | Completed | Completed | August 2022 Update - confirmation received from Bridgend ILG - and now MC as well (July 2022). This is now complete and green. | November 2021 Update - for PC this is complete. February 2022 Update - further information needed from MC and Bridgend but the target remains March 2022. April 2022 Update - No further information available - anticipate that this is complete but there will be an update at the next meeting. June 2022 - confirmation received from MC. Now only awaited from Bridgend ILG. |
| 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 | In progress | In progress | August 2022 Update - Work has continued to remind managers and staff of their Welsh Language responsibilities. This is picked up during routine departmental 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. | November 2021 Update - The Risk Register has been updated. Although the risk register has been updated. The senior leadership of the ILGs have not received communication or action plans as the new Welsh Language Committee hasn't met. This means there is no progress with ILGs monitoring their compliance and updating their own risk registers. Jan 2022 update 6.1) A short communication plan will be written by the recently appointed Welsh Language Manager, including resources to share regarding the Welsh Language Standards i.e. videos and graphics to promote understanding of them. This will be discussed in a meeting arranged with the Asst Director of Communications and Engagement on 3 February 2022. 6.2) The inclusion of Welsh Language risks on the ILG Risk Registers will be an agenda item all forthcoming Welsh Language Committee meetings, with effect from 17 March 2022. 6.3) The Welsh Language Risk Register has been reviewed and appropriate risks added, including the findings of this audit. 6.4) The inclusion of Welsh Language risks on the ILG Risk Registers will be a standing agenda item on the new Welsh Language Committee, which is scheduled for 17 March 2022. 6.1) Regular communications are drafted and sent via staff updates with SharePoint reviewed regularly. 6.2) Departmental risk registers will be added to once weaknesses are identified through action planning 6.4) The inclusion of Welsh Language risks on the ILG Risk Registers will be a standing agenda item on the new Welsh Language Steering Group, which was scheduled for 17 March 2022 but new date to rescheduled June 2022 Actions points 6.1, 6.3 and 6.4 have been completed previously. 6.2) The inclusion of Welsh Language risks on the ILG Risk Registers will be an agenda item all forthcoming Welsh Language Committee meetings, which is in the process of being arranged. |
| 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 | In progress | In progress | 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. | 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. |
| 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 quorum 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 quorum 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 | In progress | In progress | August 2022 Update - no change. Further update at the next meeting. | 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. |
| 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 | In progress | In progress | August 2022 Update - response awaited from Finance. | 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. |
| CHC and FNC 5.1 | Feb-22 | Reasonable | The importance of accurately capturing information and decisions within panel documentation and then accurately transferring that information to the NCC and finance databases should be re-iterated to all staff. | Medium | Review and amend processes to ensure the information from Panel is accurately reflected and transcribed to both the NCCD and Finance Database. The FNC administrator will perform quarterly random sampling to demonstrate compliance. | Chief Operating Officer | Lead Nurse for CHC and NHS Funded Care | Mar-22 | Now July 2022 Now September 2022 | In progress | In progress | August 2022 Update - not completed as planned due to sick leave. Planned to be completed this 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. Information from Panel is now accurately reflected. The first quarterly sampling will commence July 2022. |



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| CHC and FNC 6.1 | Feb-22 | Reasonable | The Invoice Query Log should be developed further so that it becomes a more effective document for the CHC team to use. It could be used to help identify what the key themes and trends are and escalating common reasons will help prevent them reoccurring. This could be reported and discussed at the fortnightly 'Query Log' meeting that takes place with the CHC team, procurement, and finance. | Medium | Review and develop the Invoice Query Log with Finance and Procurement teams to ensure that the log provides evidence of effectively resolving and reducing queries. | Chief Operating Officer | Lead Nurse for CHC and NHS Funded Care | Apr-22 | Now July 2022 Now September 2022 | In progress | In progress | August 2022 - escalation process developed and being circulated before ratification | 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. July 2022. This is undertaken in the quarterly meetings with Finance Team. Escalation process is being put in place to resolve queries. |
| IT Service Management Follow Up 01 | Aprile 2022 | Reasonable | The problem management process should be formalised and an SOP developed. | Medium | The new Head of Service Management post is currently out for advert and this will be picked up by the new appointment | Director of Digital | Head of Service Management | 01.08.2022 | | Completed | Completed | August 2022 Update - Propose to close - published on 11/07/2022 | June 2022 Update - The new Head of Service Management commenced in post in April 2022. As at the beginning June the content of the SOP has been produced in draft format and will be consulted on by members of the digital team with a view to adoption at the start of August 2022. |
| IT Service Management Follow Up 03 | Apr-22 | Reasonable | The process of clarifying and agreeing digital services with the wider organisation should be completed. | Medium | The new Digital Director will be working with the Head of Service Management feeding back responses from the service | Director of Digital | Head of Service Management Director of Digital | 01.09.2022 | Now November 2022 | In progress | In progress | August 2022 Update - work ongoing / will roll into the Autumn of 2022. Propose to change date to November 2022 | June 2022 Update - SLAs, Recovery Point Objective (RPO) and Recovery Time (RTO) figures will be agreed for each service as we establish and improve our documentation, service onboarding and management of services. This will be run in parallel with the development of the knowledge base but given the capacity and competing pressures |
| Digital Strategy | Apr-22 | Reasonable | 3.1. Work should continue to ensure benefits are fully defined within business cases, along with a baseline position and a process for benefits realisation. 3.2 Consideration should be given to defining an overall benefits position for the Digital Strategy. | Medium | All moderate to major digital developments now require a business case and are subject to a degree of scrutiny which incorporates not only the anticipated benefits but the process by which these benefits will be measured and actions taken where there is limited delivery. In regards to overall benefits measuring, the UHB is committed to ensuring that this is incorporated within the WG digital and data strategy and that there is alignment to the Value Based Health Care Programme. In addition to this, the Health Board is currently reviewing its operating model and there is an opportunity to re-align and strengthen the relationship and ways of working between major digital developments and the change hub where the majority of capacity for programme and project management, service change and benefits management. This review is planned to be complete by the end of September 2022 | Director of Digital | Director of Digital | Qtr 3 2022/2023 | | In progress | In progress | August 2022 - new operating model and proposed digital operating model to be completed by September 2022 | June 2022 Update - Operating model phase 1 nearing completion, 2nd stage yet to commence. |
| Innovation & Improvement 08 | Apr-22 | Reasonable | Lessons learned from completed projects should be more widely shared and disseminated amongst PMO staff. | Medium | Agreed. A paper will be taken to the IIB detailing the incorporation of lessons learnt within the standard project framework and suggested mechanisms for accessing the learning for the PMO and the wider health board including the Community of Practice | Director of Nursing | Head of Change Hub / PMO | Mar-22 | Now July 2022 | Completed | Completed | July 2022 Update - Lessons learned paper presented to the Innovation and Improvement board outlining the key actions. | June Update: A paper detailing the lessons learned approach will be submitted to the July IIB. A lessons learned repository is being created on the website and will initially be available to the team and in future non-sensitive material will be available to the health board and Community Of Practice members |



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| PCH Financial Management 06 | Apr-22 | Reasonable | 6.1 All signed deeds should be obtained. 6.2 Resolution is required on under-claimed costs and anomalies to date | Medium | 6.1 Noted. Request made to SCP for signed Joining Deeds. 6.2 Actioned since audit fieldwork, the variance now stands at £14k. | Director of Finance | Responsible Officer PCH Construction Programme | Jul-22 | Now October 2022 | Red | Part Completed | August 2022 Update - 6.1 Joining deeds have been obtained for 18 of the 20 sub-contractors participating in the Project Bank Account. The 2nr outstanding are being sought. | June 2022 Update - 6.1 Further Joining Deeds received. Some awaited. |
| Overtime & Additional Hours 1.1a | May-22 | Reasonable | 1.1a If the Health Board acknowledges that there are occasions when overtime and additional payments may need to be made outside of the AFC terms and conditions, then the process should be documented. | Medium | The UHB Executive Leadership Group (ELG) will be responsible for approving the rare occasions when overtime and additional payments may need to be made outside of the AFC terms and conditions of service. The discussion and decision will be formally documented via the ELG meeting notes. The other rare and less likely situation is when an agreement has been struck across Wales to cover extreme circumstances. This agreement would be undertaken at the All-Wales Workforce & OD Directors Group and endorsed by the UHB ELG. | Director for People | Director for People | As and when requests are made | | Green | Completed | August 2022 Update - These robust approval arrangements are now in place. | |
| 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 eSystems / Assistant Director of Policy, Governance and Compliance | Jun-22 | Now November 2022 | Red | In progress | 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. | |
| Overtime & Additional Hours 1.2 | May-22 | Reasonable | Procedure documents in relation to overtime should be developed and made available to those areas that do not currently use Health Roster. The procedure should cover key points such as how overtime is captured and any prior authorisation required, and the checking and authorisation process that managers should follow. A standardised claim form should form part of the procedure. | Medium | There currently is guidance contained in the Overtime Policy directing managers on overtime use and application. The WPRG will undertake to review this policy to ensure that it is fit for purpose and reflects the requirement of the audit recommendation. | Director for People | Assistant Director of Policy, Governance and Compliance | Nov-22 | | Yellow | In progress | 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. | |
| 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 | | Yellow | In progress | 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. | |



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| 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 eSystems | Nov-22 | | In progress | | August 2022 Update - This work is being progressed by the Head of Workforce Efficiency and e-systems. | |
| 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 eSystems | Nov-22 | | In progress | | 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. | |
| 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 eSystems Assistant Director of Policy, Governance and Compliance | July 2022 | November 2022 | In progress | | 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. | |
| 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 | | In progress | | 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. | June 2022 Update - In progress - on target for September 2022 completion |
| Consultant Job Planning 4.1 | May-22 | Reasonable | The discrepancies identified by management following their review of Anaesthetics SAS Doctors paper-based job plans and the e-job planning system should be resolved. | Medium | A paper dealing with the pay / job plan issue for the anaesthetics SAS doctors in PCH and RGH has been submitted to the Medical, Finance and HR Directors. A formal response directing action will be issued. | Medical Director | Medical Director | May-22 | Now May 2023 | In progress | | July 2022 Update - On target for completion May 2023 | June 2022 update - We have reviewed the situation. With a change in the new structure of the Health Board there will be a need to align specialties across the Health Board so there is an equitable JP approach. As such this issue will be part of that resolution. In the interim the current process that works will be maintained using an excel approach. Compliance can be monitored and reported by the CSG. |



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| 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 | | Yellow | In progress | 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 workstream. The rate card development and delivery has therefore been incorporated into the PID for the medical workforce productivity. | |
| NIS Directive 1.1 and 1.2 | May-22 | Reasonable | 1.1 Management should have plans in place to map other critical systems to the CAF. 1.2 Management should ensure that any records of discussions and information pertaining to the CAF are captured for future annual self-assessments. | Medium | Agreed A process for baselining and ensuring that all critical systems that the UHB actively supports have cyber and data protection improvement plans plus documented backup and disaster recovery programmes has been agreed and initiated. The UHB will be taking a pragmatic approach in that the documentation will incorporate that required to operationally support the systems and provide on-call services. Incident response and business continuity plans already in place in the clinical services will be attached to these documents within a central 'asset register / service catalogue' | Director of Digital | SIRO, Head of Server Management & Head of Clinical Systems | Commenced 9th May 2022 Attempting to follow a rolling programme whereby 1 system is updated each week and cyber impact assessments undertaken | End of Q3 2022/2023 | Yellow | In progress | August 2022 - Planned to complete at the end of Q3 2022/2023 | June 2022 Update - On track - Development programme initially focus on 20 critical systems working to have in place a target knowledge base established and has made fast progress, as pragmatic approach of enhancing operational documents rather than creating separate information taken |
| 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 ie CMRs, LFERs etc. | Director of Corporate Governance/ Board Secretary | Legal Services Manager | 1.1a Dec 2022 1.1b June 2022 1.1c August 2022 | | Yellow | In progress | 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. | |
| Welsh Risk Pool Claims | Jun-22 | Reasonable | Procedures should be in place that provide staff with clear guidance on how to process claims, especially the dates that are to be used in relation to the 'Decision to Settle' and 'Final Payment', and the circumstances of when these dates should be updated in Datix. Guidance should also cover the other issues we identified including the correct process for capturing financial transactions in Datix and the process that should be followed if a claim is dismissed when taken to court. | Medium | 2.1 Legal Services SOPs to be reviewed and updated and staff to be retrained where appropriate. 2.2 SOP to be devised to assist staff through the financial process if a claim is dismissed. | Director of Corporate Governance/ Board Secretary | Legal Services Manager | Dec-22 | | Yellow | In progress | August 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 | | Red | In progress | 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. | |



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| Financial Systems 2.1 | Jun-22 | Reasonable | 2.1a To support budget holders in their roles, management should develop a more consistent approach to training provision and delivery, with detailed training materials created that incorporate the use of QlikView. (See also recommendation from Matter arising 1) 2.1b Consideration should be given to providing training and refresher training to wider groups of staff at the same time, such as all budget holders within a CSG. This will allow more efficient use of the Finance Business Partners time, ensure consistent approaches are being adopted and allow budget holders to learn from one another. | Medium | 2.1a) The team will undertake a review of the use of Qlikview and training requirements and how this can be best monitored. A number of areas receive their budget information through "finance packs" outside of qlik which provide further information currently unavailable through the system. 2.1b As per 2.1a, this will be reviewed to understand how training will be delivered and monitored across the different areas. | Director of Finance | Senior Finance Team | Sep-22 | | Completed | Green - Action | August 2022 Update - Budget holders receive training and new training has been developed by the Central Team that will be rolled out to all budget holders. In terms of QlikView all budget holders have access to the reports on Qlik View and this is being reviewed for accuracy currently. However finance packs are used to provide further detailed information that is not available on Qlik. Finance packs have been updated to standardise and ensure it provides the required information. | |
| Financial Systems 2.2 | Jun-22 | Reasonable | The Scheme of Delegation training requirements set up against ESR accounts should be reviewed to ensure that those who require training as part of their role have been identified and informed of this requirement. | Medium | We will review the budget holder training requirements and monitoring on ESR and ensure there is appropriate training undertaken by budget holders | Director of Finance | Head of Corporate Finance | Sep-22 | | In progress | Yellow - Action | August 2022 Update - ESR continues to be an issue and is outside of the control of Finance staff, but will reference to monitoring to ESR will be included in future budget holder training. | |
| 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 | In progress | Red - Action | August 2022 Update - This will be updated in line with the update of FCP. | |
| Financial Systems 7.1 | Jun-22 | Reasonable | Management should ensure that there are structured refresher training arrangements in place for staff responsible for, and involved with, the delivery of the purchase to pay process. | Medium | We will update the SharePoint page within CTM with links to the NWSSP e enablement training. We will offer training sessions and increase engagement to departments to ensure participation NWSSP e-enablement team are developing online training. | Director of Finance | Head of Procurement | Jul-22 | | Completed | Green - Action | Aug-2022 update - Refresher training has been undertaken within Facilities with the support of Finance Systems and NWSSP enablement. Next area to be targeted is Estates/Facilities in September. Lunch and Learn sessions will start in October 2022, to align to the new CTM structure and will be held bi-monthly for targeted areas. | |
| 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 | Yellow - Action | August 22 update - Alternative methods of payments will be reviewed within the NO PO/Retrospective order review by March 2023. | |



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| 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 | August 2022 Update - Refer to the update provided for 7.1 | |
| 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 | 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 | |
| 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 | | In progress | 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. | |
| Waste Management 1.1 | Jun-22 | Reasonable | At Ysbyty Cwm Cynon: • Staff should be reminded that outer bin colours should align with the bin liners used wherever possible; and • Signage should be placed on/near bins to clarify the required contents, in line with the good practice observed at PCH. | Medium | We encourage the use of all white 'Wybone' bins with magnetic signage within all departments and staff will be reminded to align bin colours with the bin liners used. | Chief Operating Officer | Environment, Waste and Fleet Manager | Jul-22 | | | Completed | August 2022 Update - Waste segregation bulletins have been sent out to site management and relevant wards and departments concerned at this site. Since the audit report and with the relaxation of Covid rules on our sites, the Waste management Team have set a site rolling audit plan and have re-started site waste audits of all our sites to report on compliance and conformance with the waste policy and waste segregation procedure. Details and findings of the audit are to be shared with ILG site management, wards and department, facilities porter and cleanliness services senior service managers. | |
| Waste Management 1.2 | Jun-22 | Reasonable | Staff at both PCH and YCC should be reminded of the importance of locking waste storage rooms when not in use. | Medium | The waste team are currently auditing health board sites to action signage, share presentations and posters, and encourage segregation. Staff will be reminded of the importance of locking waste storage rooms. | Chief Operating Officer | Environment, Waste and Fleet Manager | Jul-22 | | | Completed | August 2022 Update - Waste segregation bulletins have been sent out to site management and relevant wards and departments concerned at these sites. Since the audit report and with the relaxation of Covid rules on our sites, the Waste management Team have set a site rolling audit plan and have re-started site waste audits of all our sites to report on compliance and conformance with the waste policy and waste segregation procedure. Details and findings of the audit are to be shared with ILG site management, wards and department, facilities porter and cleanliness services senior service managers. | |



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| PCH Technica I 1.1 | Jun-22 | Reasonable | The risk register should include details of the residual risk to reflect the mitigating action taken to date. | Medium | Agreed. The mitigated risk position will reported to the Project Board by the Responsible Officer. | Director of Finance | Senior Reponsible Officer | Aug-22 | | Completed | Completed | August 2022 Update - Risk reviewed to reflect the position of the project and adjusted accordingly. The value of risk is reported identifying high / medium / low risk. | |
| PCH Technica I 3.1 | Jun-22 | Reasonable | All parties should be reminded of their obligation to make prompt payments to avoid incurring unnecessary interest charges. | Medium | Agreed. The issue will be escalated in accordance with existing reporting channels. | Director of Finance | Senior Responsible Officer | Aug-22 | | Completed | Completed | August 2022 Update - Correspondence has been exchanged to stress the need for prompt payment. | |
| 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 | Part Completed | Part Completed | 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. | APRIL 2021: An audit tool is being developed, taking learning from the social distancing audit tool developed. The package itself is developed, and by July we will have determined the key areas to be examined via the audit tool. This will be complete and ready to use by the end of July. A revised implementation date has been provided. July 2021 - Audit Package currently undergoing further testing due to some reporting issues on the AMaT system. SEPTEMBER 2021: The above audit findings were presented as a draft to the last Health, Safety and Fire Committee in September 2021. There are still some issues with the audit package producing an executive summary of the audit undertaken. The Health, Safety and Fire Team are in further discussions with the Clinical Audit Team and AMaT to resolve this. Whilst awaiting this system fix an audit programme is being set up and will be rolled out once the system fixes have been completed. November 2021 - No further update provided. April 2022 Update - Health & Safety Team has been working closely with Clinical Audit colleagues to determine whether the AMaT system could be used to capture audit information. The Team were now working towards a revised target date of end of May 2022 to complete this recommendation. April 2022 Update - Health & Safety Team has been working closely with Clinical Audit colleagues to determine whether the AMaT system could be used to capture audit information. The Team were now working towards a revised target date of end of May 2022 to complete this recommendation |
| 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 | In progress | In progress | 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. | July 2021 Update - Action on target to be completed by September 2021. September 2021 - No further update. November 2021 - No further update provided. January 2022 Update - Due to changes in post and the significant pressure on the team as a result of IFRS implementation and preparation for the new quinquennial revaluation this has been unable to be addressed. It is proposed that this is picked up post the year end audit process over the summer of 22/23 post IFRS 16 adoption. April 2022 - No further update to report. |
| Facilities Director ate Review (Workforce Arrangements) Follow up on Sunnyside Health & Wellbeing Centre 09 | Aug-21 | Reasonable | Both sites Work should continue in relation to the procurement of a more up to date portering management system that would allow the service to be delivered in a more efficient and effective manner. | Low | RGH / RTE and PCH / M&C 1. Work will continue to progress forward in view of managing rota alignment that will support service demands and pressures. This will be always flexible and open to change in view of changing service needs within the Hospitals. 2. A bid for funding for a new Porter Services IT management system solution (Symbiotic) has been submitted in the Facilities IMTP 2021-2022. | Chief Operating Officer | Facilities Regional Managers | Sep-21 | Nov-22 | In progress | In progress | August 2022 Update. Date for completion remains November 2022. In terms of progress, both MC and RTE can confirm that that point 1 is completed. New porter trasversion has been procured and training / go live dates are awaited. | September 2021 - No further update. December 2021 update - plans for Facilities to review other Porter Management Systems year 2022. Procurement will support any tender process. Staffing resources will continue to be managed with services pressures and demands and flexibility to work with the rota. February 2022 Update - confirmation from Facilities that this is undercontinual review and the completion date remains November 2022. April 2022 Update - Date for completion remains November 2022. June 2022 - no update available this month. |
| Sunnyside 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 | In progress | In progress | 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. | 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 |
| 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 | In progress | In progress | 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. | 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 |
| Integrated Locality Groups Review 05 | Oct-21 | Reasonable | Primary Care, Merthyr Cynon and Bridgend ILGs Management should ensure that all terms of references are reviewed, updated where applicable and then appropriately formally finalised. | Low | Primary Care, Merthyr Cynon and Bridgend ILGs - all terms of references will be reviewed and then formally finalised. | Chief Operating Officer | ILG Group Director | Dec-21 | 01/02/2022 Now June 2022 | Completed | Completed | August 2022 Update - confirmation received from Bridgend ILG. Now complete. | November 2021 Update - an answer will be available at the next meeting. February 2022 Update - PC confirms that this is the case, as does MC. Confirmation needed from Bridgend. April 2022 Update - No further confirmation - anticipated that it is complete, will be confirmed for next meeting. June 2022 update - final confirmation needed from BILG. |
| CAMHS Follow Up Governance & Risk 1.1 | Dec-21 | Reasonable | A structure diagram that shows the inter-relationship between each of the key committees and groups and any other groups within the Clinical Service Group, and how these feed into the ILG's governance arrangements should be documented. | Low | Flow chart will be produced to reflect current structure | Chief Operating Officer | Lead Nurse | Dec-21 | Now June 2022 Now August 2022 | Completed | Completed | August 2022 - Each LMT has provided the list of meetings and CGSM has reviewed. An updated approach and agenda for SMT/LMT has been implemented with draft TORs to be taken to the next SMT/LMT meetings and then to QPSE for sign off | February 2022 Update - no permanent CSG Manager in post. Update will be available for the next meeting. April 2022 - New CSG Manager in post will review the structures and meetings and how these feed into the IL G structures. June 2022 - LMTs have been asked to provide list of meetings in each area for CGSM to review. Revised approach to SMT/LMT meetings is being drafted to implement in June. |
| CAMHS Follow Up Governance & Risk 5.3 | Dec-21 | Reasonable | Concerns regarding the new policy format highlighted with the Corporate Governance Team. | Low | Concerns regarding the new policy format highlighted with the Corporate Governance Team. | Chief Operating Officer | Lead Nurse | Dec-21 | Now August 2022 | Completed | Completed | August 2022 - Feedback has been provided. | 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 including any concerns regarding the new policy format. June 2022 - 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 and use of the templates. This will be discussed at Senior Nurse meeting on 14th June with an outline of timescales. |
| PCH GOV 2.1 | Feb-22 | Reasonable | The PEP should be reviewed for consistency and updated as the primary reference document for the project. | Low | Accepted and will be addressed. | Director of Finance | Responsible Officer for PCH Construction Programme | May-22 | Now August 2022 | Completed | Completed | August 2022 Update - Updated PEP distributed at Project Board 27/07/22 | April 2022 Update - Review commenced and ongoing. June 2022 Update - PEP revised and issued to Project Management for publishing. |



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| IT Service Management Follow Up 04 | Apr-22 | Reasonable | A process for monitoring the change process to ensure compliance with all the requirements of the process should be established. | Low | Will be reviewed by the Head of Service Management when in post | Director of Digital | Head of Service Management | 01.08.2022 | Now end of Q3 2022/2023 | In progress | August 2022 - Propose to extend to end of Q3 2022/2023 | June 2022 Update - Will be reviewed by the Head of Service Management once the 3 higher priority recommendations have been addressed | |
| Uo 04 Digital Strategy 01 | Apr-22 | Reasonable | A process to enable digital to contribute to the revision of the WG Digital Strategy for NHS Wales should be enabled, alongside contribution to the revision of Health Board Strategy and IMTP. Once these have been finalised, consideration should be given to updating the Digital Strategy to reflect the current organisational vision, objectives and priorities. The e-job planning guide should be updated to include the requirement to factor in breaks to job plans. | Low | Members of the UHB to take part in the steering group and WG strategy development meetings - A workstream will be developed to identify the digital plan for 'digitally' enabling the new strateg | Director of Digital | Director of Digital | Qtr 3 2022/2023 | | Completed | August 2022 - New Transformation Programme and Governance launched that will support digital planning/strategy across the Health Board - including adoption of WG strategies - propose to close | June 2022 Update - Members of the UHB are taking part in the steering group and WG strategy development meetings, - engagement around digital requirements and the digital strategy has commenced | |
| Consultant Job Planning Follow Up 2.1 | May-22 | Reasonable | Management should ensure the SoD documents are updated to ensure consistency, reflecting the current job titles. | Low | The eJP User Guide will be updated to include the requirement to take breaks | Medical Director | Senior Medical Workforce Manager | Sep-22 | | In progress | July 2022 update - In progress - On target for September 2022 completion | June 2022 Update - In progress - on target for September 2022 completion | |
| Financial Systems 3.1 | Jun-22 | Reasonable | To ensure a consistency in approach across the Health Board, all budget holders should have relevant access to, and training on, QlikView, to enable them to scrutinise and monitor their budget information appropriately. Presenting opportunities for staff to learn how to use the additional functions of QlikView should be considered. | Low | Agreed - this review and update is being undertaken as part of the restructure of the operating model and will be updated accordingly. | Director of Finance | Head of Corporate Finance | Aug-22 | | Completed | August 2022 Update - This is being brought to August Audit & Risk Committee for Approval | | |
| Financial Systems 4.1 | Jun-22 | Reasonable | Management should ensure there is consistency by providing explanations for variances as required | Low | Monitoring of the use of Qlikview is undertaken by the Systems team. As per action 2.1a a review will be undertaken on the use of Qlikview and how this can be applied consistently | Director of Finance | Senior Finance Team | Sep-22 | | In progress | August 2022 Update - Budget holders receive training and new training has been developed by the Central Team that will be roled out to all budget holders. In terms of QlikView all budget holders have access to the reports on Qlik View and this is being reviewed for accuracy currently However finance packs are used to provide further detailed information that is not available on Qlik. Finance packs have been updated to standardise and ensure it provides the required information. | | |
| Financial Systems 5.1 | 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 | An updated finance pack is being developed and material variances are flagged for comment. | Director of Finance | All Finance Staff | Immediate | | Completed | August 2022 Update - Finance packs have been reviewed and developed to provide explanations as required. | | |
| Financial Systems 6.1 | Jun-22 | Reasonable | The Waste Team should liaise with local domestic and Infection Control staff to promote consistent compliance with WHTM 07-01 in the approach to clinical waste segregation across the UHB. | Low | Agreed, as per action 1, an updated process will be developed | Director of Finance | Head of Corporate Finance | Jul-22 | Now October 2022 | In progress | August 2022 Update - Will be updated in line with the update of FCP. | | |
| Waste Management 2.1 | Jun-22 | Reasonable | Consideration should be given to reducing the level of checking based on a sampling/ risk-based approach. | Low | The Waste management team regularly sends out reminders of WHTM 07-01 regulation and what is required from the Health Board to meet the segregation standard. All Senior IPC Nurses, Senior Clinicians, Senior Medical and Surgical leads, and all Facilities ILG leads will be briefed on a regular basis via email, Bulletins, SharePoint and Environmental and IP&C meetings. We are also recommencing regular internal waste audits following the relaxed measures of Covid 19, in addition to our annual pre-acceptance audits to again encourage waste segregation, | Chief Operating Officer | Environment, Waste and Fleet Manager | Jul-22 | | Completed | August 2022 Update - Since the audit report and with the relaxation of Covid rules on our sites, the Waste management Team have set a site rolling audit plan and have re-started site waste audits of all our sites to report on compliance and conformance with the waste policy and waste segregation procedure and WG HTM best practice. Details and findings of the audit are to be shared with ILG site management, wards and department, facilities porter and cleanliness services senior service managers and the Environmental Management group and the IP&C Committee as part of the Facilities exception report for action. The findings and relevant action taken are also reported to our contractors to provide assurance of the actions taken CTM commitment to waste sanitation | | |
| PCH Technical 1.2.1 | Jun-22 | Reasonable | The stakeholder engagement strategy will be defined. | Low | Agreed. A discussion has been held with the external advisers to determine an appropriate approach and how to re-focus resource | Director of Finance | Senior Responsible Officer | Aug-22 | | Completed | August 2022 Update - Dialogue conducted with Cost Advisors to advise. | | |
| PCH Quality Assurance 1.1 | Jun-22 | Substantial | Consideration should be given in any future projects to ensuring that there is not over-reliance on a small number of individuals to be managing the programme on a day-to-day basis. | Medium | Agreed. This will be included within the Project Execution Plan and will define key individuals/ groups and their responsibilities. | Director of Finance | Senior Responsible Officer | Aug-22 | Now October 2022 | In progress | August 2022 Update - Dialogue commenced with Project Manager to amend the PEP. | | |
| Mass Vaccination Programme 01 | Aug-21 | Substantial | The Request for Information reporting to Project Board will include the date of response to assist the Project Board in overseeing UHB responsiveness. | Low | The COVID vaccination programme has been established as part of the emergency response to COVID and learning from this will feed into the wider COVID learning. The continued requirements for COVID vaccination, mean that the project needs to be converted to 'business as usual'. A business case is being developed to create a core team for 2022/23. | Director of Public Health | Senior Responsible Officer for Vaccinations and Immunisations | Dec-21 | Now February 2022 Now end of May 2022 | In progress | August 2022 Update - No update received on this occasion | September 2021 Update - On track to be approved by December 2021 and in place by 1 April 2022. November 2021 Update - With constant changes to the COVID-19 vaccination campaign, clear planning assumptions have been challenging to develop. The National Programme is beginning to articulate high level assumptions, which will allow planning through the Health Board IMTP process and the development of a permanent Vaccination and Testing Department in 2022/23. January 2022 Update - With constant changes to the COVID-19 vaccination campaign, clear planning assumptions have been challenging to develop. The National Programme is beginning to articulate high level assumptions, which will allow planning through the Health Board IMTP process and the development of a permanent Vaccination and Testing Department in 2022/23. Draft plans will be presented to the Covid-19 Regional Strategic Oversight Board in February before further discussion with Welsh Government, in line with anticipated policy changes. March 2022 Update - A Business Case for a Joint Vaccination/Testing directorate under Exec leadership of the DPH was presented at Executive Leadership Group on March 21st. There was agreement on the model and approach proposed but it was the assessment of the Execs that given the funding requirement detailed in the BC and the context of the organisation's challenged financial landscape, the BC would need to be presented for Board discussion and decision in May 2022 | |
| PCH Quality Assurance 2.1 | Jun-22 | Substantial | | Low | Agreed | Director of Finance | Senior Responsible Officer | Aug-22 | | Completed | August 2022 Update - Incorporated in Project Manager's report. | | |