

Audit & Risk Committee

Tue 17 December 2024, 10:00 - 13:00

Virtual Via Teams



Agenda

10:00 - 10:05 1. PRELIMINARY MATTERS
5 min

1.1. Welcome and Introductions

Patsy Roseblade, Chair

1.2. Apologies for Absence

Information Patsy Roseblade, Chair

1.3. Declarations of Interest

Information Patsy Roseblade, Chair

10:05 - 10:15 2. CONSENT AGENDA
10 min

2.1. Items for Approval

2.1.1. Unconfirmed Minutes of the Meeting held on 17 October 2024

Decision Gareth Watts, Director of Corporate Governance/Board Secretary

2.1.1 Unconfirmed Minutes 17.10.24 ARC 17 December 2024.pdf (12 pages)

2.1.2. Unconfirmed Minutes of the In Committee Meeting held on 17 October 2024

Decision Gareth Watts, Director of Corporate Governance/Board Secretary

2.1.2 Unconfirmed IC Minutes 17.10.24 ARC 17 December 2024.pdf (3 pages)

2.1.3. Ratification of Chairs Urgent Action - Charitable Fund Financial Control Procedure (FPC) and Update of the Scheme of Delegation

Decision Gareth Watts, Director of Corporate Governance/Board Secretary

2.1.3 Ratification of Chairs Urgent Action Report ARC 17 December 2024.pdf (6 pages)

2.1.3a Appendix A Amended Charitable Funds FCP October 2024.pdf (20 pages)

2.1.3b Appendix B Access to Charitable funds SoD - Tracked Changes.pdf (1 pages)

2.2. Items for Noting

2.2.1. Annual Cycle of Business 2024-25

Information Gareth Watts, Director of Corporate Governance/Board Secretary

2.2.1 Annual Cycle of Business Cover Report ARC 17 December 2024.pdf (4 pages)

2.2.1a Appendix 1 - Annual Cycle of Business ARC 17 December2024.pdf (4 pages)

2.2.2. Committee Forward Work Plan

Information Patsy Roseblade, Chair

 2.2.2 Forward Work Plan ARC 17 December 2024.pdf (6 pages)

2.2.3. Declarations of Interest and Gifts & Hospitality Report

Information Gareth Watts, Director of Corporate Governance/Board Secretary

 2.2.3 DOI and GHS Cover Report ARC 17 December 2024.pdf (4 pages)

 2.2.3a App 1 DOI Register 23-24 & 24-25 Board and Non Board.pdf (32 pages)

 2.2.3b - App 2 Register of Gifts Hospitality and Sponsorship 2023-24.pdf (1 pages)

2.2.4. IA Report - PCH Management Actions Follow Up

Information Internal Audit

 2.2.4 IA Report - PCH Validation of Mmt Actions ARC 17 December 2024.pdf (6 pages)

10:15 - 10:25 3. MAIN AGENDA

10 min

3.1. Action Log

Discussion Gareth Watts, Director of Corporate Governance/Board Secretary

 3.1 Action Log ARC 17 December 2024.pdf (11 pages)

3.2. Matters Arising Not Contained within the Action Log

Discussion Patsy Roseblade, Chair

10:25 - 10:55 4. SUSTAINING OUR FUTURE

30 min

4.1. Local Counter Fraud Report

Discussion Matthew Evans, Local Counter Fraud Officer

 4.1 Local Counter Fraud Update Report ARC 17 December 2024.pdf (3 pages)

 4.1a Local Counter Fraud Update Report Dec 24.pdf (3 pages)

 4.1b - Appendix 1 Counter Fraud Benchmark Report.pdf (5 pages)

 4.1c Appendix 2 - Counter Fraud Investigations Update.pdf (13 pages)

4.1.1. Outcome of the Committee Referral to People & Culture Committee - Recruitment Process Risk Assurance

This item will be taken in the CLOSED In Committee Session

4.2. Losses & Special Payments Report

Discussion Sally May, Executive Director of Finance & Procurement

 4.2 Losses Special Payments Report ARC 17 December 2024.pdf (9 pages)

4.3. Procurements & Scheme of Delegation Report

Information Sally May, Executive Director of Finance & Procurement

 4.3 Procurement SoD ARC 19 December 2024.pdf (11 pages)

 4.3a Appendix 1 - Petty Cash (002).pdf (5 pages)

 4.3b Appendix 2 Losses Special Payments (002).pdf (28 pages)

 4.3c Appendix 3 General Ledger FCP December 2024 (002).pdf (12 pages)

 4.3d Appendix 4 - Construction Industry Scheme (002).pdf (6 pages)

 4.3e Appendix 5 - Capital Assets Register_ (002).pdf (13 pages)

5.1. Organisational Risk Register

Discussion Gareth Watts, Director of Corporate Governance/Board Secretary

📄 5.1 Org RR Nov 24 - Cover Paper ARC 17 December 2024.pdf (7 pages)

📄 5.1a Appendix 1 - Org RR ARC 17 December 2024.pdf (8 pages)

5.2. Audit Recommendations Tracker

Discussion Gareth Watts, Director of Corporate Governance/Board Secretary

📄 5.2a Audit Recs Tracker - ARC 17.12.24.pdf (9 pages)

📄 5.2b Appendix 1 - Audit Recs Tracker - ARC 17.12.24.pdf (21 pages)

📄 5.2c Appendix Copy of HIW Inspections Tracker_19.11.2024 QSC 19 November 2024.pdf (11 pages)

5.3. Internal Audit Progress Report

Discussion Paul Dalton, Head of Internal Audit

📄 5.3 CTM -Progress report ARC 17 December 2024.pdf (12 pages)

5.3.1. IA Report - Energy Management

Discussion Internal Audit

📄 5.3.1 IA Energy Management ARC 17 December 2024.pdf (11 pages)

5.3.2. IA Report - Additional Medical Pay

Discussion Internal Audit

📄 5.3.2 IA Report Additional Medical Pay Final ARC 17 December 2024.pdf (32 pages)

5.3.3. IA Report - Charitable Funds

Discussion Internal Audit

📄 5.3.3 IA Charitable Funds Final Report ARC 17 December 2024.pdf (11 pages)

5.3.4. IA Report - PCH Validation of Management Actions

Discussion Internal Audit

📄 5.3.4 PCH Validation of Mmt Actions ARC 17 Dec 24.pdf (6 pages)

5.4. Audit Wales - Audit & Risk Committee Update

Discussion Audit Wales

📄 5.4 Audit Wales Update ARC 17 December 2024.pdf (12 pages)

5.4.1. Audit Wales Report - Primary Care Follow Up Review

Discussion Audit Wales

📄 5.4.1 Primary Care Follow-Up Report (Final).pdf (24 pages)

📄 5.4.1a Primary Care Follow-Up Final Management Response ARC 17 Dec 2024.pdf (8 pages)

5.4.2. Audit Wales Report - Review of Cost Savings Arrangements - Final Management Response

Discussion Audit Wales

📄 5.4.2 AW Cost Savings - Final Report ARC 17 December 2024.pdf (24 pages)

📄 5.4.2a Review of Cost Savings Arrangements - Final Management Response.pdf (4 pages)

12:45 - 12:50
5 min

6. CLOSE OF BUSINESS

6.1. Any Other Urgent Business

Discussion *Patsy Roseblade, Chair*

6.2. Committee Highlight Report to Board

Discussion *Patsy Roseblade, Chair*

6.3. How Did We Do In This Meeting?

Discussion *Patsy Roseblade, Chair*

12:50 - 12:55
5 min

7. PRIVATE/IN COMMITTEE SESSION

The following items will be discussed at the In Committee Session of the Audit & Risk Committee:

Organisational Risk Register - Business Sensitive Risks

Financial Control Procedure - Medical Variable Pay - Summary of Authorised Breaches

Outcome of Committee Referral to People & Culture Committee

12:55 - 13:00
5 min

8. DATE AND TIME OF NEXT MEETING

Information *Patsy Roseblade, Chair*

13 FEBRUARY 2025 AT 10:30 AM

Agenda Item

2.1.1

Unapproved / Minutes of the Audit & Risk Committee

Date and Time of Meeting	Thursday 17 October 2024 at 2:00 pm
Venue	Virtual via Microsoft Teams

Members Present	Patsy Roseblade	Independent Member (Chair)
	Kath Palmer	Health Board Vice Chair/Independent Member
	Ian Wells	Independent Member
In Attendance	Sally May	Executive Director of Finance & Procurement
	Gethin Hughes	Chief Operating Officer (in-part)
	Dom Hurford	Medical Director (in part)
	Nigel Downes	Assistant Director of (in part)
	Paul Dalton	NWSSP - Internal Audit & Assurance
	Emma Samways	NWSSP - Internal Audit & Assurance
	Martyn Lewis	NWSSP – Internal Audit & Assurance (in part)
	Nathan Couch	Audit Wales
	Mark Jones	Audit Wales
	Owen James	Head of Corporate Finance
	Matthew Evans	Local Counter Fraud Officer (in-part)
	Gareth Watts	Director of Corporate Governance/Board Secretary
	Emma Walters	
	Kathrine Davies	Corporate Governance Manager/Meeting Secretariat
Meeting Observers	Kelly Eddington	Quality Assurance & Compliance Officer

Agenda Item	Meeting Business
1.	PRELIMINARY MATTERS
1.1	Welcome and Introductions
	P. Roseblade, Committee Chair welcomed everyone to the meeting, particularly those joining for the first time, those observing and colleagues joining for specific agenda items. The format of the proceedings in its virtual form were



	also noted. Members noted that the meeting would be recorded to aid the Committee Secretariat in ensuring the accuracy of scrutiny related discussions and decisions made during the meeting. Members noted that the recording would be destroyed once the minutes had been confirmed as accurate. Members confirmed they were happy to proceed. The Committee Chair advised that at the end of the meeting, she would be seeking Members views as to how the meeting went.
1.2	Apologies for Absence
	Apologies were received from: • Steve Stark – Audit Wales • Geraint Hopkins – Independent Member • Amanda Legge – Post Payment Verification Manager
1.3	Declarations of Interest
	No declarations were identified.
2.	CONSENT AGENDA BUSINESS
2.1	Items for Approval
2.1.1	Unconfirmed Minutes of the meeting held on 15 August 2024
Resolution	The minutes were APPROVED as an accurate record.
2.1.2	Unconfirmed Minutes of the In Committee meeting held on 15 August 2024
Resolution	The In Committee minutes were APPROVED as an accurate record.
2.2	ITEMS FOR NOTING
2.2.1	Audit & Risk Committee Annual Cycle of Business 2024-25
Resolution	The Annual cycle of Business was NOTED .
2.2.2	Audit & Risk Committee Forward Work Programme
Resolution	The forward work programme was NOTED
3.	MAIN AGENDA
3.1	GOVERNANCE
3.1	Audit & Risk Committee Action Log
	G. Watts presented the Action Log and provided an update on the following:



	• 3.1 & 6.1 – Local Counter Fraud Report and Re-referral to People & Culture Committee – Referral has been made to the Committee and will be received at the November 2024 meeting, the outcome of which will be reported back to the Committee. • 4.1 – Local Counter Fraud Report – M. Evans advised that a meeting between NWSSP Recruitment Services and the Counter Fraud Team was held on the 14 October 2024. A quality assurance process is in place within Recruitment which is applied to individual files, this process was reviewed during the meeting also looking at sample tests and quality checks working with the People Services Team. Internal Audit will also be undertaking a large sample check as part of their IA review and this is scheduled for this financial year. Proposed to close the Action. • 5.3 JAG Accreditation Report – Added to forward plan for February 2025. • 5.2 Audit Recommendations Tracker – An extensive review of the audit recommendations tracker was underway and an update would be provided under that item on the agenda. I Wells referred to 5.1 and the completed risk 5432 for adult weight management where the narrative had been updated to advise that a Business Case would be completed by the end of quarter 3 and he queried whether funding had been made available to progress this now. S. May confirmed that during quarter 3 they would be discussing financial plans going into the next financial year and there would be an opportunity to look at priorities and resources. However, she added that this was still on the risk register as to be resolved but would form part of the Integrated Medium Term Plan (IMTP) discussions.
Resolution	The Committee DISCUSSED and NOTED the action log.
3.2	Matters Arising not contained within the Action Log
Resolution	There were no matters raised.
4.	SUSTAINING OUR FUTURE
4.1	Local Counter Fraud Report M. Evans presented the report that provided detail on tasks and actions undertaken with the four strategic counter fraud work areas. The Chair referred to the options appraisal for delivering counter fraud services across Wales going forward and asked that before they bring everyone together that they gain consensus and a recommendation right from the beginning from the Directors of Finance (DoFs) so that the meeting should hopefully go ahead and would be fairly straight forward. S. May, in response advised that a presentation had been received by the DoFs in terms of centralising services counter fraud into shared services. S. May confirmed that it was not a decision making forum but allowed discussion on those matters. They had supported this work through the finance academy to bring together the counter fraud community to work through this and bring back some proposals.



	The Chair referred to page 5 of the open cases and in particular the overpayment of salary in December 2023 where it stated that Counter Fraud Services (CFS) Wales were undertaking the investigation. The Chair queried why this was the case. M. Evans confirmed that it was due to the value of the amount which would then dictate that CFS Wales would take on the investigation. M. Evans advised that progression on these cases was quite slow and it would be useful for the Committee to receive a presentation from CFS Wales on some of their cases so that the Committee had an oversight of them. The Chair referred to the mention of circumventing the rules and queried whether this was due to managers signing off excessive hours rather than putting through an additional pay claim. M. Evans confirmed that this was correct and that Counter Fraud were working with the Peoples Services with regard to the next stage.
Resolution	The report was NOTED .
Action	M Evans to arrange for CFS Wales to present at the next meeting of the Committee to provide an overview of their current cases.
4.2	Procurements and Scheme of Delegation Report O. James presented the report and highlighted the position on procurement matters for the period 1st August – 30th September 2024. K. Palmer referred to the No PO No Pay and the increasing amount of invoices on hold awaiting payment and queried whether that would cause cash flow problems. S. May advised that ensuring that people got paid promptly was important, they did meet their overall target but some areas were different. However, the No PO No Pay did not affect the voluntary sector. O. James, in response, advised that a high percentage of invoices on hold were with a limited number of organisations. He added that 49% of invoices were on hold with 10 suppliers with a number of those low value, for example the water company they deal currently have 800 invoices on hold which they were dealing with procurement colleagues to try and resolve. O. James advised that there was an issue across Wales with the same company and relatively low value. O. James advised that with regard to historic invoices still on the system work was ongoing at the moment looking at those to cancel them off the system which hopefully should bring the numbers down. K. Palmer queried whether there would be exceptions for charity or third sector organisations. O. James advised that if any queries were received from them where the process had fallen down with procurement it would be escalated to him immediately to deal with. O. James confirmed that they would also have to follow up on why the process had fallen down and there was also an all Wales



	P2P governance group working well that he chairs with the shared services team jointly. I Wells referred to variable pay and commented that it was good to see that one of the outcomes was a further audit. I Wells made an observation that the flow chart symbols were not the correct ones to be used and asked if they could be reviewed. S. May confirmed that they would ask workforce colleagues to look at this and make any necessary adjustments. The Chair queried where the JCC was included in the scope of the No PO No Pay Policy. O. James advised that it was an All Wales Policy and they would adopt it within the CTM Policy. The Chair referred to urgent requests for agency staff on Appendix 1, and the exceptions list for nurse agency and queried whether this was an exception to the No PO No Pay policy. O. James advised that the process for nurse agency was undertaken by a self-billing exercise and a PO was not required as the invoices were matched against the booking and time sheet. The Chair, in response to the above, queried whether the self-billing process was also used for locum doctors. D. Hurford confirmed that they use Retinue to find locums which does take a few days as they have to vet and approve and they have to manage in house until they can obtain a locum doctor. The Chair queried whether the Medical Variable Pay Policy had now been approved. D. Hurford advised that the Non Consultant and Consultant rate cards had now been rolled out without it having to be agreed with the Local Medical Committee (LMC). He added that the LMC had been informed that this is what the Health Board were doing and it had now been launched and was being used and adopted. D. Hurford advised that further information was contained in the report on the agenda for the meeting today.
Resolution	The Committee; APPROVED the updated following FCPs: MEDICAL WORKFORCE CONTROLS AND ASSURANCE PROCEDURE- MEDICAL VARIABLE PAY • ENDORSE TO BOARD FOR APPROVAL the update to the Pay Expenditure Scheme of Delegation in line with the update to the Medical Variable Pay FCP • NOTED the position on procurement matters for the period 01.08.2024 to 30.09.2024; • NOTED the update regarding Purchase to Pay and achievement of PSPP target up to Month 5 of 2024/25;
4.3	Post Payment Verification – Mid Year Review The Chair advised that A Legge was unable to attend to present the report and that any questions raised would be forwarded on outside of the meeting.



Resolution	The Committee; • NOTED the report.
5.	IMPROVING CARE
5.1	Organisational Risk Register G. Watts presented the Report report and highlighted key updates to members. G. Watts reassured the Committee that in view of the current events at the Princess of Wales Hospital this was being properly articulated in terms of the risk register. S. May confirmed that Silver and Gold Command had approved two risks to be added to the risk register, one in relation to Phase 1 of the building up of water ingress and the second in relation to the water ingress across other areas of the hospital. S. May added that because of the magnitude of phase 1 the risks had to be separated out. The Chair queried that the first risk had occurred so was now an issue. S. May advised that the risk was in relation to the roof collapsing which thankfully had not occurred and had been scored at 5 in terms of impact and 4 in regard to likelihood. S. May confirmed that they were keeping a very close eye on weather conditions and to also ensure a safe decant. K. Palmer, in response to the above, queried whether there was a risk to staff and patient safety. S. May advised that this had been included within the risks and taking actions in relation to the level of risk to justify immediate risk of changing services very quickly and moving patients and the potential risk of collapse based on the structural engineers report. D. Hurford in relation to K. Palmer's query advised that for assurance purposes they were completing a quality impact process for every patient that was being moved ensuring that risk assessments were in place. K. Palmer referred to the Board Assurance Framework where there was an emerging new strategic risk in relation to estates and queried whether this should be scrutinised by this Committee or at the main Board Meeting. S May advised that one of the difficulties with how the risk is articulated is that they actually have a different risk in different areas and some of those are unknown. S. May added that she would be working with the Assistant Director of Planning, Capital and Estates and the team who they describe the risk perhaps by site rather than by the whole estate. S. May offered to discuss outside of the meeting with K. Palmer on how the risk would be best articulated. The Chair queried whether the risk impacted on the strategic objective of patient services and delivery of patient care so that the overarching strategic objective would be different. S. May confirmed that this would be something that they would have to look at.



	The Chair referred to the decreased risk 5755 – Princess of Wales air handling unit and electrical infrastructure for Labour ward and Neonatal unit and advised that there was an explanation on page 4 but there was no correlation between the reduced consequence and the explanation used as a method of reducing the target risk score and asked if this could be reviewed. G. Watts advised that he would take this away as an action to review.
Resolution:	The Committee NOTED the report.
Action:	S. May offered to discuss the new emerging strategic risk on estates with K. Palmer on how the risk would be best articulated outside of the meeting.
Action:	Risk 5755 to be reviewed in relation to the correlation between the reduced consequence and the method of reducing the target risk score.
5.2	Audit Recommendations Tracker G. Watts presented the report to the Committee which outlined the progress of implementing audit report recommendations and actions in the revised format following transition to an automated system using the Audit Management and Tracking (AMaT) inspection module. G. Watts extended his thanks to C. Brown and K. Eddington from Quality Assurance and Compliance for their work in the development of the tracker. G. Watts outlined the work which he had commenced with the objective to cleanse the data in the tracker leading to a reduction of the number of overdue recommendations. He would work with Executive colleagues and internal and external audit, as appropriate, to identify any recommendations that had been superseded or could not be implemented and could be removed from the tracker. Each Executive had been sent details of the all recommendations pertaining their area of responsibility to undertake their own checks. It was noted that these had been sent just in advance of the issues identified at POWH. Therefore, further work would be required to ensure momentum is maintained in this area. He promised to keep the committee up to date with developments in this area and hoped to be in position to complete this work by the spring of 2025. M. Jones referred to pages 134 and 137 of the pack where there was reference to the 2020-2021 audit addendum where Welsh Government approval was required for certain senior salaries above a certain amount and advised that from an Audit Wales perspective the one was now closed in terms of recent audit findings. M. Jones advised that with regard to the addendum report for 2021-22 and the report for 2023-24 which was on the agenda there were some recommendations outstanding, however these were not contained within this report and suggested that a cross check should be undertaken between the addendum report and this report.

	In response, G. Watts advised that this was something that he had eluded to in his earlier introduction and he confirmed that they would clearly involve both internal and external audit just to get a sense check and ensure that all recommendations are reconciled going forward. I Wells referred to the tracker dashboard and advised that he was finding it difficult to understand how progress was being made as it based on month to month and not general progress overall. I Wells advised that a bit more information on the trends would also be helpful. G. Watts advised that part of the issue was the volume of what they were trying to deal with. G. Watts confirmed that he was confident that the Committee would be able to see those trends and progress when they were able to reset this to a more manageable size. K. Palmer extended her thanks to G. Watts and the team on the huge amount of work that had been undertaken to date and pushing hard on some of the overdue actions. K. Palmer advised that the Healthcare Inspectorate Wales action was being received by the Quality & Safety Committee.
Resolution	The Committee NOTED the Report and AGREED the assurances provided.
Action	To include the feedback received for the next iteration of the Tracker.
5.3	Welsh Risk Pool and Legal & Risk Services Annual Review 2023-24 <u>N.B. This item was taken first on the agenda.</u> N. Downes presented the Annual Report for 2023-24. I Wells referred to the redress cases and queried why there was such a high percentage and whether there was a reason for that. N. Downes advised that this was positive in that it showed that the Health Board were managing the cases, however, they did need to close these cases in a more timely fashion and the team were reviewing these and the moment and looking at alternative ways to manage the cases so that they could be closed quicker which would then reduce the numbers. K. Palmer queried whether clinical negligence claims were reported to this Committee as well as Quality & Safety Committee. N. Downes advised that the report that is received by Quality & Safety Committee in relation to claims does contain an element of clinical negligence claims. N. Downes added that redress claims under £25k were also reported to Quality & Safety Committee. However, he advised that they could look to section out the report for this. N. Downes, in relation to the above discussion, advised that in May 2023 the Health Board had a number of Learning from Event Records (LFERS) fines of £25k, however, since then they had only received three due to more robust processes in place to ensure they did not incur penalties. In response to the above, S. May advised that the delays in relation to LFERS do present a risk to the Health Board. S. May added that it was not an enormous



	financial in the context of what they have to deal with but was worth noting by the Committee. S. May advised that the Health Board had seen their overall share of the Welsh Risk Pool increase over recent years which reflected the level of cases which should be kept a close eye on as this puts pressure onto the overall financial position. N Downes advised that the team were doing everything they possibly could and reviewing cases on a weekly basis to ensure they get over the line. The Chair queried what the percentage rate was of acceptance of first submissions of LFERS. N. Downes advised that the system has changed, and they now have four months to submit into the Welsh Risk Pool with a total of 12 months from the trigger date to the end date of either submission or penalisation. N. Downes confirmed that the Health Board did not submit any blank LFERS anymore and this would not be tolerated. The Chair referred to the supplement appendix report where it stated that information on the cases were yet to be concluded and were marked as confidential and she queried whether this should be in the public domain. N. Downes confirmed that he would check this and come back to the Committee following the meeting.
Resolution:	The Committee NOTED the report and commended the higher-than-average rate of clinical negligence and personal injury matters closed without damages and explore how these successful defence strategies can be further enhanced.
Action:	To review the Supplement Appendix outside of the meeting to ensure it was ok to publish in the public domain.
5.4	Update on Consultant Job Planning Dom Hurford presented the report that provided the Committee with an update on progress. The Chair commented that the Committee were aware of the time that this was taking to implement, however, it did need to be monitored by the Committee and the expectations of when they would start to see some results. K. Palmer, in response to the above queried what the risks were with this taking so much time to complete. D. Hurford, in relation to the comments made advised that they had been ambitious when setting the target and realistically they needed to reset the target to something that was more achievable and then provide a time frame to the Committee. The Chair, in response, thanked D. Hurford for his reassurance and suggested that they catch up directly when the next steps are received so they could discuss what the Committee wants to achieve in relation to this.
Resolution:	The Committee NOTED the report.



Action	Chair and Medical Director to have a discussion outside of the meeting once the next steps are developed.
5.5	Medical Rostering Progress Report Dom Hurford presented the report that provided the Committee with an update on the progress achieved in relation to the audit report on Medical Rostering. The Chair queried when they would have a final outcome. D. Hurford advised that once the LMC have approved the policy they will then go out to the Consultants to provide two options for them to decide which one works for them and this would then also be included within the job planning process.
Resolution	The Committee NOTED the report.
	INTERNAL AUDIT
5.6	Internal Audit Progress Report P. Dalton presented the progress report that provided the Audit & Risk Committee with the current position of the work undertaken by Internal Audit. K. Palmer referred to the new internal audit standards and queried whether an internal audit strategy would need to be developed if there was not one in place. P. Dalton advised that there was a strategic approach within NHS Shared Services for all internal audit across Wales and there is a strategic document, however, whether it needed to be granulated to each individual organisation he was not quite sure at this stage. P. Dalton added that they were currently mapping through the process and he would provide an update report to the December meeting of the Committee. The Chair congratulated everyone for the huge improvements made in the turnaround time of reviews.
Resolution:	The report was NOTED
5.6.1	IA Review – Medical Variable Pay – Follow Up E. Samways presented the report which has been given a 'Reasonable' Assurance rating.
Resolution:	The Committee NOTED the report.
5.6.2	IA Review – Reasonable Offer E. Samways presented the report which has been given a 'Reasonable' Assurance rating. I Wells referred to the management response and in particular the training of staff and queried whether that response could be realised currently as the two systems were different. E. Samways confirmed that there was two sets of training being undertaken for the two different constituent parts of the system



	and the training analysis needs to be done for the system as whole and until there is one you system the analysis will not be able to be done. E. Samways confirmed however, that staff training was still being undertaken. G. Hughes confirmed that the integration of two systems into one would not happen for at least another 9 to 12 months and he queried whether this should remain on the tracker until then or suspend and bring it back once the action had been completed. The Chair, in response to the above, commented that it would be problematic to provide one set of training for two different systems. G. Watts confirmed that he would pick this up as part of the wider work that he had referenced earlier with regard to making a sense check with regard to all the audit recommendations they currently have outstanding and discuss with internal audit.
Resolution:	The Committee NOTED the report.
5.6.3	IA Review – Patient Pathway – Follow Up E. Samways presented the report that had received a 'Limited' Assurance rating. The Chair observed that significant progress had been made from the 9 original recommendations down to 2.
Resolution:	The Report was NOTED .
5.6.4	IA Review – Embedding Quality Framework E. Samways presented the report which has been given a 'Reasonable' Assurance rating.
Resolution:	The Report was NOTED .
5.6.5	IA Review - Information Provision – Intelligence Led Organisation M. Lewis presented the report which had received a 'Reasonable' Assurance rating.
Resolution:	The Report was NOTED .
5.6.7	Internal Audit Review - Facilities Governance Arrangements – Follow Up E. Samways presented the report which had received a 'Substantial' Assurance rating. The Chair advised that G. Hughes had referenced earlier the significant amount of work that the team had put in in terms of processes and had extended his thanks. The Chair referred to the invoices on hold and queried whether the issue was down to improving retrospective orders and orders on hold. E. Samways



	confirmed that it was and when they undertook the initial audit and looked at the data from then to now it had dropped to about 10% and about 20% of those orders were retrospective and were now down to 9%. E. Samways confirmed that the team were still working with those suppliers to try and put in alternative ways to clear the remaining 9%. S. May commented that J. Venables and her team had undertaken a huge amount of work to try and tackle the issues and it was good to see the progress that has been made and showing real improvement that will hopefully be sustained.
Resolution:	The Report was NOTED .
5.7	Audit Wales - Audit & Risk Committee Update M. Jones advised that from the financial audit perspective - Audit Wales had received the Charitable Fund Accounts this week. M. Jones advised that the main work on the Charitable Funds financial audit would be commencing on the 4th November when other members of the audit team would be joining them. With respect to the performance audit N. Couch advised that the work on unscheduled care, cost savings, primary care and the Structured were either at the field work or draft reporting phase and it was hoped that all of these report would be presented at the December 2024 meeting.
Resolution:	The Report was NOTED .
6.	CLOSE OF BUSINESS
6.1	Any Other Urgent Business There was no urgent business to report.
6.2	How Did we Do in this meeting The Committee Chair advised that if Committee Members had any comments to raise as to how the meeting went today, then they could share these with herself and the Head of Corporate Governance outside the meeting.
6.3	Committee Highlight Report
Resolution:	The Committee Chair advised that this would be drafted outside the meeting by the Governance Team.
7.	CLOSE OF MEETING

Agenda Item	2.1.2

Unapproved Minutes of the Audit & Risk (CLOSED) In Committee

Date and Time of Meeting	Thursday 17 th October 2024 at 16:15 pm
Venue	Virtual via MS Teams

Members Present	Patsy Roseblade	Independent Member (Committee Chair)
	Kath Palmer	Independent Member
	Ian Wells	Independent Member
In Attendance	Owen James	Head of Corporate Finance
	Dom Hurford	Executive Medical Director
	Paul Dalton	NWSSP- Internal Audit & Assurance
	Emma Samways	NWSSP- Internal Audit & Assurance
	Mark Jones	Audit Wales
	Nathan Couch	Audit Wales
	Gareth Watts	Director of Corporate Governance/Board Secretary
	Emma Walters	Head of Corporate Governance & Board Business
Meeting Observers	None	

Agenda Item	Meeting Business
1.	PRELIMINARY MATTERS
1.1	Welcome and Introductions P. Roseblade, Committee Chair welcomed everyone to the meeting.
1.2	Apologies for Absence Apologies for absence were received from: - Geraint Hopkins, Independent Member - Steve Stark, Audit Wales
1.3	Declarations of Interest There were none to declare.
2.	MAIN AGENDA
2.1	Organisational Risk Register (Business Sensitive Risks)



	G. Watts presented the report for the Committee to review and discuss the organisational risk register and consider whether the assigned risks have been appropriately assessed. P Roseblade sought clarity as to the reasons behind the change in consequence for the risks. G Watts agreed to discuss further with the Assistant Director of Governance & Risk outside the meeting and would provide a response.
Resolution:	The Organisational Risk Register was DISCUSSED and NOTED .
Action:	Discussion to be held with the Assistant Director of Governance & Risk as to why there had been a change in the reported consequence.
2.2	Financial Controls Procedure - Medical Variable Pay – Summary of Authorised Breaches D. Hurford presented the report summary of all approved rates up to and above 10% of the ADH and agency rate cards for each Care Group relating to, 1st June to 31st August 2024. Members noted that whilst spend was still high, there had been a positive reduction in agency and locum spend within some Care Groups. In response to a query raised by P Roseblade as to why costs paid to a doctor contradicted the total cost, D Hurford advised that costs per hour increased when cover was arranged via an agency. In response to a query raised by P Roseblade as to what change was required to enable Care Groups to accurately reflect the reasons for booking agency workers, D Hurford advised that there were issues with coding which needed to be reviewed moving forwards.
Resolution:	The report was NOTED .
2.3	Audit Wales – Audit of Accounts Addendum Report M. Jones presented the report. O James commented on the audited items for the 2022/2023 review and advised that whilst narrative had not been provided against these items, each recommendation had been followed up with individual managers who had provided an update on progress. Members noted that work would now need to be undertaken with Audit Wales and the Governance Team to determine how these need to be recorded on the tracker. K Palmer made reference to the recommendation identified in the 2020/2021 audit which related to the restoration of the RAM system and queries how Committee Members could be provided with assurance on this matter given that the recommendation had not yet been addressed. G Watts referred to the discussion held in the public session in regards to the wider piece of work being undertaken by the Executive Team in regards to the review of older recommendations. N Couch added that Audit Wales also undertakes a high level review of tracking recommendations as part of the Structured Assessment Review. Members noted that monthly meetings with recommendation leads

	were also being introduced by the Assistant Director of Governance & Risk to track progress against recommendations. P Roseblade made reference to a recommendation contained within Exhibit 8 which had not been accepted by the Health Board and questioned whether this should be included on the tracker. M Jones advised that recommendations should not be added to the tracker if they had not been accepted.
Resolution:	The Report was NOTED .
3.	ANY OTHER BUSINESS
	There was no urgent business to report on this occasion.
4.	DATE AND TIME OF NEXT MEETING:
	17th December 2024 at 13:00 pm



Agenda Item

2.1.3

Audit & Risk Committee

**Ratification of Chairs Urgent Action – Charitable Fund
Financial Control Procedure (FPC) & Update of the
Scheme of Delegation**

Dyddiad y Cyfarfod / Date of Meeting	17/12/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Kathrine Davies, Corporate Governance Manager
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance/Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Charitable Funds Committee	23/10/2023	Agreed by Chair of Audit & Risk Committee to take Chairs Action out of Committee
Urgent Chair's Action – People & Culture Committee Members by Email	23/10/2024	Endorse for Approval at Audit & Risk Committee
Health Board Meeting	28/11/2024	Approved



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg UHB
FCP	Financial Control Procedure
SFI	Standing Financial Instructions

1. Situation /Background

- 1.1 The purpose of the report is to present the revised Charitable Fund Financial Control Procedure (FCP) and the SFI Scheme of Delegation which has been endorsed by the Charitable Funds Committee.
- 1.2 The Charitable Fund Financial Control Procedure details the principles underlying the Cwm Taf Morgannwg University health Board's system for operating Charitable Funds.
- 1.3 As previously reported to the Charitable Funds Committee, there are significant issues with ensuring that every fund has a delegated fund holder. Following review with the Head of Charity and Income Generation it was recognised there was little contingency when a current fund holder moved or left the organisation, regularly leaving funds without a fund holder.
- 1.4 In order to increase the level of governance and control, it was proposed that an approval hierarchy was implemented, where if a fund holder departed there was appropriate cover for administering and managing the fund in line with the FCP.
- 1.5 A request seeking urgent support for approval of the Charitable Funds FCP and Scheme of Delegation was circulated on the 23rd October 2024 following agreement with the Audit & Risk Committee Chair. This resulted in the following responses indicating support from Committee IMs:
 - Sally May – Executive Director of Finance (Executive Lead)
 - Patsy Roseblade – Independent Member (Chair)
 - Ian Wells – Independent Member
 - Kath Palmer – Vice Chair

This was approved on the 24th October 2024 and the Executive Director of Finance was notified.

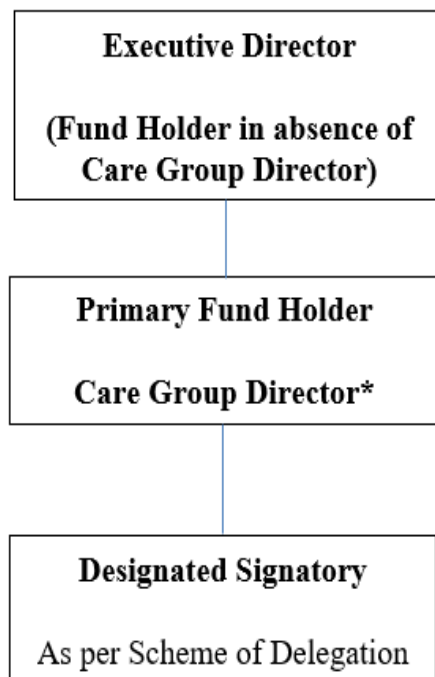
2. Specific Matters for Consideration

- 2.1 The updated FCP is included at Appendix A. This includes a proposal to bring in an approval hierarchy for funds, where the primary fund holder will be the appropriate Care Group Director (where the fund is general / CTMUHB wide the fund holder will be the Chief Executive. Where the Care Group Director is vacant / unavailable the fund will be delegated to the relevant Executive Director.
- 2.2 Fund holders can assign designated signatories to funds, who can authorise expenditure within the delegated limits set out within the Scheme of Delegation.

2.3 The benefits of bringing in this approval hierarchy include the following:

- Provides a consistent level of authorisation for management and administration of all funds
- Provides additional cover for when fund holders move roles / leave the Health Board.
- Allows the approval hierarchy on Oracle to be set up in a consistent and clear way.
- Allows funds to be reviewed in a strategic manner when coming under a Care Group Director.
- Funds are structured in line with the Health Boards Care Group structure.

2.4 The approval hierarchy structure will be as below:



*For General / LHB Wide Funds the Fund Holder will be the Chief Executive unless otherwise delegated.

2.5 If approved the Head of Corporate Finance and Head of Charity and Income Generation will review where all funds will sit and update the approval hierarchy accordingly.

3. Key Risks / Matters for Escalation

3.1 The Charitable Fund Committee endorsed approval of the updated FCP which includes the new approval hierarchy. The FCP will then require final approval by Audit & Risk Committee in line with the Standing Orders.



- 3.2 To ensure consistency with the FCP, the Scheme of Delegation was updated as per Appendix B, and approved by the Board at their meeting held on the 28th November 2024.

4. Assessment

5. Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Not Applicable
	The Charity links to ALL of CTMUHB Strategic Goals
Dolen i Feysydd Strategol BIP CTM /Link to CTMUHB Strategic Areas	Not Applicable
	The Charity links to ALL of CTMUHB Strategic Areas
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant /Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	Whole-systems Perspective
	If more than one applies please list below:
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))	Person Centred
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality Have you undertaken a Quality Impact Assessment Screening?	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: N/A
Cydraddoldeb Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:



Equality Have you undertaken an Equality Impact Assessment Screening?		N/A
Cyfreithiol / Legal	Yes (Include further detail below)	
	Charitable funds are required to be managed in accordance with charity legislation and requirements of the Charity Commissioner.	
Enw da / Reputational	Yes (Include further detail below)	
	If Charitable Funds are not utilised in line with the objectives of the Charity, this could cause a reputational risk for the organisation.	
Effaith Adnoddau (<i>Pobl /Ariannol</i>) / Resource Impact (<i>People / Financial</i>)	Yes (Include further detail below)	

5. Recommendation

5.1 The Audit & Risk Committee is asked to:

- **RATIFY** the **APPROVAL** the amended Charitable Funds Financial Control Procedure at Appendix A.
- **NOTE** the update of the Scheme of Delegation that was approved by the Health Board on the 28th November 2024.

6. Next Steps

6.1 Following the Board Approval the Head of Corporate Finance and Head of Charity and Income Generation will review where all funds will sit and update the approval hierarchy accordingly.



FINANCIAL CONTROL PROCEDURE: CHARITABLE FUNDS

Initiated by:	Executive Director of Finance
Approved by:	Audit & Risk Committee
Date approved:	TBC
Operational Date:	TBC
Version:	v. 4
Date for review:	TBC
Distribution:	Executive Directors/Trustees Fundholders

Freedom of Information Status: Open

This policy has been subject to a full equality impact assessment.

CONTENTS

- 1 Introduction
- 2 Creation of New Charitable Funds
- 3 Fund holders and approvals
- 4 Donations and Legacies
- 5 Fundraising and Gift Aid
6. Order, Receipt and Payment of Goods & Services
7. Reporting
8. Bank Accounts
9. Investments & Administration Costs
10. Equality Impact Assessment

Appendices

Appendix A:	Request for New Charitable Fund to be Set Up
Appendix B:	Receipt for an Individual Donation
Appendix C:	Gift Aid Declaration
Appendix D:	Cwm Taf University Health Board Fund Expenditure Authorisation Form
Appendix E:	Request for expenditure reimbursement
Appendix F:	VAT Exemption Certificate

1.0 INTRODUCTION

- 1.1 This procedure details the principles underlying the Cwm Taf Morgannwg University Health Board's system for operating Charitable Funds in order to enable the funds to be properly controlled and accounted for. Charitable Funds arise when monies are received in the form of donations, gifts, grants and legacies. The funds are governed by the laws affecting Trustees and Charities.
- 1.2 The receipt, recording, and the management of all charitable funds shall be in accordance with the Cwm Taf Morgannwg University Health Board's Standing Financial Instructions, Standing Orders and other relevant Financial Control Procedures. Expenditure against any Fund shall be conditional upon:
 - a. The item being within the objects of the appropriate fund.
 - b. Delegated limits of approval as determined by the Health Board's Scheme of Delegation

The Cwm Taf Morgannwg UHB is the Corporate Trustee for all of the charitable funds. The individual board members act as the Trustees of the funds.

- 1.3 Charitable funds are subject to certain legal controls and conditions and they must be accounted separately from revenue funds. The conditions normally relate to the fund uses and stem from the terms of the original donation or legacy. All funds must be registered with the Charities Commission which has responsibility to ensure any conditions are complied with.

2.0 Creation of New Charitable Funds

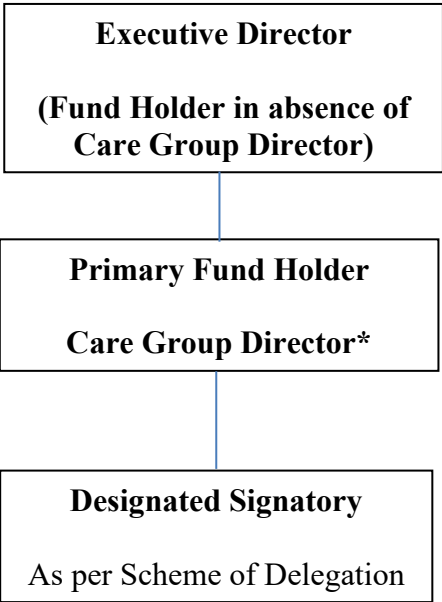
- 2.1 Where possible the setting up of new funds should be avoided, and the monies received will be allocated to existing funds. If there are no suitable funds to meet the donor's wishes, a request to set up a new fund will be submitted to the Chief Executive (CEO) or Director of Finance who will need to approve accordingly.
- 2.2 The application to the CEO/Director of Finance should be made in writing via the completion of a form (see Appendix A). This should contain the objective/purpose of the fund, source of donation, the type of purchases that the fund would be used to support, and the proposed delegated fund holders who are

responsible for managing the fund and approve expenditure within the Scheme of Delegation.

- 2.3 The fund name and number will be allocated by the Senior Finance Officer (Charitable Funds), who will inform the requesting officer accordingly.
- 2.4 The fund holders should ensure that they possess full documentation for each of the funds under their control.

3.0 Fund Holders and Approval Hierarchy

- 3.1 All funds require a designated fund holder and to ensure there is always an appropriate fund holder, funds will be assigned in line with the following hierarchy:



*For General / LHB Wide Funds the Fund Holder will be the Chief Executive unless otherwise delegated.

- 3.2 A fund can have a number of designated signatories who can authorise expenditure within the delegated limits detailed in the Scheme of Delegation. Authorisation limits for Charitable Funds are shown in the table below:

Access to Charitable funds

Delegated authority	Approve expenditure from charitable funds
(i) Approval and setting up of designated fund signatories for new funds.	(i) Director of Finance
(ii) Approval of changes to fund signatories	(ii) Head of Finance/Assistant Director of Finance
All expenditure requests for Charitable funds	To be submitted to Senior Finance Officer - Charitable Funds for initial review and subject to confirmation that sufficient funds are available
Up to £5,000 ¹	Designated fund signatories (must be Head of Department or equivalent)
Up to £15k ¹	Directorate Manager
Up to £30k ¹	Care Group Director / Deputy COO or Relevant Director
Up to £50k ¹	Executive Director
Over £50k or Contentious expenditure	Charitable Funds Committee

¹ Contentious expenditure will require approval by Charitable Fund Committee - "contentious" refers to the appropriateness of the expenditure either due to its nature or its compatibility with fund objectives and will be determined by the Senior Finance Officer - Charitable Funds during initial review.

3.3 Fund holders and designated signatories will receive appropriate training and understand the objectives of the Charity.

3.4 Fund holders will be responsible for ensuring funds are utilised in an efficient and timely manner and in line with the objectives of the Charity.

4.0 Donations and Legacies

4.1 Prior to the acceptance of any large donations or any legacy, the Head of Corporate Finance shall assess whether the wishes of the donor can be met. If for any reason the terms cannot be satisfied, then the donation/legacy should be declined. All situations where monies are refused will be with the written authorisation of the CEO. In the case of legacies, legal advice may need to be sought.

4.2 Before large donations/legacies for the purchase of a specific item(s) of equipment/service are accepted, the Head of Corporate Finance, with assistance from capital finance colleagues, shall ascertain whether the use of the donation would generate any revenue costs and if these are within the UHB's approved operational plans.

- 4.3 The Senior Finance Officer shall assess whether monies received from third parties such as drug companies or other sponsors, should be treated as charitable donations or classified as trading activities, in compliance with the Charity Commission rules.
- 4.4 *All donations must be receipted* via the ORACLE financial cash receipting system. All receipts for charitable funds will be banked in the Charitable Fund Current Account.
- 4.5 Where practicable donors will be asked to complete and sign a receipt form with a duplicate being signed and retained by the donor. This form will remove any subsequent misunderstanding or confusion as to the wishes of the donor. The forms will be held at Hospital ward level and within Hospital General Offices.
- 4.6 Monies should be paid into General offices rather than to individuals at ward level. Where this is unavoidable the person in charge should receipt the monies and pay the monies into the General Office at the earliest opportunity. The money should be held in a secure location prior to payment into the General Office.
- 4.7 The receipt should be completed with details of the donation, e.g. which fund to credit, name of donor, and amount. The coding of the C&D Sheet must be completed at source.
- 4.8 Where hospital sites have access to the ORACLE Financial System, input shall be done by the Collecting Officer prior to the forwarding of the relevant documentation to the Senior Finance Officer (Charitable Funds).
- 4.9 For areas without access to the ORACLE Financial System the relevant C&D Sheets must be submitted, at regular intervals, to the Senior Finance Officer (Charitable Funds).
- 4.10 The donations will be recorded into the Charitable Fund accounting system by the Senior Finance Officer.
- 4.11 The control over receipt of cash in respect of legacies is the same as that applied to normal donations. However, greater attention must be paid to such bequests, since they may involve large amounts of money and in some cases property.
- 4.12 All correspondence relating to legacies should be sent **immediately** to the Senior Finance Officer (Charitable Funds), who will then take the appropriate action.

- 4.13 Donors should be encouraged where practicable to donate via the Health Board's Just Giving site and, for qualifying donations, to make use of Gift Aid provisions (see 4.7 below).

5.0 Fundraising and Gift Aid

- 5.1 Where external parties propose to undertake fund raising activities on behalf of the Health Board they must be assessed for suitability.
- 5.2 Details of fundraising activities shall be notified to the Senior Finance Officer (Charitable Funds) so that appropriate accounting records can be maintained. The Senior Finance Officer will supply the fund holder with information on records that need to be completed on income and expenditure for all activities.
- 5.3 Fundraisers shall be encouraged to use the Health Board's Just Giving website to receive donations, and publicise their appeal.
- 5.4 Cwm Taf Morgannwg UHB is registered with HMRC for Gift Aid. A HMRC number and an account number is maintained, and these details can be provided by the Senior Finance Officer on request.
- 5.5 A Gift Aid declaration has to be made and signed by the donor to benefit the Charity. A copy of the required declaration is attached as Appendix C. After completion, the form should be sent to the Senior Finance Officer who shall collate and obtain reimbursement from the HMRC.
- 5.6 Alternatively, donors using the Just Giving site may apply for Gift Aid directly through declaring the appropriate information and accepting the relevant conditions.
- 5.7 **It is important that only UK Income Tax and/or Capital Gains Tax payers are able to claim Gift Aid. All conditions that must be satisfied to qualify for Gift Aid are stated on the declaration form and Just Giving site. It is the donor's responsibility to read these conditions and declare accordingly.**

6.0 ORDER, RECEIPT AND PAYMENT OF GOODS & SERVICES

6.1 Requisitions & Requests for Reimbursement

- 6.1.1 For all expenditure from a Charitable Fund an electronic requisition on Oracle should be approved by the fund holder or designated signatory authorised by the fund holder. The requisition shall be forwarded to the Charitable Funds Officer, where the fund balance will be checked (also taking into account any unpaid orders). If there is found to be "insufficient funds" then the requisition must be return to the fund holder stating the reason. Under no circumstances shall a requisition be drawn which would cause the fund to become overdrawn.
- 6.1.2 If sufficient funds are available and the expenditure is within the authorised limit and deemed "non-contentious" (i.e. it is appropriate and compatible with fund objectives), the requisition is forwarded to the Procurement Department for processing of the order. If deemed contentious, this will be discussed in the Charitable Funds committee for approval.
- 6.1.3 All requisitions have to be approved in line with the Scheme of Delegation.
- 6.1.4 Requisitions must be accompanied by a Charitable Fund Expenditure Authorisation Form (Appendix D). This shall include details of any revenue consequences that may arise from the purchase and how those revenue costs are to be funded.
- 6.1.5 Requests for reimbursement (Appendix E) shall be processed in the same way as requisitions, and in accordance with the Scheme of Delegation.
- 6.1.6 The Senior Finance Officer is responsible for identifying any purchases that are eligible for VAT Exemption, and complete a VAT exemption certificate (Appendix F). This will be authorised by the Head of Finance and forwarded, along with the requisition, to the Procurement Department. The requisition should be clearly marked "VAT EXEMPT".

6.2 **Ordering**

- 6.2.1 Ordering of all items will be carried out by the Shared Services Procurement Department following receipt of a properly authorised requisition.
- 6.2.2 When a capital purchase is made from Charitable Funds, the Charitable Funds Officers shall liaise with the Capital Finance

team to ensure the expenditure is correctly accounted for on the UHB's fixed asset system and Capital Resource Limit.

- 6.2.3 Statements of Need (SoN) may be requested when purchasing medical equipment to be considered by the Clinical Engineering Department as part of their responsibilities around safety and compatibility of medical equipment.

6.3 Payment for orders raised on ORACLE

- 6.3.1 For orders that have been raised on the ORACLE system the Requesting officer must ensure that goods or services are receipted when the order is satisfied.
- 6.3.2 The payment for goods relating to Charitable Fund orders carrying ORACLE order numbers are paid in accordance with the UHB's Financial Control Procedure for Creditor Payments.
- 6.3.3 Once all the above procedures have been adhered to, a cheque can be raised against the Charitable Fund Account for signing by an authorised signatory in accordance with the bank mandate. All cheques to the value of £20,000 or more must be countersigned by an authorised second signatory.

6.4 Direct reimbursement for expenditure not on ORACLE

- 6.4.1 The Cash section within the Finance Department shall process any payments, through raising of cheques or Bacs Transfers, for authorised requests for reimbursement (Appendix E).
- 6.4.2 The Charitable Funds Officer ~~Senior Finance Officer~~ shall be notified of cheque numbers for payments of this nature, which shall be kept on file.
- 6.4.3 Cheques shall be signed in accordance with the bank mandate and as described in para 5.3 above.

7.0 REPORTING

7.1 Fund Balances

- 7.1.1 At the end of each month, all fund holders shall be provided with a statement of charitable fund balances in order to facilitate management control over their funds. Any anomalies should be reported immediately to the Senior

Finance Officer, who will investigate as appropriate and make any necessary corrections.

- 7.1.2 Funds with nil or small unused balances should be closed or merged. The Senior Finance Officer shall discuss accordingly with the fund holder and obtain approval for such actions.
- 7.1.3 Fund holders are obliged to ensure that Charitable Funds are used for the purpose intended at the time of donation. Funds should not be allowed to accumulate indefinitely and should be spent as soon as is practicable. The Senior Finance Officer shall periodically request spending plans for particular funds for reporting to Charitable Funds Committee.

7.2 Management and Statutory Reporting

- 7.2.1 The Charitable Funds Committee has delegated powers to oversee Charitable Fund matters on behalf of the Trustees. The Head of Finance shall report to each Charitable Funds Committee the level of fund balances held, investment performance (see section 7 below) and other governance issues that may be of interest to Trustees in the management of their charitable funds.
- 7.2.2 A set of annual accounts and an annual report must be prepared at the end of each financial year, externally audited or examined as appropriate in accordance with prescribed thresholds, and approved by Trustees. A full meeting of the Trustees shall be convened once a year to approve the accounts and annual report.
- 7.2.3 The Annual Accounts and Report must be filed with the Charity Commissioner prior to the 31 January following year-end.

8.0 BANK ACCOUNTS

8.1 Current Account

- 8.1.1 The Charitable Fund's Current Account balance is monitored daily in order to determine whether outstanding commitments can be satisfied and/or whether cash is available when required.
- 8.1.2 The Current Account balance should be kept to a minimum. Any surplus cash available should be swept across to an interest bearing Deposit Account in order to generate interest income.

8.1.3 All receipts are deposited in the current account and cheques are drawn against this account. All cheques must be signed, and the account operated, in accordance with the bank mandate.

8.2 Interest Bearing Deposit Account

8.2.1 Such an account can be used for transfers of cash from the current account to gain interest income. When funds are required to meet outgoing commitments, an appropriate cash transfer can be swept back into the current account.

8.3 Reconciliation of Bank Accounts

8.3.1 At the close of each month, a reconciliation of the bank accounts will be undertaken by the Senior Finance Officer and reviewed by the Financial Accountant. Any reconciling items should be cleared by the following month, or an explanation provided if this was not possible.

9.0 INVESTMENTS & ADMINISTRATION COSTS

9.1 Investments

9.1.1 Trustees are expected to maximise the investment return on the funds entrusted to them, whilst minimising the risk to the funds themselves.

9.1.2 Funds may be invested in equities, bonds, property etc as directed by Trustees, having due regard to their responsibilities around risk, in order to maximise returns.

9.1.3 The Trustees may appoint investment agents to advise on, and manage investments as required. The Audit Committee shall monitor performance of investment agents and the underlying investments on behalf of the Trustees, and may require the appointed agent to attend meetings as required for this purpose.

9.1.4 In determining the nature of investments to be held, the Audit Committee shall consider any ethical issues that may arise from such investments.

9.1.5 The Trustees will agree an investment policy to act as a guide for making any investments, considering the level of returns expected and the level of risk to be tolerated. This policy will

be reviewed periodically and any changes will require Audit Committee approval.

9.1.6 The Head of Corporate Finance, on behalf of the Director of Finance, shall review investments held against the agreed policy and advise on increasing or reducing the level of investment held as appropriate. Any change to the nature of investments will be guided by advice from the appointed agents. The Audit & Risk Committee shall be requested to approve any change to either the level or nature of investments held.

9.1.7 The placing of investments, or withdrawal of any investment, shall be authorised by the CEO and Director of Finance.

9.1.8 The value of the investments held shall be regularly reviewed by the Head of Corporate Finance, and any increases or fall in values will be charged against a charitable fund revaluation account.

9.1.9 At the end of each financial year, a valuation will be received from the investment agents and accounted for appropriately within the Annual Accounts. A negative revaluation reserve balance at the end of the financial year will need to be apportioned against underlying funds.

9.1.10 A positive revaluation reserve will be carried forward to the following year. This reserve may be distributed across underlying funds should it reach the level prescribed within the investment policy. Any distribution of this capital surplus will require approval by the Director of Finance and Charitable Funds Committee.

9.2 **Investment Income**

9.2.1 Interest and dividend income will be apportioned to individual funds based on the average fund balance during the period.

9.2.2 Interest and dividends due at the end of each financial year shall be accrued and included in the above apportionment.

9.3 **Administration Costs**

9.3.1 Where relevant, each fund will be charged an annual administration fee, which will be a share of the total cost of managing the Charitable Funds for that year. The charge will be based on an estimate of the number of hours spent on the

Charitable funds by UHB staff and will include a charge for the proportion of the annual statutory audit fee and any other administrative costs incurred. The apportionment of administration costs over individual funds shall be on the same basis as the apportionment of investment income. Where the funds are unrestricted the recharge for the administration fee and investment income can be charged to an LHB wide general purpose fund. A schedule of the annual administration cost to be charged to charitable funds shall be prepared by the Senior Finance Officer and approved by the CEO.

10.0 EQUALITY IMPACT ASSESSMENT

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

APPENDIX A

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD

REQUEST FOR A NEW CHARITABLE FUND TO BE SET UP

PROPOSED FUND NAME

SOURCE OF FUNDS:

INITIAL FUND

BALANCE

EXPECTED LEVEL OF FUTURE RECEIPTS

DEPARTMENT/WARD

Purpose of Fund

Patient benefit

☐

Staff benefits

☐

((Please tick relevant box(es))

Equipment benefit

☐

Brief Description (Fund Objectives):

FUND

HOLDER

Personnel who can authorise expenditure (Signatories)

Name

Title

Signature

PLEASE RETURN COMPLETED FORM TO FINANCE

DEPARTMENT

ADMIN BLOCK, DEWI SANT HOSPITAL

Approved
(Director of Finance)

Fund No

Finance Signature

Form of Receipt for an Individual Donation

16

APPENDIX C



Bwrdd Iechyd Prifysgol
Cwm Taf
University Health Board

giftaid it

Gift Aid Declaration

Name of charity: **Cwm Taf University Health Board**

Please treat as Gift Aid donations:

☐ The enclosed gift of £ _____

Donor's details

Title: _____ Initial(s): _____ Surname: _____

Home address: _____

Postcode: _____ Date: _____

Signature: _____

I confirm I have paid or will pay an amount of Income Tax and/or Capital Gains Tax for each tax year (6 April to 5 April) that is at least equal to the amount of tax that all the charities or Community Amateur Sports Clubs (CASCs), that I donate to, will reclaim on my gifts for that tax year. I understand that other taxes such as VAT and Council Tax do not qualify. I understand the charity will reclaim 25p of tax on every £1 that I give.

Please notify Cwm Taf ULHB if you:

1. Want to cancel this declaration.
2. Change your name or home address.
3. No longer pay sufficient tax on your income and/or capital gains.

If you pay income tax at the higher rate, you must include all your Gift Aid donations on your Self Assessment tax return if you want to receive the additional tax relief due to you.

*Cwm Taf NHS General Charitable Fund, C/O Finance Department, Dewi Sant Hospital,
Albert Road, Pontypridd, RCT CF37 1LB
Registered Charity number 1049765*

APPENDIX D

Charitable Fund Expenditure Authorisation Form
TO BE ACCOMPANIED BY A COMPLETED NON STOCK REQUISITION)
SECTION A (to be completed by designated officer) NAME OF FUND: _____ FUND NO. _____ EXPENDITURE REQUESTED BY: _____ DESIGNATION: _____ <u>DESCRIPTION OF ITEM/EQUIPMENT TO BE PURCHASED:</u> _____ _____ COST: _____ REVENUE CONSEQUENCES: _____ _____ WHY IS PURCHASE REQUIRED/WHAT USE WILL BE MADE: _____ _____ HOW IS IT PROPOSED TO FUND REVENUE CONSEQUENCES: _____ _____ IS THE PURCHASE VAT EXEMPT: YES/NO/NOT SURE (Please delete where appropriate). If YES please attach a VAT Exemption Certificate duly completed. If in any doubt signify NOT SURE for Finance Department to process. (If money has been/will be specifically donated for the above give details of donations) _____ _____ SIGNED: _____ DATE: _____ SECTION B (To be completed by Finance Department) BALANCE OF FUND BEFORE APPROVAL: _____ VERIFIED BY: _____ DATE: _____

EXPENDITURE AUTHORISED BY: _____

DATE: _____

APPENDIX E

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD	
Request for reimbursement from a Charitable Fund	
SECTION A (to be completed by designated officer)	
HOSPITAL:	_____
NAME OF FUND:	FUND NO: _____
REQUESTED BY:	DEPARTMENT: _____
AMOUNT REQUIRED: _____ (a receipt must be produced where appropriate)	
CHEQUE PAYEE:	_____
ADDRESS:	_____
REASON:	_____ _____ _____
SIGNED:	DATE: _____
AUTHORISED SIGNATORY	
SECTION B (to be completed by Finance Department)	
BALANCE OF FUND BEFORE APPROVAL: _____	
VERIFIED BY:	DATE: _____
EXPENDITURE AUTHORISED BY:	DATE: _____

APPENDIX F

VAT EXEMPTION CERTIFICATE

I hereby certify that the goods to which this order relates is being purchased with the funds of:

Cwm Taf NHS General Charitable Fund

and/or with voluntary contributions donated by the public and will be donated to (Name of Hospital):

.....

Which I believe are:

medical equipment ☐ sterilising equipment ☐

scientific equipment ☐ laboratory equipment ☐

computer equipment ☐ refrigeration equipment ☐

video equipment ☐

parts or accessories of the equipment indicated above ☐

repairs or maintenance of the equipment indicated above ☐

For use solely in: medical research, diagnosis, training or treatment.

I have read the guidance in the Customs and Excise VAT Notice 701/6 and apply for zero-rating of the supply under Group 15, items 5 or 6 of the zero rate Schedule to the VAT Act 1994.

Signed:

Trustee.....(Status in Charity)

Date:

Access to Charitable funds

Delegated authority	Approve expenditure from charitable funds
(i) Approval and setting up of designated fund signatories for new funds.	(i) Director of Finance
(ii) Approval of changes to fund signatories	(ii) Head of Finance/Assistant Director of Finance
All expenditure requests for Charitable funds	To be submitted to Senior Finance Officer - Charitable Funds for initial review and subject to confirmation that sufficient funds are available
Up to £5,000¹	Designated fund signatories (must be Head of Department or equivalent)
Up to £15k¹	Directorate Manager
Up to £30k¹	Care Group Director / Deputy COO or Relevant Director
Up to £50k¹	Executive Director
Over £50k or Contentious expenditure	Charitable Funds Committee

¹ Contentious expenditure will require approval by Charitable Fund Committee - “contentious” refers to the appropriateness of the expenditure either due to its nature or its compatibility with fund objectives and will be determined by the Senior Finance Officer - Charitable Funds during initial review.



Agenda Item

2.2.1

Audit & Risk Committee

Audit & Risk Committee Annual Cycle of Business

Dyddiad y Cyfarfod / Date of Meeting	17/12/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Kathrine Davies, Corporate Governance Manager
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance/Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	

1. Situation /Background

- 1.1 The Audit & Risk Committee should, on annual basis, receive a Cycle of Business which identifies the reports which will be regularly presented for consideration. The annual cycle is one of the key components in ensuring that the Committee is effectively carrying out its role.
- 1.2 The Cycle of Business covers the period 1 January 2024 to 31 December 2024.
- 1.3 Any changes made to the Annual Cycle of Business since the last meeting have been identified in red.

2. Specific Matters for Consideration

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

3. Key Risks / Matters for Escalation

- 3.1 Please refer to **Appendix 1** – Audit & Risk Committee Cycle of Business for further detail. Any changes have been identified in red.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUEB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM /Link to CTMUEB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	Learning, Improvement & Research
	If more than one applies please list below:



Dolen i Feysydd Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /</i> Link to Domains of Quality <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	Safe	
	If more than one applies please list below:	
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable	
	If more than one applies please list below:	
Impact Assessment		
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not applicable for this report
Cydraddoldeb a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /</i> Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: Not applicable for this report
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau <i>(Pobl /Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 The Audit & Risk Committee are asked to **NOTE** the Annual Cycle of Business.

6. Next Steps

6.1 There are no next steps required.

Audit & Risk Committee

Cycle of Business (1st January 2024 – 31st December 2024)

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

The Cycle of Business covers the period 1st January 2024 to 31st December 2024.

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

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

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

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

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

Audit & Risk Committee Cycle of Business (1st January 2024 – 31st December 2024)

Item of Business	Executive Lead	Reporting period	Jan 2024	Feb 2024	Mar 2024	April 2024	May 2024	June 2024	July 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024
Consent Agenda														
Minutes of the previous Board Meeting	Director of Corporate Governance	All Regular Meetings		R		R		R		R		R		R
Audit & Risk Committee Annual Cycle of Business	Director of Corporate Governance	All Regular Meetings		R		R		R		R		R		R
Committee Forward Work Programme	Director of Corporate Governance	All Regular Meetings		R		R		R		R		R		R
Audit & Risk Committee Annual Report	Director of Corporate Governance	Annually								R				
Audit & Risk Committee Annual Self-Assessment	Director of Corporate Governance	Annually				R								
Audit & Risk Committee Terms of Reference	Director of Corporate Governance	Annually								R				
Declarations of Interest and Gifts & Hospitality Report	Director of Corporate Governance	Quarterly				R				R				R
National Clinical Audit Annual Plan	Medical Director	Annually						R						
Governance														
Action Log	Director of Corporate Governance	All Regular Meetings		R		R		R		R		R		R
Annual Financial Accounts	Director of Finance	Annually						R Draft	R Final					
Accountability Report (Including the Governance Statement)	Director of Corporate Governance	Annually						R Draft	R Final					
Annual Review of the Risk Management Strategy / Board Assurance Framework	Director of Corporate Governance	Annually				R								
Sustaining our Future														
Losses & Special Payments Report	Director of Finance	Quarterly		R				R		R				R
Procurements & Scheme of Delegation Report	Director of Finance	All Regular meetings		R		R		R		R		R		R

Item of Business	Executive Lead	Reporting period	Jan 2024	Feb 2024	Mar 2024	April 2024	May 2024	June 2024	July 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024
Local Counter Fraud Report	Director of Finance	All Regular Meetings		R		R		R		R		R		R
Counter Fraud Annual Report	Head of Local Counter Fraud	Annually				R								
Counter Fraud Annual Self Review	Head of Local Counter Fraud	Annually				R								
Counter Fraud Draft Work plan	Head of Local Counter Fraud	Annually				R								
Post Payment Verification Annual Report	Post Payment Verification Manager	Annually				R								
Post Payment Verification Mid-Year Update	Post Payment Verification Manager	Annually										R		
Improving Care														
Audit Recommendations Tracker	Director of Corporate Governance	All regular meetings		R		R		R		R		R		R
Organisational Risk Register	Director of Corporate Governance	All regular meetings		R		R		R		R		R		R
Consultant Job Planning	Medical Director	Bi-Annually				R						R		
Medical Rostering	Medical Director	Bi-Annually				R						R		
Internal Audit Progress Report	Head of Internal Audit	All Regular Meetings		R		R		R		R		R		R
Internal Audit Annual Audit Plan	Head of Internal Audit	Annually				R								
Internal Audit Reviews	Head of Internal Audit	All regular meetings		R		R		R		R		R		R
Head of Internal Audit Opinion and Annual Report	Head of Internal Audit	Annually						R						
Audit & Risk Committee Update	Audit Wales	All regular meetings		R		R		R		R		R		R
Audit Wales Review Reports (as relevant)	Audit Wales	All regular meetings		R		R		R		R		R		R
Audit Wales Annual Audit Report	Audit Wales	Annually				R								
Audit Wales Audit Plan	Audit Wales	Annually				R								

Item of Business	Executive Lead	Reporting period	Jan 2024	Feb 2024	Mar 2024	April 2024	May 2024	June 2024	July 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024
Audit Wales Audit of the Financial Statements (ISA 260) Report (Including the letter of representation and Audit Opinion)	Audit Wales	Annually						℞						
Structured Assessment	Audit Wales	Annually				℞								
Audit of Financial Statements Addendum Report (if required)	Audit Wales	Annually										℞		
Hosted Bodies														
JCC Internal Audit Recommendations Tracker	JCC Director of Finance	All regular meetings		℞		℞		℞		℞		℞		℞
JCC Corporate Risk Assurance Framework including the risk register.	JCC Committee Secretary/Head of Corporate Services	All regular meetings		℞		℞		℞		℞		℞		℞
JCC Governance Statement	JCC Committee Secretary/Head of Corporate Services	Annually						℞						
JCC Annual Accounts	JCC	Annually						℞						
National Imaging Academy for Wales Hosted Compliance Statement.	Director of the National Imaging Academy	Annually						℞						
National Imaging Academy for Wales Risk Register	Director of the National Imaging Academy	Bi-Annually		℞								℞		



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Agenda Item 2.2.2

AUDIT & RISK COMMITTEE – FORWARD WORK PLAN

Origin of Request	Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)	Item Title	Lead Officer	Intended Meeting Date
Action from October 24 meeting (CLOSED) In Committee Meeting	Additional Item	Outcome of Committee Referral to People & Culture Committee – Recruitment Process Risk Assurance Report	Assistant Director of People Policy and Compliance/Local Counter Fraud Officer	17 December 2024
Deferred from October 2024 meeting	Deferred IA Item	PCH Management Actions – Follow Up	Internal Audit	17 December 2024
Deferred from October 2024 meeting	Deferred IA Item	Energy Management	Internal Audit	17 December 2024
Requested via IA	IA Item	Additional Medical Pay	Internal Audit	17 December 2024
Requested via IA	IA Item	Charitable Funds	Internal Audit	17 December 2024
Deferred from October 2024 Meeting	IA Item	Energy Management	Internal Audit	17 December 2024
Requested via Audit Wales	Audit Wales Item	Primary Care – Follow Up Review	Audit Wales	17 December 2024



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Deferred from October Meeting	Audit Wales Item	Cost Savings Review – Final Management Response	Audit Wales	17 December 2024
Deferred from December 2024 Meeting	Deferred IA Item	Medical Jon Planning	Internal Audit	13 February 2025
Deferred from December 2024 Meeting	Deferred IA Item	Capital Systems	Internal Audit	13 February 2025
Deferred from December 2024 Meeting	Deferred IA Item	Regional Integration Fund	Internal Audit	13 February 2025
Deferred from December 2024 Meeting	Deferred IA Item	Internal Audit Review – PCH Supply Chain Partner	Internal Audit	13 February 2025
Deferred from December 2024 Meeting	Deferred IA Item	Financial Savings - Follow Up	Internal Audit	13 February 2025
Deferred from December 2024 Meeting	Deferred IA Item	SLA Arrangements – Follow Up	Internal Audit	13 February 2025
Deferred from October 2024 Meeting	Deferred IA Item	Vaccination Policy Implementation	Internal Audit	13 February 2025
Deferred from October 2024 Meeting	Deferred IA Item	Performance Management 4 Hour Target – follow Up	Internal Audit	13 February 2025
Deferred from October 2024 Meeting	Deferred IA Item	New PDR Process	Internal Audit	13 February 2025



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Requested via IA	IA Item	Cancer Process Tracking	Internal Audit	13 February 2025
Requested via IA Audit	IA Item	Elective Care Criteria	Internal Audit	13 February 2025
Requested via IA Audit	IA Item	End of Life Care Management	Internal Audit	13 February 2025
Requested via IA Audit	IA Item	Ensuring Quality when Commissioning Care Services	Internal Audit	13 February 2025
Requested via IA Audit	IA Item	Core Financial Systems	Internal Audit	13 February 2025
Requested via IA Audit	IA Item	Stroke	Internal Audit	13 February 2025
Requested via IA Audit	IA Item	Clinical Coding	Internal Audit	13 February 2025
Requested via IA Audit	IA Item	Follow Up - INNU	Internal Audit	13 February 2025
Requested via Audit Wales	Audit Wales Item	Audit Wales Annual Audit Report	Audit Wales	13 February 2025
Requested via Audit Wales	Audit Wales Item	Structured Assessment	Audit Wales	13 February 2025



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Requested via Audit Wales	Audit Wales Item	Planned Care	Audit Wales	13 February 2025
Requested via Audit Wales	Audit Wales Item	Urgent & Emergency Care Review	Audit Wales	13 February 2025
Requested via Audit Wales	Audit Wales Item	Digital Transformation National Review	Audit Wales	15 May 2025
Requested via IA Audit	IA Item	Digital Benefits Realisation	Internal Audit	15 May 2025
Requested via IA Audit	IA Item	Continuing Health Care	Internal Audit	15 May 2025
Requested via IA Audit	IA Item	Discharge Planning	Internal Audit	15 May 2025
Requested via IA Audit	IA Item	Digital Benefits Realisation	Internal Audit	15 May 2025
Requested via IA Audit	IA Item	Primary Care	Internal Audit	15 May 2025
Requested via IA Audit	IA Item	Service User Experience	Internal Audit	15 May 2025
Requested via IA Audit	IA Item	Welsh Risk Pool	Internal Audit	15 May 2025



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Agenda Item 2.2.2

Requested via IA Audit	IA Item	Risk Management	Internal Audit	15 May 2025

COMPLETED ITEMS

Annual Item (deferred from August 24 meeting)(CLOSED ITEM)	Audit Wales	Audit of Financial Statements Addendum Report	Audit Wales	17 October 2024 - Completed
Deferred from August 2024 meeting	Deferred Item	Internal Audit Review – Quality Framework	Internal Audit	17 October 2024 - Completed
Deferred from August (CLOSED) In Committee Meeting	Deferred Item	Financial Control Procedure – Medical Variable Pay	Medical Director	17 October 2024 - Completed
Deferred from August 2024 Meeting	Deferred Item	Consultant Job Planning	Medical Director	17 October 2024 - Completed
Deferred from June 2024 meeting	Deferred Item	Internal Audit Review – Reasonable Offer Follow Up	Internal Audit	17 October 2024 - Completed
Deferred from June & August 2024 Meetings	IA Item	Patient Pathway Follow Up	Internal Audit	17 October 2024 - Completed



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Agenda Item 2.2.2

Deferred from August 2024 meeting	Deferred Item	Information Provision – Intelligence Led Organisation	Internal Audit	17 October 2024 - Completed
Deferred from August 2024 meeting	Deferred Item	Facilities Governance Arrangements	Internal Audit	17 October 2024 – Completed
Proposed approach suggested by the Director of Corporate Governance	Additional Item	Endoscopy JAG Accreditation Closure report - Progress and Associated Risk Mitigation	Chief Operating Officer	15 August 2024 - Completed
Requested via email	Audit Wales Item	MIU follow Up Report	Audit Wales	15 August 2024 – Completed
Deferred from June 2024 meeting	Deferred Item	Internal Audit Review – PCH Key Project Objectives	Internal Audit	15 August 2024 – Completed



Agenda Item

2.2.3

Audit & Risk Committee

Declarations of Interest & Gifts, Hospitality and Sponsorship Register

Dyddiad y Cyfarfod / Date of Meeting	17/12/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Emma Walters, Head of Corporate Governance & Board Business
Cyflwynydd yr Adroddiad / Report Presenter	Cally Hamblyn, Assistant Director of Governance & Risk
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Executive Leadership Group	02/12/2024	PENDING

Acronyms / Glossary of Terms	



1. Situation /Background

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

2. Specific Matters for Consideration

- 2.1 The form in the Standards of Behaviour Framework policy or online via SharePoint should be used to declare interests and/or seek approval for receiving hospitality/sponsorship/gifts and this should help or prevent the omission of crucial information that the authorising officer requires making an informed decision on approval or rejection. The authorised signatories should also be scrutinising the declarations prior to authorisation, in order to ensure the correct information is captured on the form before it is submitted to the Corporate Governance Team.
- 2.2 In May 2024, all Board Members were formally asked to review and update, where appropriate, their declarations for the new financial year 2024-2025. A response from all Board Members was received and is captured in Appendix 1. **In November 2024, Board Members were asked to revisit their declarations and any amendments received have been captured in the register as appropriate.**
- 2.3 A targeted email was also issued by the Corporate Governance Team in May 2024 to 548 members of staff, which included all Consultants, Very Senior Managers and Staff at Band 8d and Band 9). It should be noted that some of the returns received to date and captured in Appendix 1 are from individuals that did not receive the targeted email as there is a responsibility for all employees to declare interests. This exercise will be repeated in May 2025 for the 2025-2026 reporting period.
- 2.4 As at 30th September 2024:
- 24 declarations of interest received from Board Members (Independent Members, Associate Members, Executive Directors and members of the wider Executive Team). Please see Appendix 1 – Sheet 1 – "Board Members".
 - 244 declarations of interest received from staff (excluding Board Members / Executive Team colleagues). Please see Appendix 1 – Sheet 2 – "Non Board Members".
 - To date there have been two declarations of gifts, hospitality and sponsorship received – please see Appendix 2. It should be noted that some colleagues capture this information in their declaration of interest form.
- 2.5 Previous advice received from Information Governance is that any information published on the register, which is then published in the public domain, excludes first and last names and includes job titles only (for non-



Board Members). This has been actioned in terms of the appendices to this report.

3. Key Risks / Matters for Escalation

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

4. Assessment

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

Impact Assessment		
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
		Not required for this report



Have you undertaken a Quality Impact Assessment Screening?		
Cydraddoldeb a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /</i> Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	Yes: ☐ Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	No: ☒ If no, please include rationale below: Not required for this report
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau <i>(Pobl / Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

- 5.1 The Audit & Risk Committee are asked to **NOTE** the entries on the registers included at Appendix 1 and Appendix 2.

6. Next Steps

- 6.1 The Board Members register of interest will be published on the Health Boards public facing website.

Targeted DOI Request Sent	Full Name	Designation	Date DOI Approved	Nature of Declaration	Period of Involvement "From"	Period of Involvement "to"	Financial Benefits /Benefits in Kind	End of Financial Year Check	Annual Eligibility Form and Indemnity Check	Notes		
New Starter Request	Jonathan Morgan	Chair	30/03/2023 Hard Copy Submission	Director of Insight Wales Consulting Limited (100% Share Ownership: Insight Wales Consulting Limited)	2012	Present	Dividend	Confirmed via O365 Forms 28.2.2024 that the declaration of interest returned for the period 2023-2024 remains up to date and there are no changes required.	Confirmed continued eligibility via O365 Forms 28.2.2024. No issues identified.			
				Associate with Practice Solutions Limited	2011	Present	Consultant fee					
				Wife employed as a Welsh Government Lawyer	2010	Present	Salaried					
09.05.2023	Dom Hurford	Executive Medical Director	06/11/2023 Hard Copy Submission	Nil Interests Declared	Not applicable	Not applicable	Not applicable	Confirmed via O365 Forms 21.2.2024 that the declaration of interest returned for the period 2023-2024 remains up to date and there are no changes required	Confirmed continued eligibility via O365 Forms 27.2.2024. No issues identified.			
09.05.2023	Paul Mears	Chief Executive	09/05/2023 Online Submission	Director of Drake Consultancy Services (dormant company)	May 2018-present Amendment 17.11.2023 - declaration updated to confirm company dissolved 1st October 2023.		Nil	Confirmed via O365 forms 21.2.2024 - No longer interest as a Director of Drake Consultancy Services Ltd as the company has been dissolved on 10/10/23 - this had been noted but date from 1.10.2023. All other interests remain up to date.	Confirmed continued eligibility via O365 Forms 21.2.2024. No issues identified.			
			Email amendment received 17.11.2023.	Member of Advisory Board, Awen Cultural Trust	sep-22	Present	Nil					
				Observer Member, Board of Life Sciences Hub Wales	jun-22	Present	Nil					
09.05.2023	Dilys Jouvenat	Independent Member (Third Sector)	10/05/2023 Online Submission	Chair of the Rhondda Cynon Taff Citizens Advice	jun-15	26th November 2023	Not applicable	O365 Form returned 21.2.2024 confirmed role change at the RCT Citizens Advice.	Confirmed continued eligibility via O365 Forms 27.2.2024. No issues identified.	Companies House registered as a Director when Dilys became a Trustee in these positions.		
				Trustee Newport Citizens Advice	2 Years	Present	Not applicable					
				Trustee South East Wales Citizens Advice	1 Year	Present	Not applicable					
				Trustee Interlink	6 months	Present	Not applicable					
				Trustee Rhondda Cynon Taff Citizens Advice	27th November 2023	Present	Not applicable					
09.05.2023	Lauren Edwards	Executive Director of Therapies & Health Science	10/05/2023 Online Submission	Nil Interests Declared	Not applicable	Not applicable	Not applicable	Confirmed via O365 Forms 21.2.2024 that the declaration of interest returned for the period 2023-2024 remains up to date and there are no changes required	Confirmed continued eligibility via O365 Forms 21.2.2024. No issues identified.			
			21/08/2023 - In Year Change (Online Submission)	Trustee and Director of Royal College of Speech and Language Therapists	Ongoing	Ongoing	Nil					
45055	Linda Prosser	Executive Director of Strategy & Transformation	12/05/2023 (Online Submission)	Director Altyn Tepe Ltd	Since 2019	Ongoing	Yes	Confirmed via email 26.2.2024 that Director Altyn Tepe Ltd remains unchanged however added two entries relating to family members.	Confirmed continued eligibility via O365 Forms 27.2.2024. No issues identified.			
			Amendment email 26.2.2024	Son (1) Chief Operating Officer Salisbury NHS Foundation Trust	Since Feb 2024 (previously RUH Bath)	Ongoing	Yes					
				Son (2) Service manager (Urology and Ophthalmology) Royal United Hospital Bath	Since 2021	Ongoing	Yes					
45055	Carolyn Donoghue	Independent Member (University)	18/05/2023 (Online Submission)	Welsh Wound Innovation Centre - Chair	9 Years	Ongoing	Payment for each Board meeting	Confirmed via O365 Forms 26.2.2024 that the declaration of interest returned for the period 2023-2024 remains up to date and there are no changes required.	Confirmed continued eligibility via O365 Forms 27.2.2024. No issues identified.	Companies House reference Carolyn Donoghue as a Director. It has been confirmed via email with Carolyn on the 28th March that she has been a Director of WWIC since 2014 and became Chair in 2020.		
				Independent Governor University West of England	2 years	Ongoing	None					
				Magistrate - Newport Bench	3 Years	Ongoing	None					
				Chair South East Wales Student Mental Health Partnership	3 Years	Ongoing	Consultancy Fee-Hourly					
				Senior Professional Fellow - Cardiff University	3 Years	Ongoing	None					
				Son (ED) is employed by Seating Matters a company which supplies clinical seating to healthcare organisations. I am not involved in any way	1 Year	Not applicable	Not applicable					
			21/11/2023 - Update to current DOI noted. Additional Entry received via email notification	Appointed as Independent Member on the Welsh Health Specialised Services Committee (WHSSC)	1st July 2023	30th June 2025 31st March 2024	Remunerated	Confirmed via O365 Forms 26.2.2024 IM was appointed as an independent member of the Welsh Health Specialised Services Committee in June 2023. Anticipates this role will end on 31st March 2024				
09.05.2023	Hywel Daniel	Executive Director for People	22/05/2023 (Online Submission)	Nil Interests Declared	Not applicable	Not applicable	Not applicable	Confirmed via O365 Forms 23.2.2024 that the declaration of interest returned for the period 2023-2024 remains up to date and there are no changes required	Confirmed continued eligibility via O365 Forms 23.2.2024. No issues identified.			
09.05.2023	Jayne Sadgrove (Term ended 31.8.2023)	Vice Chair	23/05/2023 (Online Submission) Confirmed 31.10.2023 that declaration did not change at date of term ending.	Director, Cardiff Union Services Ltd	2019	Ongoing	Voluntary/Unremunerated	Confirmed 31.10.2023 that declaration did not change at date of term ending.				
				Vice Chair of Trustee Board , Cardiff University Students Union	2019	Ongoing	Voluntary/Unremunerated					
				Director, home study courses ltd	1994	Ongoing	None stated					
				Director, Keyford Properties Ltd	2023	Ongoing	50 %					
				Senior Professional Fellow, Cardiff University	2019	Ongoing	Honorary Title					
				IM (designate) HEIW	2023	Ongoing	Remunerated					
				Spouse: Director, home study courses ltd	1994	Ongoing	50 %					
				Director, Keyford Properties Ltd	2023							

Targeted DOI Request Sent	Full Name	Designation	Date DOI Approved	Nature of Declaration	Period of Involvement "From"	Period of Involvement "to"	Financial Benefits /Benefits in Kind	End of Financial Year Check	Annual Eligibility Form and Indemnity Check	Notes
09.05.2023	Nicola Milligan	Independent Member (Trade Union)	12/07/2023 (Online Submission)	Royal College Of Nursing Wales Board member	Term completes December 2024	Term ends December 2024	Nil	Confirmed via O365 Forms 27.2.2024 that the declaration of interest returned for the period 2023-2024 remains up to date and there are no changes required.	Confirmed continued eligibility via O365 Forms 27.2.2024. No issues identified.	
09.05.2023	Gregory Padmore-Dix	Executive Director of Nursung, Midwifery & Patient Care / Deputy CEO	12/07/2023 (Online Submission)	Trustee - Royal College of Nursing Foundation	September 2021	Ongoing	Voluntary role, travel / accommodation paid for by the charity	Confirmed via O365 Forms 27.2.2024 that the declaration of interest returned for the period 2023-2024 remains up to date and there are no changes required.	Confirmed continued eligibility via O365 Forms 27.2.2024. No issues identified.	Companies House reference Greg Dix commencing at Director at WWIC in April 2022. Email confirmation received 28.3.2024 confirms the following: That Greg Dix attended the WWIC Board meeting on 20/1/22 and were the nominated CTM representative. The notification however, in terms of the Director changeover and registration at Companies House, occurred in April 2022.
				Board Director - Welsh Wound Innovation Centre	jan-22	Ongoing	No financial or benefits in kind			
				Visiting Professor, University of South Wales	2020	Ongoing	Nil			
				Associate Professor, University of Plymouth	2015	Ongoing	Nil			
09.05.2023	Gethin Hughes	Chief Operating Officer	04/08/2023 Hard Copy Form	School Governor and Trustee Ditcham Park School	Since March 2015 (Confirmed via email 27th March 2024)	Ongoing	Not applicable	Confirmed via O365 Forms 5.3.2024 that the declaration of interest returned for the period 2023-2024 remains up to date and there are no changes required.	Confirmed continued eligibility via O365 Forms 5.3.2024. No issues identified.	Companies house registered as a director.
				Wife is Parliamentary Assistant to Natasha Ashgar MS	From 7th August 2023	Email update from Gethin Hughes 27th March 2024 confirming that this can be removed as wife no longer works for Natasha Ashgar	-			
09.05.2023	Sally May	Executive Director of Finance	04/08/2023 Hard Copy Form	Cousin is Director of DECIPHER; Professor in Social Interventions and Health, Cardiff University	Ongoing	Ongoing	Salaried	Office 365 form received 13.3.2024 confirmed an additional entry for daughter.	Confirmed continued eligibility via O365 Forms 5.3.2024. No issues identified.	
				Ongoing Salaried position						
				Cousin is Regional Sales Manager South West Arthrex Ltd Ongoing Salaried position	Ongoing	Ongoing	Salaried			
			Cousin is Partner, Knight Frank Project and Building Consultancy Ongoing Salaried position	Ongoing	Ongoing	Salaried				
			Office 365 Form 13.3.2024	Daughter appointed to Lead Physiologist role for In Health South West Community Diagnostic Centre	Ongoing	Ongoing	Salaried			
09.05.2023	Stuart Morris	Director of Digital	04/08/2023 Hard Copy Form	Chair of Governors for Penyfai Primary School, Bridgend	2017	Ongoing	Nil	Confirmed continued eligibility via O365 Forms 4.3.2024. No issues identified.	Not applicable.	
09.05.2023	Lisa Curtis-Jones	Associate Member - Third Sector	17/08/2023 Hard Copy Form	Statutory Director of Social Services in MerthyrTydfil	apr-15	Ongoing	Member of the regional partnership board (RPB) – RIF funding to local authorities through RPB.	Confirmed via O365 Forms 21.2.2024 that the declaration of interest returned for the period 2023-2024 remains up to date and there are no changes required.	Confirmed continued eligibility via O365 Forms 27.2.2024. No issues identified.	
09.05.2023	Mel Jehu	Independent Member (Community)	17/08/2023 Hard Copy Form	Independent Member (Vice Chair) South Wales Police Crime Panel.	2012	Ongoing	Attendance Fee	Confirmed via O365 Forms 28.2.2024 that the declaration of interest returned for the period 2023-2024 remains up to date and there are no changes required.	Term ends 31.3.2024.	
				Trustee, Safe Merthyr Tydfil.	2008	Ongoing	Voluntary no financial gain			
				Independent Member - Merthyr Tydfil County Borough Council Standards Committee	24th February 2022	Ongoing	Attendance Fee	Mel Jehu's term comes to an end with CTMUHB on the 31st March so confirmed as accurate at point of leaving.		
				Deputy Lord Lieutenant for Mid Glamorgan	sep-21	Ongoing	No remuneration or benefits in kind			
				Spouse is employed in CTMUHB in a part time role as Lymphoedema Nurse since 2012 and prior to that Breast Care Specialist Nurse	2012	Ongoing	Not applicable			
09.05.2023	Patsy Roseblade	Independent Member (Finance & Audit)	17/08/2023 Hard Copy Form	Non Executive Director Tennis Wales	2020	Ongoing	Voluntary	Confirmed via O365 Forms 12.3.2024 that the declaration of interest returned for the period 2023-2024 remains up to date and there are no changes required.	Confirmed continued eligibility via O365 Forms 12.3.2024. No issues identified.	
25.10.2023	Philip Daniels	Interim Executive Director of Public Health	30.10.2023 Hard copy form	Board Member / Welsh Chair - Faculty of Public Health	jun-23	Ongoing	Nil	Confirmed via O365 Forms 24.2.2024 that the declaration of	Confirmed continued eligibility via O365 Forms	

Targeted DOI Request Sent	Full Name	Designation	Date DOI Approved	Nature of Declaration	Period of Involvement "From"	Period of Involvement "to"	Financial Benefits /Benefits in Kind	End of Financial Year Check	Annual Eligibility Form and Indemnity Check	Notes
				Partner is Director - The Performance Centres	2011	Ongoing	Owner / Chief Executive	interest returned for the period 2023-2024 remains up to date and there are no changes required.	24.2.2024. No issues identified.	
09.05.2023	James Hehir (Term ended 30.09.2023)	Independent Member (Legal)	Confirmed no change to declarations on term ending 30.09.2023. Email dated 27.10.2023 on file.	Non-Executive Director, Llandarcy Park Ltd.	14.06.2018	Present	None	Confirmed no change to declarations on term ending 30.09.2023. Email dated 27.10.2023 on file.		
				Trustee Neath Port Talbot Contact Centre.	01.05.2007	Present	None			
				Vice Chairman, Neath Port Talbot Group of FE Colleges.	29.03.2006	Present	None			
				Solicitor of the Supreme Court.	14.02.1984	31/8/2016.	None			
				Honorary Vice President, West Glamorgan Magistrates Association.	16.10.2017	life time appointment.	None			
				Associate member, magistrates Association.	01.06.1993	Present	None			
				Patron Neath YMCA.	apr-15	Present	None			
09.05.2023	Ian Wells	Independent Member (Digital)	8/11/2023 Hard Copy Form	Director of the Wales Institute of Digital Information which undertakes research with Digital Health and Care Wales/NHS Wales Informatics Service in collaboration of University of Wales Trinity St David and the University of Wales. Research projects also undertaken for various health boards including CTM	3 days per week from 1/2/20	Present	Nil financial transactions or benefits in kind.	Confirmed via O365 Forms 21.2.2024 that the declaration of interest returned for the period 2023-2024 remains up to date and there are no changes required.	Confirmed continued eligibility via O365 Forms 21.2.2024. No issues identified.	
New Starter Request	Gareth Watts	Director of Corporate Governance / Board Secretary	13/09/2023 Hard Copy Form	Board Member of Coleg Gwent (Further Education College) Since 2015 onwards	2015	Present	Voluntary	Confirmed via O365 Form return that amendment made on 28 February to ensure that voluntary is against the Coleg Gwent role and not the Gwent Police role for which a daily rate is received.	Not applicable.	
				Voluntary Member of the Joint Audit Committee of Gwent Police and the Police and Crime Commissioner for Gwent	2022	Present	Daily rate for meeting attendance and preparation			
09.05.2023	Geraint Hopkins	Independent Member (Local Authority)	, Saf	Llanharan Community Development Project Limited	10 years +	Present	Not applicable	Confirmed via O365 Forms 14.3.2024 that the declaration of interest returned for the period 2023-2024 remains up to date and there are no changes required.	Confirmed continued eligibility via O365 Forms 27.2.2024. No issues identified.	
				Elected Member, Rhondda Cynon Taff County Borough Council	19 years	Present	Not applicable			
09.05.2023	Lynda Thomas	Independent Member (Corporate Business)	8/11/2023 Hard Copy Form	Chair of Norfolk Community Health and Care NHS Trust.	Since February 2023	Present	Remunerated.	Confirmed via O365 Forms 13.3.2024 that the declaration of interest returned for the period 2023-2024 remains up to date and there are no changes required.	Confirmed continued eligibility via O365 Forms 13.3.2024. No issues identified. Although identified that she has been been Chair of Norfolk Community Health and Care NHS since 01/02/2023	Companies house have registered Lynda Thomas as a Director from February 2023. Confirmed via email with Lynda on the 28.3.2024 that she is a Trustee and commenced this role in January 2023.
				Trustee of Age UK	jan-23	jan-26	None			
09.05.2023	Anne Morris	Associate Member - Chair of SRG	7/11/2023 Hard Copy Form	Nil interests declared.	Not applicable	Not applicable	Not applicable	Confirmed via O365 Forms 21.2.2024 that the declaration of interest returned for the period 2023-2024 remains up to date and there are no changes required.	Confirmed continued eligibility via O365 Forms 27.2.2024. No issues identified.	
09.05.2023	Sally Bolt	Associate Member - Chair of CAG	7/11/2023 Hard Copy Form	Nil interests declared.	Not applicable	Not applicable	Not applicable	Confirmed via O365 Forms 21.2.2024 that the declaration of interest returned for the period 2023-2024 remains up to date and there are no changes required.	Not applicable	
New Starter - November 2023	Kath Palmer	Vice chair	23/11/2023 Hard Copy Form	Natural Resources Wales – Board member and Chair of Audit, Risk and Assurance committee.	feb-23	Present	Paid Position	Confirmed via O365 Forms 21.2.2024 that the declaration of interest returned for the period 2023-2024 remains up to date and there are no changes required.	Confirmed continued eligibility via O365 Forms 21.2.2024. No issues identified.	
				Interim CEO Cynon Taf Community Housing Group which has a Care and Repair subsidiary and Down to Zero subsidiary.	sep-23	November 2023 - with a handover period between November and December 2023. Handover with Cynon Taf Housing Association finished 8.12.2023.	Paid Position			
				Trustee of Crisis (national homelessness charity) and chair of the client services governance committee.	des-22	Present	Voluntary (Expenses Paid)			
				Member of the Residential Decarbonisation Implementation Group for Welsh Government.	sep-19	Present	Voluntary			
New Starter 2.1.2024	Helen Lentle	Independent Member - Legal	15/01/2024 Hard Copy Form	Non-Executive Director: CISWO (the Coal Industry Trustee: Dyslecsia Cymru/Wales Dyslexia Charity	Since September 2022 Since August 2022	Present Present	Voluntary role - no salary Voluntary role - no salary	Confirmed via O365 Forms 3.3.2024 that the declaration of interest	Confirmed continued eligibility via O365 Forms	Email confirmation 2.4.2024 from Helen Lentle advising

Date Approved	Name	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
04.04.2023	Isabelle Williams	Acute Clinical Lead Dietician	Nutrition and Dietetics	Work as an associate lecturer for Cardiff Metropolitan University on an ad hoc basis.	Applied for the role in March 2022 but first paid session was 27th March 2023.	Paid £50 per session.	No	
06.04.2023	Maria Cole	Department Professional Lead	Adult Weight Management Service	Nil Interests Declared	Not applicable	Not applicable	No	
11.04.2023	Melody Cranbourne-Rosser	Senior Applied Psychologist	Psychology	Nil Interests Declared	Not applicable	Not applicable	No	
11.04.2023	Matthew Butt	Chief of Staff	Executive Office	Nil Interests Declared	Not applicable	Not applicable	No	
12.04.2023	Melanie Russ	Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
12.04.2023	Terri-Louise Dalton	Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	Mahmoud Abdel-dayem	Consultant Surgeon	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	Namir Al-Mokhtar	Consultant Radiologist	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	Michelle Richardson	Consultant Community Paediatrician	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	Marc Aneurin Morgan Penny	Director of Improvement and Innovation	Improvement and Innovation	Trustee and Board Secretary Brynawel Rehab Llanharry Rd, Llanharan, Pontyclun CF72 9R Independent Member St John Ambulance CymruPriory House, Beignon Close, Ocean Way, Cardiff. Spouse/Partner/Close Family or Friend: Independent Member St John Ambulance Cymru Priory House, Beignon Close, Ocean Way, Cardiff.	Since 2021 Since 2022 Since 2015	Not applicable	No	
17.04.2023	Peter M Neville	Consultant Gastroenterologist	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	David PHILLIP Anthony Wardle	Consultant Radiologist Director of NIAW	Medical	Part-time employment from May 2023: Deputy Clinical Lead, Musculoskeletal Radiology, Telemedicine Clinic Private Practice: Cobalt Health Care & Nuffield-Vale Healthcare. Wardle Consulting Partnership Spouse/Partner/Close Family or Friend: Board Member, Techniquet Board Member, Theatr Iolo	Telemedicine Clinic since July 2023 Nuffield Private Practice since 2015 Cobalt Private Practice since 2009. 2011 2017 & 2020 respectively	TMC - salaried position Private Practice, paid on a patient case basis. See Personal Entries Nil	No	
17.04.2023	Dr Susan Margaret Jeal	Locum Consultant Psychiatrist	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	Karen Winder	Assistant Director Informatics	Digital	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	Ana Llewellyn	Nurse Director	Mental Health & Learning Disabilities Primary Care and Community Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	Eleanor Morris	Consultant Radiologist	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	Humphre Osarenren Okuonghae	Consultant Paediatrician	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	Dr Omar Alex Pemberton	Consultant in Anaesthetics & Intensive Care	Medical	President of the Society of Anaesthetists of Wales	16 March 2023 to present	No Financial Involvement	No	
17.04.2023	Sarah Jane Smith	Consultant Histopathologist	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	Cally Hamblyn	Assistant Director Governance & Risk	Corporate Governance	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	Sallie Davies	Deputy Medical Director	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	Mridul Biswas	Consultant	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	Rani Nagrani	Consultant Gynaecologist	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	Rosie-Marie Louise Cavill	Head of Capital	Capital Planning	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	Lesley Woakes	Deputy Director of Planning	Primary Care	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	Nader Naguib	Consultant Surgeon	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	Nia Meleri Morris	Consultant (CAMHS)	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	Laura McClelland	ICU Consultant - Long Term Locum	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	Catherine Wynne Roberts	Director of Operations	Children & Families Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	Jonathan Hughes	Consultant Anaesthetist	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	Dr Simon Bagguley	Medical Consultant	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	Stephen Marco Sarasin	Medical Director - Planned Care Group	Medical	Director Stephen Sarasin Ltd. 50% Shareholder Stephen Sarasin Ltd. Spouse - 50% Shareholder Stephen Sarasin Ltd.	2014 - Present	Dividends and Expenses	No	
17.04.2023	Linda June Mary Speck	Head of Health Psychology Service	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	Genna Louise Pearson	Medical Secretary	Health Psychology Office	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	Claire Alice Lane	Principal Clinical Psychologist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	Mr S G Shering	Consultant Surgeon	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	Simon Blackburn	Assistant Director of Communications & Engagement	Executive Office	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	Dr Sarah Antcliff	Haematology Consultant	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	David Gwynfor Samuel	Consultant Hepatologist	Medical	Non Executive trustee of Brynawel Rehabilitation Centre	March 2023 - Present	None	No	

Date Approved	Name	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
17.04.2023	Tim Burns	Assistant Director - Capital and Estates	Capital & Estates	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	Victoria Wallace	Deputy Director of Strategy & Partnerships	Strategy & Partnerships	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	Jade Evans	Assistant Psychologist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	Sharon O'Brien	Director of Nursing - Planned Care	Planned Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	Jeyashree Natarajan	Consultant Paediatrician	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	Sian Jenkins	Assistant Finance Director	USC and Children and Families Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	Dr Zedekiah Sibanda	Consultant Community Paediatrician	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	Sue Holroyd	Assistant Director of Finance	Planned Care and DT&S Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	Vedran Curkovic	Locum T&O Consultant	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023	David Jones	Consultant Anaesthetics and Intensive Care	Medical	Community Governor - YGG Aberdare (Primary School)	March 2022- Present	None	No	
				Regional Clinical Lead for Organ Donation (NHS Blood and Transplant)	March 2022- Present	1 PA (NHSBT Funded)		
17.04.2023	Bethany Ranjit	Consultant Psychiatrist: Clinical Service Group Director	Mental Health	Nil Interests Declared	Not applicable	Not applicable	No	
18.04.2023	Erin Roberts	Assistant Psychologist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Volunteer as a telephone Befriender with Age UK	Since November 2021 - present.	None - Volunteer Role.	No	
18.04.2023	Michelle Hurley-Tyers	Assistant Director of OD & Wellbeing	People Services Team	Nil Interests Declared	Not applicable	Not applicable	No	
18.04.2023	Samuel Fishpool	ENT Consultant	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
18.04.2023	Michelle Smalley	Consultant Clinical Psychologist	Medical	Research collaboration with Dr JB's team at the National Centre for Mental Health, Cardiff University	Since April 2022 - ongoing	Not applicable at this time.	No	
				Part of the research team with Dr CL and RESCAPE (Virtual Reality Company providing VR equipment to the hospital as part of two ongoing research projects - SIESTA (looking at VR and improving sleep in staff and VR Ready looking at developing rehab for ITU patients through the medium of VR)	September 2022 - ongoing			
18.04.2023	Kimberley Bell	Critical Care Psychology Team	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
18.04.2023	Dr Gareth David	Paediatric Clinical Psychologist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
18.04.2023	Dr John Amit Benjamin	Consultant Physician	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
18.04.2023	Hannah Wilton	Clinical Director of Pharmacy & Medicines Management	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
18.04.2023	Dr Sinan Eccles	Consultant Respiratory Physician	Medical	Consultant respiratory physician at CTM - 2016 onwards. Lung Health Check clinical lead for the Wales Cancer Network since 2019.	2019 Onwards	None	No	
				Lung Health Check Wales Operational Pilot, for which I am clinical lead, has been financially supported by Novartis, Bristol Myers Squibb, Roche, Tenovus and MSD. My role is paid for exclusively by NHS Wales/Wales Cancer Network.				
				I was previously an affiliated consultant for Respiratory Innovation Wales (2021-22) and have received honoraria for speaking at an educational event from Novartis in 2022. I am a member of the following groups: NICE Expert Advisers Panel UK Lung Cancer Clinical Expert Group Respiratory Health Implementation Group (Wales) British Thoracic Society British Thoracic Oncology Group Welsh Thoracic Society				
				Wife: is Primary Care Cancer Lead for Swansea Bay UHB, and a GP				
18.04.2023	Dr Christopher Hodcroft	Consultant in Acute Medicine	Medical	I have spoken on behalf of Bayer at a medical educational event. I received no personal remuneration but the company has made a donation to the Welsh Acute Physicians' Society for my services.	okt-22	£400 (Paid to WAPS)	No	
18.04.2023	Minesh K R Patel	Consultant Gastroenterologist	Medical	Personal & Spouse / Partner or other Close Family and/or Friend: Director of Minesh Gastro Ltd	nov-22	Salary	No	
18.04.2023	Dawn Howes	Consultant Radiologist	Medical	Nil Interests Declared	Not applicable	Not applicable at this time.	No	
18.04.2023	Carla Dos Santos Gill	Consultant Orthogeriatrics	Medical	Nil Interests Declared	Not applicable	Not applicable at this time.	No	

Date Approved	Name	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
18.04.2023	Daniel Stubbings	Clinical Psychologist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	I hold a part-time position at Cardiff Metropolitan University. I oversee the work of students and research projects.	Ongoing	None	No	
18.04.2023	Bethan Rachel Thomas	Consultant	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
18.04.2023	Dr Clare Wright	Strategic Lead for Employee Experience & Wellbeing	People Services Team	Nil Interests Declared	Not applicable	Not applicable	No	
18.04.2023	Cristina Constantin	Consultant Cardiologist	Medical	Private practice clinic Independent General Practice, Cardiff Gate Running at weekends and during time off or annual leave.	2019-to date	Private income submitted to HMRC (tax return)	No	
18.04.2023	Jonathan Hulbert	Consultant Oral and Maxillofacial Surgeon	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
18.04.2023	Sunil Joseph	Consultant Psychiatrist	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
18.04.2023	Soleen Mohammed	Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
18/04/2023 Hard Copy Form	Suzanne Hardacre	Director of Midwifery & Nursing, Children & Families Care Group	Children & Families Care Group	Spouse is Director of Workforce at NWSSP.	Not applicable	Not applicable	No	
19.04.2023	Dr Bethan Phillips	Clinical Psychologist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Private Practice in Clinical Psychology. Primary School Governor	Ongoing	Payment received for work done	No	
19.04.2023	Nadia Zhurane Hikary-Bhal	Consultant	Medical	Infiniti Healthcare Ltd- this is a private women's health clinic based in Cardiff - Beyond Healthcare Academy Ltd: This company offers teaching, training, medicolegal support and coaching Practising privileges with the Nuffield Health group. Husband is joint director of these two companies Infiniti Healthcare Ltd Beyond Healthcare Academy Ltd Husband has practising privileges at Spire Cardiff.	2013 Onwards 2022 Onwards 2018 Onwards 2013 Onwards 2022 Onwards 2004 Onwards	Not stated	No	
19.04.2023	William Stuart Roy	Consultant T & O	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
19.04.2023	Dr Anthony Gibson	Interim Deputy Medical Director for acute services	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
19.04.2023	Dylan Harris	Consultant in Palliative Medicine	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
19.04.2023	Richard Irons	Consultant EM	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
19/04/2023 & 26/06/2023 (See in year amendment)	Shani Freeke	Specialist Paediatric Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Partner - Locum Paediatric SHO, often working at royal glamorgan hospital.	April 2022 - ongoing	None	No	Further declaration 26.06.2023 - Dr Nikolai Ciecierski-Holmes is my spouse and works as a locum doctor in CTMUHB - 2021-September 2023
19.04.2023	Timothy Mark Pearce	Consultant Radiologist	Medical	Director TP Radiology Services LTD Provide teleradiology reporting for 4ways healthcare Ltd Provide teleradiology reporting for Heart Lung Healthcare Spouse: Shareholder in TP Radiology Ltd.	Since 2019 Since 2019 Since 2022 Since 2019	None stated	No	
19.04.2023	Loishannon Dolan	Physiotherapist Rotational	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
19.04.2023	Sally Ann Price	Consultant Physician	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
19.04.2023	Philip Evans	Consultant	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
20.04.2023	Bethan Jones	Assistant Psychologist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
20.04.2023	Siobhan Moore	Principal Clinical Psychologist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Providing private psychological input to a nursing home outside of UHB	January 2023 - April 2023	Financial Transaction	No	
20.04.2023	Rahul S Kotwal	Consultant	Medical	Director of SAARK	From 2018	Annual Dividend	No	
21.04.2023	Dr Timothy Chan	Consultant Old Age Psychiatrist	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
21.04.2023	Ashraf Masoud	Consultant	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
21.04.2023	Meilyr Dafydd	Consultant Radiologist	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
21.04.2023	Meinir Davies	Medicines Management Support Officer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
22.04.2023	Harry Hunt	Clinical Lead GPOOH	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
24.04.2023	Carl Michael Verrecchia	Care Group Service Director	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
24.04.2023	Catharina Bisseling	Consultant O&G	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
24.04.2023	Jan Awad	Consultant Acute Medicine	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
24.04.2023	Emma James	Nurse Director USC	Unscheduled Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
24.04.2023	Dr Daniel Hopkins	Consultant Pathologist	Medical	Nil Interests Declared	Not applicable	Not applicable	No	

Date Approved	Name	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
24.04.2023	Laura Polligton	Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
24/04/2023 Hard Copy Form	Xavier Escofet	Consultant General Surgeon	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
25.04.2023	Martin Cole	Consultant Anaesthetist	Medical	Husband is Director of Cowbridge Specsavers Franchise	2018-Present	None stated	No	
25.04.2023	Kochuveetil Purushothaman Nair Gopakumar	Consultant Anaesthetist	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
25.04.2023	Zahra Rasheed	Lead Contact Lens Optometrist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	CTM HB Optometric Advisor (Primary Care Team)	Since January 2023	0.2 wte 8b	No	
25.04.2023	Fahad Mewazy	Consultant Radiologist	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
26/04/2023 Hard Copy Form	Puthucode Haray	Consultant Surgeon	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
26.04.2023	Dr Katherine Mary Gale	Consultant Community Child Health	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
26.04.2023	Gavin Owen	Acute General Services Manager	Chief Operating Officer Function	Nil Interests Declared	Not applicable	Not applicable	No	
26.04.2023	Thomas Wright	Clinical Psychologist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
27.04.2023	Andrew Nelson	Chief Information Officer	Digital	Ownership of shares > £5000 in: Berkshire Hathaway Inc(NYSE:BRK.B) Invesco S&P SmallCap 600 ETF (LSE:USML) iShares Core S&P 500 ETF USD Acc GBP (LSE:CSP1) Markel Corp (NYSE:MKL) iShares Core MSCI Japan IMI ETF USD Acc GBP (LSE:SJPA) Baillie Gifford Japan Ord (LSE:BGFD) Baillie Gifford Shin Nippon Ord (LSE:BGS) Herald Ord (LSE:HRI) Oryx International Growth Ord (LSE:OIG) Edinburgh Worldwide Ord (LSE:EWI) iShares Core MSCI Pac ex-Jpn ETF USD Acc GBP (LSE:CPJ1) Aberdeen New India Investment Trust (LSE: ANII) Spouse / Partner etc: Ownership of shares > £5000 in: Berkshire Hathaway,Markel Corp, Aberdeen Asia Focus Herald Ord Oryx International Growth Edinburgh Worldwide	Greater than 12 months	Value >£5000 - nb these are investment trusts or holding corporations and I have no ability to influence what stocks are held within the trusts	No	
27.04.2023	Dr Sandeep Kamath	Consultant Dermatologist and Clinical Lead	Medical	DIRECTOR 1) KAMATH DERMATOLOGY LIMITED 2)ANTANA KAMHAT LIMITED 3)CARDIFF MULTI SPECIALITY CLINIC AND DIAGNOSTICS LTD PI for UCB sponsored NIS trial ELEVATE with CTM R&D	3 Years 2 Years 6 Months	None stated	No	
02.05.2023	Reena McClure	Specialist Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	SRD LSE is also a director in companies 1.&2 listed above Private work at; Neuro Physio Wales, 60 Commercial Street, Kenfig Hill, Bridgend, CF33 6DL	Similar as above mai-23	Paid by the hour	No	
02.05.2023	Syed Junaid	Consultant Radiologist	Medical	Director: Acorn Diagnostics Ltd Director: Proton Medical Ltd Shareholder: Radiology Seminars Group Ltd Spouse/Partner or Close Family and/or Friend: Director: Proton Medical Ltd Shareholder: Radiology Seminars Group Ltd	Since 23 August 2021 to present 10 June 2019 to present	Dividends	No	
02.05.2023	Emily Payne	Clinical Director for Growing Well	Strategy & Partnerships	Nil Interests Declared	Not applicable	Not applicable	No	
02.05.2023	Dr Rebecca Louise Cushen	Consultant in Public Health Medicine	Medical	Husband - Manager of Books Plus Cardiff and member of the committee for the managing charity "Light on the Mount". Registered Charity No: 1074480	2014 - ongoing	Wage paid by charity. No other financial benefits received from the charity.	No	
03.05.2023	Alison Waters	Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
03.05.2023	Angela Davies	Primary Care Therapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Private Practice ~ offering counselling/psychotherapy to privately paying clients	Since 2019; 2 evenings per week, maximum of 1 hour each evening	payments received from clients	No	
03/05/2023 Hard Copy Form	Rutuja Kulkarni-Johnston	Consultant in Public Health	Public Health	Nil Interests Declared	Not applicable	Not applicable	No	

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04.05.2023	Victoria Bizzell	Primary Care Therapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Private client work (outside of contracted hours) - non NHS clients) Tutor and course leader at Ty Elis on Counselling Diploma	ongoing	payment for private sessions	No	
05.05.2023	Paula True	Pharmacy Technician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
05.05.2023	Hannah Maddocks	Registered Nurse	Nursing Bridgend	Declaring secondary employment/private aesthetics practice.	January 2023 ongoing	Private Ltd Company. (HanAesthetics Ltd).	No	
05.05.2023	Duncan Hope	Pharmacy Technician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
06.05.2023	Bethan Gibson	Consultant	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
09.05.2023	Sarah Jane Williams	Medicines Management Technician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Husband is a Director and land Surveyor for John Vincent Surveys.	Ongoing	Employed through Architect as and when requested / quote accepted for works.	No	
09.05.2023	Mathew Bowen Jones	ENT Consultant	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
09.05.2023	Suzanne Mayo	Accuracy Checking Pharmacy Technician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
09/05/2023 & 12/06/2023	Chloe Smith	Physiotherapy Health Care Support Worker	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
10.05.2023	Poonamallee Govindaraj	Consultant Paediatrician	Medical	Director of limited company Paediatric-care limited Private practise in my non-contracted session on Tuesday morning at spire. Family member: Secretary to the limited company	Commenced May 2023	None stated	No	
10.05.2023	Paul Gimson	Assistant Director of Improvement	Improvement and Innovation	Have agreed to judge on the Welsh Pharmacy Awards which are sponsored by TEVA (a pharmaceutical company). Host of the Aural Apothecary podcast - a podcast about medicines, improvement and prescribing.	3 Months Ongoing	Possible invite to awards dinner. Unpaid but previously has led to paid speaking engagements and expenses paid invites to conferences. These are done on own time	No	
11.05.2023	Krystal Williams	Pharmacy Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
11.05.2023	Louise Davies	Pharmacy Technician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
11.05.2023	Alison Jayne Collins	Pharmacy Technician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
11.05.2023	Kiri Leanne Evans	Medicines Management - Pharmacy Technician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
16.05.2023	Naveed Iqbal	Team Lead Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Bank work for Spire healthcare Wife works for Cardiff and vale UHB	2016 20+ Years	Paid Work	No action at this point noted.	
16.05.2023	Ritabrata Mitra (Rita Mitra)	Consultant Cardiologist		Director of limited company: R&P Mitra Ltd	From April 2019 onwards	Yearly dividends if any	No conflict of interest identified following discussion with consultant	
17/05/2023 Hard Copy Form	Ken Emmanuel	Consultant Obstetrician and Gynaecologist	Medical	Personal General Medical Healthcare Limited (Director) Spouse/Partner/Close Family and/or Friend General Medical Healthcare Limited (Director (Partner))	Not stated	Not stated	No	
18.05.2023	Dr Elizabeth Husband	Consultant	Medical	ERH PATH LTD & E&J PATH LIMITED Both: specialists medical practice activities	2022 & 2020	Director & Director Adhoc payments	Need to establish any potential conflict of interest. Finance colleagues have confirmed that no transactions between CTM and 'ERH PATH LTD' or 'E&J PATH LIMITED' from April 22 onwards.	
19.05.2023	Nicola Jayne Carrington	Project Manager	Mental Health - YCC	Nil Interests Declared	Not applicable	Not applicable	No	
22.05.2023	Giovanna Adele Nelms	Advance Pharmacist NICE and HCD Medicines	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	

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24.05.2023	Dr Geraldine Haebich	Consultant Dermatologist	Medical	Sponsorship by UCB pharma to attend the European Academy of Dermatology and Venerology 2023 in Berlin. UCB pharma sponsorship to attend the British Association of Dermatologist Conference in June 2023 I hold the title of Honorary lecturer for the University of Cardiff.	11.10.23 - 14.10.23 27th June till 29th June 2023 Current	Financial: Flight and Conference fees and hotel. Financial: Train Travel and Hotel and Conference fees No financial transactions or Benefits. I am involved in medical students on their placements at Princess of Wales Hospital.	No	
24/05/2023 Hard Copy Submission	Dr Amani Osman HASSAN	Consultant Child LD Psychiatrist	Medical	Director of own company A Hassan Ltd - Private assessments and consultations Husband is a partner in A Hassan Ltd.	Since 12 May 2022	Financial Transactions	No	
25.05.2023	Ella Simmons	Academy Administrator	National Imaging Academy Wales (Hosted Organisation)	Nil Interests Declared	Not applicable	Not applicable	No	
30.05.2023	Tracy Jayne Redman	NICE Co-ordinator	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
01.06.2023	Emily Jones	District Nurse	Nursing	Nil Interests Declared	Not applicable	Not applicable	No	
01.06.2023	Vanessa Hayward	Head of Speech & Language Therapy	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
01.06.2023	Dr Iyad Al-Muzzaffar	Consultant Neonatologist	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
01.06.2023	Harriet Henderson	Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
01.06.2023	Andrea Wiggins	Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
02.06.2023	Jemma Marie Symes	Deputy Ward Manager	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
02.06.2023	Teresa Harris	Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
05.06.2023	Angela Claire Bell	Therapies Clinical Quality Manager	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
06.06.2023	Nicola Jones	Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
06.06.2023	Suzannah Minns	Clinical Specialist Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
06.06.2023	Uma Vadivel	Clinical Specialist Physiotherapist - Palliative Care	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
07.06.2023	Joanne Middleton	Therapies Administration Manager	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
07.06.2023	Gemma Cartwright	Clinical Lead Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
07.06.2023	Margaret Manton	Assistant Head of Physiotherapy	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Family Member: Father-in-law - Aled Edwards Lay Representative for Health Education improvement Wales and also member of Welsh Government Board - Civil Service	Current	Not applicable	Agreed to discuss with Head of Physiotherapy if any potential conflict if the situation arises, although considered very unlikely.	
07.06.2023	Jenna Mulholland	Physiotherapist Team Lead	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
07.06.2023	Denise Jenkins	Head of Podiatry and Orthotics	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
07.06.2023	Anne-Laurie Noonan	Administration	National Imaging Academy Wales (Hosted Organisation)	Nil Interests Declared	Not applicable	Not applicable	No	
07.06.2023	Owen Pearce	Deputy Head of Podiatry and Orthotics	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
07.06.2023	Stephen Thomas Grove	MSK Podiatrist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
08/06/2023 Hard Copy Form	Bethan Mercer	Band 7 Physiotherapist in ESD (secondment)	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
08/06/2023 Hard Copy Form	Jordan Prirchard	Physio Tech	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	

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08/06/2023 Hard Copy Form	Jo Pearson Roberts	Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy ~~Care Group~~	Nil Interests Declared	Not applicable	Not applicable	No	
08/06/2023 Hard Copy Form	Gemma Ainscow	Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy ~~Care Group~~	Nil Interests Declared	Not applicable	Not applicable	No	
08/06/2023 Hard Copy Form	Jessica Watts	Team Lead Physiotherapist - Acute Stroke	Diagnostic, Therapies, Specialties & Pharmacy ~~Care Group~~	Nil Interests Declared	Not applicable	Not applicable	No	
08/06/2023 Hard Copy Form	Morgan Ann Marie Davies	Physiotherapy Assistant	Diagnostic, Therapies, Specialties & Pharmacy ~~Care Group~~	Head Sports Therapist at Rugby Club	3 Years	Voluntary	No	
08/06/2023 Hard Copy Form	Joseph Edwards	Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy ~~Care Group~~	Nil Interests Declared	Not applicable	Not applicable	No	
08.06.2023	Gafin Morgan	Consultant Podiatrist	Diagnostic, Therapies, Specialties & Pharmacy ~~Care Group~~	Director of charity : Canolfan a Theatre Soar ~~Private Practice~~	May 2023 Resumed April 2023	Voluntary Salaried	Undertaking private practice is normal business within the profession	
08.06.2023	Claire Parker	Physiotherapy Assistant	Diagnostic, Therapies, Specialties & Pharmacy ~~Care Group~~	Nil Interests Declared	Not applicable	Not applicable	No	
08.06.2023	Oliver Rock	Rotational Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy ~~Care Group~~	Nil Interests Declared	Not applicable	Not applicable	No	
08.06.2023	Joni McFarlane	Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
08.06.2023	Holly Anne Thomas	Band 7 Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy ~~Care Group~~	Nil Interests Declared	Not applicable	Not applicable	No	
08.06.2023	Natalie King	Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
09.06.2023	Paula Cornelius	Head of Occupational Therapy Services	Diagnostic, Therapies, Specialties & Pharmacy ~~Care Group~~	Nil Interests Declared	Not applicable	Not applicable	No	
09.06.2023	Jade Goodall	Neuro clinical specialist physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy ~~Care Group~~	Lecturing in Cardiff met university for a social care course.	Not stated	No payment	No	
09.06.2023	Julia Gilmore	Neurological Rotational Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy ~~Care Group~~	Completed level 3 sports massage diploma, will consider private work in the future.	None currently	None currently	No	
09.06.2023	Angela Karen Arensten	Principal Occupational Therapist - Adult Mental Health	Diagnostic, Therapies, Specialties & Pharmacy ~~Care Group~~	Nil Interests Declared	Not applicable	Not applicable	No	
09.06.2023	Margery Costa	Clinical Lead Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy ~~Care Group~~	Nil Interests Declared	Not applicable	Not applicable	No	
09.06.2023	Andrew Murphy	Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy ~~Care Group~~	Nil Interests Declared	Not applicable	Not applicable	No	
09.06.2023	Leanne Rowlands	Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
09.06.2023	Abigail Duncan	Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy ~~Care Group~~	Nil Interests Declared	Not applicable	Not applicable	No	
09.06.2023	Tammy Williams	Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy ~~Care Group~~	Nil Interests Declared	Not applicable	Not applicable	No	
09.06.2023	Elena-Rose Constandinou	Rotational Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy ~~Care Group~~	Nil Interests Declared	Not applicable	Not applicable	No	
12.06.2023	Joanne Prosser	Team Lead Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy ~~Care Group~~	Nil Interests Declared	Not applicable	Not applicable	No	
12.06.2023	Sanant Marared Wyn Evans	Neuro Rehab Rotational Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy ~~Care Group~~	Nil Interests Declared	Not applicable	Not applicable	No	
12.06.2023	Andrew Rose	Assistant Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy ~~Care Group~~	Nil Interests Declared	Not applicable	Not applicable	No	
12.06.2023	Deborah Jane Overton	Rotational Inpatient Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy ~~Care Group~~	Nil Interests Declared	Not applicable	Not applicable	No	
12.06.2023	Nia Giles	Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy ~~Care Group~~	Guest lecturer for Cardiff University	Yearly	Paid personally / special leave granted by health board	No	
12.06.2023	Sarah Elizabeth Argent	Consultant Child and Adolescent Forensic Psychiatrist	Medical	Honorary Research Fellow role at Cardiff University. I have an NHS Locum Consultant role in Aneurin Bevan University Health Board for 2 sessions a week. These two sessions are accounted for in my job plan.	Honorary Research Fellow contract with Cardiff University since November 2020. Locum Consultant contract with ABUHB since August 2022	The honorary contract confers no financial benefit. I am paid for my NHS Locum role through a salary as usual.	No	

Date Approved	Name	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
12.06.2023	Anna Williams	Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
12.06.2023	Shelley Powell	Dietetic Professional Manager - Public Health	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13/06/2023 Hard Copy Form	Rachael Mead	Therapy Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13.06.2023	Rachel Grace Reed	Senior Public Health Practitioner	Public Health	Nil Interests Declared	Not applicable	Not applicable	No	
13.06.2023	Madelaine Najjar	Deputy Head of Service - Nutrition and Dietetics	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13.06.2023	Paige Jennings-Brooksby	Public Health Dietetic Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13.06.2023	Lisa Sheehan	Public Health Dietetic Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13.06.2023	Frances Samuel	Specialist Public Health Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13.06.2023	Thomas Richards	Professional Manager - Acute Speech & Language Therapy	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13.06.2023	Sali Curtis	Head of Adults Speech and Language Therapy	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13.06.2023	Maria Cole	Department Professional Manager	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13.06.2023	Miles Chambers-Jones	Specialist Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13.06.2023	Terri James	Project Support Officer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13.06.2023	Vasiliki Saounatsou	Professional Manager Speech and Language Therapy in Community	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13-jun-23	Carianne Reynolds	Public Health Dietetic Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13.06.2023	Gary Howell	Head of Nutrition and Dietetics	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13.06.2023	Charlotte Emily Price	Specialist Adult Weight Management Dietitian	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13.06.2023	Lynne Burgess	Public Health Dietetic Support Worker	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13.06.2023	Christine Derrick	Clerical Support Officer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13.06.2023	Nichola Elliott	Departmental Administrative Officer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13/06/2023 Hard Copy Form	Jason Davies	Physiotherapy Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
14/06/2023 Hard Copy Form	Catherine Pollock	Band 6 neuro rotational physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
14.06.2023	Rhian Collins	Macmillan AHP Lead for Cancer.	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Volunteer committee member (secretary) on the British Dietetic Association Oncology group	2018-Present	Nil	No	
				Volunteer committee member on a social running group	2019-Present			
14.06.2023	Victoria Fleming	Public Health Dietetic Administrator	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
14.06.2023	Thomas Bush	Public Health Dietetic Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
14.06.2023	Johanna Duthie	Neuro Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	

Date Approved	Name	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
14.06.2023	Sarah O'Connor	Head of Children's Speech and Language Therapy	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
14.06.2023	Alexsie Clayton	Physiotherapy Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
14.06.2023	Anna Marie Santos	Public Health Administration and Clerical Officer	Public Health	Nil Interests Declared	Not applicable	Not applicable	No	
14.06.2023	Ewan-James Smith	Highly Specialist Public Health Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
14.06.2023	Miranda Burdett Joyce	Public Health Dietetic Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
15.06.2023	Angharad Eleanor Rich	Clinical Lead Orthotist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
15.06.2023	Gaynor Rhiannon Slocombe	Lead Podiatrist In Acute Foot	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
15.06.2023	Lauren Morgan	Public Health Dietetic Support Worker	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
15.06.2023	Jennifer Collins	Highly Specialist Public Health Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
16/06/2023 Hard Copy Form	Stuart Taylor	Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
16.06.2023	Laura Fowler	Physiotherapy Clinical Lead	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
18.06.2023	Kelly Ann Smith	Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
19.06.2023	Ceri James	Dept Head of Service, Nutrition and Dietetics	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Wife - Emma James (Director of Nursing, Unscheduled Care)	Married since 2014	Not applicable	20/6/23 - Conversation with Ceri today regarding the potential conflict, nil concerns aware of professional conduct and confidentiality that is required.	
19.06.2023	Sarah Hoidge Hughes	Specialist Oncology Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
19/06/2023 & 13/09/2023	Megan Schoen	Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
19.06.2023	Amy Elizabeth Butler	Orthotic Services Administrator	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
19.06.2023	Jessica Dawn Weaver	Physio Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
19.06.2023	Stacey James	Dietetic Professional Manager - Acute Services	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
19.06.2023	Harriet Palmer	Specialist Diabetes Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Occasional dance instructor (unpaid, once/monthly) Not actively teaching as of June 2023.	April 2022 - June 2023	None. Unpaid/volunteered.	No	
19.06.2023	Enzo Battista-Dowds	Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
19.06.2023	Helen Marshall	Dietetic Administration Clerical Officer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
19.06.2023	Sarah Jayne Powell	Diabetes Specialist Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
19.06.2023	Melanie Jayne Borja	Physiotherapy Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
19.06.2023	Victoria Barrett	Professional Lead Speech and Language Therapy	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
20.06.2023	Natalie O'Mahony	Clerical Officer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
20.06.2023	Elaine Cooper	Generic Therapy Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	

Date Approved	Name	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
20.06.2023	Menna Payne	Adult SLT Department	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Work 1 day per week for Severn Health care technologies Provide lecturing and exam marking for Cardiff.Met.	Started in post June 22. Permanent position Lecturing between Feb/March each year. Exam marking in May annually	Hourly rate	No	
20.06.2023	Lisa Williams	General Therapy Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
21/06/2023 Hard Copy Form	Aimee Owen	Specialist MSK Physiotherapy	Diagnostic, Therapies, Specialties & Pharmacy Care Group	I work privately as a Physiotherapist for Weston House college, part of Bridgend College. This is a specialist unit for young adults with physical disabilities. This secondary employment is term time only and is a commitment of 3 hours a week.	Term time only, annually. 3 hrs a week maximum.	Paid Secondary employment	No	
21.06.2023	Kristian Richard Neil Speake	Rotational Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
21.06.2023	Emma Brierley	Lead Specialist Pharmacist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
21.06.2023	Kelly Brown	Team Lead Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
21.06.2023	Jack Corney	Clinical Specialist Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
21.06.2023	Nicola Mathieson	Podiatrist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Owner of Podiatry Practice	2022 - to date	No financial payments received	No	
21.06.2023	Danielle Parry	Static MSK Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
21.06.2023	Lewis-Jon William Hudd	Physiotherapy Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Private Employment - Self Employed Business working privately delivering sports rehabilitation and performance clinics WRU - Casual Contractor S&C Coach	2020-Current 2019-Current	Financial Transactions	No	
21.06.2023	Christopher John O'Sullivan	Static Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
21.06.2023	Lauren Callen	Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
21.06.2023	Ruth May	Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
21.06.2023	Shannon Emma Burton	Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
21.06.2023	Clare Jones	Major Trauma Rehab Co-ordinator	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
21.06.2023	Samantha Bantoo	Major Trauma Rehab Co-ordinator	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
21.06.2023	Zoe Silsbury	Clinical Lead MSK Outpatient Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
21.06.2023	Lauren Eve Rees	Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
22.06.2023	Matthew O'Sullivan	Physiotherapy Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
22.06.2023	Sophie Hughes	Team Lead Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Sole trader for own business - SoPhysio. Veterinary Physiotherapy Husband part director of Specsavers Bridgend, Porthcawl and Bridgend.Derwen.	Since September 2021 Since 2003	Nil	No	
22.06.2023	Aimee Holborrow	Rotational Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
22.06.2023	Ethan Field	Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
22.06.2023	Jon Williams	Physio	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
22.06.2023	Philip Bell	Clinical Specialist Physio	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
22.06.2023	Jacqueline Margaret Jones	Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
22.06.2023	Michelle Symes	Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
22.06.2023	Charlotte Parsons	RGN	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	

Date Approved	Name	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
23.06.2023	Catrin Evans	PH Physio	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
23.06.2023	Lucy Hamilton-Clark	Pelvic Health Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
23.06.2023	Bethan Williams	Pelvic Health Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
23.06.2023	Isabel Ware	Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
23.06.2023	Vonda Price	PH Physio	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
23.06.2023	Kirsten Barrett	Clinical specialist physiotherapist womens health	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Carry out occasional private work	0 hours contract	Not stated	No	
23.06.2023	Matthew Willis	Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
26.06.2023	Keely Lugonja	Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	My sister works in IT in Velindre Trust	Not applicable	Not applicable	No	
26.06.2023	Bethan Connolly	Specialist Paediatric Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
26.06.2023	Regan Taylor	Physiotherapist Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
26.06.2023	Elizabeth Warmisham	Paediatric Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
26.06.2023	Gaynor Bull	Paediatric Team Lead	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Mrs Carol Miller sister Employee in health board Mrs Ruby James Niece Employee in health Board	1995 onwards 2019 onwards	Not applicable	No	
26.06.2023	Joanne Santos-Matthews	Principal Occupational Therapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
26.06.2023	Bernadette McAndrew	Clinical Specialist Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
26.06.2023	Suzanne Claire Williams	Admin and Clerical	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
26.06.2023	Katherine Elward	Clerical Officer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
26.06.2023	Chloe Stanaway	Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
26.06.2023	Milly Watts	Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
26.06.2023	Paramit Kaur Grewal	Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
26.06.2023	Lisa Love-Gould	Clinical Director of AHPs	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Husband is director of a Renewable energy Limited company I ha3/100th of husbands limited company as above Husband has 77% of company above 2 x daughters have 10% each of above company	Since September 2008 Since September 2008 Since September 2008 and 2018	As a shareholder i receive dividends	No	
27.06.2023	Ryan Hawkins	Clinical Lead ED Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
27.06.2023	Avril Margaret Brinkworth	Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
27.06.2023	Anna Littlejohn	Highly Specialist Podiatrist acute foot	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
28.06.2023	Victoria Collins	Speech and Language Therapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
28.06.2023	Christine Isaac	Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
28.06.2023	Rhiannon Rogers	Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
28.06.2023	Natalie Jayne Harrison	Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Private consultancy work for Alliance Pharmaceuticals	commenced June 2023	Paid private work in own time operating within HCPC codes of conduct.	No	

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28.06.2023	Emma Jones	Physiotherapist (Junior)	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
29.06.2023	Sophie Sian Eileen Lewis	Rotational Inpatient Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
29.06.2023	Laura Willis	Integrated Community Network and CRT Lead Dietitian	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
29.06.2023	Graham Burke	Community Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Sophie Lewis Physiotherapist	3 Years	None	No	
29.06.2023	Anne-Marie Adamson	Clinical Specialist Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
29.06.2023	Sarah Richards	Macmillan UGI Lead Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
29.06.2023	Lindsey Scott-Fletcher	Admin Roster Support	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
29.06.2023	Nicola Marshall	Physiotherapy Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
29.06.2023	Davide Compagnone	Advanced Pharmacist in Surgery	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
29.06.2023	Corrie Fewtrell	Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
29.06.2023	Sophie Emery	Specialist Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
29.06.2023	Robert Couzens	Physiotherapy Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
29.06.2023	Skye Popert	Specialist Paediatric Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
29.06.2023	Sara Eleri Foulkes	Paediatric Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
29.06.2023	Chelsea Thomas	Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
30/06/2023 Hard Copy Form	Kate Enfield	Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
30.06.2023	Petra Langford	Physiotherapy Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
01.06.2023	Sarah Llewellyn	Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
03.07.2023	Carly Marsh	Team Lead Paediatric Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
03.07.2023	Catherine Griffiths	Physiotherapy Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
03.07.2023	Kirsty Marchant	Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
03.07.2023	Natalie Laura Bell	Deputy Head Occupational Therapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
04.07.2023	Maisie Goman	Bank Physiotherapy Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
04.07.2023	King Fung Nicholas Lu	Clinical Specialist Physiotherapist T&O	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
04.07.2023	Catherine Pleasure James	Physiotherapy Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
04.07.2023	Olivia Crossley	Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
05.07.2023	Rebecca Foster	Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	

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05.07.2023	Dolina Morris	Professional Manager Paediatric Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
06.07.2023	Gerwyn David Butler	Medical Team Assistant Surgical & Orthopaedics	Clinical Support Services	Nil Interests Declared	Not applicable	Not applicable	No	
06.07.2023	Kathryn Lewis	District Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
06.07.2023	Catherine Rees	Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
07.07.2023	Victoria Jayne	Clinical Specialist Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
07.07.2023	Alexandra May Szuplewski	Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
10.07.2023	Hannah Wakeham	Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
10.07.2023	Sophie Medcraft	Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
10.07.2023	Nina Grans	District Nurse - Deputy Team Leader	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
10.07.2023	Georgina Evans	Static Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
10.07.2023	Anthony Lewis	Physiotherapist Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
11.07.2023	Amanda Jayne Pritchard	Clerical Officer - Physiotherapy	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
11.07.2023	Sian Thomas	Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
11.07.2023	Joanne Morgan	Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
12.07.2023	Bethan Rees	Ward Manager	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
12.07.2023	Suzanne Davies	Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
13.07.2023	Kate Norris	Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
14.07.2023	Caroline Jones	Health Care Support Worker - Community	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
17.07.2023	Mark Williams	Band 4 Primary Care	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
18.07.2023	Bethany House	Physiotherapy Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
18.07.2023	Elizabeth Jane Burgoyne	High intensity therapist Mental Health	Diagnostic, Therapies, Specialties & Pharmacy Care Group	I work in private practice 1 day a week in Cardiff as a counsellor seeing approx 4 clients a week.	Have worked in private practice since 2008	Clients pay at each session via bank transfer per hourly session	No	
18.07.2023	Gaynor Elizabeth Evans	Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
20.07.2023	Dawn French	Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
20.07.2023	Jordan Douglas	Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
21.07.2023	Alex Boe	Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
21.07.2023	Gavin Heath	Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
24.07.2023	Sophie Rhiannon Charles	Paediatric Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
25.07.2023	Chloe Jenkins	Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
25.07.2023	Judith Chidgey	Speech and Language Therapy Professional Manager	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
25.07.2023	Rebecca Woodington	Team Leader	Primary Care	Nil Interests Declared	Not applicable	Not applicable	No	
26.07.2023	Catrin Waters	Clinical Lead Pharmacist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
26.07.2023	Penny Nurse	Project Manager / TSW Manager	Corporate	Nil Interests Declared	Not applicable	Not applicable	No	
26.07.2023	Rebecca Humphries	Physiotherapy Technician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
26.07.2023	Elaine Lorton	Service Director	Mental Health and Learning Disabilities Care Group	Voluntary Chair - West Wales Care & Repair	Since 2019	£0	No	
26.07.2023	Mia Thomas	Physiotherapy Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	

Date Approved	Name	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
26.07.2023	Carly Lewis	Physiotherapy Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
26.07.2023	Karen Poulton	Specialist Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
26.07.2023	Harriet Hodgson	Public Health Dietetic Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
26.07.2023	Andrew Cooper	Public Health Dietetic Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
26.07.2023	Carol Hudson	Advanced Pharmacist Formulary and Interface	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
26.07.2023	Julie Louise Jenkins	Administration and Clerical - Weight Management	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
27.07.2023	Emma Jenkins	Dietetic Professional Manager - Paediatrics	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
27.07.2023	Liana Pengelly	Paediatric Dietitian	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
27.07.2023	Kate Williams	Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
27.07.2023	Michelle Partridge	Physiotherapy Technical Instructor	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Company Secretary for Amerex Fire International and Director Director and secretary for Thornhill Global Ltd Thornhill Global Ltd Husband Director for Amerex Fire International and Thornhill Global Ltd Husband - Thornhill Global Ltd	From 16 April 2014	Unpaid position & Health Insurance (family Business) Unpaid position (family business)	No	
27.07.2023	Joanna Goodhead	Specialist Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
28.07.2023	Eva Walpole	Team Lead Paediatric Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
31.07.2023	Helen Margaret George	Administrative Support MMPU	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
01.08.2023	Ellen Bramwell	Paeds Physio Admin	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
01.08.2023	Dr Marcus Lewton	Highly Specialist Clinical Psychologist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
01.08.2023	Jessica Smith	Clinical Specialist Paediatric Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	James Smith	jun-22	None	No	
02.08.2023	Jenna Parry	Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
02.08.2023	Lauren Passow	Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
03.08.2023	Laura Williams	Senior Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
03.08.2023	Victoria Oldham	Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
03.08.2023	Jolene Aimee Thomas	Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
03.08.2023	Dr Sue Kenneally	GPER/Obesity Medicine physician, locum	Keir Hardie Health Park	Own the company S Kenneally Medical for the purposes of private medical work	January 2019-to present and ongoing	Not stated	No	
04.08.2023	Sky Hopkin	Dietetic Support Worker	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
04.08.2023	Sarah Hooper	Senior Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	

Date Approved	Name	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
07.08.2023	Lucy Marland	Care Home Lead Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
07.08.2023	Sarah Lewis	Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
07.08.2023	Susan Bennetta	Dietetic Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
07.08.2023	Michelle Williams	Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
08.08.2023	Helen Bates	Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
10.08.2023	Helen Griffiths	Dietetic PA and Administration Manager	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
11.08.2023	Lucy Jenkins	Macmillan Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
11.08.2023	Barbara Faulkner-Davies	Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
11.08.2023	Sarah Cule	Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
13.08.2023	Leah Ashford	District Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
16.08.2023	John Hickey	DHoP - Clinical Lead Pharmacist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
22.08.2023	Stacey Garness	Sonographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Locum Sonographer in ABUHB	October 2021 - Present	Financial Transaction	No	
22.08.2023	Amanda Williams	Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
24.08.2023	Nerys Heightley	Business Support Manager	People Services Team	Nil Interests Declared	Not applicable	Not applicable	No	
24.08.2023	Dr Sarah Morris	Senior Clinical Psychologist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Private practice as a Clinical Psychologist. I do not work with anyone who lives in the catchment area of my work (ie within Cynon Valley) to ensure that no one can 'jump the waiting list' by paying to see me. I also do not do any private work within my employed NHS hours.	Since March 2022	The work is paid.	No	
29.08.2023	Darhian Shey Lee	Physiotherapy Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
30.08.2023	Rebecca Watkins	Employee Experience Lead	People Services Team	Nil Interests Declared	Not applicable	Not applicable	No	
31.08.2023	Kerry Morgan	Community Stroke Nurse	PCH	Nil Interests Declared	Not applicable	Not applicable	No	
31.08.2023	Govardham Navaratnam	Consultant Cardiologist	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
05.09.2023	Nicola Jayne Williams	Manager Looked After Children Health Team	Community	Nil Interests Declared	Not applicable	Not applicable	No	
05.09.2023	Elma Jala	Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
07.09.2023	Janet Mary Gilbertson	Head of Clinical Education	Patient, Care and Safety - Clinical Education	Director of Mosaic Leadership LTD (Private). 25% share in Mosaic Leadership	Since November 2020	Company commenced trading September 2023	No	
07.09.2023	Rhia Pope	Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
12.09.2023	Deborah Marion Jones	Advance Pharmacist Primary Care	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
12.09.2023	Fiona Quinn	Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13.09.2023	Ailish Bourke	Acute Team Lead Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
14.09.2023	Cara Ryan	Acute Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
14.09.2023	Lucy Nicolson	Speech and Language Therapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	External guest lecturer on a casual basis with The University of the West of England (UWE), in the education field delivering adhoc lectures on work about Speech and Language Therapy. I will not hold a contract with the university.	This is an adhoc period of involvement. I am likely to only deliver 2-4 hours worth of lectures per academic year	I will be paid a standard hourly rate for an external guest lecturer by UWE.	No	
19.09.2023	Hannah Magill	Rotational Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
20.09.2023	Rhian Thomas	Specialist Head and Neck Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
20.09.2023	Megan Kate Jones	Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
21.09.2023	Emilie Sharp	Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
22.09.2023	Matthew Barnard	Rotational Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
26.09.2023	Sian Watkins	Strategic Planning & Commissioning Manager	Strategy & Partnerships	Nil Interests Declared	Not applicable	Not applicable	No	
26.09.2023	Lucy Williams	Acute Lead and ICU Specialist Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	

Date Approved	Name	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
26.09.2023	Erin Roberts	Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
02.10.2023	Harriet Palmer	Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Podcasting (personal project)	As of October 2023	Nil to declare currently.	No	
02.10.2023	Paighton Leigh Lewis	Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
04.10.2023	Karen Dando	Nurse Practitioner	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
05.10.2023	Lauren Alexandra Williams	Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
10.10.2023	Sarah Wilson	CAMHS Therapist	CAMHS	clinical supervisor-own private practice	Current	Hourly rate paid.	No	
				guest lecturer at University of South Wales for MSc Play Therapy course.	November 2023 - ongoing			
10.10.2023	Brian Hawkins	Deputy Chief Pharmacist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Expert advisor to Public health ombudsman for Wales	November 2016 - current	Payment for advice March 2017	No	
11.10.2023	Rachel Aylward-Clark	Senior Pharmacy Technician - Medicines Information & Governance	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
11.10.2023	Elicia Lake	Superintendent Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
11.10.2023	Felicia Rees	Advance Nurse Practitioner	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
19.10.2023	Susan Louise Wooller	Principal Pharmacist Anticoagulation & Thrombosis	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
24.10.2023	Michelle Pope	Advance Nurse Practitioner	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
24.10.2023	Charlotte Ball	Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
24.10.2023	Bethany Scott	Senior Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
25.10.2023	Emma Jones	Community Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
25.10.2023	Emma Reed	Community Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
25.10.2023	Carla Finney	Community Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
25.10.2023	Kate Chivers	Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
25.10.2023	Emily Griffiths	Community Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
25.10.2023	Delyth Jones	Clinical Specialist Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
31.10.2023	Annmarie Lewis	Physio Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
3.11.2023	Hilary Mott	Assistant Head of Physiotherapy	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
14.11.2023	Linda Karen Mary Webb	Sonographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
15.11.2023	Lowri Roberts	Speech and Language Therapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Private Welsh medium speech and language assessment carried out on 18/05/2023 in Ceredigion. Work carried out for Clinical Psychologist based in N.Wales	1 day - 18.5.2023	Payment for travel assessment, observation and report.	No	
15.11.2023	Desna Phillips	Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
16.11.2023	Rhian Davies	Radiology Nurse Manager	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
23.11.2023	Laura Ellis-Moseley	Advanced Pharmacist - Medicines Governance and Safe Medical Practice	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
27.11.2023	Dr Hannah John-Evans	Highly Specialist Clinical Psychologist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Offering consultation to Youth Justice Services as part of the Youth Endowment Fund. Offering clinical supervision to staff and carrying out Enhanced Case Management meetings with professionals.	12 Months -Meeting with project leaders to discuss involvement undertaken but not yet commenced the work outlined. Offer will be made in the New Year 2024.	Financial Payment	No - No conflict of interest identified. Manager and employee to discuss in a meeting additional safeguards to further ensure there are clear boundaries between Bridgend FACS work and independent work.	
27.11.2023	Alessandra Roberts	Clinical Psychologist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Offering consultation to Youth Justice Services as part of the Youth Endowment Fund. Offering clinical supervision to staff and carrying out Enhanced Case Management meetings with professionals.	Up to 16 Months from January 2024.	Financial Payment	No - Manager and employee to discuss in a meeting additional safeguards to further ensure there are clear boundaries between Bridgend FACS work and independent work.	
27.11.2023 & 7.2.2024	Roma Ravaliya	Experienced Rotational Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
15.2.2024	Edward Matthews	Pharmacist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
28.11.2023								

Date Approved	Name	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
29.11.2023	Charles Mowbray	Senior Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
04.12.2023	Emma Hill	Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
05.12.2023	Rhys Blackwell	Senior Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
06.12.2023	Genine Peacock	Advanced Tissue Viability Podiatrist Community Services	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Employment SANDS Private Health Clinic Talbot Green	Start date: 12/11/2023	nil to date of completion of this form	No - All private work undertaken will be outside of NHS contracted hours, Genine is aware of the extra undertaking and ensuring extra activity doesnt impact on her own health.	
06.12.2023	Loren Davies	Community Nurse	Ysbyty George Thomas	Nil Interests Declared	Not applicable	Not applicable	No	
11.12.2023	Carol Williams	Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
13.12.2023	Helen Owen	Band 5 - Child Health	Bridgend - Children and Family Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13.12.2023	Judith Constant	Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
14.12.2023	Katie Langley	Band 5 Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
15.12.2023	Yasmin Ford	Clinical Specialist Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
18.12.2023	Jessica Chong	Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
19.12.2023	Clare Frost	Senior Nurse	Primary Care	Nil Interests Declared	Not applicable	Not applicable	No	
20.12.2023	Lynnette Davies	Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
20.12.2023	Zoe Stapley	Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
22.12.2023	Louisa Walker	Clinical Specialist Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Volunteer for Central Beacons Mountain Rescue team. Spouse also a volunteer with Central Beacons Mountain Rescue	2007 - Present 2002 - Present	Nil Nil	No No	
28.12.2023	Michael Smith-Lewis	Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
5.1.2024	Dixita Leigh	Prescribing Advisor Pharmacist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
12.1.2024	Christopher Lewis	Assistant Head of Assets, Governance & Technical Services	Estates	Employment on a casual basis by Eastwood Park Training to provide training / teaching and to mark assignments (subject matter is sustainability and environmental management)	Approx 6 days per year time commitment	Financial payment on an agreed day rate	Manager has concluded that the type of service C Lewis is providing to Eastwood Park does not create a conflict with the Health Board's service requirements from C Lewis.	
15.1.2024	Cerys Anne Mills	Community Nurse	Primary Care	Nil Interests Declared	Not applicable	Not applicable	No	
17.1.2024	Andrew Lewis	Dietetic Support Worker	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
22.1.2024	Huw Gallivan	Physiotherapy Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
22.1.2024	Rosie Cross	Physiotherapy Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
23.1.2024	Emma Walters	Head of Corporate Governance & Board Business	Corporate Governance	Nil Interests Declared	Not applicable	Not applicable	No	
23.1.2024	Sarah Porter	Community Staff Nurse	Children & Families Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
31.1.2024	Midhun Mohan	Bank Physiotherapy Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
5.2.2024	Erin Steele	Trauma Rehab Co-ordinator	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
8.2.2024	Charlotte Price	Specialist Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Exploring the start up a small, private dietetic business as a 2nd job around current NHS full-time work. Evenings + weekends only. No other parties involved. Private 1:1 and group based sessions.	Not yet commenced.	Not yet commenced	No	
11.2.2024	Katharine Williams	SCPHN for Youth Justice Service	People Services Team	Nil Interests Declared	Not applicable	Not applicable	No	
12.2.2024	Emma Cole	Band 5 Community Nurse	Children & Families Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13.2.2024	Dr Megan Elliott	Principal Public Health Researcher	Public Health	Honorary appointment as 'Visiting Fellow at the University of South Wales'	01/02/2024 - 01/03/2029	No financial benefits. Access to USW resources (e.g. library, software)	No	

Date Approved	Name	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
15.2.2024	Victoria Hover	Physiotherapy Team Lead	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
14.2.2024	Annabel Jones	Healthcare Support Worker	Ward B2 Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
15.2.2024	Rachel Kibble (Hard copy form)	Pre Assessment Nurse	Prince Charles Hospital	Working for Spire Healthcare, OPD and Pre Assessment.	Approximately 3 shifts per month.	Remunerated.	No -Management marked as no action required.	
20.2.2024	Alexandra Richards	Generic Therapy Assistant - Pulmonary Rehabilitation	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
21.2.2024	Jade Bazykiewicz	Clinical Lead ACP Frailty	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
21.2.2024	Karen Stacey	Registered General Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
23.2.2024	Mark Furmage	Decontamination Officer	Patient, Care and Safety	Sole trader status as Mark Furmage AE Services	August 2023- current	Paid via consultancy basis.	No	
26.2.2024	Cori Melly	Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
27.2.2024	Channon Cox	Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
1.3.2024	Claire Louise Powell	Senior Nurse	Ysbyty Cwm Cynon	Husband owns own business not related to NHS	4 years	None	No	
6.3.2024	Hywel McGlinchy	Cluster Pharmacist North Bridgend	Primary Care	Nil Interests Declared	Not applicable	Not applicable	No	
13.3.2024	Samantha Jayne Fisher	Chief Pharmacist	Primary Care	Charity Trustee / Treasurer - Hands up for Downs CIO	2016 - Present	None	No	
				Vice Chair Welsh Pharmaceutical Committee - Ministerial statutory advisory committee	2012 - Present	None	No	
13.3.2024	Bev Woods	Principal Pharmacist - Primary Care Governance	Primary Care	Nil Interests Declared	Not applicable	Not applicable	No	
14.3.2024	Ellis James	Pharmacist	Diagnostics, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
14.3.2024	Naomi Rose Elias	Advanced Clinical Pharmacist	Diagnostics, Therapies, Specialties & Pharmacy Care Group	Content delivery to foundation year pharmacists for HIEW.	Undertaken in March 2023.	Financial Transaction	No	
				Secured funding for a three year research role with Cardiff and Vale Health board research and development department.		Research Funding	No	
15.3.2024	Anne-Marie Mehegan	Pharmacist	Diagnostics, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
15.3.2024	Danielle Sullivan	Pharmacist	Diagnostics, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
15.3.2024	Lauren Grisley	Pharmacist	Diagnostics, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
19.3.2024	Zoe Silsbury	Clinical Lead Physiotherapist	Diagnostics, Therapies, Specialties & Pharmacy Care Group	Reviewed book proposal for Class Professional Publishing on 'Essentials of Musculoskeletal Practice for Primary Care'. Completed in own personal time.	Undertaken in March 2024	£50 received	No	
20.3.2024	Elizabeth Nelson	Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
27.3.2024	Katie Jenkins	Advance Pharmacist - Anticoagulation	Diagnostics, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
27.3.2024	Nadeeshani Hansika Dias Jayasuriya Jayasuriya Appuhamilage Dona	Dietetic Support Worker	Diagnostics, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	

Targeted DOI Request Sent	Full Name	Designation	Date DOI Approved	Nature of Declaration	Period of Involvement "From"	Period of Involvement "to"	Financial Benefits /Benefits in Kind	End of Financial Year Check	Annual Eligibility Form and Indemnity Check	Notes
Change Declared April 2024 and New Financial Year request 20.5.2024	Jonathan Morgan	Chair	25.4.2024 - Via hard copy form.	Trustee and Director of the NHS Confederation	Since April 2024	ongoing	Travel Expenses reimbursed			
				Director of Insight Wales Consulting Limited	Since 2012	ongoing	Nil			
				100% Share Ownership of Insight Wales Consulting Limited	Since 2012	ongoing	Dividend			
				Associate Consultant with Practice Solutions Ltd	aug-11	ongoing	Fees for work undertaken			
				Wife employed as a Welsh Government Lawyer	Since 2010	ongoing	Salaried.			
New Member - request on commencement nd New Financial Year request 20.5.2024	Rachel Rowlands	Independent Member Community	30.04.2024 - via hard copy form.	Chief Executive / Company Secretary, Age Connects Morgannwg	2005	ongoing	Annual Salary			
				Trustee / Director, Age Connects Wales	2017	ongoing	Nil			
Change Declared April 2024 and New Financial Year request 20.5.2024	Carolyn Donoghue	Independent Member University	07.05.2024 - via hard copy form.	Chair, Welsh Innovation Centre	9 Years	31.05.2024	Payment for each Board meeting			Declaration 22.5.2024 - Chair Welsh Wound Innovation Centre will cease from 31st May 2024 Chair South East Wales Student Mental Health Partnership will cease from 31st July 2024 Magistrate Newport Bench will cease from 31st May 2024
				Independent Member of the Board of Governors, University West of England	2 Years	ongoing	None			
				Special Advisor Joint Commissioning Committee	11th April 2024	30th June 2024	Remunerated position x1 day per month			
				Chair, South East Wales Student Mental Health Partnership	4 Years	31.07.2024	Consultancy Fee			
				Magistrate, Newport Bench	4 Years	31.05.2024	None			
				Senior Professional Fellow, Cardiff University	4 Years	ongoing	None			
				Member of Health and Care Research Wales Advisory Board	From May 2024	ongoing	None			
				Son (ED) employed as a Business Development Manager for Seating Matters						
20.05.2024	Gethin Hughes	Chief Operating Officer	11.06.2024 - Via Email	Nil interests declared.	Not applicable	Not applicable	Not applicable			
				Gethin Hughes confirmed resignation from School Governor and Trustee Ditcham Park School on the 9th April 2024.						
20.05.2024	Sally May	Executive Director of Finance	11.06.2024 - Via Email	Cousin is Director of DECIPHER; Professor in Social interventions and Health, Cardiff University	Ongoing	Ongoing	Salaried			
				Ongoing Salaried position	Ongoing	Ongoing	Salaried			
				Cousin is Regional Sales Manager South West Arthrex Ltd Ongoing Salaried position	Ongoing	Ongoing	Salaried			
				Cousin is Partner, Knight Frank Project and Building Consultancy Ongoing Salaried position	1.5.2024	Ongoing	Salaried			
20.05.2024	Paul Mears	Chief Executive	11.06.2024 - Via Email	Daughter appointed to Lead Physiologist role for In Health South West Community Diagnostic Centre						
				Member of Advisory Board, Awen Cultural Trust	sep-22	Present	Nil			
20.05.2024	Nicola Milligan	Independent Member - Trade Union	11.06.2024 - Via Email	Observer Member, Board of Life Sciences Hub Wales	jun-22	Present	Nil			
20.05.2024	Stuart Morris	Director of Digital	11.06.2024 - Via Email	Board Member - Royal College of Nursing Wales	jan-16	Term ends December 2024	Nil			
20.05.2024	Simon Blackburn	Director of Communications, Engagement & Fundraising	11.06.2024 - Via Email	Chair of Governors for Penyfal Primary School, Bridgend	jul-17	Ongoing	Nil			
20.05.2024	Lauren Edwards	Executive Director of Therapies & Health Science	11.06.2024 - Via Email	Nil interests declared.	Not applicable	Not applicable	Not applicable			
				Trustee and Director of Royal College of Speech and Language Therapists	08-nov-23	Ongoing	Nil			Appointment date taken from Companies House.
Amendment via email 25.9.2024			25.9.2024 via email	Visiting Professor at the University of South Wales	1st October 2024	1st October 2027	Nil			
20.05.2024	Linda Prosser	Executive Director of Strategy & Transformation	11.06.2024 - Via Email	Director Altyn Tepe Ltd	Since 2019	Ongoing	Yes			
				Son (1) Chief Operating Officer Salisbury NHS Foundation Trust	Since Feb 2024 (previously RUH Bath)	Ongoing	Yes			
				Son (2) Service manager (Urology and Ophthalmology) Royal United Hospital Bath	Since 2021	Ongoing	Yes			
20.05.2024	Anne Morris	Associate Board Member - Chair of the Stakeholder Reference Group	21.05.2024 - Via hard copy form.	Deputy Chief Executive of Interlink	2009	Ongoing	Yes - Salaried.			
20.05.2024	Philip Daniels	Interim Executive Director of Public Health	11.06.2024 - Via Email	Board Member / Welsh Chair - Faculty of Public Health	jun-23	Ongoing	Nil			
22.05.2024	Hywel Daniel	Executive Director for People	11.06.2024 - Via Email	Partner is Director - The Performance Centres	2011	Ongoing	Owner / Chief Executive			
22.5.2024	Greg Dix	Executive Director of Nursing / Deputy Chief Executive	11.06.2024 - Via Email	Nil interests declared.	Not applicable	Not applicable	Not applicable			
				Trustee - Royal College of Nursing Foundation	September 2021	Ongoing	Voluntary role, travel / accommodation paid for by the charity			There are likely to be changes to both my director role at WWIC and my Associate Professor role at Plymouth University - I will ensure that the Health Board is kept updated.
				Board Director - Welsh Wound Innovation Centre	jan-22	Ongoing	No financial or benefits in kind			
				Visiting Professor, University of South Wales	2020	Ongoing	Nil			
				Associate Professor, University of Plymouth	2015	Ongoing	Nil			In year amendment - Email 5.8.2024 - Associate Professor Role with the University of Plymouth has lapsed.
				In year amendment - Email 5.8.2024 - Associate Professor Role with the University of Plymouth has lapsed.						
20.05.2024	Dilys Jouvenat	Independent Member - Third Sector	11.06.2024 - via email	Chair of the Rhondda Cynon Taff Citizens Advice	jun-15	26th November 2023	Not applicable			
				Trustee Newport Citizens Advice	2 Years	Ended. Email 11.11.2024 advising resigned from Newport Citizens Advice in October and received notification of removal from the Charity Commission register on 21st October	Not applicable			
				Trustee South East Wales Citizens Advice	1 Year	Present	Not applicable			
				Trustee Interlink	6 months	Present	Not applicable			
			11.9.2024 - Via email	Trustee Rhondda Cynon Taff Citizens Advice	27th November 2023	Present	Not applicable			
				Trustee of the Cymru Older Peoples Alliance (COPAL) it's a charity trustee appointment	3rd September 2024	Present	Not applicable			In year amendment received 11.9.2024
28.05.2024	Kath Palmer	Vice Chair	11.06.2024 - via email	Natural Resources Wales – Board member and Chair of Audit, Risk and Assurance committee.	feb-23	Present	Paid Position			
				Trustee of Crisis (national homelessness charity) and chair of the client services governance committee.	des-22	Present	Voluntary (Expenses Paid)			

Targeted DOI Request Sent	Full Name	Designation	Date DOI Approved	Nature of Declaration	Period of Involvement "From"	Period of Involvement "to"	Financial Benefits /Benefits in Kind	End of Financial Year Check	Annual Eligibility Form and Indemnity Check	Notes
				Member of the Residential Decarbonisation Implementation Group for Welsh Government.	sep-19	Confirmed in declaration on the 28th May that this Group ceased in April 2024.	Voluntary			
Email update 11.7.2024			12.07.2024	Board Member (Crisis Trustee) for Pathway UK (Subsidiary of Crisis).	8th July 2024	Present	Voluntary (Expenses Paid)			
29.05.2024	Lynda Thomas	IM Corporate	11.06.2024 - via email	Chair of Norfolk Community Health and Care NHS Trust.	Since February 2023	Present	Remunerated.			
03.06.2024	Lisa Curtis-Jones	Associate Member - Third Sector	5th June 2024 - via hard copy form.	Trustee of Age UK Statutory Director of Social Services in Merthyr Tydfil	jan-23 apr-15	Jan-26 Ongoing	None - Voluntary role			
03.06.2024	Gareth Watts	Director of Corporate Governance / Board Secretary	11.06.2024 - Via Email	Member of the regional partnership board (RPS) – RIF funding to local authorities through BBR. Board Member of Coleg Gwent (Further Education College) Since 2015 onwards	2015	Present	Voluntary			
				Member of the Joint Audit Committee of Gwent Police and the Police and Crime Commissioner for Gwent	2022	Present	Daily rate for meeting attendance and preparation			
05.06.2024	Geraint Hopkins	Independent Member (Local Authority)	19.6.2024 - Via Email.	Llanharan Community Development Project Limited	10 years +	Present	Not applicable			
				Clerk to Llantrisant Community Council.	okt-21	Present	Remunerated			
				Elected Member, Rhondda Cynon Taff County Borough Council	19 years	Present	Not applicable			
05.06.2024	Helen Lentle	Independent Member (Legal)	Via Email- 5.6.2024	Non-Executive Director: CISWO (the Coal Industry Social Welfare Organisation).	Since September 2022	Present	Voluntary role.			
				Trustee - Dyslexia Cymru/Wales Dyslexia Charity - Charity Number 114416	Since September 2022	Present	Voluntary role.			
06.06.2024	Patsy Roseblade	Independent Member (Finance & Audit)	11.06.2024 - via email	Non Executive Director Tennis Wales	2020	Ongoing	Voluntary			
10.06.2024	Ian Wells	Independent Member (Digital)	11.06.2024 - via email	Director of the Wales Institute of Digital Information which undertakes research with Digital Health and Care Wales/NHS Wales Informatics Service in collaboration of University of Wales Trinity St David and the University of Wales. Research projects also undertaken for various health boards including CTM.	3 days per week From 1/2/20	Ongoing- Notified in June 2024 that this can now be removed from the declaration as I Wells no longer undertakes the 3 days per week as described.	All financial transactions or benefits in kind.			

Date Approved	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
02.04.2024	Education and Training and Paediatric Pharmacist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
02.04.2024	Pharmacist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
04.04.2024	Physiotherapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
04.04.2024	Physiotherapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
08.04.2024	Physiotherapy Assistant	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
09.04.2024	Community Pharmacy Facilitator	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Community pharmacist (and IP) without managerial responsibilities at Valleys Link Pharmacy Ltd (Cilfynydd and Gelli) Husband works as Placements Lead for Cardiff University School of Pharmacy, and is responsible for allocating students to placement sites across CTMUHB. I am not involved in the decision making and would be unlikely to benefit in any way from this association.	6 months (started October 2023) Approx. 1 year in role	Permanent salaried role None	Any contractual or performance issues relevant to Valleys Link Pharmacies located in CTMUHB will be managed by Jason Carroll and/or Meinir Davies. Carys will avoid any circumstances which ,may present a conflict of interest.	
15.04.2024	Consultant in Radiology	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Chief Medical Officer Adaptix Imaging Centre for Innovation and Enterprise Oxford University Begbroke Science Park Woodstock Road Oxford.OX5 1PF.	Since July 2021	Salaried half day/ week	None Identified.	
18.04.2024	Senior Healthcare Science Practitioner	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
19.04.2024	Registered General Nurse	Primary Care and Community Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
23.04.2024	Speech and Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Working with the Neurodevelopment Service. Noted as no conflict with current position held.	8 hours across the month of April	Not stated.		
23.04.2024	Clinical Technologist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
23.04.2024	Planning Assistant	Planning & Partnerships Directorate	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
23.04.2024	Healthcare Science Associate	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
23.04.2024	Superintendent Radiographer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
24.04.2024	Speech & Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
25.04.2024	Academy Office and Events Manager	National Imaging Academy Wales	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
25.04.2024	Speech and Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
29.04.2024	Registered General Nurse	Primary Care and Community Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
3.05.2024	Superintendent Radiographer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
6.5.2024	Deputy Ward Manager	Primary Care and Community Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
7.5.2024	Primary Care Therapist	Primary Care and Community Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
8.5.2024	Advanced Pharmacist for Cardiology and Anticoagulation	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
8.5.2024	Registered General Nurse	Primary Care and Community Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
13.5.2024	Project Manager	Mental Health & Learning Disabilities Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
14.5.2024	Rotational Physiotherapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
16.5.2024	District Nurse	Primary Care and Community Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	

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16.5.2024	District Nurse	Primary Care and Community Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
16.5.2024	Healthcare Support Worker	Primary Care and Community Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
21.5.2024	Academy Administrator	National Imaging Academy Wales	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
22.05.2024	Pharmacist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
26.05.2024	Registered General Nurse	Primary Care and Community Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
28.05.2024	Information Analyst	Digital & Data Directorate	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
28.05.2024	Healthcare Support Worker	Primary Care and Community Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
29.05.2024	Medicines Management Support Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
29.05.2024	Clinic Co-ordinator	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
29.05.2024	Head of Assets, Governance & Technical Services	Estates Directorate	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
31.05.2024	Staff Nurse	Primary Care and Community Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
03.06.2024	Medicines Management Support Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
05.06.2024	Consultant Old age Psychiatrist and Clinical Director for Older Adult Mental Health Services CTMUHR	Mental Health & Learning Disabilities Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
05.06.2024	Lead Nurse - Angelton Clinic	Mental Health & Learning Disabilities Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
05.06.2024	Nurse Director - MHL D Care Group	Mental Health & Learning Disabilities Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
06.06.2024	Consultant Urologist	Planned Care Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
06.06.2026	Strategy Group Clinical Director	Planning & Performance Directorate	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
06.06.2024	Consultant ENT Surgeon	Planned Care Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
06.06.2024	Consultant General Surgeon	Planned Care Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
06.06.2024	LHP Infrastructure Programme Director	Estates Directorate	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
06.06.2024	Consultant Gastroenterologist	Unscheduled Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
06.06.2024	Assistant Director Capital & Estates	Estates Directorate	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
06.06.2024	Microbiology Consultant	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
06.06.2024	Consultant Haematologist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
06.06.2024	Consultant Surgeon	Planned Care Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
06.06.2024	Consultant Pathologist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
06.06.2024	Consultant Haematologist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
06.06.2024	Consultant Ophthalmologist	Planned Care Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
06.06.2024	Care Group Service Director	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
06.06.2024	Directorate Manager	Mental Health & Learning Disabilities Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
06.06.2024	Directorate Lead Psychologist OPMH/Consultant Clinical Psychologist OPMH	Mental Health & Learning Disabilities Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
06.06.20024	Consultant Breast Surgeon and Clinical Director for Breast Services	Planned Care Care Group	1. Two Together's Limited (undertaking my private practice) 2. Moondance Cancer Foundation Clinical Advisory Board 3. Medical advisor for ITV and Netflix 4. Raise Healthcare consultant	1. Since January 2021 Since June 2023 Since June 2021 Since August 2023 2. 3. 4.	1. Salary/Dividends and Shareholder 2. Unpaid Paid Consultancy Rates 3. Paid Consultancy Rates 4.	Not applicable	
06.06.2024	Consultant Hepatologist/Clinical Director Gastroenterology and Endoscopy	Diagnostics, Therapies, Pharmacy and Sciences Care Group	1. Trustee of Brynawel Rehabilitation Centre, Llanharan, CF72 9RN 2. Member of the British Society of Gastroenterology clinical Standards Committee which drafts national policy and guidelines	1. 2 Years 2. 2 Years	1. No financial or benefits in kind 2. None	Not applicable	

Date Approved	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments	
06.06.2024	Deputy Director Commissioning Ambulance and 111	Joint Commissioning Committee	1. Bank Paramedic Contract with the Welsh Ambulance Service 2. Acting corporal British Army Reserves 3. Spouse is advanced clinical practitioner Swansea Bay	1. Since February 2016 From October 2017 Since March 2018	2. 3.	1. Paid per shift Paid per hours worked 3. Salaried Employee	2. Not applicable	
06.06.2024	Consultant Child & Adolescent Psychiatrist	Mental Health & Learning Disabilities Care Group	1. Second Opinion Approved Doctor (SOAD), Health Inspectorate Wales 2. Sole Director of SL Healthcare Solutions Ltd	1. 2018-present 2017- present	2.	1. Remunerated at the nationally agreed rate plus expenses for SOAD visits undertaken 2017- present	2. Not applicable	
06.06.2024	Consultant Gastroenterologist	Unscheduled Care Care Group	Sponsorship 2023 by AbbVie drugs company for digital attendance at ECCO IBD conference.		2023	Paid conference fee.	Not applicable	
06.06.2024	Consultant Intensivist and Clinical Director for ICU	Planned Care Care Group	1. School Governor - YGG Aberdare 2. Regional Clinical Lead for Organ Donation	1. February 2023 April 2022	2.	1. None PA (NHSBT Funded)	2. 1 Not applicable	
06.06.2024	Assistant Director of Facilities	Facilities Directorate	Nil Interests Declared	Not applicable		Not applicable	Not applicable	
07.06.2024	Assistant Director of Governance & Risk	Corporate Governance - Central Function	Nil Interests Declared	Not applicable		Not applicable	Not applicable	
07.06.2024	Consultant in Acute Medicine	Unscheduled Care Group	Nil Interests Declared	Not applicable		Not applicable	Not applicable	
07.06.2024	Advanced Pharmacist - Formulary and Interface	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable		Not applicable	Not applicable	
07.06.2024	Medical Director	Mental Health & Learning Disabilities Care Group	Nil Interests Declared	Not applicable		Not applicable	Not applicable	
07.06.2024	Consultant in Emergency Medicine	Unscheduled Care Group	Nil Interests Declared	Not applicable		Not applicable	Not applicable	
07.06.2024	Consultant	Mental Health & Learning Disabilities Care Group	Nil Interests Declared	Not applicable		Not applicable	Not applicable	
07.06.2024	Consultant	Medical Director Function	Nil Interests Declared	Not applicable		Not applicable	Not applicable	
07.06.2024	Deputy Chief Operating Officer	Chief Operating Officer Function	Nil Interests Declared	Not applicable		Not applicable	Not applicable	
07.06.2024	Consultant Cardiologist	Unscheduled Care Group	1. Trustees for Swansea Chinese Christian Church 2. Joint working project to run pharmacist led heart failure 3. Hold Cardiff University Honorary Lecturer Post clinic	1. Since 2011 2023-2024 2017	2. 3. Since	1. Nil Pharmaceutical Company 1 PA from HEI/WS	2. 3. Not applicable	
07.06.2024	Consultant Physician	Unscheduled Care Group	Spouse is a Director of limited liability company			Nil financial transactions	Not applicable	
07.06.2024	Consultant Anaesthetist/ Associate Clinical Director	Planned Care Care Group	School governor - Caldicot School, and Durand Primary School, Caldicot	Since 2018		Nil financial transactions	Not applicable	
08.06.2024	Consultant Anaesthetist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Honorary Tutor title with Cardiff University, Medical School	Renewed 01/05/2024		Nil financial transactions		
10.06.2024	Healthcare Support Worker	Primary Care and Community Care Group	Nil Interests Declared	Not applicable		Not applicable	Not applicable	
10.06.2024	Consultant Radiology	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable		Not applicable	Not applicable	
10.06.2024	Assistant Director of Finance	Finance Directorate	Nil Interests Declared	Not applicable		Not applicable	Not applicable	
10.06.2024	Deputy Director for People	People Service Directorate	Nil Interests Declared	Not applicable		Not applicable	Not applicable	
10.06.2024	Public Health Consultant	Public Health	Nil Interests Declared	Not applicable		Not applicable	Not applicable	
10.06.2024	Committee Secretary / Deputy Director Corporate	National Collaborative Commissioning unit	Nil Interests Declared	Not applicable		Not applicable	Not applicable	
10.06.2024	Consultant Gastroenterologist	Unscheduled Care Group	Nil Interests Declared	Not applicable		Not applicable	Not applicable	
10.06.2024	Stroke Consultant	Unscheduled Care Group	Nil Interests Declared	Not applicable		Not applicable	Not applicable	
10.06.2024	Assistant Director of Transformation	Planning & Partnerships Directorate	Nil Interests Declared	Not applicable		Not applicable	Not applicable	
10.06.2024	Consultant Radiologist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable		Not applicable	Not applicable	
10.06.2024	Deputy Director of Finance	Finance Directorate	Nil Interests Declared	Not applicable		Not applicable	Not applicable	
10.06.2024	Deputy COO	Chief Operating Officer Function	Nil Interests Declared	Not applicable		Not applicable	Not applicable	
10.06.2024	Consultant Dermatologist	Medical Director Function	Nil Interests Declared	Not applicable		Not applicable	Not applicable	
10.06.2024	Consultant Paediatrician	Children & Families Care Group	Nil Interests Declared	Not applicable		Not applicable	Not applicable	
10.06.2024	Locum Consultant Radiologist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable		Not applicable	Not applicable	

Date Approved	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
10.06.2024	Consultant Paediatrician	Children & Families Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
10.06.2024	Consultant Physician	Unscheduled Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
10.06.2024	Consultant Physician	Unscheduled Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
10.06.2024	Chief of Staff	Corporate Functions	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
10.06.2024	Locum Consultant in General and Acute Medicine	Unscheduled Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
10.06.2024	Consultant in Palliative Medicine	Unscheduled Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
10.06.2024	Locum Consultant Maxillofacial Surgeon	Planned Care Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
10.06.2024	Service Director	Mental Health & Learning Disabilities Care Group	1. Chair of West Wales Care & Repair Board Member ATEB 2. Spouse is a Clinical Nurse Specialist at Hywel Dda Health Board 3. Daughter is a nurse at Aneurin Bevan UHB 4.	1. Since 20 March 20223 2. Since 1 April 2024 3. Since March 2023 4. Since September 2023	1. Voluntary role 2. Salaried role 3. Not applicable 4. Not applicable	Not applicable	
10.06.2024	Head of Psychology	Mental Health & Learning Disabilities Care Group	1. Trustee at Adferiad Glamorgan Psychotherapy & Consultation Private psychotherapy and consultation 2.	1. Since 2021 2. Since 2013	1. Voluntary private healthcare systemic organisational consultation 2.	Not applicable	
10.06.2024	Consultant Physician & Site Clinical Lead	Unscheduled Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
10.06.2024	Consultant Gastroenterologist	Unscheduled Care Group	1. Director of Minesh Gastro Ltd 2. Spouse is Director of Minesh Gastro Ltd 3. Works at Nuffield Hospital in Cardiff Bay to do a clinic and endoscopy.	1. Since 2022 2. Since 2022 3. Since 2018	1. Share options 2. Share options	Not applicable	
10.06.2024	Consultant Anaesthetist	Planned Care Care Group	1. Director Private Limited Company 2. Spouse is Director of Private Limited Company	1. Since October 2016 2. Since October 2016	1. Receive dividends 2. Receive dividends	Not applicable	
10.06.2024	Consultant Anaesthetist	Planned Care Care Group	1. Deputy Regional Advisor Royal College of Anaesthetics 2. Examiner for the Royal College of Anaesthetist	1. Since April 2024 2. Since April 2024	1. Nil financial transactions 2. Nil financial transactions	Not applicable	
11.06.2024	Consultant General and Colorectal Surgeon	Planned Care Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
11.06.2024	Consultant Physician	Unscheduled Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
11.06.2024	Consultant Anaesthetist	Planned Care Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
11.06.2024	Consultant Respiratory and General Internal Medicine	Unscheduled Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
11.06.2024	Locum Consultant Rheumatologist	Unscheduled Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
11.06.2024	Consultant Urologist	Planned Care Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
11.06.2024	Deputy Director of Strategy and Partnerships	Planning & Performance Directorate	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
11.06.2024	Consultant in Acute Medicine	Unscheduled Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
11.06.2024	Consultant Cardiologist	Unscheduled Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
11.06.2024	Consultant Anaesthetist	Planned Care Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
11.06.2024	Consultant Physician	Unscheduled Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
11.06.2024	Clinical Director	National Collaborative Commissioning unit	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
11.06.2024	Consultant Gastroenterologist	Unscheduled Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
11.06.2024	Consultant Anaesthetist	Planned Care Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
11.06.20241	Consultant in Community Paediatrics	Children & Families Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
11.06.2024	Assistant Director of Finance	Finance Directorate	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
11.06.2024	Care group medical director	Medical Director Function	1. Director of a limited Company 2. Spouse is a Director of a limited Company	1. From October 2022 2. From October 2022	1. Dividends share 2. Dividends share and monthly salary	Not applicable	
12.06.2024	Head of Health Psychology Service	Diagnostics, Therapies, Pharmacy and Sciences Care Group	1. Spouse is Principal Solicitor / Private Law Practice 2. Professor of Health Psychology (Honorary - unpaid)	1. 36 Years 2. 10 Years	1. Not applicable 2. Nil	Not applicable	
12.06.2024	Director of Planning, Vaccination Programme Wales (currently on secondment).	Planning & Performance Directorate	1. Spouse is GP Partner, Afon Elai Partnership 2. Spouse is Director, Cardiff Southwest Cluster Community Interest	1. Since August 2015 2. Since January 2022	1. Not applicable 2. Not for profit organisation	Not applicable	
13.06.2024	Consultant Oral Surgeon / Clinical Service Director	Planned Care Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
13.06.2024	Consultant Paediatrician	Children & Families Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
13.06.2024	Consultant Obstetrician & Gynaecologist	Children & Families Care Group	Honorary Professor Reproductive Medicine and Gynaecological Oncology Swansea University	Since 2018	Nil financial transactions	Not applicable	
13.06.2024	Consultant Surgeon	Planned Care Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
13.06.2024	Speech and language admin	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
13.06.2024	Deputy Medical Director	Medical Director Function	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
14.06.2024	Consultant Anaesthetist	Planned Care Care Group	President of Society of Anaesthetists of Wales	March 2023 to present	None	Not applicable	
14.06.2024	Consultant in Restorative Dentistry	Planned Care Care Group	1. Directorship in a limited company providing private dental care in Cardiff and Bristol 2. Spouse has Directorship in a limited company providing private dental care in Cardiff and Bristol	1. 2018 to present 2. 2018 to present	1. Financial transactions 2. Financial transactions	Not applicable	

Date Approved	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
17.06.2024	Consultant Radiologist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
17.06.2024	Consultant in Sports Medicine	Unscheduled Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
17.06.2024	Directorate Manager CAMHS and specialist services	Mental Health & Learning Disabilities Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
17.06.2024	Energy Support Officer	Estates Directorate	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
17.06.2024	Emergency Medicine Consultant	Unscheduled Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
18.06.2024	Consultant Orthogeriatrician	Planned Care Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
18.06.2024	Consultant Gynaecologist	Children & Families Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
18.06.2024	Consultant Histopathologist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
18.06.2024	Consultant Paediatrician	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
18.06.2024	Nurse	Primary Care and Community Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
18.06.2024	Pelvic Health Physiotherapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Private Practice Work	Since April 2024	Financial	Not applicable	
18.06.2024	Registered General Nurse	Primary Care and Community Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
18.06.2024	Director of Nursing	Unscheduled Care Group	1. Trustee in City Hospice Cardiff 2. Spouse works in DTPS Directorate within Health Board	1. Since 2020	1. Not applicable 2. Not applicable	Not applicable	
19.06.2024	Family Psychotherapist	Mental Health & Learning Disabilities Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
19.06.2024	Responsible Office PCH Construction Programme	Estates Directorate	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
21.06.2024	Dietetic Support Worker	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Secondary employment through Direct Payment in Neath Port Talbot Council as a Personal Assistant in Care for an individual. Contract will only be on the weekend	Once a month until contract terminates	Paid role. Paid via Neath Port Talbot Council	Not applicable	
24.06.2024	Physiotherapy Assistant	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not Applicable	Not applicable	
24.06.2024	Physiotherapy Assistant	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
24.06.2024	Healthcare Support Worker	Primary Care and Community Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
24.06.2024	Speech and Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Soon to begin a second paid employment as a specialist speech and language therapist at a private company "Cardiff Speech Therapy" operating outside of the health board area only.	From 20th July 2024 - onwards	Paid employment	Not applicable	
25.06.2024	Highly Specialist Speech and Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
25.06.2024	Speech and Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
25.06.2024	Community Speech and Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
25.06.2024	Highly Specialist Speech and Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
25.06.2024	Specialist Speech and Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
25.06.2024	Speech and Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
25.06.2024	Highly Specialist Speech and Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable	
25.06.2024	Professional Lead Speech and Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable	
25.06.2024	Specialist Speech and Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable	
25.06.2024	Staff Nurse	Primary Care and Community Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable	
26.06.2024	Healthcare Support Worker	Primary Care and Community Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable	
26.06.2024	Healthcare Support Worker	Primary Care and Community Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable	

Date Approved	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
26.06.2024	Staff Nurse	Primary Care and Community Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable	
26.06.2024	Healthcare Support Worker	Primary Care and Community Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable	
26.06.2024	Speech and Language Technical Instructor	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable	
26.06.2024	Anaesthetics Consultant	Planned Care Care Group	Director of Bridgend Anaesthetists limited.	Current	None	Not applicable	
27.06.2024	Specialist Speech and Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable	
27.06.2024	Specialist Speech and Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable	
27.06.2024	Speech and Language Assistant	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable	
28.06.2024	Consultant Acute Medicine	Unscheduled Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable	
01.07.2024	Cancer Services MDT Coordinator	Patient Care & Safety Directorate	Nil Interest Declared	Not applicable	Not applicable	Not applicable	
01.07.2024	Speech and Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable	
01.07.2024	Director of Improvement & Innovation	Patient Care & Safety Directorate	1. Independent Member St John Ambulance Cymru Trustee Brynawel House Rehab Spouse is Trustee St John Ambulance Cymru	1. 2 Years 2. 3 years 3. 5 Years	2. 3 3. 5	None	Not applicable
02.07.2024	Advanced Pharmacist - HIV & HOMECARE	Diagnostics, Therapies, Pharmacy and Sciences Care Group	1. Co-applicant on a Fellowship grant Project 2. Co-Investigator and Member of the Patient and Public Involvement Team 3.Secondment with Health Education & Improvement Wales 4. Awarded scholarship to complete a PGCert in Advanced Management with Swansea University	1. July 2023 - ongoing 2. May 2023-Ongoing 3. NIL 4. February 2024-Present (Intend completion date September 2024)	1. NIL at time of completing declaration 2. Financial transaction 3. NIL 4.NIL		
2.07.2024	Specialist Speech and Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable	
2.07.2024	Healthcare Support Worker	Primary Care and Community Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable	
2.07.2024	Speech & Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable	
2.07.2024	Healthcare Support Worker	Primary Care and Community Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable	
3.07.2024	Professional Manager Speech and Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable	
3.07.2024	Highly Specialist Speech and Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	I will be working independently for a new company South Wales Psychology as part of their MDT conducting Autism Diagnostic assessments. I have made it clear that I am employed by Cwm Taf UHB and therefore will not be able to work with any children living in the Cwm Taf area.	Commencing September 2024	Paid role	Not applicable	
3.07.2024	Healthcare Support Worker	Primary Care and Community Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
3.07.2024	ENT Consultant	Planned Care Care Group	1. Director of Vale ENT Ltd. Spouse is Director of Vale ENT Ltd. Principal Investigator in PoWH for the UK national TALGITS (Trial of Alginates in Throat Symptoms) Trial.I multi RCSEdinburgh QI Director Expert panel member of the International QI WONDER Study 6. Cardiff University HSL for Phase 1 students in PoWH	1. Since 2018 Since 2018 Since 2022 (Trial launch) Since 2017 Since 2023 Since 2022	2. 3. 4. 5. 6.	1. Financial as provider of private ENT services 2. Admin support for provider of private ENT services 3. Registered with CTMUHB R&D Study sponsored by Reckitt-Benckiser as Gaviscon is Alginate in trial. CTMUHB R&D receive payment for each patient recruited. 4. No financial gain 5. No financial gain 6. HSL stipend from University	The conflict of interest is noted from a service perspective and happy to confirm this will not affect the role within ENT.

Date Approved	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
03.07.2024	Radiographer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable	
4.07.2024	Consultant Anaesthetist	Planned Care Care Group	1. Director of Specsavers Penarth Store 2. Spouse is Director of Specsavers Penarth Store (50% shareholder)	1. One Year 2. One Year	1. None 2. None	Not applicable	
5.07.2024	Healthcare Support Worker	Primary Care and Community Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable	
5.07.2024	Community Registered Nurse	Primary Care and Community Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable	
5.07.2024	Staff Nurse	Primary Care and Community Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable	
10.7.2024	Community Staff Nurse	Primary Care and Community Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable	
11.07.2024	Speech & Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	1. Working on as a Bank Speech and Language Therapist for Betsi Cadwalader Health Board 2. Extra Hours for the Neurodevelopmental Service for Cwm Taf Morgannwg Health Board	1. 8 July 2024 2. February 2024	1. Salary from Betsi Cadwaladr Health Board 2. Salary received for extra hours	Not applicable	
15.07.2024	Superintendent Radiographer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil interests declared	Not applicable	Not applicable	Not applicable	

Date Approved	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
16.07.2024	Principle Pharmacist Mental Health	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil interests declared	Not applicable	Not applicable	Not applicable	
16.07.2024	Clinical Psychologist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Offering consultation to Youth Justice Services as part of the Youth Endowment Fund. This includes offering clinical supervision to staff, attendance at meetings and support to the project manager.	Until March 2025	Financial Payment	Not applicable	
16.07.2024	Professional Speech and Language Therapy Manager	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable	
16.07.2024	District Nurse	Primary Care and Community Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable	
16.07.2024	Staff Nurse	Primary Care and Community Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable	
16.07.2024	Healthcare Support Worker	Primary Care and Community Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable	
23.07.2024	Speech and Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable	
23.07.2024	Community Staff Nurse	Primary Care and Community Care Group	Nil Interest Declared	Not applicable	Not applicable	Not Applicable	
23.07.2024	Staff Nurse	Primary Care and Community Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable	
23.07.2024	Healthcare Support Worker	Primary Care and Community Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable	
29.07.2024	Speech & Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable	
29.07.2024	Healthcare Support Worker	Primary Care and Community Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable	
	Consultant Clinical Scientist & Assistant Director for Research & Development	Clinical Biochemistry Department (PCH)	1. Visiting Professor of Clinical Science: University of South Wales (Research and Education) 2. Visiting Professor of Clinical Science: University of South Wales (Research and Education) 3. Honorary Professor of Clinical Biochemistry: Cardiff Metropolitan University (Research and Education) 4. Vice Chair of the Welsh Scientific Advisory Committee (WSAC)	1. 2012 2. 2019 3. 2018 4. 2022	1. NONE 2. NONE 3.Health Board receives funding for x1 session/week from the National Pathology Programme 4. NONE	Not applicable	
31.07.2024	Dental Teaching Unit Manager	Primary Care & Communities Care Group	Nil interest declared	Not applicable	Not applicable	Not applicable	
01.08.2024	Specialist Speech & Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Soon to begin a second paid employment as a specialist speech and language therapist at Cardiff Speech Therapy. I will be working around two Saturdays per month for half a day. My client base will be children only outside of the Cwm Taf Morgannwg Health Board areas.	From 3 August 2024 - ongoing	Paid employment	Already agreed that caseload should not include children who reside in the UHB.	
07.08.2024	District Nurse Team Leader	Primary Care and Community	Nil interest declared	Not applicable	Not applicable	Not applicable	
07.08.2024	Consultant Clinical Psychologist	Princess of Wales Hospital	Self-employment into Hillside Secure Children's Home offering psychological assessment, consultation and advice to inform staff on how to support children in their care.	until 25.09.2024	None	Not applicable	
12.08.2024	Dental Nurse	Primary Care and Communities	Nil interest declared	Not applicable	Not applicable	Not applicable	
14.08.2024	Consultant	Diagnostics, Therapies, Pharmacy and Sciences Care Group	ERH PATH LTD; Private limited company; Nature of business: specialists medical practice activities	Incorporated May 2022	Director (ad hoc payments)	Not applicable	
28.08.2024	Lead Systemic Psychotherapist	Mental Health & Learning Disabilities	1. Centre for Systemic Studies 2. CTM UHB - employee supervision 3. Private supervision arrangements	1. Sept 2023 June 2023 2017	2. 1. Paid Tutor 3. June Paid external supervisor Paid.	2. 1. Paid Tutor 3. June Paid external supervisor Paid.	Not applicable
02.09.2024	Macmillan Advanced Oncology Pharmacist	Therapies & Health Sciences	Sponsorship from Pfizer Ltd to attend British Oncology Pharmacy Association Annual Conference 2024	11/10/2024-13/10/2024	Pfizer covering costs of registration fee and accommodation costs which would otherwise be paid for by CTMUHB	Not applicable	
12.09.2024	Assistant Director Digital Systems	ICT Department	Nil interest declared	Not applicable	Not applicable	Not applicable	
18.09.2024	Rotational Physiotherapist	Therapies & Health Sciences	Nil interest declared	Not applicable	Not applicable	Not applicable	
19.09.2024	Healthcare Support Worker	Primary & Community Care	Nil interest declared	Not applicable	Not applicable	Not applicable	
23.09.2024	National Workforce Lead	Urgent and Emergency Care	Nil Interest Declared	Not applicable	Not applicable	Not applicable	
23.09.2024	HCSW	Rhondda Taf, Ely integrated locality group	Nil Interest declared	Not applicable	Not applicable	Not applicable	
23.09.2024	Consultant Orthogeriatrician	Bridgend Integrated Locality Group	Nil Interest declared	Not applicable	Not applicable	Not applicable	
23.09.2024	Cardiologist	Rhondda Taf, Ely integrated locality group	Nil interest declared	Not applicable	Not applicable	Not applicable	
23.09.2024	Department of Rheumatology	Retire and Return Locum Consultant	Nil interest declared	Not applicable	Not applicable	Not applicable	
23.09.2024	Academy Administrator	Radiology	Nil interest declared	Not applicable	Not applicable	Not applicable	

Date Approved	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
23.09.2024	Head of Employee Engagement & Involvement	Corporate Functions	Nil interest declared	Not applicable	Not applicable	Not applicable	
23.09.2024	Employee Experience Lead	Workforce & OD	Nil interest declared	Not applicable	Not applicable	Not applicable	
23.09.2024	Consultant Public Health	Public Health	Nil interest declared	Not applicable	Not applicable	Not applicable	
23.09.2024	Head of Corporate Governance	Corporate Governance	Nil interest declared	Not applicable	Not applicable	Not applicable	
23.09.2024	Staff Nurse	Rhondda Taf, Ely integrated locality group	Nil interest declared	Not applicable	Not applicable	Not applicable	
23.09.2024	Healthcare Science Assistant	Facilities	Nil interest declared	Not applicable	Not applicable	Not applicable	
23.09.2024	HCSW Band 4	Primary Care	Nil interest declared	Not applicable	Not applicable	Not applicable	
23.09.2024	HCSW	Rhondda Taf, Ely integrated locality group	Nil interest declared	Not applicable	Not applicable	Not applicable	
23.09.2024	Staff Nurse	Rhondda Taf, Ely integrated locality group	Nil interest declared	Not applicable	Not applicable	Not applicable	
23.09.2024	HCSW	Rhondda Taf, Ely integrated locality group	Nil interest declared	Not applicable	Not applicable	Not applicable	
23.09.2024	HCSW	Rhondda Taf, Ely integrated locality group	Nil interest declared	Not applicable	Not applicable	Not applicable	
23.09.2024	Principle Pharmacist Specialist Therapies and High Cost Medicines	Therapies & Health Sciences	Nil interest declared	Not applicable	Not applicable	Not applicable	
23.09.2024	Community Staff Nurse	Primary Care	Nil interest declared	Not applicable	Not applicable	Not applicable	
23.09.2024	Consultant	Merthyr Cynon Integrated Locality Group	Nil interest declared	Not applicable	Not applicable	Not applicable	
23.09.2024	Consultant Physician	Rhondda Taf, Ely integrated locality group	Nil interest declared	Not applicable	Not applicable	Not applicable	
23.09.2024	Consultant	Rhondda Taf, Ely integrated locality group	Nil interest declared	Not applicable	Not applicable	Not applicable	
23.09.2024	Therapies Admin Support Officer	Therapies & Health Sciences	Nil interest declared	Not applicable	Not applicable	Not applicable	
30.09.2024	Principal Pharmacist Haematology	Therapies & Health Sciences	ROCHE Sponsorship for attendance of British Oncology Pharmacy Association annual symposium in Birmingham 2024	11th - 13th October	total sponsorship equivalent to £750. covering attendance of conference, two nights accommodation and transport to and from conference.	Not applicable	
14.10.2024	Radiographer	Radiology	Nil interest declared	Not applicable	Not applicable	Not applicable	
14.10.2024	Radiographer	Radiology	Nil interest declare	Not applicable	Not applicable	Not applicable	
14.10.2024	Dental Nurse	primary care	Nil interest declared	Not applicable	Not applicable	Not applicable	
25.10.2024	Dietician	Therapies & Health Sciences	Nil interests declared	Not applicable	Not applicable	Not applicable	
31.10.2024	Head of Quality Assurance and Compliance	Corporate Governance	I am a Peer reviewer with HIW however I am not permitted to take part in any inspection activity involving CTM	7 years	I obtain expenses for inspections that I take part in	Not applicable	

Date Declaration Made	Date Received by Corporate Governance	Designation / Department	Provided by / From	Date Received	Details	Gift/Hospitality and or Sponsorship	Accepted or Declined
30.08.2024	02.09.2024	Macmillan Advanced Oncology Pharmacist	Pfizer Limited	11th October 2024-13th October 2024	Sponsorship for the registration fee and accommodation costs to be paid directly by sponsor. Approximate value: Accommodation £200-£300 and Conference / Registration Fees £300.	Sponsorship	Accepted. Approved by Chief Pharmacist.
01.10.2024	01.10.2024	Dermatology	Sanofi	Circa Start date of 1.7.2024 to have library established by 1.10.2024	Donation of monies in the value of £2441.79 to purchase Dermatology books for trainees at POWH. Sanofi was contacted by the Trainee who have an educational fund for the books. The objective being: Development of a contemporary departmental library of dermatology reference books - to support the education and professional development of our doctors and nurses - to facilitate the management of challenging cases	Sponsorship	Accepted. Approved by Clinical Director Dermatology Supported by Deputy Executive Medical Director 8.10.2024.

Prince Charles Hospital Redevelopment - Validation of Management Actions Final Internal Audit Report 2024/25

Cwm Taf Morgannwg University Health Board



Substantial Assurance

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Status of Previously Agreed Recommendation 2

Appendix A 5

Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

CTM-SSU-2425-37

November 2024

December 2024

December 2024

Sally May, Executive Director of Finance

Huw Richards, Head of Internal Audit

Eifion Jones, Deputy Head of Internal Audit

Executive Summary

Purpose

This audit originates from the 2024/25 integrated audit plan agreed with management and approved by the Audit & Risk Committee. The overall objective of this audit is to deliver assurance to the Audit Committee that timely and appropriate management action has been applied to address risks identified and reported at the PCH Redevelopment Audit Reports from 2023/24, particularly:

- Validation of Management Action – December 2023 – Substantial Assurance
- Supervisor Role – December 2023 – Substantial Assurance
- Financial Assurance – April 2024 – Reasonable Assurance
- Key Project Objectives – July 2024 – Reasonable Assurance

Overview

All 14 of the agreed actions from the prior reviews have been closed as per table below:

	High	Medium	Low	Total
Closed	-	13	1	14
Partially Implemented	-	-	-	-
Outstanding	-	-	-	-
Total	-	13	1	14

Further audits will be progressed in these areas as a part of the 2024/25 agreed Integrated Audit Plan. This will enable us to further consider and appraise the ongoing effectiveness of the actions taken by management. As a result, we have concluded **substantial assurance** on this area.

Further details on each recommendation are provided below.

Status of Previously Agreed Recommendation

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
Validation of Management Action – December 2023 – Substantial Assurance				
No outstanding recommendations.				
Supervisor Role – December 2023 – Substantial Assurance				
1	The management of observations / defects (and specifically the rate of closure) should be highlighted at progress meetings to gain increased traction.	Responsible Officer, PCH Construction Programme December 2023	Medium Priority	Closed - Supervisor's report re-formatted to draw attention to outstanding defects.
2	The monthly Supervisor Reports could be improved in terms of the clarity of key information provided. The following is suggested: Assurance dials could be used for each key area (progress against programme, quality of works, progress in closing defects/observations etc.), with an indication of movement from the prior month.	Responsible Officer, PCH Construction Programme January 2024	Medium Priority	Closed - Supervisor's report re-formatted to draw attention to priority of outstanding defects.
	The data provided in respect of defects/observations closed/outstanding, could be enhanced to provide information regarding the priority nature of the defects which have not been actioned (e.g. high priority/low priority).	Responsible Officer, PCH Construction Programme January 2024	Medium Priority	Closed- Supervisor's report re-formatted to include visual representation of assurance status.
Financial Assurance – April 2024 – Reasonable Assurance				
1	Improved monitoring protocols should be embedded within the valuation scrutiny process for individual hours worked on-site.	Responsible Officer, PCH Construction Programme July 2024	Medium Priority	Closed – Additional controls had been established to monitor time charged on site. Effectiveness of these controls will be reviewed as part of future reviews.
2	On a periodic basis, management should review the administration of compensation events against contractual requirements.	Responsible Officer, PCH Construction Programme July 2024	Medium Priority	Closed - Change control mechanisms had been adapted to incorporate additional administration dates. Effectiveness of these controls will be reviewed as part of future reviews.

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
3	Management should ensure compliance with payment timescales e.g. communicate with NWSSP Accounts Payable to confirm contractual obligations and ensure compliance.	Responsible Officer, PCH Construction Programme July 2024	Medium Priority	Closed- Correspondence exchanged with NWSSP stressing the need to comply with contracted payment timescales.
4	Management should engage with the Supply Chain Partner to ensure that subcontractors are promptly paid for certified work.	Responsible Officer, PCH Construction Programme July 2024	Medium Priority	Closed - Discussions haeld with Supply Chain Partner and with NWSSP SES. There is recognition of the differing contractual payment stipulations between existing sub-contractor contract terms prior to the PBA being introduced.
Key Project Objectives – July 2024 – Reasonable Assurance				
1.1	The Health Board should evaluate and source possible funding options (if full, partial, or no additional funding is realised) as a matter of priority. This may also include an evaluation of wider options e.g. continuation, reduced scope etc.	Responsible Officer, PCH Construction Programme September 2024	Medium Priority	Closed – Various sources of funding had been evaluated including gain share on previous sections. Also, discussion fronted by UHB VAT advisers, on behalf of the Health Board, is ongoing with HMRC about VAT recovery.
1.2	The current programme funding risks should be noted at the programme risk register.	Responsible Officer, Prince Charles Hospital Construction Programme September 2024	Medium Priority	Closed - Risk register updated.
2.1	The dispute on design fees for Section 7 should be agreed as a matter of priority.	Responsible Officer, Prince Charles Hospital Construction Programme October 2024	Medium Priority	Closed– design fees have been agreed with certain elements disallowed by the Project Manager. However, design services had been fully reinstated.
2.2	The performance indicator for the 'programme' should be updated to reflect potential delays that may arise from the issues relating to Section 7.	Responsible Officer, Prince Charles Hospital Construction Programme September 2024	Medium Priority	Closed – Performance indicator updated.

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
2.3	The programme risk register should include risks pertaining to the Section 7 design fee, disputed/ withheld fees and the increased cost/ programme associated with the works.	Responsible Officer, Prince Charles Hospital Construction Programme September 2024	Medium Priority	Closed – Risk register updated.
3.1	The risk register should be reviewed for accuracy and updated to reflect the status of the programme.	Closed	Medium Priority	Closed - Risk register updated.
4.1	The externally appointed PM will verify that contractor's insurances remain current and update the progress report accordingly.	Responsible Officer, Prince Charles Hospital Construction Programme September 2024	Low Priority	Closed – Updated insurance documents provided.

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

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



Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

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

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

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

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.





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ACTION LOG – AUDIT & RISK COMMITTEE					
Minute Reference	Date of Meeting Action Originated	Issue	Lead Officer	Timescale for Action to be completed	Status of Action (as at 18.10.24)
2.1	October 2024 CLOSED In Committee	Organisational Risk Register (Business Sensitive Risks) Clarity was sought as to the reasons behind the change of consequence for the risks. It was agreed to discuss further with the Assistant Director of Governance & Risk outside of the meeting and provide a response.	Director of Corporate Governance/ Board Secretary	December 2024	In progress Meeting held with the Assistant Director of Governance and Risk who has reminded colleagues to ensure that colleagues provide appropriate supporting narrative to explain any changes in risk scores. We can also confirm that for data and digital risks in particular the Assistant Director for Digital Delivery is currently undertaking a review of all risks in that area so the focus and detail of these risk is also likely to be updated in the coming months.
5.1	October 2024	Organisational Risk Register To review Risk 5755 - Princess of Wales (POW) Air handling unit and electrical	Director of Corporate Governance/ Internal Audit	December 2024	Complete Emails have been exchanged between C. Hamblyn and the ARC Chair clarifying the reasons



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		infrastructure for Labour ward and Neonatal Unit – no correlation between reduced consequence and explanation used for the method of reducing the target risk score.			for the residual risk score. Query now resolved and no further work proposed
5.6.2	October 2024	Internal Audit Review – reasonable Offer To review the management response in relation to staff training with Internal Audit outside of the meeting.	Director of Corporate Governance/ Internal Audit	December 2024	Complete G. Watts and E. Samways have exchanged emails and agreed that the recommendation can be taken off the tracker for 12 months. While there remains 2 systems in place, training for new (and existing staff) still needs to be provided and that is what is happening, tailored to the different WPAS systems at the different sites
3.1 & 6.1	August 2024	Action Log/Any Other Urgent Business Further re-assurance to be sought from the previous Committee Referral to the People & Culture Committee with regard to the Local Counter Fraud Report - Recruitment of Agency Staff.	Director of Corporate Governance/ Board Secretary	November 2024	In Progress Process to provide assurance is underway working with counter fraud and NWSSP colleagues with a report being received by the People & Culture Committee at their meeting to be held on 5 th December 2024. The



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					outcome of which will be fed back to the Audit & Risk Committee.
4.1	August 2024	Local Counter Fraud Report To discuss whether random spot checks at the recruitment process could be undertaken with the people and recruitment team.	Local Counter Fraud Officer	October 2024	Completed – propose to close A meeting between NWSSP Recruitment Services and the Counter Fraud Team was held on the 14 October 2024. A quality assurance process is in place within Recruitment which is applied to individual files, this process was reviewed during the meeting also looking at sample tests and quality checks working with the People Services Team. Internal Audit will also be undertaking a large sample check as part of their IA review and this is scheduled for this financial year.
5.3	August 2024	JAG Accreditation Progress Report To receive a further update in six months' time.	Chief Operating Officer	February 2025	In progress Added to Forward Work Plan
5.2	June 2024	Audit Recommendations Tracker	Director of Corporate Governance/	October 2024	In Progress Review underway. This has been extended to



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		To review the high level overdue tracker actions and bring an update back to the next meeting	Board Secretary		review where recommendations may need to be reviewed in conjunction with audit colleagues if significant time has passed since the recommendation was set and in light of operational changes. Request to push timeframe back to the October 24 meeting.

Completed Actions

5.5.	June 2024	Internal Audit Review – Technical Resilience Digital Team to provide a more robust update on the agreed management actions on 4.1 and 5.1 and provide an update to the next meeting	Internal Audit/Digital Team	August 2024	Completed Management Actions updated and received at the August 2024 meeting.
5.2	August 2024	Audit Recommendations Tracker To advise on the comments and feedback provided to the Committee to the Director of Corporate Governance.	Assistant Director of Governance & Risk	October 2024	Completed The report has been updated for the October meeting to incorporate further detail in terms of a performance dashboard which hopes to address the queries and requests received at the meeting in August 2024.
5.1	August 2024	Organisational Risk Register	Assistant Director of	October 2024	Completed Captured in the Organisational Risk Register paper at item 5.1.



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		To review, discuss and feedback comments to the Executive Leads and Care Groups on the risks 5820, 5462, 4906, 5755 and 1133 and provide updates outside the Committee or via the next iteration of the Organisational Risk Register as appropriate	Governance & Risk		• Risk 5820 has been updated in terms of the articulation of the risk (See row 38). • Risk 5462 – update in risk register notes that the A business case to propose an expansion of the staffing model is in progress, and is due for completion by the end of Q3. (See row 10) • Risk 4906 – risk updated to reflect rationale for closure (See row 2 in de-escalated risks). It should be noted that this has been further updated since publication following discussion at the September QSC. • Risk 5755 – rationale for consequence change shared outside the Committee via email on the 1.10.2024. Risk 1133 – additional rational for de-escalation added. (See row 4 in d-escalated risks)
3.2	April 2024	Committee Annual Self-Effectiveness Survey Outcome & Improvement Plan – To provide an explanation of the Statement of Internal Control and Assurance Framework at the next meeting of the Committee in June 2024.	Director of Corporate Governance/ Board Secretary	June 2024	Completed Received by the Committee at the Extra Ordinary Meeting on the 10 July 2024 <i>This is an issue on terminology used in the self-effectiveness survey. The Statement of Internal Control was a precursor</i>



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					<i>to the Annual Governance Statement, which the ARC will now review as part of the year end Annual Report and Accounts. The Assurance Framework should be referenced as the Board Assurance Framework for CTM. We will update the terminology in the next Annual Effectiveness Survey to ensure that ARC members and attendees have clarity on what is being referred to.</i>
5.5.5	April 2024	Internal Audit Review – Decarbonisation - To review the management response on recommendation 4.1 and bring back to a future meeting.	Internal Audit/Deputy Director of Strategy & Partnerships	June 2024	Completed Received at the June 2024 meeting.
3.1	June 2024	Action Log Query on when the Committee would receive an update on JAG Accreditation report or	Chief Operating Officer	August 2024	Completed Updated received at the August 2024 meeting.
4.2	June 2024	Losses & Special Payments Report - To provide more context to the report for future meetings including comparators for year on year with regard to cash write offs.	Head of Corporate Finance	August 2024	Completed Report has been fully updated with revised layout and content and on agenda for August 24 meeting.



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5.1	June 2024	Organisational Risk Register To provide further clarity and updates with regard to risks 5755 and 1183	Assistant Director of Governance & Risk	August 2024	Completed Response provided via email on 15.7.24
4.1	April 2024	Local Counter Fraud Annual Report – Annual Report to be amended to reflect the red and amber components and brought back to the next meeting of the Committee.	Local Counter Fraud Officer	June 2024	Completed Annual Report revised and on Agenda June 2024
4.5	April 2024	Progress on the Grant Thornton Recommendations – To feedback the comments made by the Committee and to review the wording on 2.8 and 2.9 with regard to the Born Well Strategy	Deputy Director of Strategy & Partnerships	June 2024	Completed Document revised and circulated 23.4.24
5.2	April 2024	Organisational Risk Register – To review risks 5276 LIMS Software, 4103 Ophthalmology and 5417 Community Dental outside of the meeting.	Assistant Director of Governance & Risk	June 2024	Completed Risk ID 5276 – an update on the mitigating action for the Laboratory Information System has been captured in the May iteration of the organisational Risk Register included on the agenda for this meeting.



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					• Risk ID 4103 – updated mitigation provided by the Planned Care Group relating to the Ophthalmology risk which is included in the May iteration of the organisational Risk Register included on the agenda for this meeting. • Risk ID 5417 – Mitigating action has been reframed to ensure the action being taken around additional lists is clearer and this is reflected in in the May iteration of the organisational Risk Register included on the agenda for this meeting.
5.3	April 2024	Audit Recommendations Tracker – To review the Bridgend Transfer of Services closed recommendation outside of the meeting.	Director of Corporate Governance/ Board Secretary	June 2024	Completed There was only one recommendation which remained open from this audit review and we sought an update as follows which supported this action being closed



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					and that closed the recommendation actions arisen out of that specific review: <i>Consideration should be given to requesting that services fully quantify the impact of the lack of integration on the delivery of services and service change, with monitoring with reporting at an appropriate committee.</i> The update at the December 2023 meeting stated that - Risks are now reviewed at every Bridgend Transition Board and any risks raised with the Joint Executive Group and the Digital & Data Committee - Propose to close. Following the April 2024 meeting Cally Hamblyn shared the full report with Ian Wells and provided Ian with the explanation as above which addresses the



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					query which Ian raised in the meeting.
4.2	22/02/2024	Procurement & Scheme of Delegation Report – To discuss agency non-receipting with the People Directorate.	Executive Director of Finance & procurement	18 th April 2024	Completed Raised with Director of People with proposal to undertake some joint Workforce and Finance work on agency processes
4.1.1	21/06/2023	National Fraud Initiative Progress and Outcomes - Future reports to include an opening paragraph which explained the purpose of the national fraud initiative and what the process means for the Health Board	Head of Local Counter Fraud	Next report due February 2024	Completed Received at the February 2024 meeting.
5.2	21/06/2023	Audit Recommendations Tracker - Lead officers to be asked for rationale to be provided as to why they were proposing a change to the implementation date.	Head of Corporate Governance & Board Business	16 August 2023 Now October 2023 Now December 2023	Completed Propose to Close as captured in the Audit Tracker work programme included at agenda item 5.3b. This will be an ongoing action in the work programme as the process has moved to the AmAT inspection module where there is no current field to capture this data, however



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					a development request to the system provider has been made. ARC members will continue to receive the work plan indicating timeframes for completion. In the meantime, rationale will be asked of leads to include in the narrative update field.
4.4	24/10/2023	Changes to the Welsh Risk Pool Agreement - Report to be shared with the Planning, Performance & Finance Committee for information only.	Head of Corporate Governance & Board Business	27 February 2024	Completed Report received and noted by the Planning, Performance & Finance Committee at it's February 2024 meeting. .
4.1.1	22/02/2024	Local Counter Fraud Report Agreed that the report should be referred to the People & Culture Committee as the report raised a fraud risk in relation to fitness to practice.	Director of Corporate Governance	15 th April 2024	Completed Referral received and discussed at the People & Culture Committee held on 15 April 2024



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Audit & Risk Committee

Local Counter Fraud Update Report

Dyddiad y Cyfarfod / Date of Meeting	17/12/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Matthew Evans, Head of Local Counter Fraud Services
Cyflwynydd yr Adroddiad / Report Presenter	Matthew Evans, Head of Local Counter Fraud Services
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

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



1. Situation / Background

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

2. Specific Matters for Consideration

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

3. Key Risks / Matters for Escalation

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

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Sustaining Our Future
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	Not Applicable
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	Not Applicable
	If more than one applies please list below:
Dolen i Feysydd Ansawdd (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Domains of Quality	Not Applicable
	If more than one applies please list below:



(Duty of Quality Statutory Guidance (gov.wales))		
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable	
	If more than one applies please list below:	
Impact Assessment		
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Cydraddoldeb a'r Gymraeg? /</i> Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below:
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	

5. Recommendation

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

6. Next Steps

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



Cwm Taf Morgannwg University Health Board

Audit & Risk Committee – 17 December 2024

Counter Fraud Progress Report

Matthew Evans
Head of Local Counter Fraud Services

1. INTRODUCTION

The purpose of this report is to update the Audit Committee on key areas of work undertaken by the Health Board Local Counter Fraud Specialists (LCFS) since the last meeting.

2. BACKGROUND

The following sets out activity under the Key Principles specified within the Fraud, Bribery and Corruption Standards for NHS Bodies (Wales).

3. RESOURCE UTILISATION

AREA OF WORK	Planned Days	Days to Date
Strategic Governance		
Ensuring that anti-crime measures are embedded at all levels across the organisation	48	42
Inform and Involve		
Identifying the risks and consequences of crime against the NHS, and raising awareness of these risks amongst NHS staff, stakeholders, and the public.	100	51
Prevent and Deter		
Discouraging those who may want to commit crimes against the NHS and ensure that such opportunities are minimised.	148	116
Hold to Account		
Detecting and investigating crime, prosecuting those who have committed crimes and seeking redress as a result.	310	222
TOTAL	606	431

4. STRATEGIC GOVERNANCE

A finalised model outlining potential future counter fraud arrangements for NHS Wales, devised and agreed by Counter Fraud Specialists, was presented to DoFs Group. DoFs supported the model in principle as a way forward. This was then discussed at Counter Fraud Steering Group and a sub-group established to explore the model further and take forward an action plan.

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

5. INFORM AND INVOLVE

The Counter Fraud Team have proactively sought out front line teams who have not received counter fraud training for a number of years. This approach was identified following review of the predominantly virtually delivered training instigated as part of Covid response. Face to face training appears to be preferred by some business areas which better aligns to their working practices.

International Fraud Awareness week took place on 17-23 November. The Counter Fraud Team undertook communications to take part in the event.

6. PREVENT AND DETER

A risk assurance paper, relating to a prosecution of recruitment fraud, was presented at the People & Culture Committee and well received. The paper is included for discussion in the in-committee section of this Committee meeting. This concludes the counter fraud work internally around this case.

7. HOLD TO ACCOUNT

The status of the LCFS investigative caseload is summarised in Appendix 2 to this report. A summary of basic investigation KPI data is presented at outset of the appendix.

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

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

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

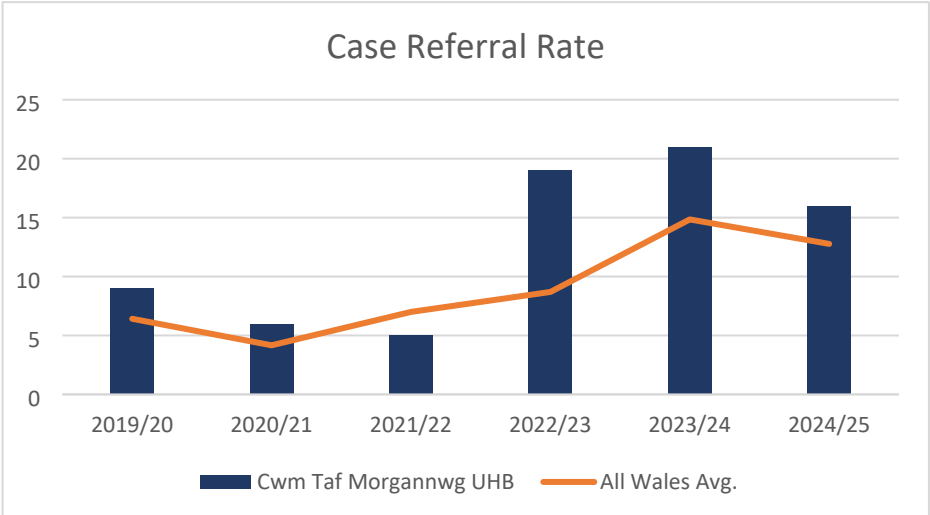


Item 4.1 – Appendix 1

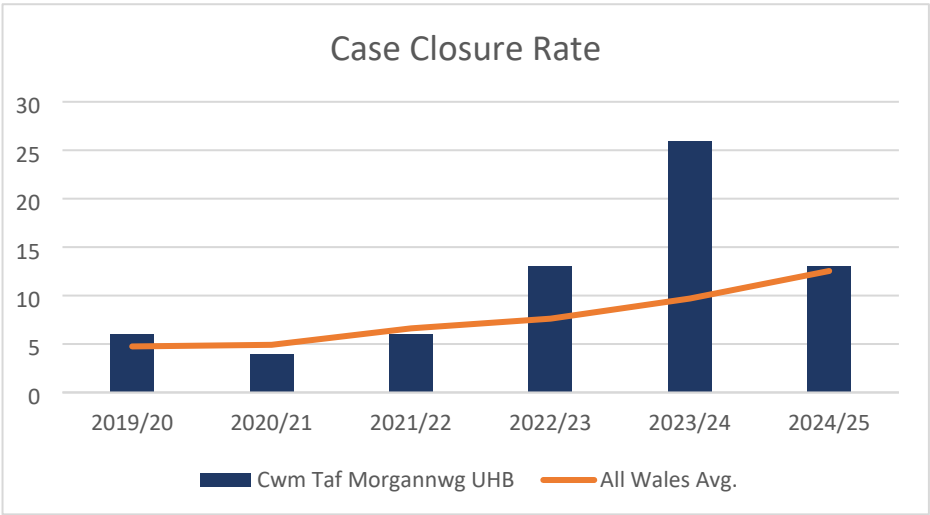
Counter Fraud Benchmark Report

Counter Fraud Benchmarking Statistics – Half Year

Case Referral Rate	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	9	6.4
2020/21	6	4.2
2021/22	5	7.0
2022/23	19	8.7
2023/24	21	14.8
2024/25	16	12.8



Case Closure Rate	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	6	4.8
2020/21	4	4.9
2021/22	6	6.6
2022/23	13	7.6
2023/24	26	9.7
2024/25	13	12.5



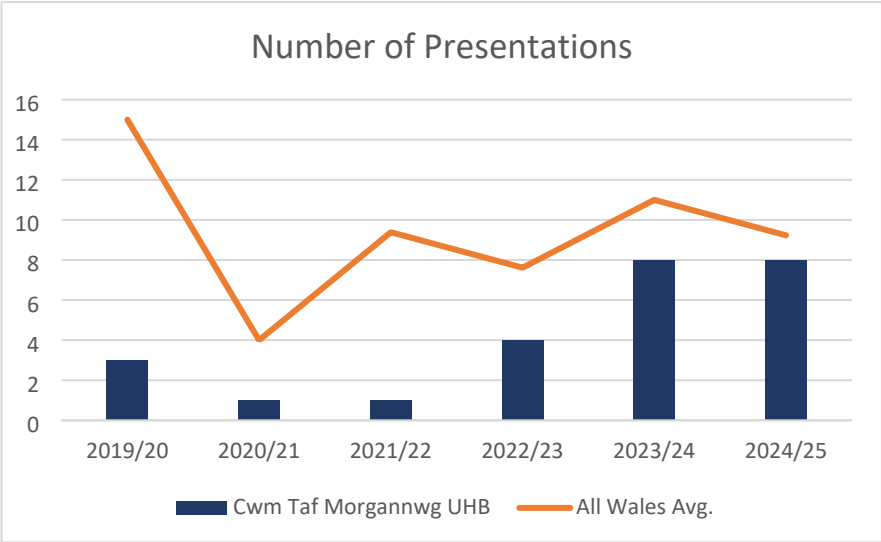
Counter Fraud Benchmarking Statistics – Half Year

Investigation Progression Rate	Cases Open at Start of FY	Referrals Received	Cases Closed	Total Cases Open End of Period
2019/20	11	9	6	14
2020/21	18	6	4	20
2021/22	13	5	6	12
2022/23	11	19	13	17
2023/24	20	23	16	22

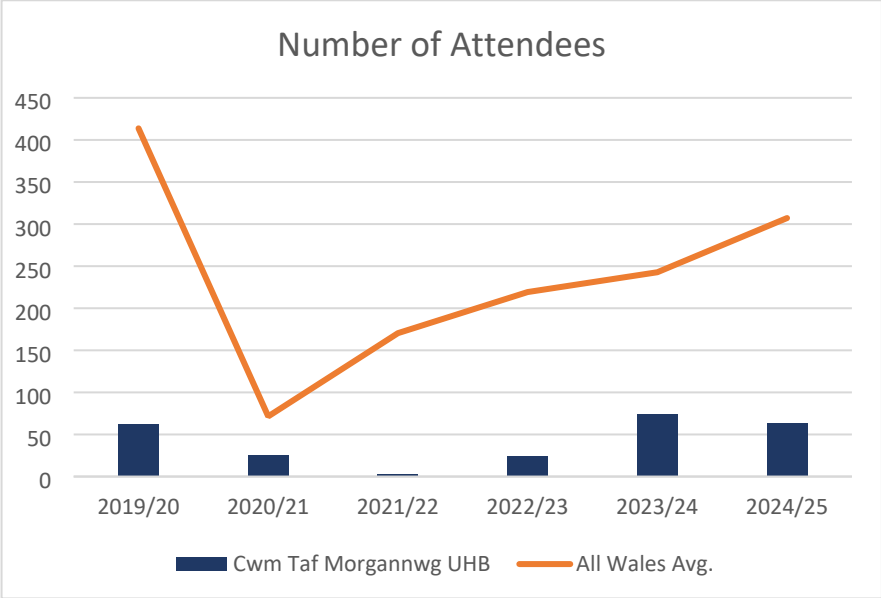
Sanctions	2021/22			2022/23			2023/24			2024/25		
	Criminal	Disp	Civil	Criminal	Disp	Civil	Criminal	Disp	Civil	Criminal	Disp	Civil
Cwm Taf Morgannwg UHB	1	0	6	0	0	4	0	1	2	0	1	1
All Wales Avg.	0.3	2.3	1.6	0.3	1.4	2.1	0.7	2.9	4.9	0.7	2.9	4.9
All Wales Total	4	30	21	4	18	27	5	13	27	4	24	25

Counter Fraud Benchmarking Statistics – Half Year

Number of Presentations	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	3	15
2020/21	1	4
2021/22	1	9
2022/23	4	8
2023/24	8	11
2024/25	8	9

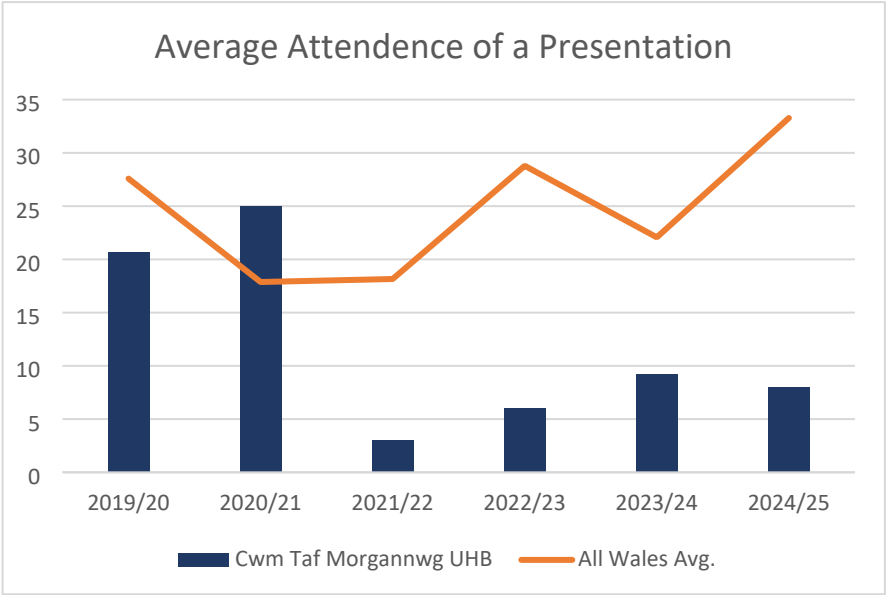


Number of Attendees	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	62	414
2020/21	25	72
2021/22	3	170
2022/23	24	219
2023/24	74	243
2024/25	64	307



Counter Fraud Benchmarking Statistics – Half Year

Average Attendance of a Presentation	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	21	28
2020/21	25	18
2021/22	3	18
2022/23	6	29
2023/24	9	22
2024/25	8	33





Item 4.1 – Appendix 2

Counter Fraud Investigations Update Report

Summary

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

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

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

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

Case Status		
Cases Under Investigation	Cases Pending 3rd Party Outcome	Cases Closed 2024/25
13	1	18
Case Rates		
Referrals Received 2024/25	Cases Under Investigation for Over 12 Months	
13	4	
Sanctions/Outcomes		
Criminal Sanctions	Civil Sanctions (Inc. Financial Recovery)	Disciplinary Sanctions
1	1	2

Open Cases			
Reference Number	Date Opened	Allegation	Status
WARO/20/00032	24/01/2020	Alleged theft of petty cash/False representation of employment history and qualifications	The subject has been found guilty in relation to 9 counts faced at Crown Court. The subject received a 5 years immediate custodial sentence. The subject resigned their Health Board position whilst disciplinary proceedings were underway. NMC have been updated of the outcome of the criminal case and are assessing.
INV/22/01136	18/08/2022	Unknown third party attending to complete an agency shift	Enquiries have corroborated referral information with witnesses with statements and documentation gathered. Digital forensics of mobile devices has been undertaken and evidence analysed. An interview under caution has been undertaken and an account gained. This investigation forms part of a wider investigative strategy with Home Office immigration and Police involvement. A case file has now been submitted to CPS consideration of charges.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/23/02885	18/12/2023	Annual Leave Concerns	Information received from the Fraud and Corruption Reporting line that staff member records only half of annual leave take and works for 2 Health Boards. Enquiries have sought to identify secondary employer. A request for information to potential secondary employer has been issued to seek clarity on role fulfilled there. Annual leave records have been gathered from the ESR system and analysed. Subject's managers have been approached and information for use in further enquiries has been gained including car registration and system access details to request audit logs. Witnesses have been identified and approached to gain account and potential documentary evidence. Analysis of information undertaken this established discrepancies in leave records but this fell short of the criminal threshold due to evidential quality. Advice has been provided to management in this area to strengthen processes for booking and recording annual leave. The subject has also left employment with the Health Board.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/23/02888	18/12/2023	Overpayment of Salary	Referral received from NWSSP Payroll stating that a Junior Fellow whose fixed term contract ceased 31/10/22 but salary continued to be paid until 31/10/23, causing an overpayment of salary of Gross £95,931.70, Net £61,334.42. Identified by Pensions when subject found to be being paid by two different NHS employers. CFS Wales to investigate as financial investigator powers are required under agreed criteria.
INV/24/00221	29/01/2024	Timesheet Fraud	Locum Doctor alleged to have been claiming incorrect rate and inflated hours. Allegation refers to claiming of on-site on call rate when actually absent. Additionally, there appears to be inflation of hours claimed for weekends. Enquires have gathered timesheets and analysis is being undertaken. Further enquiries with supplying agency have provided a background of payment methods and further data to cross match.
INV/24/00223	29/01/2024	Timesheet Fraud	Locum Doctor alleged to have been claiming incorrect rate and inflated hours. Allegation refers to claiming of on-site on call rate when actually absent. Additionally, there appears to be inflation of hours claimed for weekends. Enquires have gathered timesheets and analysis is being undertaken. Further enquiries with supplying agency have provided a background of payment methods and further data to cross match.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/24/00224	29/01/2024	Non-Completion of Contracted Hours	Allegation that Consultant has not worked job plan sessions following a denied request to drop sessions. Enquiries have established communications confirming what expectations are in relation to sessions. An overpayment of salary arose due to a subsequent job plan reduction and pay remaining the same. There were questions around the start date of the job plan reduction. A date has been settled on by Managers in this case and overpayment calculated on that basis. No evidence has been established to support dishonesty on part of the subject in this case. Overpayment of salary to be recovered through normal mechanisms.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/24/00465	23/02/2024	Authorisation of hours not worked	Concerns have been raised regarding bank staff submitting timesheets for hours beyond initially agreed shift hours and outside of hours of operation of unit worked at. Claims have been authorised by managers. Meetings have been held with senior managers and People Services colleagues to discuss concerns. Access has been gained to the allocate system and shift data gathered. Analysis is being undertaken. Enquiries established that staff identified had been uplifted in banding and hours authorised were intended to align with the pay of this higher banding. This appears to be a case of poor process rather than dishonesty. An ongoing disciplinary process was exploring the concerns and an audit is now being undertaken in this area. Outcome report is drafted and is awaited for review to inform next steps.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/24/01324	23/05/2024	Timesheet Fraud	Allegation received via Fraud and Corruption Reporting Line naming 2 staff members who have not been completing hours but submitting timesheets with full hours inputted. Management for individuals have been approached and various data sources have now been obtained for analysis. Following analysis of available data no discrepancies or outliers established to indicate criminal dishonesty. A meeting was then held with a Senior Manager in this area to outline findings and concerns raised as part of referral. The Senior Manager confirmed that no other data is available to support ongoing investigation. Potential disruptive/preventive actions discussed and counter fraud training to be provided to all in Department. A further reference has been created to separate subjects into individual investigations. INV/24/01334 is the linked reference.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/24/01334	23/05/2024	Timesheet Fraud	Allegation received via Fraud and Corruption Reporting Line naming 2 staff members who have not been completing hours but submitting timesheets with full hours inputted. Management for individuals have been approached and various data sources have now been obtained for analysis. Following analysis of available data no discrepancies or outliers established to indicate criminal dishonesty. A meeting was then held with a Senior Manager in this area to outline findings and concerns raised as part of referral. The Senior Manager confirmed that no other data is available to support ongoing investigation. Potential disruptive/preventive actions discussed and counter fraud training to be provided to all in Department. A further reference has been created to separate subjects into individual investigations. INV/24/01324 is the linked reference.
INV/24/02125	28/08/2024	Theft of Controlled Drugs	Intelligence report received following contact via the Fraud and Corruption Reporting Line. A named employee has been alleged have stolen boxes of co-codamol from an identified department store. Controlled Drug Investigation Guidelines are being followed and Pharmacy colleagues have been engaged who along with Ward Manager are undertaking an audit of order and usage records. Counter Fraud have followed up with Pharmacy for feedback on their review.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/24/02428	30/09/2024	Overpayment of Salary	An existing staff member moved to a new post within the Health Board. Process was intended to be undertaken as an internal transfer but a new ESR record was established for new role that led to subject being paid for both assignments resulting in an overpayment from 07/01/24 to 31/07/2024 with gross value of £10,508.17 and Net £7,216.78. An interview was arranged with the subject. Upon attendance it was clear to the interviewers that the subject did not have a clear understanding of the process and potential outcomes. The interview was postponed to allow subject to properly assess need for legal representation following advice given.
INV/24/03044	28/11/2024	Manager not working their contracted hours	Referral received via the fraud and corruption reporting line. Multiple potential subject matches have been identified from information supplied as part of referral, work underway to formally identify person of interest.

Closed Cases			
Reference Number	Date Opened	Allegation	Outcome
INV/23/02311	16/10/2023	Contractor Prescription Fraud	A dispensing GP Practice is alleged to have been dispensing cheaper medications but endorsing prescriptions for more expensive brands. Initial enquiries have established that CFS Wales have undertaken a previous investigation in this area. The case file from this previous investigation has been gained and was being reviewed in conjunction with new evidence. Following a case review meeting further meetings with CFS Wales and separately with NHS Counter Fraud Authority specialists in this area were held to inform investigative strategy. The assessment was that the drug tariff guidance and policy underpinning this matter is ambiguous. Visits to a sample of patients to verify that the medication dispensed matches claims has been undertaken with no concerns identified. A meeting has been held with senior Primary Care colleagues to discuss investigation and current barriers to progression. An agreement was reached to proceed with seeking an independent expert opinion. This will then feed into providing clarity to this area to strengthen response to claims disputes as well as future counter fraud actions. The Counter Fraud Team will maintain presence across these discussions and provide advice

Closed Cases			
Reference Number	Date Opened	Allegation	Outcome
			along with review of ongoing fraud risk on a proactive basis.
INV/24/01164	07/05/2024	Falsified Sickness	Allegation that a staff member is absent due to workplace injury but has submitted photographs of injury which is believed to not be them due to lack of a tattoo. Review of photographic evidence showed that 2 photographs had been forwarded one front view and one side view. Tattoo was present on one and obscured by viewpoint on the other. No evidence to support ongoing investigation.
INV/24/01873	23/07/2024	Overpayment of Salary	Staff member continued to receive salary payments following leaving Health Board employment. Intelligence checks have been completed and Financial Investigators engaged. An interview was arranged with the subject who was accompanied by an appropriate adult and a legal representative. A disclosure of an ongoing and serious mental health condition led to interview not being undertaken. An agreement was offered by the subject's legal representative around repayment with an acceptance of monies received which were not entitled to. Given this situation this case has been assessed as not being in the public interest to pursue and civil recovery is underway.

Closed Cases			
Reference Number	Date Opened	Allegation	Outcome
INV/24/02326	19/09/2024	Working Elsewhere Whilst Sick	Staff member is alleged to be working for a private business whilst on sick leave from their Health Board role. Matter discussed with People Services contact and subject's manager. It was established that the subject is in fact in a period of unauthorised absence from their role and not on sick leave. A disciplinary procedure resulted in the subject being dismissed from employment with the Health Board.



Agenda Item

4.2

Audit & Risk Committee

Losses and Special Payments 01.07.24 to 30.09.24

Dyddiad y Cyfarfod / Date of Meeting	17/12/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Owen James – Head of Corporate Finance
Cyflwynydd yr Adroddiad / Report Presenter	Sally May - Executive Director of Finance & Procurement
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

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

1. Situation /Background

- 1.1 This report advises the Audit & Risk Committee on the losses and special payments made by the University Health Board (UHB) for the 3 month period from 1 July 2024 to 30 September 2024, as required by in Standing Financial Instruction.
- 1.2 The Health Board is liable for the first £25k of any Personal Injury or Medical Negligence claim (not including Redress cases), with amounts over this being borne by the Welsh Risk Pool (WRP) managed by the NHS Wales Shared Services Partnership (NWSSP). For any "other" cases such as Employment Matters or Voluntary Early Release (VER) for example, the full cost of the loss is borne by the UHB. Where the WRP would be liable for a reimbursement to the UHB then there will be timing differences between payments being made and any reclaim from the Risk Pool. There is a strict protocol in place for reclaiming from the WRP.
- 1.3 General Medical Practice Indemnity Scheme (GMPI) was introduced in recent years by the Welsh Government as a state-backed scheme within NHS Wales. Legal and Risk Services and WRP operates this scheme and cases settled under the scheme are presented to WRP for reimbursement.
 - Scrutiny of the Learning from Events Report is conducted in the same manner as cases settled under NHS Indemnity or as part of the redress scheme.
 - Payments in relation to claims managed under GMPI are made by the defendant Health Board, and reimbursement by the WRP is made to the Health Board.
 - No excess in relation to reimbursement of cases settled under the GMPI will apply to the Health Board and all costs incurred are fully reimbursed.
- 1.4 In accounting for losses on claims, liability is recognised when legal advice states that there is a probability in excess of 50% of the Health Board having to settle. The quantum of the claim, and associated plaintiff costs are therefore recognised as "expenditure" at this point, with the risk pool recovery element also being recognised. Other losses are recognised as and when they arise.
- 1.5 There is therefore a significant timing issue (which can be several years) between expenditure being recognised within the Health Board's accounts and cash payments being made. Write-off approval action is only required for cash payments. This report highlights:
 - a) Losses & special payments recoded during the period.



- b) Claims that have been identified as a provision on the balance sheet as they have been deemed as probable but have yet to be paid.
- c) The impact of these claims being recognised on the Health Boards in year revenue position.

2. Specific Matters for Consideration

- 2.1 Standing Financial Instructions require all losses to be reported to the Audit & Risk Committee. This report is therefore a key element of the governance process around losses and special payments.
- 2.2 The number of claims, both Medical Negligence and Personal Injury, continues to result in significant levels of expenditure. These levels of expenditure are determined case by case and are based on information supplied by Welsh Legal Services.

a) Losses and Special Payments recorded during period

- 2.3 The losses and special payments recorded during this period totalled £2,929k, with the majority of this comprising of payments in respect of Clinical Negligence, Redress and Personal Injury.
- 2.4 It is important to note that the majority of these losses would have been recorded in the revenue position when the claim was deemed as probable, this is showing the cash impact of the payments made during the period.
- 2.5 The total recovered from Welsh Risk Pool during the period is £921k, giving a net cash out position for the period of £2,008k.
- 2.6 The losses and special payments are available in detail on request from the Head of Corporate Finance if required, but are summarised in the table below.

	01.07.24 - 30.09.24 £000	Previous Periods	Total 24-25 £000
Medical Negligence Claims	1,759	574	2,333
Medical Negligence Costs	510	875	1,385
Medical Negligence Defence Fees	206	444	650
Medical Negligence Totals	2,475	1,893	4,368
Redress Medical Negligence Claims	41	26	67
Redress Medical Negligence Costs	16	25	41



Redress Medical Negligence Defence Fees	23	29	52
Redress Medical Negligence Totals	80	80	160
GP Indemnity Claims	0	35	35
GP Indemnity Costs	112	0	112
GP Indemnity Defence Fees	2	11	13
GP Indemnity Totals	114	46	160
Personal Injury Claims	24	24	48
Personal Injury Costs	48	82	130
Personal Injury Defence Fees	33	29	62
Personal Injury Totals	105	135	240
Permanent Injury Benefit	119	0	119
Permanent Injury Benefit Totals	119	0	119
Other:			
Ex-Gratia	36	18	54
Debt Write Off	0	0	
WRP Penalty Charge	0	0	
Ombudsman	0	0	
Employment Matter/Other	0	0	
Other Totals	36	18	54
TOTAL	2,929	2,172	5,101
Recovered from Welsh Risk Pool	(921)	(1,115)	(2,036)
Net Cash Write-Off/(Recovery)	2,008	1,057	3,065

2.7 There are three categories of Decision in relation to cases submitted to WRP:

APPROVE

APPROVE: The learning and case information submitted was accepted by the Committee and where reimbursement is requested it has been approved. Where the case is a review of learning only, the matter will be reconsidered when reimbursement is requested.

DEFER

DEFER: Additional information is requested which should be gathered and supplied to the Safety & Learning Advisor and this will be presented to the next WRP Committee.

We would like to receive this information within 1 calendar month. A maximum of six calendar months applies for the submission of additional information, from the date it was first requested. – after which the reimbursement will be permanently deferred. Details of the additional information requested is outlined in the case detail below



DEFER UNTIL
INFO REC'D

DEFER UNTIL INFO REC'D: The Committee delegated approval of the reimbursement to the Head of Safety & Learning. Additional information is requested which should be gathered and supplied to the Safety & Learning Advisor – who will present it to the Head of Safety & Learning. We would like to receive this information within 1 calendar month. A maximum of six calendar months applies for the submission of additional from, from the date it was first requested. – after which the reimbursement will be permanently deferred.

- 2.8 At its latest meeting, the WRP committee approved the payment of a further £767k of claims (32 claims), this will be paid in December. 9 further claims reviewed by the committee were deferred, and another 16 claims were deferred until further information was received.

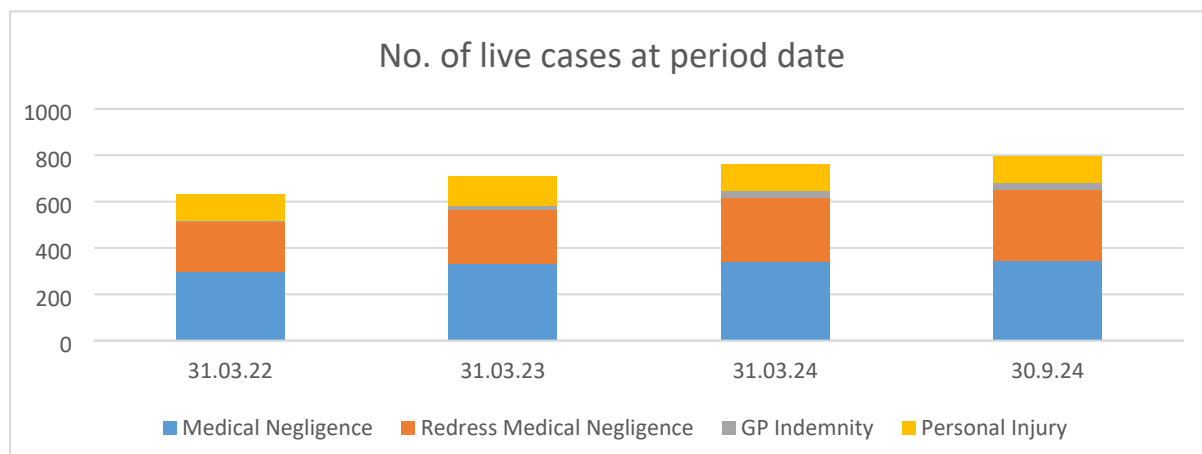
b) Provision as at 30 September 2024

- 2.9 A provision reflecting the estimated value of the claim will be made on the balance sheet as a claim is deemed probable. There will also be an estimate for the value recoverable from Welsh Risk Pool, leading to a net provision value on the balance sheet.
- 2.10 The table below shows the provision made for each type of claim and the amount recoverable from Welsh Risk Pool as at the period stated. It could be deemed the lower value the net claim provision the more efficient the health board are at recovering from Welsh Risk Pool i.e. payments have been made out and they have been recovered from Welsh Risk Pool in an efficient manner.
- 2.11 The total claims provision has increased by £22,278k since 31st March 2024, this is mainly due to an increase in value of medical negligence claims.
- 2.12 The net provision at the end of 30th September 2024 was £8,004k which is £974k higher than the previous reported period.

	30.09.24	31.03.24	31.03.23	31.03.22
	£000	£000	£000	£000
	Cumulative	Cumulative	Cumulative	Cumulative
Medical Negligence claims/costs	116,756	94,478	72,198	65,127
Redress Medical Negligence claims/costs	571	372	385	235
GP Indemnity (Note 1)	1,117	612	0	0
Personal Injury claims/costs	1,418	917	701	611
TOTAL CLAIMS/COSTS PROVISION	119,862	96,379	73,284	65,973
Recoverable from Welsh Risk Pool	(131,708)	(106,450)	(83,623)	(93,074)
NET CLAIMS / COSTS PROVISION	(11,846)	(10,071)	(10,339)	(27,101)
Permanent Injury Benefit	3,842	3,755	4,077	6,201
NET PROVISION inc Perm Injury Ben.	(8,004)	(6,316)	(6,262)	(20,900)

Note 1: GP Indemnity provision is fully reimbursable by WRP as such no net impact to the Health Board's Budget.

- 2.13 The chart below shows the number of live cases as at period stated. You will note that the number of live cases have remained relatively steady over the last couple of years following an increase in cases after 2021/22.



c) Revenue impact for the year to date

- 2.14 As previously highlighted, the Health Board is liable for the first £25k of any Personal Injury or Medical Negligence claim (not including Redress cases), with amounts over this being borne by the Welsh Risk Pool (WRP). For any "other" cases such as Employment Matters or Voluntary Early Release (VER) for example, the full cost of the loss is borne by the UHB. The net impact of this value impacts the revenue account of the Health Board in the period the claim is recognised.
- 2.15 The table below shows the year to date position for each of type of claim. The "other" category mainly consists of payment of retirement gratuities, Employment Matters and voluntary early releases.

	Year to
	30.09.24
	£000
Medical Negligence claims/costs	26,645
Redress Medical Negligence claims/costs	358
GP Indemnity	666
Personal Injury claims/costs	741
Recoverable from Welsh Risk Pool	(27,293)
Net claim expenditure (Note 1)	1,117
Permanent Injury Benefit	206
Other	54
Total Net expenditure	1,377

Note 1: The annual budget for net claim expenditure for 2024-25 is £1,785k, with a year to date budget of £892k, actual expenditure for the year is £1,117k,



therefore an overspend of £225k to September 2024. It is important to note that these costs can fluctuate during the year. In previous years there has been a significant overspend at outturn against these costs.

WRP Risk Sharing Agreement

- 2.16 The Audit & Risk Committee will be aware that any overspend incurred by the Welsh Risk Pool will need to be shared amongst NHS organisations, and is therefore an additional financial risk to those organisations.
- 2.17 At the time of reporting we are projecting the value to be on budget for 2024/25.

3. Key Risks / Matters for Escalation

- 3.1 Note that there is an increase in the net cash write off and net provision of values owed from WRP, which reflects that the amount being paid out is higher than the value being recovered.
- 3.2 This is largely a timing issue, but there is a need to ensure there is timely completion of learning submitted in order from reimbursements to be approved in a timely manner, reducing value owed from WRP.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Starting Well
	If more than one applies please list below: Growing Well Living Well Ageing Well Dying Well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd	Whole-systems Perspective



(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	If more than one applies please list below:	
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))	Safe	
	If more than one applies please list below:	
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable	
	If more than one applies please list below:	
Impact Assessment		
Ansawdd Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality Have you undertaken a Quality Impact Assessment Screening?	Yes: ☒	No: ☐
	The majority of losses and special payments are as a result of things going wrong and where quality, safety or patient experience may therefore have been compromised. Details of medical negligence and personal injury claims are provided quarterly to the Concerns (Claims) Scrutiny Panel who subsequently reports to the Quality, Safety & Risk Committee	If no, please include rationale below: Not applicable for this report
Cydraddoldeb a'r Gymraeg Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? / Equality and Welsh Language Have you undertaken an Equality and Welsh Language Impact Assessment Screening?	Yes: ☒	No: ☐
	Outcome for Equality Completed as part of the Financial Control Procedures for Losses & Special Payments (FP 15) POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below: Not applicable for this report
Cyfreithiol / Legal	Yes (Include further detail below)	
	Losses provided for are informed by legal advice where appropriate based on probability of a successful claim	



Enw da / Reputational	Yes (Include further detail below)
	As noted within Quality Impact Assessment section above, reputational risk is managed via the reporting hierarchy.
Effaith Adnoddau (Pobl / Ariannol) / Resource Impact (People / Financial)	Yes (Include further detail below)
	The report highlights the resource impact of losses both in expenditure and cash terms. It also highlights the level of provision within the balance sheet for potential future payments

5. Recommendation

5.1 The Audit & Risk Committee is requested to:

- **NOTE** the losses and special payments made for the period 1 July 2024 to 30 September 2024.

6. Next Steps

6.1 The Audit & Risk Committee is requested to note the information provided in this report and regular updates will be provided to the Committee as required by the Governance arrangements.



Agenda Item

4.3

Audit & Risk Committee

Procurement & Scheme of Delegation Update

Dyddiad y Cyfarfod / Date of Meeting	17/12/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Owen James - Head of Corporate Finance
Cyflwynydd yr Adroddiad / Report Presenter	Sally May – Executive Director of Finance
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance

Pwrpas yr Adroddiad / Report Purpose	For Approval

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

Acronyms / Glossary of Terms	
OJEU	Official Journal of the European Union
FCPs	Financial Control Procedures
SoD	Scheme of Delegation
PSPP	Public Sector Payment Policy
JCC	Joint Commissioning Committee

1. Situation / Background

1.1 Procurement Matters

The following areas within the Scheme of Delegation (SoD) are reported to the Audit & Risk Committee so that members of the Committee have the opportunity to ask questions or request further information:

- a) Engagement off contract of non-medical staff not paid via the payroll. The Director of People and the Head of Procurement would need to confirm agreement prior to any commitment.
- b) Waiver of competitive tenders, as authorised by the Director of Finance and Procurement.
- c) Contracts requiring Ministerial approval (over £1m)
- d) Summary of contracts over £500,000
- e) Free of charge services
- f) Retrospective orders and non-receipting areas
- g) Consultancy contracts
- h) Invoices on Hold & No PO No Pay summary

This report provides details of any such transactions within the period 01.10.24 to 30.11.24

1.2 Purchase to Pay (PSPP)

In order to comply with the Public Sector Payment Policy, 95% of the number of non-NHS invoices must be paid within 30 days. This report provides an update on the Prompt Payment compliance for 2024-25.

1.3 Scheme of Delegation and Financial Control Procedures

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

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

2. Specific Matters for Consideration

2.1 Procurement Matters

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

There were no engagements or contracts entered into during the period 01.10.24 to 30.11.24.

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

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

The Scheme of Delegation allows the Director of Finance and Procurement to approve a waiver of the requirement for competitive tenders up to OJEU or other exceptions to tender rules. **Tables A and B** below provides details of such actions during the period 01.10.24 to 30.11.24

Table A – Single Tender Actions 01.10.24 to 30.11.24

STA	Revenue / Capital	Division	Contract description	Supplier	Contract Value Exc. VAT	Reason for approval	Date Returned
CTM-STA 1741	Revenue	Strategy & Planning	Support for CYP Pre and Post Autism ADHD Diagnosis Bridgend	Autside Education & Training	£45,000.00	(a)	18/10/24
CTM-STA 1742	Rev	Strategy & Planning	Support for CYP Pre and Post Autism ADHD Diagnosis RCT	Behaviour Support Hub	£45,000	(a)	18/10/24

CTM-STA-1743	Rev	Strategy & Planning	Support for CYP Pre and Post Autism ADHD Diagnosis Merthyr Tydfil	HomeStart	£40,000	(a)	18/10/24
CTM-STA-1748	Rev	Community Health	Provision of D2RA Pathway 3 Assessment Beds	Caron Group - Abergarw	£96,249.60	(c)	17/10/24
CTM-STA-1749	Maintenance	Radiology	BK Medical Priority Care Maintenance Bundle for BK Spectoultraso und system including biplane endocavity transducer and advanced urology bundle	BK Medical	£38,362.50	(a)	14/11/24
CTM-STA-1751	Other (NHS Exec)	Pathology	Rental of high capacity digital Pathology scanner	Leica biosystems	£83,795.36	(b)	28/11/24

Reasons for approval:

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

b) Compatibility issue

c) Genuine 1 provider

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

TABLE B – Single Tender Actions – Retrospective – there are no retrospective STAs to report for this period.

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



Reference	Title	Supplier	Value	Date Approval Received
CTM-MIN-57759	Llantrisant Health Park Modular Building Construction	TBC	£90,000,000	24/09/24

d) Summary of contracts awarded over £500,000 –

Health Board's must provide a contract summary to Welsh Government for contracts between £500,000 and £1 million prior to the contract being let. This requirement also applies to contracts that are to be let through a mini-competition under a public sector contract framework, such as National Procurement Service, NHS Supply Chain or Crown Commercial Services. Below is a retrospective summary of contracts awarded between 01.10.24 to 30.11.24

There were no contracts awarded over £500,000 for this period.

e) Free of Charge Services

Where free of charge services are made available to the Health Board, NWSSP Procurement Services must be consulted to ensure that any competition requirements are not breached, particularly in the case of pilot activity to ensure that the Health Board does not unintentionally commit itself to a single provider or longer term commitment. Below is a summary of free of charge services that have been provided between 01.10.24 to 30.11.24:

There are no free of charge services to report for this period.

f) Retrospective orders and non-receipting areas

Below shows the trend of numbers of retrospective orders being placed across the Health Board and the main non-receipting areas:

Supplier	Area	Value of RT Order	Comments
BLUE ARROW LTD	559148_Houskeeping YCC	£194,403.15	Agency Staffing
	533928_RGH CAT STORE 533912_RGH H'SKEEP		

	533315 POW DOMS TENDER		
BRIDGEND COUNTY BOROUGH COUNCIL	533513 MAESTEG ADMIN	£71,461.25	COUUMNITY SERVICES
	533870_RGH SURG OFFI		
	555972 Surg Dir Off		
MANPOWER UK	555109 PCH CATERING 555057 KIER HARDIE CATERING	£45,317.64	Agency Staffing

g) Consultancy Contracts

Below is a table detailing consultancy contracts that have been awarded between 01.01.24 to 30.11.24

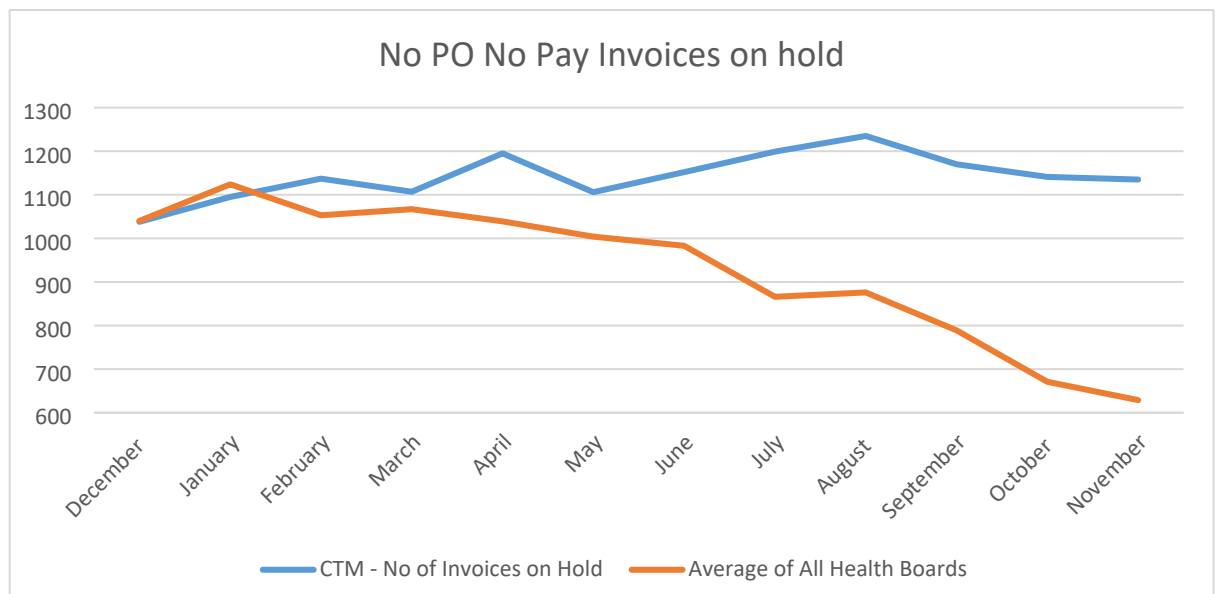
None for this period

h) Invoices on hold & No PO No Pay Summary

No PO No Pay

Below shows the trend of number of No PO No Pay holds over the past 12 months.

The table below shows that the number of CTM invoices against the average across other Welsh Health Boards.



- CTM continue to have a higher number of invoices on hold due to NO PO compared to the average of all Welsh Health Boards.

- The trend of other health boards is an improving position since January, whereas the trend for CTM is remaining relatively steady.
- Recent communication has been included on staff news and circulated to all Oracle users on the recently updated All Wales No PO No Pay policy shown in Appendix 1. Highlighting the importance of raising POs in a timely manner.
- 565 (50%) of the invoices on No PO No Pay holds are relating to just 5 organisations. Procurement are prioritising focus on the category areas which are causing main issues.
- Without a PO an invoice cannot be assigned to a directorate or cost centre, therefore an assessment by directorate cannot be provided.

Other Invoices on Hold

Invoices can be put on hold in circumstances where a PO number has been provided, and this can be for various reasons, such as the good/service not being receipted; the value of the invoice being above the value of the PO; the quantity of the goods on the invoice being above the quantity on the PO etc.

At December 2024 there were 8,199 invoices on hold. Where the invoice quotes a PO the invoice can be associated to a directorate, below are number of invoices on hold by directorate:

Directorate	No of Invoice on Hold
Unknown	3,901
Chief Operating Officer	1,356
Planned Care	736
Corporates	621
Diagnostics, Therapies & Specialities	478
Primary & Community Care	407
Unscheduled Care	349
Children & Families	247
Mental Health & Learning Disabilities	97
Contracting & Commissioning	7
Grand Total	8,199

2.2 Purchase to Pay (P2P)

The PSPP figures are reported to 30th October 2024.



The Health Board has met its 95% target of paying non-NHS invoices within 30 days to Month 7 2024-25 achieving 95.1% (value 91.0%). This is below the target of 95%, however it is an improving position and it is projected the target will be met by the end of the financial year.

	0 - 30 Days		Total		%	
	Number	Value	Number	Value	Number	Value
Apr-24	22,259	35,686,635	23,700	38,481,025	93.9%	92.7%
May-24	19,805	37,360,833	20,890	41,651,491	94.8%	89.7%
Jun-24	19,966	38,227,242	20,971	40,869,496	95.2%	93.5%
Jul-24	23,805	39,853,482	24,837	47,066,950	95.8%	84.7%
Aug-24	19,654	44,403,473	20,477	46,830,448	96.0%	94.8%
Sep-24	21,349	45,020,421	22,146	47,512,201	96.4%	94.8%
Oct-24	22,358	43,052,769	23,832	46,241,647	93.8%	93.1%
YTD	149,196	283,604,856	156,853	308,653,258	95.1%	91.9%

The NHS invoice position continues to be challenging and shows that 81.8% (number) and 96.4% (value) of invoices were paid within 30 days to Month 5 2024-25.

2.3 Scheme of Delegation and Financial Control Procedures (FCPs)

There are a number of FCPs that require update as per the review schedule. All FCPs have been shared with the relevant officers involved in delivering the procedure for review and comment. The FCPs requiring approval by Audit & Risk Committee are as follows (where there are a large number of changes the documents in the Appendix include track changes to highlight changes from previous version):

i. Petty Cash (Appendix 1)

2.3 Removed reference to cheque being raised for float, as cheques cannot be cashed now branches have been closed.



2.4/4.5-4.7 Removed as relates to cheques.

4.8 cheque removed and that the reimbursement claim is signed by the cashiers department

ii. Losses and Special Payments (Appendix 2)

Updates shown as tracked changes

iii. General Ledger (Appendix 3)

Updates shown as tracked changes

iv. Construction Industry Scheme (Appendix 4)

Updates shown as tracked changes

v. Capital Asset Register (Appendix 5)

Updates shown as tracked changes

There are still a number of FCPs that are currently out for review which are being worked through to ensure they have adequate scrutiny before being brought to Audit & Risk Committee for approval. We anticipate these will be brought to February Audit & Risk Committee for finalisation. Outstanding FCPs are as follows:

- Salaries & Wages – this has been substantially reviewed, with comments and changes made by finance, payroll, pension and People services colleagues. There are a small number of queries remaining, but expect these to be cleared shortly.
- Budgetary control – this has been substantially reviewed, there are a small number of queries outstanding, but expect these to be cleared shortly.
- Private Patients – out with service for further review / comment.
- Overseas Patients - out with service for further review / comment.
- Creditor Payments - out with service for further review / comment.

3. Key Risks / Matters for Escalation

None



4. Assessment

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

Impact Assessment		
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: No impact
Cydraddoldeb	Yes: ☐	No: ☒



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

5. Recommendation

5.1 The Audit & Risk Committee is asked to:

APPROVE the updated FCPs

NOTE the position on procurement matters for the period 01.08.2024 to 30.11.2024;

NOTE the update regarding Purchase to Pay and achievement of PSPP target up to Month 7 of 2024/25;

6. Next Steps

If updated FCPs approved, the FCPs will be implemented and communicated across the Health Board for adherence.



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WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

FINANCIAL CONTROL PROCEDURE: PETTY CASH

Initiated by: Director of Finance & Procurement

Approved by: Audit & Risk Committee

Date approved: **December 2024**

Operational Date: **December 2024**

Version: Five

Date for review: December 2027

Distribution:

- Executive Directors
- Board Secretary
- Assistant Directors
- Group Directors
- Operational Directors
- Nurse Directors
- General Managers
- Clinical Service Group Managers

Freedom of Information Status: Open

This policy has been subject to a full equality impact assessment.

CONTENTS

1. Introduction
2. Request of floats
3. Petty cash payments
4. Reconciliation and Reimbursement
5. Accounting
6. Equality Impact Assessment

1. INTRODUCTION

- 1.1 The purpose of this procedure is to ensure petty cash floats operating within the Health Board are held securely and used appropriately.
- 1.2 Petty cash use is for the reimbursement of low value purchases where it would not be appropriate to raise an official order, the refunding of patient travelling expenses and patient money withdrawals.
- 1.3 The Head of Corporate Finance shall be responsible for determining the locations and the level of petty cash floats.
- 1.4 The management and security of a petty cash float shall be the responsibility of the nominated imprest holder.
- 1.5 The Treasury Manager will be responsible for maintaining records of floats and reconciling the petty cash balances in the general ledger.

2. REQUEST FOR FLOATS

- 2.1 Requests to set up a new float or to change an existing float should be made in writing to the Head of Corporate Finance.
- 2.2 The request shall detail the proposed use, the likely weekly value of payments, the nominated imprest holder and their deputy and how the cash will be held.
- 2.3 Where a new float is approved the Treasury Manager will arrange a cash delivery by the Health Board's approved security company. Increases to existing floats shall be actioned when the float is next reimbursed.

3. PETTY CASH PAYMENTS

- 3.1 Single payments from petty cash shall not exceed £75. No payment from petty cash shall be made above this limit unless the Director of Finance and Procurement has given prior approval.
- 3.2 Payments from petty cash shall only be made on production of either

- a) A petty cash voucher with supporting receipts. The voucher shall provide a description of the items purchased, the financial code to be charged and shall be signed by an authorised manager.
 - b) Travel receipts, patient appointment letter/card verifying attendance and evidence the patient is entitled to claim.
 - c) Authorised patient money withdrawal form
- 3.3 Under no circumstances should individual purchases be deliberately split in an attempt to circumvent the set limit.
- 3.4 Under no circumstances shall petty cash be used for private transactions.

4. RECONCILIATION AND REIMBURSEMENT

- 4.1 The imprest holder shall be responsible for reconciling the float daily if a reimbursement has been made or at least once a week. The cash in hand plus the value of the petty cash vouchers should agree to the authorised float. Any unresolved discrepancies shall be reported immediately to the Head of Corporate Finance (or representative).
- 4.2 The imprest holder shall complete a petty cash reimbursement form when cash levels require topping up together with a breakdown of the cash denominations if having the cash delivered.
- 4.3 The form shall list the payments made, state the cash retained and reconcile these two amounts back to the authorised float. The imprest holder must sign the form. The completed form together with all the supporting petty cash vouchers and receipts shall be e-mailed or posted to the Cashiers office in the Finance Department.
- 4.4 Within the Cashiers Department the request for reimbursement shall be checked to ensure vouchers/receipts tally and the form has been authorised. Any discrepancies shall be investigated and resolved prior to the request being processed.
- 4.5 Where a site has their monies delivered directly to the General Offices by the security company (The General Offices require a large supply of coins to supply the canteens with change), the reimbursement claim will be signed by an authorised signatory.

- 4.6 The Cashier will then contact the security company to order the change in the denominations requested by the General Office.
- 4.7 The change will be delivered and checked and signed for by a member of the General office and the security company will deduct the sum via a Direct Debit.
- 4.8 The Cashier will enter the charge, to the ledger, via a monthly journal. The Treasury Manager will reconcile the Direct Debit to the reimbursement requests. Any unresolved discrepancies should be discussed with the Local Counter Fraud Specialist.

5. ACCOUNTING

- 5.1 The Treasury Manager will on a monthly basis reconcile the general ledger balance for petty cash back to the total of the individual floats. The reconciliation will be reviewed and counter-signed by the Head of Corporate Finance (or their representative).
- 5.2 On the last day of the financial year the Treasury Manager will arrange for all floats to be reimbursed and for certificates confirming the balance to be signed.
- 5.3 The certificates shall be held as part of the Annual Accounts audit papers.

6 EQUALITY IMPACT ASSESSMENT

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



**FINANCIAL CONTROL PROCEDURE:
LOSSES AND SPECIAL PAYMENTS**

Initiated by: Director of Finance and Procurement

Approved by: Audit and Risk Committee

Date approved: **December 2024**

Operational Date: **December 2024**

Date for review: December 2027

Distribution: Executive Directors
Board Secretary
Clinical Service Group Managers
Assistant Directors
SharePoint

Freedom of Information Status: Open

This policy has been subject to a full equality impact assessment.

CONTENTS

- 1 Introduction
- 2 Categorisation of Losses and Special Payments
- 3 Delegated limits
- 4 Reporting of losses
- 5 Special / ex-gratia payments
- 6 Irrecoverable debts
- 7 Condemnations and obsolescence
- 8 Welsh Risk Pool
- 9 Losses & special payments register (LaSPaR)
- 10 Insurance
- 11 Equality Impact Assessment

1 INTRODUCTION

- 2.2 1.1 This procedure details the principles underlying the reporting of condemnations and losses and the issue of special payments as covered in the ~~Welsh Government Losses and Special Payments Manual (WHC 99) 33. In cases of doubt, reference should be made to the manual, a copy of which is held in the Finance Department.~~Standing Financial Instructions and Manual for Accounts.
- 1.2 This procedure should be read in conjunction with the UHB's Standing Orders, Standing Financial Instructions and other relevant Financial Control Procedures.
- 1.3 Losses refer to the loss of cash or property. Special Payments are those which fall outside the normal day to day business of Cwm Taf Morgannwg University Health Board (UHB) and for which no statutory authority to pay exists.
- 1.4 The Director of Finance ~~and Procurement~~ is responsible for ensuring proper financial control over the identification, reporting and investigation of losses and their "write-off".
- 1.5 **All members of staff have a general responsibility for the security of UHB property and for avoiding any loss.**
- 1.6 Any member of staff discovering or suspecting a loss of any kind must inform the Chief Executive and Director of Finance ~~and Procurement~~, via their Clinical Service Group Manager Directorate Manager (or equivalent) ~~or Head of Department~~. The Director of Finance ~~and Procurement~~ is responsible for notifying the Statutory Auditor and the Welsh Government where necessary.
- 1.7 The Director of Finance ~~and Procurement~~ (DoF), via the UHB's Local Counter Fraud Specialist (LCFS), will arrange for an investigation to take place in cases of fraud, corruption, misappropriation or other financial irregularities. All investigations are performed in accordance with the UHB's Operational Policy on Fraud and Corruption.
- 1.8 Heads of Departments Directorate Manager (or equivalent) will be responsible for identifying and reporting to the Director of Finance and Procurement, in line with the Scheme of Delegation, any obsolete or condemned stock or equipment, (Appendix 4). The Director of Finance and Procurement will

arrange for appropriate “write-off” action. The Scheme [of Delegation](#) can be found on the Intranet under Finance Policies.

- 1.9 Debts deemed to be irrecoverable will be “written off”. Approval will be in accordance with the Financial Control Procedure on Income and Debtors.
- 1.10 All requests for special payments must be referred in line with the Scheme of Delegation. All losses and special payments, which are within the UHB’s delegated limits (Appendix 1), will be authorised in line with the Scheme of Delegation.
- 1.11 All losses or special payments greater than the UHB’s delegated limit will be referred to the Welsh Government for authorisation prior to any “write-off” or payment being made.
- 1.12 All losses and special payments will be reported quarterly to the Audit and Risk Committee.
- 1.13 The Chief Executive, in conjunction with the Director of Finance and Procurement, shall decide what risks will be transferred to third parties via insurance.

2. CATEGORISATION OF LOSSES AND SPECIAL PAYMENTS

- 2.1 Losses fall into the following categories which will govern the way each individual case is handled:

Category 1 Losses of Cash

These may be due to:

- i. theft, fraud, arson, negligence of duty or gross carelessness,
- ii. overpayment of salaries, wages, fees and allowances,
- iii other causes not covered by i or ii.

Category 2 Fruitless Payments, Including Abandoned Capital Schemes

These are payments for which a liability should not have been incurred, or where the order for the goods and service could have been cancelled in time to avoid liability.

Category 3 Bad Debts and claims abandoned

Category 4

Damage to buildings, their fittings, furniture and equipment and loss or theft of equipment and property in stores and in use.

2.2 Special Payments categories:

Category 5

Compensation Payments made under legal obligation

Category 6

Ex-Gratia Payments

These are payments that the UHB is not obliged to make, but which are made as an “act of grace” to compensate for financial loss, hardship or damage resulting from an act or a failure of the UHB or its staff which does not give rise to a legal liability.

Category 7

Extra Contractual Payments to Contractors

An extra contractual payment is one which, although not legally due under the original contract appears to be an obligation which the Courts are likely to uphold. Such an obligation will usually be attributable to action or inaction by the UHB in relation to the contract.

Category 8

Extra statutory or extra regularity payments

These are payments considered to be within the broad intention of a statute or statutory regulation but which go beyond a strict interpretation of its terms.

3. DELEGATED LIMITS

3.1 Welsh Government

Losses and special payments above the limits delegated to the UHB, as shown in Appendix 1, must be submitted to the Welsh Government for approval prior to any “write-off” or special payment.

-For compensation payments made under legal obligation **(other than for employment matters)** the Director of Nursing (or their representative) will be responsible for submitting details of the loss or proposed payment, together

with sufficient backing documentation, to enable the Welsh Government to reach a decision.

For all other payments or losses details will be supplied initially to the Director of Finance and Procurement (or their representative). ~~They~~ ~~who~~ will then be responsible for submitting the details of the loss or proposed payment, together with sufficient backing documentation, to enable the Welsh Government to reach a decision.

Information, ~~required by which~~ the Welsh Government ~~shall require~~, will include: -

- nature of the case and amount involved, together with the circumstances in which it arose;
- what recovery action has been taken;
- reasons why the body considers the “write-off” or special payment should be approved, whether legal advice has been sought and if so, it’s content;
- whether fraud, dereliction of duty or failure of supervision is involved;
- whether appropriate disciplinary action has been taken and if not, why not;
- whether investigation has shown defects in existing systems of control and if so, what remedy is proposed;
- whether any general lessons emerge of interest to other NHS bodies.

As an aid to ensure sufficient information is submitted, the Welsh Government has issued a checklist for each of the categories identified.

Checklists for personal injury and medical negligence cases will be completed where necessary by the Director of Nursing (or their representative).

All other checklists will be completed by the Head of Corporate Finance (or their representative). The checklist has to be completed within the Losses and Special Payments Register (LaSPaR) before a case can be closed.

3.2 UHB Approval

All losses and special payments within the limits delegated to the UHB shall require approval in accordance with the UHB's Scheme of Delegation.

4. REPORTING OF LOSSES

- 4.1 Any member of staff identifying a potential loss shall report the incident details to their Head of Department who will immediately take action to recover the loss if possible. The circumstances in which the loss arose should be investigated and where necessary tighter controls put in place.
- 4.2 The Head of Department must complete a losses form (Appendix 2) which should be forwarded to the [Directorate Manager \(or equivalent\)](#)~~Clinical Service Group Manager (or equivalent)~~, who will be responsible for contacting the police, if appropriate.
- 4.3 The [Directorate Manager](#)~~Clinical Service Group Manager~~ (or equivalent) will record their comments on the incident on the losses form. The losses form will then be forwarded to the Director of Finance and Procurement, who will need to be satisfied that all necessary steps have been taken and that the loss is within the UHB's delegated limits before considering that the loss be "written-off".
- 4.4 All details relating to the "write-off" will then be forwarded to the Head of Corporate Finance (or their representative) who shall enter the details in the UHB's Losses and Special Payments Register (LaSPaR).
- 4.5 The Chief Executive or their Deputy shall decide whether to undertake disciplinary or recovery proceedings as a result of losses arising from acts of employees of the UHB.
- 4.6 In instances where suspected fraud has occurred the University Health Board's Local Counter Fraud Specialist should be informed immediately for the matter to be considered under the University Health Board's Counter Fraud, Bribery and Corruption Policy and Response Plan.

- 4.7 In cases of overpayment of salaries and wages where the Payroll Services of NWSSP has been unable to obtain a repayment, an invoice shall be raised and the debt pursued in accordance with the Financial Control Procedure on Income and Debtors. The circumstances of each individual case will dictate whether or not legal action shall be taken.

5. SPECIAL / EX-GRATIA PAYMENTS

- 5.1 Special compensation payments made under legal obligation will be recorded as such if there exists a clear liability as a result of a Court Order, legal advice or a settlement out of court.
- 5.2 For special compensation payments **(other than for employment matters)** and redress payments made under the NHS Concerns, Complaints and Redress Arrangements (Wales) Regulations 2011 the Director of Nursing (or their representative) shall refer all claims likely to enter into this category to the UHB's Legal Advisers.
- 5.3 The Director of Nursing (or their representative) will be responsible for collating and forwarding any information required by the Legal Advisers to enable them to provide appropriate advice. This shall include, for example, medical case and consultant notes on potential medical negligence claims or accident report forms and witness/investigating officer statements for personal injury claims.
- 5.4 Following receipt of advice from the UHB's Legal Advisors, the Director of Nursing (or their representative) will prepare a Claims Summary, together with a recommendation for the Chief Executive, who will authorise the action to be taken.
- 5.5 Special payments made above the threshold set by the Welsh Risk Pool will be reclaimed from them at the earliest point. For further details see section 8 on the Welsh Risk Pool.
- 5.6 For special compensation payments **relating to employment matters** the Director of People shall refer all claims likely to enter into this category to the UHB's Legal Advisers.
- 5.7 The Director of People (or their representative) will be responsible for collating and forwarding any information

required by the Legal Advisers to enable them to provide appropriate advice.

- 5.8 Following receipt of advice from the UHB's Legal Advisors, the Director of People (or their representative) will prepare a Claims Summary, together with a recommendation for the Chief Executive, who will authorise the action to be taken
- 5.9 Ex-Gratia payments are payments that the UHB is not obliged to make, but which are made as an "act of grace" to compensate for hardship or damage resulting from act or failure of the UHB or its staff which does not give rise to legal liability.
- 5.10 Ex-Gratia payments involving loss of personal effects will be restricted to the value of actual loss.
- 5.11 Claimants of Ex-Gratia payments are required to complete the appropriate form (Appendix 3). This shall be forwarded to the [Directorate Manager Clinical Service Group Manager](#) (or equivalent) who will investigate the circumstances of the claim and provide comments and recommendations on the form.
- 5.12 The claim shall be forwarded to the [ILG Care Group](#) Nurse Directors (up to the value of £10,000) or the Chief Executive/Deputy Chief Executive (>£10,000 to within delegated limits issued by Welsh Government - £50,000) who will decide whether to approve the claim and if so, the level of compensation to be paid.
- 5.13 In determining whether to approve the claim, due regard must be taken of the appropriateness of the claim, whether there is contributory negligence on behalf of the claimant and that actual loss has taken place (i.e. that the items lost or damaged are not covered by insurance or free replacement).
- 5.14 In determining the level of compensation to be paid, the repair value of the items damaged shall be reimbursed (supported where possible by receipts). Where items have been lost or damaged beyond repair, the amount paid shall reflect the replacement cost of the item less the estimated depreciation of the item since its purchase.
- 5.15 All compensation payments must be inferred as being necessary and incidental to the running of the service. Any proposal to make an extra statutory or extra-regulatory

payment must be submitted to the Welsh Government for approval.

- 5.16 Details of all special payments, in whatever category, shall be forwarded to the Head of Corporate Finance (or their representative) for recording in the Losses and Special Payments Register (LaSPaR).

6. IRRECOVERABLE DEBTS

- 6.1 Where an account remains unpaid after all reasonable attempts to recover it have failed, the account will be "written-off" in accordance with the Financial Control Procedure on Income and Debtors, details of which will be submitted to the Audit and Risk Committee.
- 6.2 All debts that have been approved for "write-off" shall be entered into the Losses and Special Payments Register (LaSPaR) by the Head of Corporate Finance (or their representative).
- 6.3 Losses that are irrecoverable due to insolvency or liquidation shall be "written-off" and entered into LaSPaR by the Head of Corporate Finance (or their representative) annotated "claim abandoned".
- 6.4 Subsequent recoveries in respect of debts "written-off" will be shown as a contra-entry in the LaSPaR.
- 6.5 Debts "written-off" relating to an overpayment will be recorded as a loss of cash.

7. CONDEMNATIONS AND OBSOLESCENCE

- 7.1 All unserviceable articles should be disposed of [and/or](#) if necessary condemned.
- 7.2 Heads of Departments shall inform the [Directorate Manager \(or equivalent Clinical Service Group Manager \(or equivalent\)\)](#) who will record it, indicating the method of disposal.
- 7.3 Another officer will be required to countersign this record and then details of the loss shall be forwarded to the Head of Corporate Finance (or their representative) who will record it on the LaSPaR.

- 7.4 The ~~Directorate Manager Clinical Service Group Manager~~ (or equivalent) needs to be satisfied whether or not there is evidence of negligence and will report any evidence to the Chief Executive who shall take appropriate action.
- 7.5 Obsolete equipment or stock must be reported indicating suitability for sale or disposal, together with a valuation, to the Head of Procurement, who will then arrange for the items to be sold or disposed of accordingly.
- 7.6 Unexplained discrepancies found when undertaking a stock-take will be notified in writing to the Head of Corporate Finance (or their representative) who will investigate the reason for such discrepancies and if appropriate shall recommend "write-off". Such losses will be recorded in the LaSPaR.

8. WELSH RISK POOL

- 8.1 The Welsh Risk Pool (WRP) is a mutual self-assurance scheme for all health bodies in Wales. The WRP has two principal functions:
1. Reimbursement of costs for approved cases over the agreed excess levels;
 2. Provide support to Health Boards and Trusts in the development of robust risk management systems.

Under the terms of this pooling mechanism, the UHB is responsible for meeting the costs below the excess threshold, as determined by the WRP, of any successful claim.

8.2 Reimbursement Process

For cases valued at under £100,000 the UHB will make a claim to the WRP when the case has been completely resolved and all costs have been incurred by the UHB. A reimbursement request must be submitted within four calendar months of this occurring. The Director of Nursing (or their representative) will be responsible for submitting the claim in accordance with the requirements of the "WRP procedure for reimbursing Member Organisations".

For cases where total expenditure exceeds £100,000 the UHB will make an interim request for reimbursement for cases within four calendar months of this figure being reached unless alternative arrangements are agreed with the Treasury Manager.

9. LOSSES & SPECIAL PAYMENTS REGISTER (LaSPaR)

9.1 The excel database of the losses and special payments register (LaSPaR) will allow the UHB to:

- track all aspects of losses and special payments from initial registration to final outcome on a case to case basis.
- separately set up settlement/plaintiff cost provisions and defence/other administration costs provisions and action any subsequent adjustments.
- separately identify all payments and income recoveries and analyse these transactions.

Maintaining the Database

9.2 The Head of Corporate Finance (or their representative) will maintain the LaSPaR excel database in which **all** losses and special payments will be recorded together with any amounts subsequently recovered.

9.3 The excel database will be updated monthly with payment and provision data by the Head of Corporate Finance (or their representative).

9.4 The details should be recorded as per the Welsh Government guidance on the implementation and management of the LaSPaR.

9.5 Losses may be aggregated in instances where there are several identical losses. The description will include the number of individual losses.

9.6 The LaSPaR excel database will be used as a basis for reporting to the UHB's Audit and Risk Committee and the Welsh Government.

10. INSURANCE

- 10.1 The Chief Executive will be responsible for establishing the Risk Management strategy of the UHB. This should identify the risks and potential liabilities relating to the assets owned by the UHB, legal or contractual obligations, employees and third parties.
- 10.2 The Chief Executive, after taking advice from the Director of Finance and Procurement, shall decide what risks will be covered by insurance. Due regard will be taken of the value of possible losses and the frequency with which they are likely to arise. The costs and benefits of all available options for reducing risks should be appraised to establish what is most likely to provide the best value for money. Possible options are commercial insurance (except for medical negligence and business interruption claims), the Welsh Risk Pool, self-insurance or a combination of these.
- 10.3 All risks shall be taken into account in assessing insurance cover, including:
- Directors and Officers Liability
 - Employer's Liability
 - Health and Safety
 - Public Liability
 - Product Liability
 - Third Party Liability
 - Clinical Negligence (cannot be commercially insured)
 - Vehicle Use
 - Hazard Risks
 - Business Interruption (for non-NHS business)
 - Income Generation
- 10.4 The Director of Finance and Procurement will continually review insurance arrangements in the light of the actual number and value of losses experienced and premium rates and will advise the Chief Executive accordingly.

11. EQUALITY IMPACT ASSESSMENT

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

APPENDIX 1**CATEGORY OF LOSS/SPECIAL PAYMENT****DELEGATED LIMITS****£****Losses (except in respect of primary care provider services)**

1. Loss of cash due to:	
a. theft, fraud, etc.	50,000
b. overpayment of salaries, wages, fees and allowances	50,000
c. other causes, including un-vouched or incompletely vouched payments, overpayments other than those included under 1(b); physical losses of cash and cash equivalents e.g., stamps due to fire (other than arson), accident and similar causes	50,000
2. Fruitless payments (including abandoned capital schemes)	250,000
3. Bad debts and claims abandoned:	
a. private patients (Sections 65 and 66 NHS Act 1977)	50,000
b. overseas visitors (Section 121 NHS Act 1977)	50,000
c. cases other than a-b	50,000
4. Damage to buildings, their fittings, furniture and equipment and loss of equipment and property in stores and in use due to:	
a. culpable causes egg, theft, fraud, arson or sabotage whether proved or suspected, neglect of duty or gross carelessness	50,000
b. other causes	50,000

DELEGATED LIMITS

		£
Special payments (except in respect of primary care provider services)		
5.	Compensation payments made under legal obligation	FULL *
	Extra contractual payments to contractors	50,000
7.	Ex-gratia payments	
a.	to patients and staff for loss of personal effects	50,000
b.	for clinical negligence (negotiated settlements following legal advice) where the guidance relating to such payments has been applied	1,000,000 including plaintiff's costs *
c.	for personal injury claims involving negligence where legal advice obtained and relevant guidance has been applied	1,000,000 including plaintiff's costs *
d.	other clinical negligence cases and personal injury claims	50,000 *
e.	other, except cases for maladministration where there was <u>no</u> financial loss by claimant	50,000
f.	maladministration where there was <u>no</u> financial loss by claimant	NIL
g.	patient referrals outside the UK and EEA guidelines	NIL
* For all clinical negligence and personal injury cases (including court cases) the use of periodical payments should be considered for any settlement (exclusive of legal costs) involving costs to the NHS of £250,000 or more, or for lower awards when this represents good value for money. <u>Proposed out of Court periodical payment awards require approval from the WG H&SSG FD.</u>		
8.	Extra statutory and extra regulatory payments	NIL

Losses and special payments in respect of provision of primary care provider services

Losses		Limit
		£
9.	a. Losses due to overpayments to practitioners of fees, allowances or salary	
	i. involving fraud	1,000
	ii. other	1,000
	b. unvouched or incompletely vouched payments	1,000
10.	Claims abandoned	1,000
Special Payments		
11.	Ex gratia payments	1,000
12.	Extra statutory and extra regulatory payments	
	a. to pharmacist contractors for drugs supplied in good faith in respect of forged, etc., prescriptions forms	1,000
	b. excusal of statutory charges for replacement dentures in certain circumstances	up to appropriate maximum statutory charge
	c. other	NIL
Losses: Fraud cases under investigation		
13.	a. Losses in cases investigated by the health body in respect of prescription fraud.	1,000
	b. Losses in cases investigated by the health body in respect of dental fraud.	1,000
	c. Losses in cases investigated by the health body in respect of ophthalmic fraud.	1,000

APPENDIX 2**CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD****REPORT OF LOSS /THEFT OR FRAUD RELATING TO UHB**
PROPERTY AND EQUIPMENT
(INCLUDING CRIMINAL DAMAGE/ARSON)

SECTION A			
TO BE COMPLETED BY HEAD OF DEPARTMENT:			
Hospital/Clinic:			
Ward/Department:			
Financial Code:			
Date of Incident:		Approx. Time	
Details of Loss/Theft/Criminal Damage/Arson/Fraud (Please give full details of incident and items concerned)			
Total Value of Items	£		
Estimated Loss to UHB	£		
(estimated value immediately prior to the loss, less any sums recovered e. scrap value or insurance payments etc.)			
Have the Police been informed [or in the case of Fraud the DoF or LCFS]?		YES / NO	(Delete as appropriate)
If YES, give details:			
NOTE: The outcome of Police investigations must be notified to the Director of Finance when available.			
Any other relevant details to the incident:			
State below any corrective action or security measures which you feel could be implemented to help prevent a similar occurrence:			

Signed: _____ Name: _____ Ward/Departmental Head	Date

SECTION B

TO BE COMPETED BY THE Directorate Manager (or equivalent CLINICAL SERVICE GROUP MANAGER (or equivalent))

Results of Internal Investigation (if applicable)/Further Comments on Incident:

Signed: _____ Name: _____ <u>Directorate Manager Clinical Service Group Manager (or equivalent)</u>	Date

PLEASE FORWARD THIS FORM TO THE DIRECTOR OF FINANCE

SECTION C

TO BE COMPLETED BY THE DIRECTOR OF FINANCE

This form has been examined and the details reviewed and approved.

Signed: _____ Name: _____ Director of Finance	Date

SECTION D

TO BE COMPLETED BY CHIEF EXECUTIVE IF OVER £25,000

Signed: _____ Chief Executive	Date

SECTION E

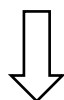
TO BE COMPLETED BY FINANCE

The necessary details have been entered in the UHB's Losses and Special Payments Register (LaSPaR).

Signed: _____ Title	Date

FLOWCHART**EX GRATIA PAYMENTS – PATIENTS AND STAFF FOR LOSS OF
PERSONAL EFFECTS**

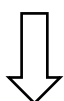
**Part 1 of Losses and Compensation –Ex Gratia payment claim
form completed by Claimant and witnessed**



**Part 2 (a) Summary of Investigation completed by Head of
Department**



**Part 2b) Value of claim endorsed by Clinical service Group
manager or equivalent director**



**Part 2c) Value of claim up to
£10k
Care Group Nurse Directors to
approve**

**Part 2c) Greater than £10k but
up to £50k
Chief Executive/Deputy Chief
Executive to approve claim and
agree level of compensation**



**2d) Completed and authorised form emailed to
CTM.LaSPAR@wales.nhs.uk**

APPENDIX 3

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD

LOSSES AND COMPENSATION: EX-GRATIA PAYMENT CLAIM FORM

PART 1			
TO BE COMPLETED BY CLAIMANT AND RETURNED TO WARD/DIRECTORATE/Care GroupILG			
Hospital/Ward/Directorate/Care GroupILG:			
Name			
Private Address			
Telephone No			
Post Held (if employee)			
Date of Incident			
Value of Claim		£ (See note 2 at the foot of this claim form) Attach receipt or estimate if applicable	
Description of Item Covered by this Claim:			
Date Item was Purchased:			
Cost at Time of Purchase:			
Have you a personal property insurance policy on which a claim could be made?		YES/NO	(Delete as appropriate)
Describe circumstances necessitating this Claim			
(Continue on a separate sheet if necessary)			

A. I CONFIRM THAT THE FACTS STATED ABOVE ARE CORRECT	
Signed: _____ Date: _____	
Name: _____	
Claimant	
Statement by Witness to the Incident	
Signed _____	
Name _____	
Post Held _____ (if employee)	
PART 2 (a)	
TO BE COMPETED BY THE HEAD OF DEPARTMENT	
Summary of Investigation:	
State below any corrective action or security measures which you feel could be implemented to help prevent a similar occurrence:	
Signed: _____	Date:
Name: _____	
Head of Department	
PART 2 (b)	
TO BE COMPETED BY THE <u>Directorate Manager</u> ~~CLINICAL SERVICE MANAGER~~ (or equivalent) \ <u>Care Group</u> DIRECTOR	
Value of Claim £	
Recommendation: Do Not Approve Claim [] Approve Claim []	
Financial Code:	
Reason:	
Signed: _____	Date:
Name: _____	
<u>Directorate Manager (or equivalent)</u> ~~Clinical Service Group Manager (or equivalent)~~ / <u>Care Group</u> Director	
PART 2 (c)	
TO BE COMPLETED BY THE <u>Care Group</u> ~~ILG~~ NURSE DIRECTORS/CHIEF EXECUTIVE	

Claim Not Approved ☐ Claim Approved ☐ Value Approved £ Reason:	
Signed: _____ Name: _____ Care Group ILG Nurse Directors/Chief Executive	Date:
PART 2 (d)	
TO BE COMPLETED BY FINANCE	
Ex-Gratia Payment ☐ Cheque No. (if applicable) BACS reference	
Losses/Compensation ☐ Insurance ☐ Date Issued _____	
The necessary details have been entered in the UHB's Losses and Special Payments Register (LaSPaR).	
Signed: _____ Title	Date:

NOTES:

- Ex-gratia payments to staff for the loss of, or damage to their personal property may be only where:
 - The incident occurs during the course of their employment.
 - The articles lost or damaged are such as might reasonably be carried out during the course of their employment.
 - The articles are sufficiently robust for the treatment they might reasonably be expected to bear.
 - The loss or damage is not due to the officer's own negligence.
 - The loss or damage is not covered by insurance or by any provision or free replacement.
- Where the article can be repaired, the payment made should cover the actual cost of repair, but where it is lost or damaged beyond repair, the value of the property immediately before the incident should be paid, i.e. the cost of replacement less the estimated amount by which the property had depreciated since purchase.

FOR HEALTH BODY USE

APPENDIX 4

Checklist to be used when compiling the summary of the case

Category – Type of case - Reference number - Health Body (name and code) -
1. Record the amount involved and the reasons why the loss arose.
2. Detail the background of case giving full reason why payment is necessary. Have other alternatives to the payment been investigated? If not, why not? If so, provide details.
3. Was fraud involved? If so complete a fraud report and ensure that the LCFS, the relevant NHS CFS Wales team, Internal and External Auditors, and where relevant the police, are informed of the fraud in accordance with Welsh Government Directions to NHS Wales health bodies on Counter Fraud Measures and using the reporting system as specified by the NHS CFS Wales. Enter dates of completion of fraud report.
4. Was theft or criminal damage involved? If so have the police been informed? If not, give the reasons why not? All security related incidents must be reported to the Local Security Management Specialist once trained, accredited and in place in accordance with forthcoming guidance issued by NHS Security Management Service.
5. For abandoned works, were detailed specifications identified before the scheme went ahead? How did the projected work compare to these detailed specifications? At what level, by whom, and why was the scheme approved? Why was the scheme abandoned and by whom? Could the scheme have been aborted earlier? Was the scheme joint financed? If so, was any agreement signed? Was legal advice taken in the drawing up of an agreement? Is the other party prepared to pay half of the costs of the scheme?

6. **For Bad Debts and Claims Abandoned.** Were invoices raised on a regular basis? Was the debt monitored and chased regularly? Were services withdrawn upon continued non-payment? Enclose report showing when invoices were raised and where relevant paid.

For cases involving businesses – has the business gone into liquidation/receivership? If so, are you listed as a creditor and do you have confirmation of this from the liquidator /receiver? If not, why not? Are any dividends being paid out? Was the financial integrity of the business looked into before goods or services were supplied? If not, why not and have procedures been revised to ensure this is carried out in the future?

7. **For rental cases only** - did the tenant enter into lease agreements prior to occupation? If not, why not? If the lease was faulty investigate whether action can be taken against legal advisors who drew up the agreement? Provide an analysis of rent and services charges.

8. **For private patients** cases was an undertaking to pay signed? If not, why not? Was a full estimate of potential costs given and full deposit taken to cover these costs? If not, why not?

For overseas private patient's cases – have the relevant embassies been contacted for payment (if applicable)? For overseas visitors, are robust procedures in place in the NHS Body to identify and charge liable overseas visitors? If not, why not? Was the overseas visitor informed that he/she would be liable to pay for the full cost of treatment? Was treatment, in a clinical opinion, immediately necessary or urgent? If treatment was not urgent why was it given before obtaining a sizeable deposit?

9. **Stores (only)** - Are any linen losses calculated at 50% of the replacement value? Is this in accordance with the guidance? Is the total loss more than 5% of the total stock value? Confirm that the loss has been valued at book value less net disposal proceeds.

10. For extra contractual payments to contractors. Have other alternatives to the payment been investigated? If not, why not? If so, provide details. Provide detailed calculations on which the payment is based.
11. For ex gratia payments. Have other options been considered? If not, why not? Explain why an ex gratia payment offers the best value for money. Confirm that the proposed payment does not place the claimant in a better position than if the error had not occurred? If it does, why? In cases of hardship record what evidence exists on this? Provide detailed calculations to support the proposed payment and demonstrate why the proposed sum is in accordance with the relevant paragraphs of this guidance. For settlements on termination of employment, has relevant central guidance on such payments been followed in all respects? If not, why not? For clinical negligence and personal injury cases has the relevant central guidance for such cases been followed in all respects? If not, why not?
12. Is the value of the loss reduced by insurance? If so, record the value of the gross loss and the value of the amount recovered by insurance.
13. Have all reasonable steps been taken to recover the loss? Provide details of the attempts that have been made to recover the loss or explain why no action has been taken. Has appropriate legal advice been sought? If not, why not? If advice has been sought, what recommendations were made and have these been followed? If not, why not?
14. Identify any failings in the actions of employees, including supervisors. Having considered this, is there a need for disciplinary action? Record what action has been taken or is proposed, or if no action is to be taken, explain why. Include dates, names of individuals and positions.

15. Was there any apparent breakdown of procedures? Detail weakness or fault in system of control or supervision.
16. What proposed improvements have been put forward to correct defects in the existing systems or procedures? Include the timetable for implementation of the improvements. What monitoring measures have been introduced to ensure the improvements are working effectively?
17. Is it necessary to inform the board/chief executive? If not, why not?
18. Do your SFIs require a Board report for this case? If so, please enclose the report. If not, consider whether in the light of this case your SFIs should be amended to require a Board report in such cases.
19. Having completed the above steps, detail the general lessons that can be drawn from this case. If a system weakness has been identified which has possible implications across the NHS the LCFS or the NHS CFS Wales should report the problem to NHS Protect using either the intranet fraud prevention referral system for fraud or the Area Security Management Specialist for security matters so that measures can be taken nationally to amend policy or systems.
20. Please give details of name and position of person forwarding this case for Welsh Government approval (if applicable). Give the date when this case was first brought to the attention of the Welsh Government H&SSG FD (if applicable). Name - Position - Date Welsh Government H&SSG FD notified -

21. I have considered fully each point on this checklist and my findings are recorded in the attached case summary and/or in the spaces above. I confirm that the details recorded above and on the attached case summary are complete and accurate, and that all aspects of the checklist have been properly considered and actioned.

Signed by -

22. I confirm that the above details are complete and accurate and all aspects of the checklist have been properly considered and actioned. I agree that write off of this loss offers the best value for money for this case.

* Note: Delete as appropriate.

* This case is not novel, contentious or repercussive. I therefore agree to write off of the loss.

* This case is novel, contentious or repercussive and I therefore request formal approval from the Welsh Government H&SSG FD

Signed by -

Date -

Countersigned by -

Date -

Please note this section must be signed by two senior officers in accordance with the delegated limits set by the board. Please print names and position held in the organisation.

Name -

Position held –

Countersigned by -

Position held -



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

FINANCIAL CONTROL PROCEDURE: GENERAL LEDGER

Initiated by: Executive Director of Finance ~~& Procurement~~

Approved by: Audit & Risk Committee

Date approved: ~~TBC~~**December 2020**

Operational Date: ~~December 2020~~**TBC**

Date for review: December 2027~~3~~

Distribution: Executive Directors
Board Secretary
Assistant Directors
Clinical Service Group Managers
SharePoint

Freedom of Information Status: Open

This policy has been subject to a full equality impact assessment.

CONTENTS

1. Scope & Principles
2. System Administration
3. Input Procedures
 - Journal Input
 - Journal Categories
 - Posting Procedures
4. Ledger Maintenance
5. Reconciliations
6. Month End Procedures
7. Year End Procedures
8. Equality Impact Assessment

Appendices

- Appendix 1 - User Set-up Form
- Appendix 2 - Financial Code set up Forms
- Appendix 3 - Financial Code changes form
- Appendix 4 - Cost centre Hierarchy guidelines

SCOPE & PRINCIPLES

- 1.1 This procedure details the controls underlying the Cwm Taf Morgannwg University Health Board's General Ledger [GL] and is applicable to the GLs that relate to both Cwm Taf Morgannwg University Health Board [the UHB] and the hosted service of the Joint Commissioning Committee (JCC). ~~Welsh Health Specialised Services Committee [WHSSC] incorporating the Emergency Ambulance Services Committee [EASC].~~
- 1.2 Where the term University Health Board [UHB] is used this applies equally, unless otherwise specified, to ~~WHSSC & EASC~~the JCC.
- 1.3 This procedure should be read in conjunction with the UHB's Standing Orders, Standing Financial Instructions and other relevant Financial Procedures.
- 1.4 The Director of Finance will be responsible for ensuring that proper financial controls and segregation of duties exist for the maintenance of the integrity, validity and accuracy of the data fed into the GL and the resulting output.
- 1.5 Subject to the responsibility of the Director of Finance for the control systems in use, the day-to-day management will be delegated to the Head of Corporate Finance [or their representative].

2. SYSTEM ADMINISTRATION

- 2.1 The UHB's accounting system, ORACLE will be protected by password control. The UHB will use the all Wales standard password renewal period of 30 days. Each individual user will be allowed access to certain applications dependent on their position.
- 2.2 There will be nominated System Administrators [SAs] who will be responsible for adding new users and end dating old users on the ORACLE system. Levels of access for each new user will be determined and approved by the new user's Head of Section/Line manager/budget holder (forms are available on Finance Sharepoint page Finance & Procurement - Systems Forms - [see appendix 1 for form to be completed]). Electronic copies of proof of the request for a user account will be retained for each financial year for a period of at least 6 months following each year end.
- 2.3 Heads of Section should also notify the SAs of staff whose system access requires termination. This is particularly important for staff with an approval limit as these are not picked up by any other checks.
- 2.4 The SAs will perform a monthly review of users for non-usage and end date accounts that have not been used for over 60 days with the exception of Approvers within the purchasing hierarchy.

2.5 The SAs will have access to the University Health Board Systems Administrator application and General Ledger SuperUser within the ORACLE system.

2.6 Under no circumstances are the SAs allowed to use the University Health Board System Administrator function to access databases of other University Health Boards within the consortium. Abuse of this privilege will lead to disciplinary action.

3. INPUT PROCEDURES

3.1 Journal Input

A journal may be entered in ORACLE in three different ways:

- *Manual journal entry*

Line by line entries can be made in ORACLE if necessary.

- *Imported [automated feeds only]*

The Journal Import function may be used to integrate information from other applications such as payroll with the General Ledger application.

For each period, accounting data from feeder systems will be imported by the SAs. The content of the feeders will not be manually amended prior to Journal Import to provide an audit trail between systems, other than where this would cause the feeder import to fail such as missing codes or formatting errors. Where this is required standard procedure is followed according to the guidance for each feed. Feeders are reconciled to the original feeder source before posting.

For non-direct ORACLE module feeds [Payroll, Stores, Pharmacy JAG and Procurement feeds], a copy of the original file is stored as an audit trail, supporting information is saved to a shared Excel folder to allow access and usage by the Finance Department.

- *Via the Application Desktop Integrator [ADI] application*

Journals may be entered directly into a Microsoft Excel spreadsheet which can then be copied into an ADI journal entry worksheet. ADI will validate the data against the ORACLE GL and then upload the journal.

3.2 Journal Categories

These will be created and maintained under the responsibility of the Head of Corporate Finance [or their representative]. Each journal category will have a document number allocated by the system to allow input control.

3.3 Posting Procedures

Input and posting procedures are agreed by each finance section. Control over the posting of journals is by limited access to the posting functionality as agreed by managers within the Finance department.

Journal batches may also be selected and posted by the SAs.

4. **LEDGER MAINTENANCE**

- 4.1 The University Health Board's financial coding structure consists of five elements: Entity [3 digits], Cost Centre [4 digits], Subjective [5 digits], Analysis [4 digits] and Other [6 digits]. All five elements form a valid financial code when linked.
- 4.2 All requests for new or changes to financial code values will be made by members of the Finance Department on the appropriate form Finance & Procurement - Systems Forms. ~~[Appendices 2 & 3].~~
- 4.3 Only the SAs are able to create new code values. However subjective codes are controlled centrally by the NHS Wales Shared Services Partnership ORACLE Central Support Team. Requests for new subjective codes will require the approval of the Head of Corporate Finance [or their representative].
- 4.4 When requesting the setting up of an elementa cost centre or analysis code, the user must specify the summary code to which the element will be linked where appropriate. These should fit within the guidelines explained in Appendix 14

5 **RECONCILIATIONS**

- 5.1 Each month a series of reconciliations will be performed and reports run, to provide assurance that the integrity of the account codes and data feeds to the ledger has not been compromised.
- 5.2 ~~-~~The reconciliations provide evidence that the subsidiary modules/underlying records reconcile to the General Ledger. Balance Sheet reconciliations are the responsibility of the Financial Accounts section. System creditor reconciliations are the responsibility of NHS Wales Shared Services. Capital creditor, cash and expenditure reconciliations are the responsibility of the Capital Finance section.
- 5.3 The Head of Corporate Finance [or their representative] will assign each reconciliation to individual members of staff. Each reconciliation

will be completed in accordance with a timetable set by the Head of Corporate Finance [or their representative].

- 5.4 When completed, all reconciliations will be reviewed and **signed confirmed** by the preparer and the Head of Corporate Finance [or their representative who will be of a more senior grade than the preparer].
- 5.5 The responsibility for allocation of reconciliations of the **WHSSC-JCC** GL resides within **WHSSCJCC**. However, where applicable the same series of monthly reconciliations is required.

6 MONTH END PROCEDURES

- 6.1 The SAs shall confirm that the accounting information from the sub-ledgers [*ORACLE Payables, Receivables*] has been transferred to the General Ledger.
- 6.2 The Shared Services P2P Manager will notify the SAs when the Accounts Payable [AP] module has been closed.
- 6.3 SAs will process the system accruals, stock feed and pharmacy **-JAC** feed and make the source documents available to finance staff.
- 6.4 **-**SAs run checks to verify coding and Qlik integrity and run a General Ledger Trial Balance on the first working day of each month and verify that the system is in balance. This will also include the **WHSSC-JCC** GL.
- 6.5 Systems task list is reviewed for the month to ensure all expected feeders have been received and processed.
- 6.6 Debtors verify that their month end processing is complete.
- 6.7 SAs notify Divisional support that the month end systems processing is complete for them to start their month end adjustment and reporting processes. The target for this notification is midday on working day 1.
- 6.8 System admin checks are then undertaken to verify system user, code and transfer points are appropriate and as expected.
- 6.9 At the end of the reporting period the SAs will close the General Ledger accounting period after all the accounting transactions have been completed for the period. Periods will not be permanently closed unless instructed by the Head of Corporate Finance [or their representative]. **SAs will notify finance colleagues that the period has been closed.**

6.10 The SAs shall then open the next GL accounting period. This will generate the reversal journals.

6.11 The next Qlik reporting period is made available for CTT and ~~WHSSCJCC~~

7 YEAR END PROCEDURES

7.1 The year-end procedures will operate in the same way as the month end procedures with the only difference being the use of an additional adjusting period Month 13.

7.2 The only entries posted to Month 13 will be those that are required to adjust the year-end position to the Final Accounts reported position.

7.3 Month 13 will only be made available on request by the Financial accounts team.

7.4 The SAs will ensure that Months 12 and 13 are closed in accordance with Section 6 of this procedure upon notification by Financial Accounts.

7.5 The SAs will open the next year when instructed by the Head of Corporate Finance [or their representative].

8 EQUALITY IMPACT ASSESSMENT

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



CTM ORACLE USER FORM

ORACLE®

* MANDATORY FIELDS ARE INDICATED BY AN ASTERISK - Failure to complete all mandatory fields may result in the form being returned and/or a delay in the user account being created.
Digital signatures can only be accepted if form is recieved from managers email. Please print and sign the form.

To be completed by the User

* Date of training session Access to Iprocurement System will not be granted until attended formal Training sessions see link

* TITLE Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Rev ☐ Other

* FULL NAME * Payroll No.

* Agency

* JOB TITLE

* DEPARTMENT Base

* WKS TEL NO * NADEX NUMBER

* EMAIL @wales.nhs.uk

* EMPLOYEE SIGNATURE * DATE

*** To be completed by the Manager**

Iprocurement Qlikview Bridgend Stores Finance User

User being set up as Requisitioner Approver Limit

If an approval limit is requested has an ASL form been completed? (authorised signatory form) ☐

New User/Amendment Detail:

If new user, does this user replace an existing user Y/N or EXISTING USER

If new user, same level of access as an existing user EXISTING USER

If neither of above apply please complete required information below

* Default Cost Centre * Transfer Point No

* Requisition Approver

* MANAGERS SIGNATURE DATE

*** To be completed by Systems Team**

Employee Added to email SOD

Responsibility

User Name

If Qlikview user the following steps need to be completed

Qlikview responsibility

* Default Cost Centre * Added to User Stats Sheet

* System Administrator Name

* Signed DATE

Please return to CTT_FINANCE_SYSTEMS@WALES.NHS.UK

APPENDIX 2

New code request

~~Type of Code required: Cost Centre / Analysis / Other~~ (Please delete as appropriate)

Description for code:

For Cost Centre requests:

Link to Parent Y code: _____	Y	Oracle Hierarchy Approver	
Or same parent as cost centre code:			

Optional: Do you want this code to be grouped near another code? Y/N

Which code should it be placed near to? _____

Budget code combination links to be set up:

N.B. This is only for codes likely to be used for a budget transaction before an actual transaction.

Please return completed form to:

CTT_FINANCE_SYSTEMS@WALES.NHS.UK

Requested

by:

Date:

Systems team

use only:

Code set up by:

Code: _____

User notified date:

Please return to: CTT_FinSystemsAdmin@wales.nhs.uk

Where electronic signature is used the form must be received direct from the approvers' e-mail account.

Code Changes request

Type of Code: Cost Centre / Analysis / Other (Please delete as appropriate)

Code:

New

New

description required Y/N

Description for code:

New parent code required: Y/N

Link to Parent Y code:—	Y	Oracle Hierarchy Approver	
Or same parent as cost centre code:			

End Date Code Y/N

This will not remove the code from your reporting but will stop any future use

Cost Centre – Link to End dated codes? Y/N

This will remove the code from your reporting but you MUST follow the End Dated Code process guidance before making the request. The guidance can be accessed suing the link below;

[..\\GN79 – End dated codes check.docx](#)

Please return completed form to: CTT_FINANCE_SYSTEMS@WALES.NHS.UK

Requested

by:

Date:

Systems team

Actioned by:—

use only:

User notified date:

Please return to: CTT_FinSystemsAdmin@wales.nhs.uk

Where electronic signature is used the form must be received direct from the approvers' e-mail account.

Cost Centre Hierarchy Guidelines

Level 3 codes ~~_ begin with A and any~~ new codes should only be required if there is a change to the **Executive Director** structure of the organisation.

Level 4 – ~~C codes,~~ should equate to **Assistant Director****Care Group** Structures

Level 5 - ~~D codes,~~ should align to **Directorate** level

Level 6 - ~~E codes,~~ these are the most commonly reported parent or summary levels, they generally equate to **sub category to the Directorate Managers**

Level 7 – ~~G codes –~~ should generally equate to **Service** Level

Level 8 – ~~L~~**Cost Centre** ~~level~~codes relate to a **Service Department**.
~~These are the codes that should be provided to the systems team to Finance colleagues will need to~~ identify where in the structure any new posting level cost centre requests should be joined and provide this to the systems team.

Entity	~~3 numeric digits~~	~~110 Cwm Taf UHB~~ ~~111 Charitable Funds~~ ~~112 WHSCC~~
Cost Centre	~~4 numeric digits~~ ~~4 Alphanumeric starting with H~~ ~~4 Alpha digits~~	~~0001 – 8889 = Revenue~~ ~~9001 – 9998 = Trust funds~~ ~~9999 – Balance sheet~~ ~~WHSCC~~ ~~Summary~~
Subjective (All Wales)	~~5 Numeric~~ ~~5 Alpha numeric~~ ~~5 Numeric~~	~~00600 – 00950 – Other NHS~~ ~~01100 – 09440 – Income~~ ~~09450 – 09500 – Charitable funds Income~~ ~~09510 – 09670 – Income~~ ~~1***** – Ambulance~~ ~~2***** – Payroll~~ ~~3***** – Supplies & Services~~ ~~5***** – Primary care (Pharmacy, Dental etc.)~~ ~~91100 – 91420 – Capital jobs~~ ~~9***** – Balance Sheet~~
Analysis	~~4 Alpha numeric~~ ~~4 Numeric~~	~~Capital~~ ~~Revenue~~
Other	~~6 Numeric~~	~~000000 – Default~~ ~~Others – WHSCC~~



**FINANCIAL CONTROL PROCEDURE:
CONSTRUCTION INDUSTRY SCHEME**

Initiated by	Director of Finance & Procurement
Approved by	Audit Committee
Date approved	December ~~2020~~ <u>2024</u>
Operational Date	December ~~2020~~ <u>2024</u>
Version	~~Three~~ <u>Four</u>
Date for review	December 202 ~~3~~ <u>December 2027</u>
Distribution	Assistant Director (Capital & Estates) NHS Wales Shared Services Partnership

Freedom of Information Status: Open

This policy has been subject to a full equality impact assessment.

CONTENTS

1. Scope & Principles
2. Scheme Overview
3. Accounts Payable Procedures
4. Equality Impact Assessment

Appendices:

Appendix 1 Payment and Deduction Statement –
Construction Industry Scheme

1. SCOPE AND PRINCIPLES

- 1.1 This procedure details the principles and requirements of HM Revenue & Customs Construction Industry Scheme, and the controls that are required to ensure compliance of Cwm Taf Morgannwg University Health Board (UHB) with the Construction Industry Scheme (CIS).
- 1.2 This procedure should be read in conjunction with HM Revenue & Customs guide 'Construction Industry Scheme: A Guide for contractors and subcontractors (CIS 340)'.
- 1.3 The procedure should also be read in conjunction with other relevant financial procedures, in particular FP6 which deals with creditor payments.
- 1.4 Under the scheme, the UHB is deemed to be a contractor and must therefore operate the relevant procedures whenever it sub-contracts work that is within the scope of the scheme.
- 1.5 The scheme applies to specified construction work and also includes services such as installation, repairs, decoration and demolition. A comprehensive list of services that are included in the scheme can be found in Appendix C of the guide CIS 340 referred to in paragraph 1.2 above. The definition of a contractor and subcontractor is also provided within Section 1 of the guide.
- 1.6 This procedure also applies to those staff who are employed by the NHS Wales Shared Services Partnership (NWSSP) who process and pay transactions on behalf of the UHB.

2 SCHEME OVERVIEW

2.1 The Construction Industry Scheme.

The scheme sets out the rules for how payments to subcontractors for construction work must be handled by contractors in the construction industry and certain other businesses, such as the National Health Service.

Under the scheme, all payments made by the UHB to subcontractors must take account of the subcontractor's tax status as determined by HM Revenue & Customs (HMRC). This may require the UHB to make a deduction, which is paid to HMRC, from that part of the payment that does not represent the cost of materials incurred by the subcontractor.

2.2 Classification of subcontractors.

Subcontractors should register for the scheme for assessment by HMRC prior to commencing any work within the construction industry. Contractors will pay the subcontractor in one of the following ways:

Gross – without any deductions taken from the payment

Net - deduction at the current standard rate of 20%

Net - deduction at the higher rate of 30% where the subcontractor has not registered for the scheme.

2.3 All deductions made by the UHB shall be paid to HMRC.

2.4 The UHB is required to make a monthly online return to HMRC.

3. ACCOUNTS PAYABLE PROCEDURES

3.1 A schedule of verified subcontractors will be maintained by the NWSSP Accounts Payable team indicating their current tax status. Subcontractors not included in the schedule may be verified on line in order to ascertain their tax status.

3.2 NWSSP Accounts Payable staff will review all invoices received from subcontractors to ascertain whether the work carried out falls within the scope of the scheme.

3.3 Where an invoice falls within the scheme NWSSP Accounts Payable staff will take the following action:

Subcontractors to be paid gross – invoice entered in ORACLE and processed in the normal way.

Subcontractors to be paid net, or have not registered with the scheme – invoices are passed to the NWSSP Accounts Payable officer responsible for CIS, for processing in ORACLE. ORACLE will automatically make the necessary deductions dependent on status and allocate the withholding amount against the HMRC account.

3.4 A report is produced to identify all payments made under the CIS Scheme for the month (The 6th of the previous month to the 5th of the current month). This report is verified by the NWSSP Accounts Payable officer responsible for CIS. Once

December 2024

Financial Procedure

verified, the withholding tax held in the HMRC account is then released for payment. This payment must be received by the 19th of the month.

- 3.5 At the close of each tax month (5th of each month), the NWSSP Accounts Payable officer responsible for CIS will enter the payment and deduction totals of each subcontractor into a monthly return within the HMRC online system. A nil return must be made where no payments exist. The return must be finalized prior to the 18th of the month.
- 3.6 The NWSSP Accounts Payable officer responsible for CIS will forward schedules of payment and deduction (Appendix 1) to each subcontractor who has been subject to deduction. The deadline for the receipt of these schedules is 19th of the month.
- 3.7 The NWSSP Accounts Payable officer will then forward relevant information to the Financial Accountant who will arrange for a monthly reconciliation of deductions to the General Ledger to be completed.

4 EQUALITY IMPACT ASSESSMENT

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

Appendix 1

CWM TAF MORGANNWG UHB

TEL:

PAYMENT AND DEDUCTION STATEMENT - CONSTRUCTION INDUSTRY SCHEME

Contractor's Name & Address

Contractor's Employer's Reference Number
Construction Industry Scheme
Statement of payment and deduction for month
ending:

948 PK00145199

05/ xx/20xx

SUBCONTRACTOR

Name

Unique Taxpayer Reference

Verification Number

Gross amount paid (Excl VAT) - (A)

Less Cost of Materials

Amount liable to deduction @ 20%

Amount Deducted - (B)

Amount payable (A-B) **£0.00**

*** Verification number only to be entered where
deduction at the higher rate is made**

Invoice Details



FINANCIAL CONTROL PROCEDURE: CAPITAL ASSETS REGISTER

Initiated by: Director of Finance & Procurement

Approved by: Audit & Risk Committee

Date approved: ~~June 2021~~ Dec 2024

Operational Date: ~~June 2021~~ Dec 2024

Date for review: ~~April-Dec~~ 20242027

Distribution: Executive Directors
Board Secretary
Clinical Service Group Managers

Freedom of Information Status: Open

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7. Appendices

1. SCOPE AND PRINCIPLES

- 1.1 This procedure details the principles underlying the University Health Board's Capital Asset Register.
- 1.2 This procedure should be read in conjunction with the University Health Board's Standing Financial Instructions and other financial control procedures.
- 1.3 The University Health Board (UHB) is obliged to maintain an accurate asset register to ensure that assets are accounted for correctly and that the assets are properly utilised and secure from loss or theft.
- 1.4 Capital Charging (depreciation) takes account of the cost of employing capital assets by Health Boards in the provision of health care. In order to achieve this objective, it is necessary to compile and maintain an asset register in order to calculate and apply the charges to these assets.
- 1.5 A computerised Fixed Asset system has been implemented by the UHB in order to account for its Fixed Assets, to process the data into meaningful information and also to calculate the Capital Charges.
- 1.6 The Capital Charge (depreciation) will be calculated using the cost over the expected life of the asset. The methodologies used will be in accordance with directions issued by the Welsh Government.

2 PURPOSE OF THE ASSET REGISTER

2.1 The purpose of the asset register is:

- To ensure that all UHB assets are accounted for.
- To ensure that the UHB's asset information is up to date and maintained regularly.
- To ensure that all Directorates are aware of their responsibilities regarding their assets.
- To ensure accurate capital charges are calculated on a timely basis.
- To assist in the allocation of capital funding.
- To provide detailed information for the annual accounts

3 CAPITALISATION THRESHOLD

3.1 There is a **£5,000** capitalisation threshold for individual assets, although assets of a lesser value may be capitalised if they form part of a **group**, with a group value in excess of £5,000. The £5,000 figure includes VAT where this is not recoverable.

3.2 Grouped assets are a collection of assets which form a single collective asset, as defined by satisfying **all** the criteria below:

- All the items are functionally interdependent.
- The items are acquired at the same date and have the same expected life.
- The items are under single managerial control.
- Each individual asset thus grouped has a value of over £250.

3.3 IT hardware may be considered interdependent if it is attached to a network, the fact that it may be capable of stand-alone use notwithstanding. Effectively all IT equipment purchases, where the final three criteria above apply will be capitalised.

3.4 In the calculation of an asset's cost, the UHB shall follow the Capital section in the Manual of Accounts and International Financial Reporting Standards (IFRS).

4 FINANCE DEPARTMENT RESPONSIBILITIES

4.1 Providing Asset Register Information

4.1.1 The Director of Finance & Procurement shall be responsible for the Asset Register System, which will be maintained by the Senior Finance Officer (Capital)

4.1.2 Biannually the Capital Accountant shall produce a list of each Directorate's assets held on the register and distribute them to the appropriate managers. The information provided will include the following:

- Asset ID and Description
- Location
- Date of Acquisition
- Replacement Cost
- Current Life
- Net Book Value

4.2 Updating the Asset Register

4.2.1 The Senior Finance Officer (Capital) shall update the Asset Register for any new additions, based on information from purchase orders, invoices, certificates and other entries through the general ledger system.

4.2.2 It is the responsibility of the Senior Finance Officer (Charitable Funds) to inform the Capital Accountant, on a monthly basis, of any donated assets purchased through charitable funds that are above the capital threshold.

4.2.3 For Land, Building and Fittings additions, the Senior Finance Officer (Capital) shall request additional information as required, from the Head of Capital Planning when allocating expenditure to categories and blocks.

4.2.4 For grouped IT assets PO numbers will also be recorded in the fixed asset register to enable tracing of assets through IT systems to a specific device.

4.2.5 For amendments to existing assets, the register ~~will~~be updated on the receipt of an authorised document (see appendix 1) or an email from an appropriate person within the directorate responsible for that asset.

4.2.6 In addition, prior to the disposal of equipment and irrespective of condition, the Head of Clinical Engineering (medical equipment) or Head of Procurement (other equipment) should be contacted to consider the possibility of resale of the asset.

4.2.7 Disposals will only be actioned on the Asset Register upon receipt of an authorised document (see appendix 1) or equivalent detail in an email. If the asset has a Net Book Value (NBV) greater than £500, written authorisation from the Head of Capital will have to be sought.

4.3 Capital Charges

4.3.1 The Capital Accountant shall be responsible for the calculation of all capital charges on assets held within the register, in accordance with the rules set out in the capital section of the Manual of Accounts produced by the Welsh Government and IFRS.

4.3.2 The Capital Accountant shall undertake sample checks to ensure the accuracy of the system produced calculations.

4.3.3 Actual capital charges shall be posted to the UHB's general ledger on an annual basis and estimated charges will be accrued on a monthly basis to adequately reflect the up to date balance sheet position.

4.3.4 The Capital Accountant will be responsible for producing forecasts and estimates of capital charges payable as determined by the Welsh Government.

4.4 Reconciliations

4.4.1 The Capital Accountant shall reconcile the total net book values of assets held on the asset register to those held in the UHB's general ledger at the end of the year. Any difference identified shall be rectified as appropriate.

- 4.4.2 The Capital Accountant shall produce all the fixed asset returns required for the UHB's annual accounts, for the Finance Manager to review. The returns shall be in the required format and will include working papers to reconcile the figures in the asset register and the general ledger.
- 4.4.3 The Senior Finance Officer (Capital) shall reconcile capital expenditure to the asset register on a quarterly basis.
- 4.4.4 The Senior Finance Officer (Capital) will maintain a clear audit trail of all workings and reconciliations to the ledger on a monthly basis.
- 4.4.5 The Capital Accountant shall review the reconciliations and sign and date them accordingly.

5 DIRECTORATE RESPONSIBILITIES

5.1 Security of Assets

Clinical/Non Clinical Directors and delegated managers in individual Directorates shall be responsible for the safety and security of all assets (including those donated) within their departments.

5.2 Verification of Assets

- 5.2.1 Clinical/Non Clinical Directors and delegated managers in individual Directorates shall be responsible for the management of equipment assets (including those donated) within their departments.
- 5.2.2 Biannually the Capital Accountant will send each Clinical Service Group Manager (or equivalent) an up to date list of their capital equipment assets held on the register.
- 5.2.3 The individual managers shall be responsible for verifying the information and informing the Capital Accountant or Senior Finance Officer (Capital) of any inaccuracies or discrepancies.
- 5.2.4 On an annual basis, following the issue of the quarter 2 register, Clinical Service Group Managers (or equivalent) are required to return a signed and dated copy of the report to

the Capital Accountant, which will confirm that the information held is correct.

5.2.5 Prior to the end of the financial year the Capital Accountant will issue a reminder to the Clinical Service Group Managers (or equivalent) regarding the need to inform the Capital Finance section of any changes/amendments, such as to assets lives and disposals, to their capital assets.

5.2.6 There may be several reasons as to why information on the report may appear to be inaccurate. In such cases, the appropriate manager shall discuss the issue with the Capital Accountant or Senior Finance Officer (Capital). The primary consideration must be to comply with the rules contained within the capital section of the Manual of Accounts.

5.2.7 The asset register will ~~only~~ be updated, ~~where~~ when the Clinical Service Group Manager (or equivalent) and/or delegated Manager has provided the appropriate written documentation (see appendix 1) or equivalent email. All amendments must be with the agreement and authorisation of the Capital Accountant.

5.2.8 In addition to the above it will be the responsibility of the Senior Finance Officer (Capital) to undertake or arrange a sample physical verification exercise of each directorate on a 3 year rolling period. This exercise will include an element of physical verification by the Senior Finance Officer but also using data available from Clinical Engineering records of equipment service and maintenance.

5.2.9 —A record of the physical verification exercise will be formally recorded in the Fixed Asset Register

5.3 Notification of Changes

5.3.1 Managers in individual Directorates shall be responsible for informing the Senior Finance Officer (Capital) of any changes to the assets under their control as soon as they are known. Examples of such changes will include amongst others:

- Equipment acquisitions not included (including leased assets, donated assets and assets on loan free of charge).
- Disposals.
- Incorrect asset lives
- Transfers to other departments/NHS Trusts or Health Boards.
- Part exchanges.
- Free upgrades or replacements
- Damaged & obsolete assets

5.3.2 In any of the above circumstances, the relevant manager **must** provide the following information **in writing or by email** (see appendix 1) to the Capital Accountant.

- Additions
 - Description of Asset
 - Date of purchase
 - Method of purchase
 - Order/Requisition Number
 - Total Cost
 - Life-span
 - Location
 - Serial Number/EBME Ref
- Disposals
 - Asset ID
 - Asset Description
 - Location
 - Method of Disposal
 - Date of Disposal
 - Net Book Value
 - Proceeds of Sale (if appropriate)
 - Authorisation
- Transfers
 - Asset ID
 - Asset Description
 - Original Location
 - Date of Transfer
 - New Location
 - New Accepting Manager

- Change in Life of Asset/Revaluation
 - Description of Asset
 - Asset ID
 - Location
 - New Life/Value
 - Reason for Change
 - Date of Change

Advice should be sought from the Senior Finance Officer (Capital) if managers are unsure of the requirements.

5.3.3 In the case of transferring assets to a new directorate, the manager should seek written confirmation from the new manager to accept the assets.

5.3.4 When a department needs to dispose of an asset, the Clinical Services Group Manager (or equivalent) should contact the Senior Finance Officer (Capital) to ascertain the Net Book Value (NBV) of the asset in question. For equipment disposals the Head of Clinical Engineering or Head of Procurement should also be contacted to consider the possibility of resale of the asset.

5.3.5 The Clinical Services Group Manager (or equivalent) should then complete the authorisation (see appendix 1). If the asset has a NBV greater than £500, written authorisation from the Head of Finance will have to be sought before the disposal can be actioned.

5.3.6 The officers responsible for authorising amendments to the asset register shall be:

- Clinical Directorates
Manager or
Clinical Service Group
Clinical Director (or in
their absence an
appropriate deputising
officer)
- Non Clinical Directorates
Director or Nominated
Heads of Department

6 CAPITAL PLANNING DIRECTORATE RESPONSIBILITIES

6.1 Liaison with the District Valuer

6.1.1 The Director of Finance & Procurement shall be responsible for the management of the UHB's land, buildings, engineering services and fittings.

6.1.2 The Finance Manager (Capital) shall liaise with the District Valuer regarding the valuation of these assets as well as defining the appropriate blocks.

6.1.3 The Finance Manager (Capital) shall seek advice from the District Valuer on completion of any major works that may increase substantially the valuation of the building, or conversely, the taking of a building out of operational use that may decrease the valuation.

6.1.4 The Finance Manager (Capital) shall contact the District Valuer to provide a valuation if the use of the land or buildings has changed, and when new or upgraded buildings are brought into operational use.

6.1.5 The Head of Capital shall inform the Finance Manager of any impending changes to the use of land or buildings to enable appropriate financial planning.

6.1.6 The Head of Capital shall inform the Finance Manager (Capital) of any valuation of the estate not instructed by Finance, such as for the planned sale of a building.

6.2 Verification of Land and Buildings

6.2.1 The Head of Capital shall provide written notification to the Head of Finance of any inaccuracies or discrepancies on the asset information supplied and the Senior Finance Officer (Capital) shall make any necessary amendments to the register in compliance with the manual.

6.3 Notification of Changes

6.3.1 The Head of Capital Planning shall inform the Capital Accountant of the blocks/buildings and asset categories affected by expenditure on building and engineering works schemes contained within the Capital Programme when the scheme is completed.

6.3.2 The Head of Capital Planning shall also be responsible for informing the Finance Manager, of any such changes or planned changes that may affect the valuation of the estate and therefore capital charges.

6.3.3 The planned disposal of land and buildings, either through sale or demolition, must be in line with the latest Welsh Government guidance. In the case of such disposals the Head of Capital Planning must:

- Inform the Director of Finance & Procurement in writing.
- Request a valuation from the District Valuer.
- Request authorisation to proceed from the Chief Executive and the Board.

ASSET REGISTER AMENDMENT FORM

FROM _____ DIRECTORATE _____

TO: Senior Finance Officer (Capital), FINANCE DEPARTMENT, DEWI SANT

Addition to Asset Register if NOT acquired through annual discretionary capital programme

Description _____ Order/Requisition No. _____

Date Acquired _____ Method of Acquisition _____

Total Cost if purchased _____ Value if donated _____

Estimated Life Expectancy of Asset _____ Location _____

Serial No _____ EBME Ref _____

Disposal of Asset

Description of Asset _____ Asset ID _____

Location _____ Method of Disposal _____

Proceeds (if any) _____ Net Book Value _____ Date of Disposal _____

Transfer of Asset

Description of Asset _____ Asset ID _____

Old Location _____ New Location _____

Date of Transfer _____ New Manager's Signature _____

Revaluation of Asset

Description of Asset _____ Asset ID _____

Location _____ New Valuation _____

Reason for Revaluation _____ Date of Revaluation _____

Change in Life of Asset

Description of Asset _____ Asset ID _____

Location _____ New Life _____

Reason for Change _____ Date of Change _____

Please Tick as appropriate:-

I certify that the above changes are required to the asset register.

I certify that there are NO changes required to the asset register for this quarter.

Signed: _____

Print Name _____ Date _____

If you have any queries regarding completion of this form please contact the Senior Finance Officer (Capital) **at Dewi Sant Hospital on extension 3802- Diane.webber@wales.nhs.uk**



Agenda Item

Audit & Risk Committee

Organisational Risk Register

Dyddiad y Cyfarfod / Date of Meeting	17/12/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Cally Hamblyn, Assistant Director of Governance & Risk
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance & Risk
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Review

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Service, Function and Executive Formal Review	October 2024	RISKS REVIEWED
Operational Management Board	October 2024	ENDORSED RISKS WHERE APPLICABLE FOR ELG
Executive Leadership Group	11 th November 2024	MANAGEMENT SIGN OFF RECEIVED

Acronyms / Glossary of Terms	

1. Situation / Background

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

2. Specific Matters for Consideration

Risk Review

- 2.1 Care Groups and Central leads are continuing to review and update their assigned risks taking into account feedback received from Members in relation to scoring, actions with associated timeframes and ensuring timely reviews. This will be a continuous improvement area that Members will hopefully note will evolve and improve over the next 12 months.
- 2.2 The Operational Management Board / Chief Operating Officer approves escalation of Care Group risks to the Organisational Risk Register.
- 2.3 The Executive Lead approves escalation of central/core function risks to the Organisational Risk Register.
- 2.4 Risks on the organisational risk register have been updated as indicated in red in Appendix 1.
- 2.5 Please note that the risk updates are captured at the time the Organisational Risk Register being finalised for submission, which on this occasion was the 4th November 2024. Where review dates have passed and updates were not available these have been followed up and a request to update sent. Reviews received after this date will be reflected in the next iteration.

Training

- 2.6 Risk training, although not a core training requirement under the statutory and mandatory framework, has been added to the Electronic Staff Record (ESR) to support staff in registering for training and to support ease of reporting. This is managed by the Quality Assurance and Compliance Team. Interest in the course continues with positive uptake.
- 2.7 The sessions are run by the Assistant Director of Governance & Risk and Heads of Quality and Safety. The session is held virtually via Teams on a monthly basis for a duration of 1 hour and covers the following areas:
Risk Management Approach

Practical Approach to Managing Risk
Risk Assessment and Scoring
Datix Risk Management Module

- 2.8 To date **754** members of staff trained to date since training commenced in 2021. Based on the Risk Management Awareness Training Needs Analysis all attendees completed Training Profile 2. In addition to this number training has also been provided to the Joint Commissioning Committee Senior Leadership Team during this period and their feedback is captured in the evaluations at 2.1.4.
- 2.9 In addition, the Health, Safety & Fire Directorate have run Managing Safely Courses during the period which has a designated section on risk. These sessions were held as follows:
- 30th September – 2nd October 2024 – 7 attendees
- 2.10 Focussed sessions to discuss risk have also been undertaken with Care Group Leads and other departments/directorates as required.
- 2.11 96 attendees have provided formal feedback (using the URL Code for the Evaluation Form, which was introduced in November 2023). The average rating for the course is 4.77 out of a maximum score of 5.
- 2.12 100% of the 96 attendees providing formal feedback found that:
- The session provided the right amount of information.
 - They gained more confidence and knowledge in risk management having attended.
 - They would recommend this training to a colleague.
- 2.13 98% of the 96 attendees providing formal feedback said they felt more confident to escalate a risk through the organisation.
- 2.14 Some of the recent comments from the session in June, received through evaluation, have been included below:
- *Really helpful to help shape the risk culture in the JCC*
 - *It was good to see how Datix is used to report risks as I am a newer member of staff and haven't used it before. It was also interesting to see how different people respond differently to risks from the pictures of the boats in the river as it shows how risks can be seen differently in real life situations*
 - *Covered exactly what I needed for risk and my knowledge has expanded.*
 - *Provided just enough information, without overloading.*
 - *The descriptions of risks vs incidents was really clear, the practical walk through Datix was really useful for me as I've not used it before. I would recommend this session to all my colleagues.*
 - *Perfect level of information and good length of session. Generated good level of discussion and food for thought.*

3. Key Risks / Matters for Escalation

3.1 NEW RISKS

Estates Directorate

- **Datix Risk ID 5932 - Roof covering replacement works to resolve identified roof integrity issue and consequent risk of tiles falling internally and externally from weakened roof at POWH Phase 1.** New risk escalated, current risk score of 20.
- **Datix Risk ID 5961 - Remedial roof works to resolve the water ingress at POWH.** New risk escalated, current risk score of 16.

Corporate Governance Directorate

- **Datix Risk ID 4885 - Failure to deliver and sustain effective Policy Management System and Process.** New risk escalated, current risk score of 16.

3.2 CHANGES TO RISKS

Risk Score Increased

Finance Directorate

- **Datix Risk ID 5764 – Failure to achieve the break-even position in 2024-2025.** Risk score increased from a 16 to a 20 as at this stage there is a significant risk that the forecast break-even position for 24/25 will deteriorate in the coming months.
- **Datix Risk ID 5765 – Failure to reduce the £19.4m recurrent deficit at the start of 24/25 down to the planned £2.1m recurrent surplus at the end of 24/25.** Risk Score increased from a 16 to a 20 as at this stage, there is a significant risk that the forecast recurrent surplus of £2.1m will deteriorate in the coming months.

Primary Care & Community

- **Datix Risk ID 5417 - Paediatric Dentistry - General Anaesthetic (GA) theatre list.** Risk score increased from a 16 to a 20 because as a result of the issues with the POW, all paediatric GA lists have been cancelled for the service, this relates to the 2 x regular GA lists in RGH and any ad hoc list allocated through the 642 process.

Risk Score Decreased

Digital & Data Directorate

- **5669 - Increased cost of Citrix Subscription.** Risk score decreased from a 16 to a 12 as the licensing arrangements have now been finalised and the procurement has been completed. CTMUHB have purchased 3,000 Citrix licenses. The licenses will run for a year, from December 2024 to December 2025. CTMUHB look to significantly reduce its Citrix use over the coming year to reduce/eliminate reliance on Citrix technology.

Diagnostics, Therapies, Pharmacy & Specialties

- **5730 - No Health Board MRI Pacemaker Service.** This risk has been reduced from a 16 to a 9 this period as the MRI service for patients with pacemakers now in place at Prince Charles Hospital.
- **4152 – Backlog for Imaging in all modalities / areas and reduced capacity.** This risk has been reduced from a 16 to a 12 at present as non-recurrent schemes in place which have brought NOUS, MRI and now CT with additional capacity being delivered/ this is dynamic and may increase the risk again when the schemes stop if capacity does not meet demand.
- **5755 - Princess of Wales (POW) Air handling unit and electrical infrastructure for Labour ward and Neonatal Unit.** This risk has been reduced from a 16 to a 4 as with work underway and the areas decommissioned whilst this is concluded the risk has reduced significantly.
- **2808 - Waiting Times/Performance: ND Team.** This risk has been reduced from a 16 to a 12. Waiting lists are being managed and reported regularly through the care group Operational Management Board and ND improvement board and reported nationally. The team are doing everything within their capability to deliver improvements and are with Welsh Government support showing an improved trajectory to March 2025. Due to the improved trajectory the likelihood score has been reduced.

3.3 CLOSED RISKS REMOVED FROM THE ORGANISATIONAL RISK REGISTER

There were no risks escalated to the Organisational Risk Register that were closed this period.

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

Consequence	5			3337 3993 4080	4664 5276 5932	
	4			5820	4337 4809 4417 5374 4671 4908 4907 4885	5646 5579 5658 5761 5691 5961 4491 4071 4103 3826 5590 5462 5821 4632 5764 5765 5417
	3					4672 4691 5040
	2					
	1					
	CxL	1	2	3	4	5
		Likelihood				

3.5 EMERGING RISKS

Planned Care – Care Group

In the September 2024 iteration of the Organisational Risk Register, the Planned Care - Care Group Senior Leadership Team were undertaking a risk assessment relating to inequalities in orthopaedic paediatric services aligned to the risk identified by the Wales Orthopaedic Network (National Clinical Strategy for Orthopaedic Surgery). It was anticipated that this risk once assessed and a mitigating action plan developed will be escalated to the Organisational Risk Register as appropriate, however this risk has now been resolved as a joint consultant appointment is being made with Cardiff & Vale University Health Board.

Pathology Risk - Diagnostics, Therapies, Pharmacy and Specialties & Digital & Data

Risk assessments are underway in terms of the sustainability of pathology services and the delivery of a digital cellular pathology solution for the Health Board. Once the assessments are complete they will be considered for escalation to the Organisational Risk Register as appropriate.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Resilient Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	Learning, Improvement & Research
	If more than one applies please list below:
Dolen i Feysydd Ansawdd (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Domains of Quality	Safe
	If more than one applies please list below:



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

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

5. Recommendation

5.1 The Committee are asked to:

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

6. Next Steps

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

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
Date ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (Current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Heat	Opened	Last Reviewed	Next Review Date
5932	Executive Director of Finance Executive Lead for Estates	Central Corporate Estates	Assistant Director of Planning - (Capital and Estates), Strategic and Operational Planning	Sustaining Our Future	Environmental / Infrastructure	Roof covering replacement works to resolve identified roof integrity issue and consequent risk of tiles falling internally and externally from weakened roof at POWH Phase 1.	If the Health Board fails to act upon the recommendations or the findings of the report from the appointed Structural Engineers in relation to the roof area at the POWH. Then: there is a risk of collapse of the roof coverings which could result in the roof coverings falling through the roof void into occupied clinical areas and externally from the edges of Phase 1. This risk increases in adverse weather with additional loading on the roof. Resulting in: significant impact/harm to patient, staff and public safety. Healthcare facilities which are not fit for purpose or sustainable for the future. Service delays impacting the patient experience and service performance of the Health Board. Potential legislative challenges and reputational damage. Loss of confidence in the Health Board estate infrastructure across CTH.	Command structure established to manage the critical incident following identification of roof structure failings. 1) Discharge Call - Objectives: The safe and rapid discharge of patients and services from top floor phase 1 POW site and to maintain quality of care and patient safety 2) Decant Call - Objectives are the safe but rapid decant of patients and services from top floor phase 1 POW site, to maintain quality of care and patient safety and to maintain staff safety and the deployment of the right staff to the right place. 3) Redirect Take - Objective - Reduce demand for inpatient beds on the POW site 4) Estates - focusing on ensuring decant areas are fit for purpose as well as overseeing the plans for the works on the roof. Enabling Support Cells Established: Patient Transport Wardens Digital Facilities Patient Safety Communication In addition barriers are in place around the footpaths to keep pedestrians away from the edge of Phase 1 roof.	Removal of Roof Coverings at the POWH site in accordance with the recommendations in the structural engineering report of 9th Oct 2024. Contractor identified. Programme being developed which will firm up timelines. Costs yet to be determined until as dependent on programme.	Planning, Performance & Finance Committee Quality & Safety Committee Health, Safety & Fire Sub Committee	20	CxL4	10 (CxL2)	New risk escalated to the Organisational Risk Register in November 2024	23.09.2024	21.10.2024	30.11.2024
5764	Executive Director of Finance	Finance Directorate	Deputy Director of Finance	Sustaining Our Future	Financial Risk	Failure to achieve the planned break-even position in 2024/25.	If: The Health Board is not able to plan and deliver expenditure cut rates that align with the available funding for 2024/25. THEN: The Health Board will not be able to deliver the planned break-even financial position for 2024/25. RESULTING IN : • Potential short term unsustainable cost reductions with associated risks and potential Welsh Government regulatory action • Failure to deliver the financial plan for 24/25. • Failure to meet the statutory financial duty to break even over a 3 year period resulting in qualification of the Annual Accounts in 24/25. • Potential cash shortfalls in the latter months of 24/25	Financial Accountability letters issued from CEO to Executive Leadership Group. • Monthly monitoring arrangements and meetings in place with Care Groups and directors. • Regular reporting to the Executive leadership Group, the Planning, Performance & Finance Committee and the Board.	• Context: The Health Board has submitted a balanced financial plan for 24/25 but this plan includes significant risks, including the delivery of £26.3m of efficiency savings. The savings plans at the 26 March 24 total £23.0m with a RAG rating of £10.0m Green, £12.1m Amber and £0.9m Red. • M6 update: The M6 YTD position is a £3.3m deficit, which includes a £8.1m shortfall in savings delivery offset by other favourable variances of £4.80m. The Health Board has maintained a forecast break-even position at M6. This forecast excludes any revenue costs associated with the roof integrity issue at POW, both the direct repair costs and any other costs arising from consequential service changes such as decanting wards etc. It is important to highlight that the level of risks that the Health Board is trying to manage remains high with a net risk of £10.2m, excluding the POW roof integrity risks. At this stage, there is a significant risk that the forecast break-even position for 24/25 will deteriorate in the coming months. • All Care Groups and directorates with forecast overspend have been asked to prepare recovery plans to show the key actions and choices needed to deliver a break-even position in 24/25 and also recurrently. A detailed review of these recovery plans and risks will be undertaken prior to the M7 Monitoring Return submission to WG. The following actions are to support savings plan identification, development and delivery: • Develop a more project and programmatic approach to planning and delivery of efficiency savings schemes, with a focus on pipeline schemes for 25/26 as well as schemes in delivery for 24/25. • Disseminate the learning from the Health Board's Value Based Healthcare projects to drive service planning and improvement going forward. • Develop the Value & Efficiency Programme with a focus on 'Enabling schemes' to support savings identification and delivery.	Planning, Performance & Finance Committee	20	CxL5	12 CxL3	↑	30.04.2024	04.11.2024	31.12.2024
5765	Executive Director of Finance	Finance Directorate	Deputy Director of Finance	Sustaining Our Future	Financial Risk	Failure to reduce the £19.4m recurrent deficit at the start of 24/25 down to the planned £2.1m recurrent surplus at the end of 24/25	If: The Health Board is not able to plan and deliver recurrent expenditure run rates that align with the available recurrent funding for 2024/25. THEN: The Health Board may not be able to deliver a break-even financial position for 2025/26. RESULTING IN : • The Health Board not being able to increase investments in services and/or reduce savings targets from current levels. • Potential short term unsustainable cost reductions with associated risks and potential Welsh Government regulatory action. • WG not supporting the Health Board's plan for 25/26. • Failure to meet the statutory financial duty to break even over a 3 year period resulting in qualification of the Annual Accounts in 25/26. • Potential cash shortfalls in 25/26.	• Financial Accountability letters issued from CEO to Executive Leadership Group. • Monthly monitoring arrangements and meetings in place with Care Groups and directors. • Regular reporting to the Executive leadership Group, the Planning, Performance & Finance Committee and the Board.	• M6 update: The M6 YTD position is a £3.3m deficit, which includes a £8.1m shortfall in savings delivery offset by other favourable variances of £4.80m. The Health Board has maintained a forecast break-even position at M6. This forecast excludes any revenue costs associated with the roof integrity issue at POW, both the direct repair costs and any other costs arising from consequential service changes such as decanting wards etc. It is important to highlight that the level of risks that the Health Board is trying to manage remains high with a net risk of £10.2m, excluding the POW roof integrity risks. At this stage, there is a significant risk that the forecast recurrent surplus of £2.1m will deteriorate in the coming months. • All Care Groups and directorates with forecast overspend have been asked to prepare recovery plans to show the key actions and choices needed to deliver a break-even position in 24/25 and also recurrently. A detailed review of these recovery plans and risks will be undertaken prior to the M7 Monitoring Return submission to WG. • The main action is to develop a more project and programmatic approach to planning and delivery of efficiency savings schemes, with a focus on pipeline schemes for 25/26 as well as schemes in delivery for 24/25.	Planning, Performance & Finance Committee	20	CxL5	12 CxL3	↑	30.04.2024	04.11.2024	31.12.2024
5417	Chief Operating Officer	Primary Care and Community Care Group	Care Group Service Director	Improving Care	Patient / Staff / Public Safety	Paediatric Dentistry - General Anaesthetic (GA) theatre list Impact on the safety – Physical and/or Psychological harm	If: Regular additional GA theatre lists (necessary to meet current and future demand) are not made available to Community Dental Service team for paediatric GA. Then, the number of children waiting list for assessment and treatment will continue to increase beyond 1000 by March 2024. Resulting in: 1. children waiting increased times for assessment/treatment who have high levels of dental caries and painful teeth requiring extraction, 2. a further increase in the number of children requiring GA, due to long waits for assessment more children need GA when assessed, conversion rate has jumped from 48% to 80%. Children can only wait 6 wks from assessment to treatment, therefore there is a large backlog of assessments due to limited GA lists to provide treatment.	Current theatre lists are run on Monday mornings and Friday afternoons and are likely to be cancelled due to bank holidays. This impacts the running of the service, no additional lists are available when lists are missed. There are currently 800+ patients waiting for appointments, with some already waiting for 17 months. Patients are advised to return to their General Dental Practitioner (GDP) if they experience pain, some children are being prescribed multiple courses of antibiotics to ease dental infections that can only be alleviated by tooth extraction. There is a risk these patients will require the removal of more teeth/more require GA when assessed/children will present as an urgent case in Accident and Emergency if left untreated.	Update November 2024 - Due to the issues with the POW estate, all paediatric GA lists have been cancelled for the service, this relates to the 2 x regular GA lists in RGH and any ad hoc list allocated through the 642 process. The backlog of children needing assessment is over 750+ (children cannot be assessed if the GA does not take place within a 9-10 week window, otherwise re-assessment is needed). Referrals continue to be submitted by dental practices with children requiring GA for dental treatment. The backlog is going to increase significantly over the coming months without any GA lists available in CTH. There are also children now being flagged as urgent requiring GA but there are no lists available to treat these patients apart for the HB CEPOD list, which comes with its own challenges in terms of access and suitability for children. The only mitigating option is being explored to identify an alternative provider (within a neighbouring Health Board) to deliver this service on a temporary basis to reduce the backlog and provide a service until the regular lists can be resumed in RGH, funding will be required to support this action. The likelihood of this risk has now been increased to a 5.	Quality & Safety Committee	20	CxL5	9 CxL3	↑	20.04.2023	06.11.2024	31.12.2024
4491	Chief Operating Officer	Deputy Chief Operating Officer - Acute Services	Deputy Chief Operating Officer - Acute Services	Improving Care	Patient / Staff / Public Safety	Failure to meet the demand for patient care at all points of the patient journey Impact on the safety – Physical and/or Psychological harm	If: The Health Board is unable to meet the demand upon its services at all stages of the patient journey. Then: the Health Board's ability to provide high quality care will be reduced. Resulting in: Potential avoidable harm to patients	Controls are in place and include: • Technical list management processes as follows: - Specialty specific plans are in place to ensure patients requiring critical review are assessed. - All patients identified will be clinically reviewed which will include an assessment of avoidable harm which will be reported and acted upon accordingly. - A process has been implemented to ensure no new sub-specialty codes can be added to an unreported list, this will be refined over the coming months. - All unreported lists that appear to require reporting have been added to the RTT reported lists - All unreported lists that are to remain unreported (as they do not form part of the RTT criteria) are being reviewed and will be visible and monitored going forward. • Patients prioritised on clinical need using nationally defined categories • Demand and Capacity Planning being refined in the UHB to assist with longer term planning • Outsourcing is a fundamental part of the Health Board's plan going forward. • The Health Board will continue to work towards improved capacity for Day Surgery and 23-59 case load. • A Harm Review process is being piloted within Ophthalmology – it will be rolled out to other areas. • The Health Board has taken advice from outside agencies especially the DU when the potential for improvement is found. • Appropriate monitoring at LG and Health Board levels via scheduled and formal performance meetings with additional audits undertaken when areas of concern identified Planned Care board established. The Health Board is exploring working with neighbouring HBs in order to utilise their estate for operating.	Elective/Planned Care - Critical incident declared at Princess of Wales on 9th October 2024 due to the roof integrity issues with immediate impact on clinical pathways, bed capacity, all theatre elective capacity (inc cardiac) and trauma capacity • There has been continuous planning on clinical pathways and diversion of emergency intakes, which again has impacted on the capacity and resilience across the full CTHUHB system. • There has been a requirement to despatch and close 190 inpatient beds on the POW site. With re-provision of the capacity across CTHUHB acute and community. • There has also been significant reallocation of internal capacity at POW and RGH to respond to the critical incident. • Planning continues on recovery phase following critical incident with the impact not yet quantified. • The financial and economic challenges faced by the third sector and local authority partners has an impact on the Health Boards ability to mitigate this risk, as capacity cannot be protected. • The large-scale capital programme at Prince Charles Hospital will temporarily reduce the number of operating theatres by 2. An ongoing work programme continues to review options to mitigate this. • The current Fire enforcement notice at Princess of Wales hospital will be completed as part of the Critical incident response and reduce the number of operating theatres until early summer 2025. Plans are ongoing for the temporary location of the theatres. • Workforce recruitment continues across the care group to enable a sustainable capacity model. There continues to be a reduction of ADH and WLL activity attributed to standardisation of pay. • Regional working continues and the positive and negative impact of this will be continuously reviewed. Unscheduled Care - Critical incident declared at Princess of Wales on 9th October 2024. Roof integrity issues with immediate impact on clinical pathways, bed capacity, all theatre elective capacity (inc cardiac) and trauma capacity • There has been continuous planning on clinical pathways and diversion of emergency intakes that again has impacted on the capacity and resilience across the full CTHUHB system. • There has been a requirement to despatch and close 190 inpatient beds on the POW site. With re-provision of the capacity across CTHUHB acute and community. • There has also been significant reallocation of internal capacity at POW and RGH to respond to the critical incident. • A Harm Review process is being piloted within Ophthalmology – it will be rolled out to other areas. • The Health Board has taken advice from outside agencies especially the DU when the potential for improvement is found. • Appropriate monitoring at LG and Health Board levels via scheduled and formal performance meetings with additional audits undertaken when areas of concern identified Planned Care board established. The Health Board is exploring working with neighbouring HBs in order to utilise their estate for operating.	Quality & Safety Committee Planning, Performance & Finance Committee	20	CxL5	12 C4 x L3	↔	13.7.2023	29.08.2024	31.12.2024
5821	Executive Director of Strategy & Transformation	Central Corporate Commissioning	Assistant Director of Transformation, Strategic and Operational Planning	Improving Care	Service / Business interruption	Provision of secondary care immunology services by external providers (this is a service that is not provided by CTH UHB). Resulting in: unacceptable level of clinical risk for both routine and urgent referrals that are currently without any available referral option. Patient experience will be impacted by delays in onward referral for investigation, diagnosis and definitive treatment/management plan. This could lead to both informal and formal concerns being submitted to the health boards.	If: CTH is unable to secure a new contract with an alternative community provider. Then: CTH residents will have no access to secondary care immunology provision. Resulting in: unacceptable level of clinical risk for both routine and urgent referrals that are currently without any available referral option. Patient experience will be impacted by delays in onward referral for investigation, diagnosis and definitive treatment/management plan. This could lead to both informal and formal concerns being submitted to the health boards.	Working group in place to seek and secure service (meets monthly), although more regular communication and updates is sent in between meetings. Exploration of suitable providers within the NHS and also private providers undertaken. Short term contract being sought for urgent referrals and expected by end July 2024. CTH UHB Referral Management Centre currently maintaining database of both urgent and routine referrals received. CTH GP's have been informed of the challenges currently experienced with immunology provision and delays can be expected.	Update November 2024 - Work ongoing to work through short term contract offer with aim to finalise and gain approval. This service would deliver assessment and first line treatment for urgent cases. Meeting with a provider 6th November. Also to be discussed at next primary care commissioning meeting so updated comms can go out to GPs	Planning, Performance & Finance Committee Quality & Safety Committee	20	CxL5	4 (CxL1)	↔	08.07.2024	01.11.2024	31.12.2024
4632	Executive Director of Therapies and Health Sciences	Unscheduled Care Group	Head of Strategic Planning and Commissioning	Improving Care	Patient / Staff / Public Safety	Provision of an effective and comprehensive stroke service across CTH (encompassing prevention, early intervention, acute care and rehabilitation) Impact on the safety – Physical and/or Psychological harm	If: changes are not made to improve and align stroke prevention initiatives, early intervention campaigns, and acute and rehabilitation stroke care pathways across CTH Then: avoidable strokes may not be prevented, patients who suffer a stroke may miss the time window for specialist treatments (thrombolysis, thrombectomy), and patients may not receive timely, high-quality, evidence-based stroke care Resulting in: higher than necessary demand for stroke services, poorer patient outcomes/increased disability, increased length of stay, and poor patient/carer experience. Impact will extend to the need for increased packages of care, increased demand for community health services, and increased care burden when discharged to the community.	• Executive-led Stroke Strategy Group in place, with targeted task and finish under development. Membership updated to reflect senior Ops changes. • Risk and membership of Strategy Group updated. • Close working amongst executive team to escalate and address operational and clinical issues in relation to stroke pathway • Board briefing to ensure all sighted to challenges • Quarterly briefings to Quality and Safety Committee • Performance data regularly presented to Performance, Planning and Finance Committee • Strong CTH input to regional and national Stroke Programme Boards • Unified, evidence-based pathway developed for thrombolysis • Preparations progressing to prepare for 24/7 thrombectomy service at Bristol and updated RCP guidance on thrombolysis and thrombectomy • Designated senior operational lead for performance and improvement leadership for stroke pathway	Update November 2024 Risk reviewed by SHY, stroke services options appraisal has been submitted to Executive Leadership Group. The Stroke consultants within CTH cover Stroke services on two acute sites (POWH and PCH). They also provide a 1-5, seven-day stroke on-call advice service. However, due to vacancies and maternity leave within the consultant workforce the ratio for the on-call rota is currently 1:1 to mitigate gaps. There are currently 4.0 WTE stroke consultants and 4.8 WTE CMC in post across CTH, broken down as follows: • PCH - 2.0 WTE consultants with 1.0 WTE vacancy • PCH - 2 WTE Clinical Nurse Specialist • POWH - 2.0 WTE consultants with an additional 0.6 WTE agency locum Consultant • POWH - 2.8 WTE Clinical Nurse Specialist The Stroke consultants at POWH also have a GBN on call commitment on a 1-21 rota, comprising of weekday evening and full weekend day cover resident cover with non-resident overnight cover. The service becomes increasingly more fragile from September 2024 when one consultant at PCH will be commencing maternity leave for a 12-month period, from July they will also be coming off the on-call rota. This will leave just 3 substantive consultants undertaking a 1:4 rota with a 50% less workforce, as well as leaving just one consultant at PCH from September which will significantly impact being to deliver a safe and sustainable stroke service at PCH. In order to try and mitigate this, a locum Consultant started at PCH on Tuesday 27th August to cover maternity leave, with a second fixed term locum due to start at the end of October, this will allow adequate time for the care group to work through more sustainable options.	Quality & Safety Committee	20	CxL5	12 (C4 x L3)	↔	11.05.2021	05.11.2024	31.12.2024
5590	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Support Care Group	Radiology Service Manager	Improving Care	Patient / Staff / Public Safety	Radiopharmaceutical Business Interruption Impact on the safety - Physical and/or Psychological harm	If: CTHUHB Radiology Department are unable to procure radiopharmaceuticals as per Service Level Agreement with CAU. Then patients will not receive the necessary imaging Resulting in delayed diagnosis/treatment/intervention and poor outcomes for patients and potential litigation .	Weekly Business Contingency meetings with all Health Boards. Wild directive is in share capacity regionally. Clinical stratification of patient priority - USC i.e. imaging at Princess Of Wales. Use of Mag Trac or alternative for SMLB - Breast Services	Update November 2024 - 07/11/24 Further shortage of Technetium HDP until 11/11/24 impacting Isotope provision, particularly bone scans. The Reactor in Poland restarted 31/10/24. Confirmation received that the usual levels of supply will be reinstated by 11/11/24. No change to Risk score.	Quality & Safety Committee	20	CxL5	4 CxL1	↔	23.10.2023	21.08.2024	16.09.2024
5276	Director of Digital	Central Support Function - Digital and Data	Pathology Directorate Manager	Sustaining Our Future	Business Objectives - Operational Patient safety	Failure to deliver replacement Laboratory Information Management System, LINC Programme, by summer 2025, Impact on the safety – Physical and/or Psychological harm	If: the new Laboratory Information Management System (LIMS) service is not fully deployed before the contract for the current LIMS expires in June 2025. Then: operational delivery of pathology services may be severely impacted. Resulting in potential delays in treatments, affecting the quality and safety of a broad spectrum of clinical services and the potential for financial and workforce impact.	Currently LINC Programme reports progress against timeline to LINC Programme Board and Chief Executive Group. Business continuity options are being explored including extending the contract for the current LIMS to cover any short term gap in provisions. An expert stock take review of the LINC programme has been completed with findings presented to Collaborative Executive Group (CEG) to inform next steps.	Update November 2024: LIAI has been extended and resulting in a 4 month delay to go live, however the end date of December 2025 is non-negotiable. Activity to understand the consequences of the delay such as dependencies on other projects such as APMA are being investigated.	Digital & Data Committee Quality & Safety Committee	20	CxL4	5 (CxL1)	↔	26.10.2022	31.10.2024	15.01.2025

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4071	Chief Operating Officer Planned Care - Care Group	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety	Failure to sustain services as currently configured to meet cancer targets. Impact on the safety - Physical and/or Psychological harm	IF: The Health Board fails to sustain services as currently configured to meet cancer targets. Then: The Health Boards ability to provide safe high quality care will be reduced. Resulting in: Compromised safety of patients, potential avoidable harm due to waiting time delays for treatment.	Tight management processes to manage individual cases on the cancer pathway. Regular reviews of patients who are paused on the pathway as a result of diagnostics or treatment not being available. To ensure patients receive care as soon as it becomes available. Regular Quality impact assessments with the MDTs, to understand areas of challenge and risk. Harm review process to identify patients with waits of over 104 days and potential pathway improvements. Initiatives to protect surgical capacity at the Vale hospital for ASA 1+2 level patients until alternatives become available. All three sites are working to maximising access to ASA level 3+4 surgery on the acute sites. HB working to ensure haematological SACT delivery capacity is maintained. Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies. Considerable work around recommending endoscopy and other diagnostic services whilst also finding suitable alternatives for impacted diagnostics. Alternative arrangements for MDT and clinics, utilising Virtual options Cancer performance is monitored through the more rigours monthly performance review process. Each Care Group now reports actions against an agreed improvement trajectory.	Update July 2024 - risk ongoing, mitigation continues to be - ongoing increased scrutiny of pathways, focused work with urology, Gynae and colorectal, enhanced monitoring with Velindre Cancer Centre. Update November 2024 - Performance is improving, however, CTM are still not meeting the set Trajectory so the risk remains.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4 x L5	12 (C4 x L3)	↔	01.04.2014	4.11.2024	31.12.2024		
4103	Chief Operating Officer	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety	Sustainability of a safe and effective Ophthalmology service. Impact on the safety - Physical and/or Psychological harm	IF: The Health Board fails to sustain a safe and effective ophthalmology service. Then: The Health Boards ability to provide safe high quality care will be reduced. Resulting in: Sustainability of a safe and effective ophthalmology service	Measure and ODTIC DU reviews nationally. Clinical staffing structure stabilised and absence reduced (new consultant, nurse injectors, ODTICs, weekend clinics). On going monitoring in place with regards RTT impact of Ophthalmology. In line with other services, to meet the RTT requirement services are being outsourced - maintaining this level of performance will be challenging going forward. Additional funding for follow up appointments provided and significant outsourcing undertaken (6,500 cases) with harm review planing to assess all potential harms. Additional services to be provided in Community settings through ODTIC (January 2020 start date). Intra-treatment injection room x2 established with nurse injectors trained. Follow up appointments not booked being closely monitored and outsourcing enacted. Regular updates re follow up appointments not booked being monitored by Management Board / Q&SR (patient safety issues) and Finance, Performance and Workforce Committee (performance issues). Reviewing LHM Action Plan in light of more recent WAO follow up review of progress. Primary and Secondary Care working Groups in place. Ophthalmology Planned care recovery group established overseeing a number of service developments: WIL clinics, outsourcing of Cataract patients, development of an ODTIC in Maesteg Hospital, implementation of Glaucoma shared care pathway, implementation of Diabetic Retinopathy shared care pathway, regional work streams, trial of new Glaucoma procedure (HIS), streamlining pathways. Quality and Performance Improvement Manager post created to provide dedicated focus, detailed demand and capacity analysis being undertaken. All patients graded according to the WG risk stratification R1, R2, R3. Additionally, several specific waiting lists are further risk stratified to ensure that the highest risk patients are prioritised.	Update April 2024: Previous high risk areas of the injection/macular clinic and the diabetic retinopathy service are now in a much better position with significant delays mostly eliminated. They remain vulnerable and work is ongoing to try and make them more robust and sustainable. CTMHR did not have a substantive glaucoma consultant from 2017 to 2023. The glaucoma service is top of the list of services to fix but in the process of fixing it, we are going to come across many, many cases of avoidable vision loss. Aside from the human cost of avoidable blindness, there is a large financial and reputational risk to the HB. The glaucoma service is currently at score of 25 on risk matrix - catastrophic consequences (blindness in high volume of patients) (5) x almost certain to occur (5). This needs to be the highest priority area in ophthalmology for the HB. Cataracts and eye casualty are ongoing problem areas but are less urgent clinically than the risks outlined below. 1) Glaucoma - glaucoma causes irreversible vision loss due to damage to the optic nerve. 2) High volumes of long waiting patients. Many not seen for several years, increasing the with severe harm as long-waiters finally being seen with such long delays. 3) Glaucoma - glaucoma causes irreversible vision loss due to damage to the optic nerve. 4) High volumes of long waiting patients. Many not seen for several years, increasing the with severe harm as long-waiters finally being seen with such long delays. 5) Cataracts and eye casualty are ongoing problem areas but are less urgent clinically than the risks outlined below. 6) Large numbers of stage 4 glaucoma patients awaiting surgery, some for > 1 year. This is the highest risk glaucoma population. Patients are generally listed for surgery when medical treatment does not work - these patients are at high risk of vision loss with such long delays. 7) Intra-treatment injection room x2 established with nurse injectors trained. 8) Follow up appointments not booked being closely monitored and outsourcing enacted. 9) Regular updates re follow up appointments not booked being monitored by Management Board / Q&SR (patient safety issues) and Finance, Performance and Workforce Committee (performance issues). 10) Reviewing LHM Action Plan in light of more recent WAO follow up review of progress. 11) Primary and Secondary Care working Groups in place. 12) Ophthalmology Planned care recovery group established overseeing a number of service developments: WIL clinics, outsourcing of Cataract patients, development of an ODTIC in Maesteg Hospital, implementation of Glaucoma shared care pathway, implementation of Diabetic Retinopathy shared care pathway, regional work streams, trial of new Glaucoma procedure (HIS), streamlining pathways. 13) Quality and Performance Improvement Manager post created to provide dedicated focus, detailed demand and capacity analysis being undertaken. 14) All patients graded according to the WG risk stratification R1, R2, R3. 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Patients are generally listed for surgery when medical treatment does not work - these patients are at high risk of vision loss with such long delays. 7) Intra-treatment injection room x2 established with nurse injectors trained. 8) Follow up appointments not booked being closely monitored and outsourcing enacted. 9) Regular updates re follow up appointments not booked being monitored by Management Board / Q&SR (patient safety issues) and Finance, Performance and Workforce Committee (performance issues). 10) Reviewing LHM Action Plan in light of more recent WAO follow up review of progress. 11) Primary and Secondary Care working Groups in place. 12) Ophthalmology Planned care recovery group established overseeing a number of service developments: WIL clinics, outsourcing of Cataract patients, development of an ODTIC in Maesteg Hospital, implementation of Glaucoma shared care pathway, implementation of Diabetic Retinopathy shared care pathway, regional work streams, trial of new Glaucoma procedure (HIS), streamlining pathways. 13) Quality and Performance Improvement Manager post created to provide dedicated focus, detailed demand and capacity analysis being undertaken. 14) All patients graded according to the WG risk stratification R1, R2, R3. Additionally, several specific waiting lists are further risk stratified to ensure that the highest risk patients are prioritised.	Update April 2024 - risk ongoing, no new updates in addition to those reported in April 2024, to be reviewed in September 2024. Update November 2024 - risk reviewed and remains unchanged.	Quality & Safety Committee	20	C4 x L5	12 C4 x L3	↔	01.04.2014	04.11.2024	31.12.2024
5462	Executive Director of Public Health Executive Director of Therapies & Health Science	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety	Adult weight management service insufficient capacity to meet demand Impact on the safety - Physical and/or Psychological harm	IF: there is insufficient capacity within the adult weight management service to meet the demand Then: patients will not be offered timely intervention Resulting in: missed opportunity to support activated patients who want support with their weight. Patients will live with over weight or obesity for longer and will be at high risk of a range of obesity related long term conditions such as developing or worsening type 2 diabetes, long term MSK, CVD and some cancers.	People are offered the lowest intervention required in line with the Health Weight Healthy Wales pathways. Those that are waiting are being supported with 'waiting well' signposting. Digital opportunities are being explored to maximise efficiencies within pathways as well as maintaining communication with patients to manage expectations on waiting list times. Existing services, both within the Health Board and with community partners are being maximised and integrated within pathways.	Update August 2024 - Current mitigations remain in place: Pathway redesign and Demand and Capacity (D&C) oversight- Pathway redesign: 74% of level 3 patients identified as suitable for group education, this group delivery model is in progress, which has resulted in an 50% increase in annual capacity compared to the original service model D&C: Real time validation of waiting lists ensures appropriate signposting according to service specification, alongside implementation of partial booking. Referral rates continue at approx. 100/mth with service capacity of 400/mth. A business case to propose an expansion of the staffing model is in progress, and is due for completion by the end of Q3. Update October 2024 - risk reviewed and current mitigation as described in August 2024 update remains in place.	Quality & Safety Committee People & Culture Committee Population Health & Partnership Committee	20	C4xL5	8 - (C4xL2)	↔	07.06.2023	16.09.2024	14.11.2024		
4664	Director of Digital	Central Support Function - Digital & Data	Assistant Director for Data Intelligence, Compliance & Design	Creating Health	Legal / Regulatory	Ransomware Attack resulting in loss of critical services and possible extortion	Due to business sensitivities the detail of this risk will be discussed in closed session.			Digital & Data Committee	20	C5 x L4	15 (C5xL3)	↔	26.05.2021	31.10.2024	15.01.2025		
3826 Linked to 4837 and 4841 in Bridgend Linked to 4462	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director - Unscheduled Care.	Improving Care	Patient / Staff /Public Safety	Emergency Department (ED) overcrowding	IF: As a result of exit block due to hospital capacity and process issues patients spend excess amounts of time within the Emergency Department. This is manifested by, but not limited to, significant 12 hour breaches currently in excess of 400 per month. There are also large numbers of patients spending longer than 24hrs and others within the ED (please see attached information). Then: patients are therefore placed in non-clinical areas. Resulting in: Failure to deliver Emergency Department Metrics, Poor patient experience, compromising dignity, confidentiality and quality of care. The ability for timely ambulance handover with extensive delays for patients requiring assessment and treatment. Filling assessment spaces compromised the ability to provide timely rapid assessment of majors cases, ambulance arrivals and self presenters. Resulting in: Failure to deliver Emergency Department Metrics, Poor patient experience, compromising dignity, confidentiality and quality of care. The ability for timely ambulance handover with extensive delays for patients requiring assessment and treatment. Filling assessment spaces compromised the ability to provide timely rapid assessment of majors cases, ambulance arrivals and self presenters.	Increased number of nursing staff being rostered over and above establishment. Additional respos mattresses have been purchased with associated equipment. Additional catering and supplies. Incidents generated and attached to this risk. Weekly report highlighting level of above risk being generated. All patients are triaged, assessed and treatment started while waiting to offload. Escalation of delays to site manager and Director of Operations to support actions to allow ambulance crews to be released. Rapid test capacity in the POW hot lab has recently increased with a reduction in swab turnaround times. Expansion of the bed capacity in VS to mitigate against the loss of bed capacity in the care home sector and Maesteg community hospital. Daily site wide safety meeting to ensure flow and site safety is maintained. There is now a daily WAST led call (including weekends) with a senior identified leader from the Health Board representing CTN and talking daily through the plans to reduce offload delays across the 3 DGH sites. Twice weekly meetings with R&SC colleagues to ensure that any delays in discharge are escalated at a senior level to maximise the use of limited care packages/ care home capacity. Appointment of Clinical Lead and Lead Nurse for Flow appointed Feb 21 Operational Performance is now monitored through the monthly performance review. Performance review process has been restructured to bring more rigour with a focus on specific operational improvements. Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board.	Update November 2024. The USC RMT reviewed current ambulatory pathways and the site based clinical teams are in the process of developing an SOP relating to R&Sst. We continue to explore the potential to expand ambulatory footprint at the Princess of Wales site. Quality statement baseline assessment has been completed, part of this work, will result in the development of an overarching score which should help reduce the risk of harm with overcrowding in the emergency department. 1. Currently developing a standardised approach to our huddle capture and reporting. 2. Proof of concept has been completed with engagement from operational and clinical stakeholders. 3. Move to development of software project. 4. This will support a consistent approach to recording and reporting escalation levels across all our acute sites. 5. USC Dashboard which provides daily and ongoing trend data for performance metrics 1 Emergency Care. 6. Escalation of delays to site manager and Director of Operations to support actions to allow ambulance crews to be released. 7. CTN IMTP describes development of a predictive data model to enhance current systems (we already have predicted attendance) This remains an ongoing risk for all 3 sites and is reviewed regularly as implementation of targeted improvement takes place. Nurse establishments are being reviewed to ensure safe staffing. With sustained high level of escalation, risk rating to remain at 20, C4, likely hood 5.	Quality & Safety Committee Planning & Performance Committee	20	C4xL5	12 (C4xL3)	↔	24.09.2019	05.11.2024	31.12.2024		
5561	Executive Director of Finance Executive Lead for Estates	Central Corporate Estates	Estates Directorate Future	Sustaining Our Future	Environmental / Estate / Infrastructure	Remedial roof works to resolve the water ingress at POWL	IF: the Health Board fails to act upon the recommendations of the findings of the report from the appointed Structural Engineers in relation to the roof areas at the POWL Then: water ingress will continue to be a problem. Resulting in: significant impact/harm to patient, staff and public safety. Healthcare facilities which are not fit for purpose or sustainable for the future. Service delays impacting the patient experience and service performance of the Health Board. Potential legislative challenge and reputational damage. Loss of confidence in the Health Board estate infrastructure across CTN.	Command structure established to manage the critical incident following identification of roof structure failings. Immediate mitigations to vacate 1st floor wards & depts. of Phase 1 being managed under a Key Call. 1) Discharge Cell - Objectives: The safe but rapid discharge of patients and services from top floor phase 1 POW site and to maintain quality of care and patient safety from top floor phase 1 POW site, to maintain quality of care and patient safety and to maintain staff safety and the deployment of the right staff to the right place. Decant plan agreed 15th Oct. 2) Decant Cell - Objectives: The safe but rapid decant of patients and services from top floor phase 1 POW site, to maintain quality of care and patient safety and to maintain staff safety and the deployment of the right staff to the right place. Decant plan agreed 15th Oct. 3) Reduced Take - Objective - Reduce demand for inpatient beds on the POW site 4) Estates - focusing on ensuring decant areas are fit for purpose as well as overseeing the plans for the works on the roof. Enabling Support Cells Established: Patient Transport, Workforce, Digital, Facilities, Patient Safety, Communication In addition barriers are in place around the footpaths to keep pedestrians away from the edge of Phase 1 roofs.	Removal of Roof Coverings at the POWL site in accordance with the recommendations in the structural engineering report of 9th Oct 2024. Contractor identified. Programme being developed which will fill up timeframes. Costs yet to be determined until as dependent on programme.	Planning, Performance & Finance Committee Quality & Safety Committee Health, Safety & Fire Sub Committee	18	C4xL4	8 (C4xL2)		21.10.2024	21.10.2024	30.11.2024		
4885	Director of Corporate Governance / Board Secretary	Corporate Governance	Corporate Governance	Improving Care Sustaining our Future	Quality / Complaints / Assurance / Patient Outcomes	Failure to deliver and sustain effective Policy Management System and Process	IF: the Health Board fails to maintain an effective policy management process/system to monitor, store and manage the review of policy and procedural documentation Then: there is a risk that staff may act in a manner that is not consistent with strategic and functional expectations. Policies and procedures may not be readily accessible to support decision making and service delivery, and the Health Board may not be protected from litigation if policies and procedures are not regularly reviewed to reflect changes in standards and/or legislation. Resulting in: Policies not being readily available for reference in decision making / emergency situations to support courses of action. Non compliance with new standards and legislative changes leading to possible legal challenge. Limited version control which could impact decision making if there are inconsistent or varying versions of a policy available.	The Policy for the Development, Review and Approval of Organisational Wide Policies is extant and sets out the process to follow. Policy and Procedure advice and guidance is available from the Clinical Policy lead and the Assistant Director of Governance & Risk for non clinical policies. SharePoint Intranet page acts as document library. Timeframe - September 2025 Risk escalated as likelihood of increased due to the capacity constraints impacting the teams ability to undertake the mitigating actions required.	Explore available options to automate the process including a filing portal and automatic prompting. Explore if the process for the policy on policies for Non Clinical written control documents could be simplified. Review the policy library linked to the SharePoint site Produce a baseline position as to the status of all non clinical written control documents	Quality & Safety Committee	18	C4xL4	8 (C4xL2)		26.10.2021	22.10.2024	31.12.2024		

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Date ID	Strategic Risk owner	Core Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date	
1	5691	Chief Operating Officer	Facilities Directorate	Assistant Director Facilities	Sustaining Our Future	Patient / Staff / Public Safety	CCTV System Failure in Prince Charles Hospital If: Major CCTV security management platform (SMP) headend and camera outage at PCH. Unable to live view live data images at the security control centre. NVN recording function is not available to record data images. The outage is also linked with the PCH site refurbishment scheme. The Capital Major Projects team advise that the new (SMP) headend server is not part of the PCH scheme as there is no funding for it. THEN: As a consequence this presents a site security with very limited site surveillance available to identify site incidents and provide evidence of criminal activity and crime. Resulting In: The ground floor, first floor and external site areas require the roll out of 124 new CCTV cameras as part of the PCH refurbishment scheme and the existing old (SMP) headend server does not have the functionality and capacity to accept these additional cameras therefore the contractor TD are unable to roll out the new cameras on site until a new SMP is installed. Risks to the PCH site, patients and staff safety risk. Site risk of theft, property damage and personal injury/assault.	Incident meeting held by Facilities with Digital ICT, Estates, the system contractor and Capital Major Projects team who are managing the PCH site Major project scheme to review the facts and aim to resolve the issue.	Update October 2024 added in red to August update - The Estate CCTV system contractor attended site and identified the root cause of the system failure and restored the PCH security management system headend and power to the majority of existing site cameras. The outcome and recommendation from the system contractor, Capital Major Projects team and TD is that there is further CCTV system replacement and upgrade of hardware and software work to be undertaken. The existing Security Management Platform (SMP) which is the headend control system is old and not fit for purpose and requires replacement and upgrading. Until the (SMP) headend is replaced, the GFFP contractor will also be unable to fully install the 1240 new site GFFP scheme CCTV cameras and a 'moderate' risk of future system failure remains until this work is completed. A specification and estimate of cost of a new (SMP) headend has been completed and funding has been approved. Waiting for a contractor to be allocated the work and an installation date to install the SMP system. Following a recent tender process a supplier has been awarded the contract and the work to install the security management platform(headend) is due to commence in November 2024. Security Systems Risk Assessments A rolling programme of security vulnerability risk assessments is being undertaken out at a number of sites that include the suitability, compliance and provision of current CCTV and control of access systems and where systems may require replacing and upgrading or where site system provision is inadequate. Where there is a requirement for replacement/upgrade or additional systems further work is then required with support from Estates and Digital Services to complete the system technical specifications before a statement of need is provided to the Operational Capital Group for replacement or new works and security hardware/software scheme funding.	Health Safety & Fire Sub Committee Quality & Safety Committee Planning, Performance & Finance Committee	16	C&L4	C3xL4 12	↔	31.01.2024	23.10.2024	02.12.2024	
18	5761	Executive Medical Director	Medical Directorate Function	Medical Directorate Manager	Improving Care	Patient / Staff / Public Safety	Cross Health Board Data Sharing Impact on the safety - Physical and/or Psychological harm	If: Digital services across Wales are unable to resolve an ongoing issue with the ability to share patient data in both directions across health boards/trusts Then: Clinical staff across CTM will be unable to provide the safe and effective care to patients using transparent, available data Resulting in: Potential harm to the patients of CTM due to the lack of clinical information available to clinicians when making clinical assessments	For CTM, this is a particular issue in Prince Charles Hospital as there is a lot of patient cross over at the boundary of Aneurin Bevan Health Board. As a health board we continue to raise this as a serious patient safety issue and will continue to press for a solution with Digital Health Care Wales. CTMHb have asked for alternate options for a quicker solution and timescales to be aligned with these. This has been added as an agenda item for discussion at the next All Wales Medical Director meeting.	Digital Health Care Wales have been working on the ability to share data in both directions so data flows in the Health Board systems - this has been an issue for some time. ABHb have allocated some project resource to scope, map and plan the work needed, however, resources will need to be allocated by C&M and AB to get the work done. There was a strong commitment from Pan-South East Wales Regional Digital to work closer together and link into a wider regional programme board, this was repeated at the regional planning meeting. As of March 2024, the update from DHCW is that they are working on delivering the open architecture to support sharing documents and diagnostic results. Update November 2024 - DHCW have confirmed they are anticipating the work to be undertaken in March next year to resolve this issue. CTM have reiterated the specific issues that need resolving. Risk remains the same until DHCW completes this work.	Quality & Safety Committee Digital & Data Committee	16	C&L4	8 C&L2	↔	26.04.2024	28.10.2024	01.01.2025
18	5658	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Care Group Service Director	Creating Health Improving Care	Patient / Staff / Public Safety	Lack of Dietetic service provision to Princess of Wales (POW) Critical Care If there is no dietetic service to POW critical care... Then this will impact on the safe and effective provision of nutrition and hydration to critically ill patients... Resulting in poorer nutrition provision and increased risk of malnutrition, which in turn lead to increased risk of infection, dependency on mechanical ventilation, poorer patient outcomes, increased length of stay and longer rehabilitation and recovery times following critical care. In addition to increased health utilisation costs, inequity of service provision across CTM critical care units, and non compliance with national standards and guidance as highlighted in critical care peer	At present there is no dietetic provision to POW critical care unit due to lack of specialist critical care dietitian on the POW site and lack of funding. Therefore the nutritional needs of critical care patients on the POW site are managed by the critical care Multi Disciplinary Team.	Update October 2024 - The Planned Care - Care Group is currently undertaking a full gap analysis of the ITU service in line with the national ITU standards (GfPC) and will update the risk. No significant incidents of harm have been identified within the service due to the current dietetic position, but that this will be kept under review.	Quality & Safety Committee People & Culture Committee - Workforce aspect	16	C&L4	8 (C&L2)	↔	19.12.2023	23.09.2024	21.11.2024	
20	5646	Chief Operating Officer	Mental Health Care Group	Care Group Service Director	Improving Care	Patient / Staff / Public Safety	The Impact of 'Right Care Right Person' approach. Impact on the safety - Physical and/or Psychological harm	If: South Wales Police (SWP) implement Right Care Right Person This is an emerging picture and one which the Health Board are developing a fuller mitigation against, it is also a picture which has a gradual phased roll out over the next year. Nurse Director for the Care Group will be drafting a report for Operational Management Board later in the month but timelines have not allowed for this at submission to the Organisational Risk Register. Resulting In: Increased risks to our staff and the people who use our services.	Multi-agency planning meetings have been arranged to review policies. This is an emerging picture and one which the Health Board are developing a fuller mitigation against, it is also a picture which has a gradual phased roll out over the next year. Lunch and Learn sessions completed for Health Board staff. Management of Patients Who Walk out of A Healthcare Setting Policy + Absent Without Leave (AWOL) & Missing Patient Policy MILD Care Group revised to reflect RCP. Phase 3+4 due to be implemented Feb 2025.	Update October 2024 - Risk reviewed no change Phase 2 commenced 16/09/24 - no significant issues reported.	Quality & Safety Committee Mental Health Act Monitoring Committee	16	C&L4	12 (C3xL4)	↔	08.12.2023	29.10.2024	31.12.2024
21	5579	Executive Director of Public Health Executive Director of Therapies & Health Science	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Head of Nutrition and Dietetics, Therapies, PCH	Creating Health	Patient / Staff / Public Safety	Rising childhood obesity rates resulting in an increase in obesity related conditions and poorer health outcomes. Impact on the safety - Physical and/or Psychological harm	Some Level 1 weight management service exist across the Health Board, namely PIPN (0-5 CTM wide), these programmes are currently funded term funded until end March 24. There is no level 2 - multicomponent service or level 3 - specialist MDT service. An option appraisal for the introduction of a children and families weight management service has been undertaken.	Update October 2024: Meeting between DTFS, public health, planning, children and families care groups and growing well strategy leads on 17/10/24. Agreed model of care for CYP WMS and priority areas are level 1 and level 3 for business case. Agreed to develop a phased approach over 3 years. Next steps are wider engagement with care groups and refining the current business case to reflect decisions within the meeting. Business case to be developed for early Q4.	Population Health & Partnerships Committee Quality & Safety Committee	16	C&L4	8 C&L2	↔	13.10.2023	24.10.2024	12.12.2024	
22	4907	Executive Nurse Director / Deputy Chief Executive	Central Support Function - Quality Governance (Concerns & Claims)	Assistant Director of Concerns and Claims	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	Failure to manage Redress cases efficiently and effectively Then: the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. Resulting In: Risk to quality and safety of patient care, resulting from poor management of cases. Financial impact to the Health Board from Redress cases which have been poorly managed and consequently proceed to claim.	Controls are in place and include: • Regular reports run on all Redress cases, with monitoring by the Head of Legal Services & Legal Services Manager The team are having to apply an objective triage approach across the portfolio of redress, LFERs and Inquests to support the mitigation of this risk.	Update October 2024: Over the summer, all Redress cases have been reviewed by the senior staff member allocated overtime, with priorities identified for each case. The Legal Services team is currently depleted of staff, by 4 Claims Investigation Officers and 2 Legal Administrative Staff, which is due to sickness levels and members of staff leaving the organisation. This is having an effect on the workload of the Legal Services team. Staff members are being managed and supported appropriately through the Managing Attendance at Work Policy. The recruitment process of staff is also underway and the team are have temporarily recruited agency staff to address the issues identified above, relating to management of legal cases. The agency staff recruited to be recruited are: • 2 legal agency admin staff, who have been in place since August 2024, and will continue in post until end of February 2025; • 2 legal agency (solicitors) are being recruited, to cover the immediate gap in case management of Redress and Inquest cases. It is anticipated they will commence in November 2024 - for an initial period of 2 months. Legal cases continue to be monitored and escalated through the weekly Q&S Assurance Meeting, led by the Executive Nurse Director, Deputy Executive Director of Nursing and Assistant Director of Quality & Safety. It is proposed that both Data ID 4907 & 4908 are amalgamated as one for the next ARC meeting as both the risks relate to Legal Services/Concerns and are of the same nature of risk.	Quality & Safety Committee	16	C&L4	8 (C&L2)	↔	02.11.2021	04.11.2024	31.12.2024	
23	4908	Executive Nurse Director / Deputy Chief Executive	Central Function - Patient, Care and Safety	Assistant Director Quality & Safety	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	Failure to manage Legal cases efficiently and effectively Then: the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. Resulting In: Risk to quality and safety of patient care, resulting from lack of capacity to management cases in a efficient and effective manner, which could result in failure to comply with the WRP procedures resulting in financial penalties.	The Health Board are developing an action plan in response to the Welsh Risk Pool review, which includes the reviewing structures and workloads New operating model in respect of quality, safety and governance almost fully implemented. New systems and processes, including escalation, implemented to assist to effectively manage cases. The Assistant Director of Concerns & Claims, Head of Legal Services and Legal Services Manager are all carrying case loads to help mitigate this risk. The team are having to apply an objective triage approach across the portfolio of redress, LFERs and Inquests to support the mitigation of this risk.	Update October 2024: The Legal Services team is currently depleted of staff, by 4 Claims Investigation Officers and 2 Legal Administrative Staff, which is due to sickness levels and members of staff leaving the organisation. This is having an effect on the workload of the Legal Services team. Staff members are being managed and supported appropriately through the Managing Attendance at Work Policy. The recruitment process of staff is also underway and the team are have temporarily recruited agency staff to address the issues identified above, relating to management of legal cases. The agency staff recruited to be recruited are: • 2 legal agency admin staff, who have been in place since August 2024, and will continue in post until end of February 2025; • 2 legal agency (solicitors) are being recruited, to cover the immediate gap in the management of legal cases. It is anticipated they will commence in November 2024 - for an initial period of 2 months. Legal cases continue to be monitored and escalated through the weekly Q&S Assurance Meeting, led by the Executive Nurse Director, Deputy Executive Director of Nursing and Assistant Director of Quality & Safety. It is proposed that both Data ID 4907 & 4908 are amalgamated as one for the next ARC meeting as both the risks relate to Legal Services/Concerns and are of the same nature of risk.	Quality & Safety Committee	16	C&L4	8 (C&L2)	↔	02.11.2021	04.11.2024	31.12.2024	
24	5374	Executive Director of Strategy & Transformation	Central Function - Environmental Sustainability	Deputy Director of Strategy and Transformation	Sustaining Our Future	Environment (State) / Infrastructure	Fulfilling our environmental and social duties Then: the health board's decisions fail to reflect our values or consider the long term environmental or social impact Then: we will not fulfil our socio-economic duty, our Wellbeing of Future Generations objectives or our value based healthcare principles Resulting In: negative environmental and social impacts and loss of trust and confidence among stakeholders	• Integrated Medium Term Planning Process aligned to the seven Welsh wellbeing goals and five ways of working • CTM 2030 delivery focusses on community developments, employment and local procurement where possible. • CTM becoming established as an Anchor Organisation. • Decarbonisation Action Plan • Established a CTM Environmental Sustainability Group which will have oversight and delivery of CTM's decarbonisation agenda • 'CTM 2030' seeks to ensure that services take account of the impact on the environment • All-Wales approach to sustainable procurement • Green CTM Staff Forum • Fleet emissions reduction programme and trial of electric vehicles • Tree planting initiatives • Waste management - elimination of landfill for foodstuffs • Use of less environmentally impactful anaesthetic gases • CTM representatives attend the Welsh Government Green meeting • Update of the DAP by March 2024 • Board and Committee cover papers also now include environmental impact against SRs. • Sustainability Manager commenced.	Update October 2024 - No Change. Mitigating action continues to undertake work to assess the environmental impact of projects and programmes that are not classed as "sustainability" projects/programmes. Timeframe is 30th April 2025. Currently score remains unchanged.	Population Health & Partnerships Committee	16	C&L4	8 (C&L2)	↔	21.2.2023	28.10.2024	31.12.2024	
25	4337	Director of Digital	Central Support Function - Digital & Data	Assistant Director for Digital Systems	Creating Health	Operational: • Core Business Objectives • Environmental / Estates Impact • Projects	Integrating Patient Records across the Health Board Then: The Health board does not have a unified electronic health and care record and systems which are integrated across the organisation and with our primary and social care providers Then: The Health board will be unable to deliver safe, high quality, clinically and cost effective care to patients Resulting In: Compromised safety of patients needing treatment that are reliant on clinical test results and information being available to clinicians to plan and deliver the treatment plan and the requirement for sub-optimal manual processes	Key Controls 1. SRHb Service Level Agreement 2. Bridgend disaggregation and the one-CTM aggregation plan 3. NHS Wales Control Agreement and data sharing agreements 4. Numerous national service management boards and Technical oversight groups providing strategic, tactical and operation governance. 5. National ePR programme and systems Gaps in Control The full business case for the Bridgend / old-CTI integration remains unfunded. There are currently a number of CTM systems that are not compatible with Bridgend systems. There is insufficient discretionary capital funding available to support delivery of the aggregation plan There is no data item integration with GP systems, the ABHb Clinical Workstation or Local Authority system Numerous delays in NHS Wales progressing open architectural approach which results in CTM Unb being unable to access our own data as data items (required for linking systems and data analysis) Strategic approach to becoming an anchor organisation to encourage SMEs not developed, resulting in challenges in proceeding with small agile developments Discipline of organisation in keeping to the supported application platforms is being challenged - in particular staff are keen to exploit the opportunities presented by the NHS365 platform however there are no resources available to support, train or integrate this platform within the EPR architecture	Update November 2024: A workshop is planned (15/11/2024) to look at the implications of the critical incident at POW related to the roof on the WPA5 and clinical systems plan.	Digital & Data Committee	16	C4 x L4	8 (C&L2)	↔	14.10.2020	31.10.2024	15.01.2025	
26	4809	Executive Director for People	Central Support Function - Health, Safety & Fire	Assistant Director Health, Safety & Fire	Improving Care	Patient / Staff / Public Safety	Non Compliance with Mandatory Violence and Aggression Training A training review was undertaken to identify HB compliance with the Health and Safety Regulations. Following review the HB is unable to achieve full compliance on any training modules. This is due to a lack of training resource within the Health Safety and Fire Team. If the training is not delivered, then the organisation will not be compliant with mandatory Violence and Aggression Training. Restraint training is mandatory for inpatient acute services for Mental Health and CAMHS. Training is delivered by inpatient staff and the Health Safety and Fire Personnel Safety Advisor. If there is insufficient training resource available then the organisation will be unable to maintain compliance on annual refreshers. If the PSA is unable to deliver key aspects of their role due to the high demand for violence and aggression training delivery then advice to clinical areas is greatly reduced. Resulting in non compliance of mandatory training and a risk of injuries to both staff and patients and possible claims.	Personal Safety Advisor delivers training modules with some support from part time trainers within Mental Health and CAMHS. However there is insufficient resource to ensure compliance within the entire organisation. Trained tutors available from clinical areas. The PSA regularly has to support training due to ward based trainers unable to be released for delivery. This role is not currently included in their job description which has resulted in some trainers resigning from delivering, hence compounding the lack of training resource. The availability of the PSA to offer personal advice to clinical areas is greatly reduced due to the excessive training requirement.	Update August 2024 - The proposal paper was submitted to the Mental Health Care Group. Health and Safety meeting with a recommendation which was not accepted. Personal Safety Advisor discussed that the option was not feasible at the latest Mental Health Care Group Health and Safety meeting July 16th. The Health and Safety Committee has requested a further options paper. Further meetings with the Mental Health Care Group underway to discuss training options. Options discussed employing dedicated team or buying in training both options involve a significant financial commitment. Further meeting arranged for September 2nd. In the meantime PMVA training will be delivered up until December 24 Update October 2024 - Mental Health and Learning Disabilities Care Group Service Improvement Manager is currently re-writing the PMVA options seeking funding for 3 full time trainers within Mental Health to deliver.	Health Safety & Fire Sub Committee	16	C4 x L4	9 C3xL3	↔	31.08.2021	23.10.2024	31.12.2024	
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A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
Date (ID)	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (Current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
4417 (Linked to Risk IDs 4706 and 4702)	Chief Operating Officer	All Care Groups	Deputy CDO (Acute Services & Primary, Community & Mental Health)	Improving Care	Patient / Staff Public Safety	Management of Security Doors in All Hospital Settings	Following several serious incidents following patients absconding from clinical areas, the HSE have issued an Improvement Notice on Bridgend Integrated Locality Group (see Documents) In consultation with employees and involving competent persons: 1. Identify the units, wards and premises where in-patients may be at risk from wandering, absconding or escaping. 2. For each of these, undertake a suitable and sufficient risk assessment of physical and procedural measures to prevent in-patients from wandering, absconding or escaping. 3. Identify the measures needed to protect patients at risk. 4. Record the significant findings. Any lessons learned from the above should be formally shared with the other 2 Integrated Locality Groups for action. If the Health Board do not comply with the notice, THEN: the Health Board may be subject to prosecution by the HSE RESULTING IN: Large Fines and poor publicity.	Clinical areas across the Health Board should have in place local arrangements/procedures to prevent patients from absconding. A document has been circulated from Estates which outlines procedures around how and where staff should be reporting failures in doors.	Update August 2024 - Report received by Operational Capital Group and recommendations for work will be made to Executive Capital Management Group in September 24. Update November 2024 - following assessment recommended priority POW supported by ECHG Oct. Pre-dated POW Critical Incident so review meeting in W/C 4th Nov to check this is still feasible and right. No change to risk score.	Health Safety & Fire Sub Committee	16	C4 x L4	8 (C4xL2)	↔	30.09.2020	01.11.2024	31.01.2025
4671	Director of Digital	Central Support Function - Digital & Data	Assistant Director for Data Intelligence, Compliance & Design	Creating Health	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /Business interruption	Lack of a resilient and performant Digital Network Infrastructure and Assets	Due to business sensitivities the detail of this risk will be discussed in closed session.			Digital & Data Committee	16	C4 x L4	9 (C3xL3)	↔	03.05.2021	31.10.2024	15.01.2025
4080	Executive Medical Director Executive Director of People	Central Support Function - Medical Directorate & People Directorate	Assistant Medical Director	Improving Care	Patient / Staff Public Safety	Failure to recruit sufficient medical and dental staff	15) the CTMHUB fails to recruit sufficient medical and dental staff. Then: the CTMHUB's ability to provide high quality care may be reduced. Resulting in: a reliance on agency staff, disrupting the continuity of care for patients and potentially affecting team communication. This may affect patient safety and patient experience. It also can impact on staff wellbeing and staff experience.	• Associate Medical Director for workforce appointed July 2020 • Recruitment strategy for CTMHUB being drafted • Establishment of medical workforce productivity programme • Work to understand workforce establishment to meet • Development of 'medical bank' • Developing and supporting other roles including physicians' associates, ANPs • Improving induction and development of new doctors	Update November 2024 - The Critical Incident relating to the POWH Roof has resulted in the MWPP PEG and Framework being stepped down temporarily. The Strategic Workforce Planning Team note that: • Discussions have been ongoing with NUSP regarding international recruitment and no plans agreed but the prospect of Mental Health recruitment is being followed up for Jan 2025. • Reviewing with the Executive Medical Director the use of Fixed Term Contracts and how we improve the approach and limit risks. • Exploring how we improve attraction for 'hard to fill' posts and more targeted campaigns. • Sessions booked with HR CG to develop their employee value proposition so that we can advertise with clear messages for internal and external recruits what it is like to work in MH and what we can offer. • In the process of developing a 'once for CTM' job description template. This will go to MWPP Framework for comment and approval - this has been slightly delayed due to POW critical incident. • Working with Finance to identify costs/savings plans to reduce agency costs and where possible to align to substantive recruitment activity.	Quality & Safety Committee People & Culture Committee	15	C5 x L3	10 (C5xL2)	↔	01.08.2013	31.10.2024	31.12.2024
3993	Executive Director of Strategy & Transformation	Central Function Planning Project Risk	Head of Capital, Strategic and Operational Planning	Improving Care	Patient / Staff Public Safety	Fire Enforcement Notice - POW Theatres.	16) The Health Board fails to meet fire standards required in this area. Then: the safety of patients, staff, contractors/visitors etc. and the protection of the buildings could be compromised. Resulting in: potential harm, risk of fire. Possible further enforcement in the form of prosecution.	Storage room obtained on ward 16 to store theatre equipment to ensure evacuation corridor is kept free for evacuation. Staff training on fire evacuation. Closed storage cupboards purchased for safe storage of equipment. • Safe areas identified with Senior Fire officer for storage of equipment in corridors. Weekly meetings to discuss and plan building work necessary to meet requirements of the enforcement notice. Enforcement notice has been extended to December 2023. A meeting has been arranged with FRS in November with plans with a view to gaining a further extension. Need to plan for drop in theatres to mitigate work commencing	Update November 2024: Following the identification of risks with the hospital roof in POW, the first floor of the Hospital has had to be vacated to allow the remedial roofing works to take place. As a result, this has emptied the Theatre template and will therefore make the current FEN invalid. Discussions are underway with SWFRS to determine next steps as the intention is to complete all Fire Enforcement Works in this area earlier than scheduled due to area now being unoccupied.	Quality & Safety Committee Health, Safety & Fire Committee	15	C5xL3	8	↔	31.01.2020	04.11.2024	31.01.2025
4672	Director of Digital	Central Support Function - Digital & Data	Assistant Director for Data Intelligence, Compliance & Design	Creating Health	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /Business interruption	Access to a complete, integrated, and coded medical record.	17) The Health Board is not able to record information accurately and reliably, with complete and up to date information. Then: the data informing the clinical, regional and organisational decisions we and our partners (including WG) make, will be inaccurate, out of date or incomplete Resulting in: Degradation in our delivery of the quadruple aim and strategic objectives and damage to our reputational standing with our population and partners. Further we will be prevented from driving forward our ambitions to become a digital organisation, an exemplar for R&D and Value etc.	Operational controls: Coding key performance indicators covering productivity, demand and backlog robustly monitored. Digitised Patient Notes programme board monitors scanning times, adherence of contractor to terms and quality of staff in maintaining a record DHICW annual coding quality audit. Coding improvement and transformation plan established incorporating additional trained coding capacity, coding at source, use of data captured in other systems and e-forms implemented. Natural language programming resource deployed and outputs of programme being validated. Tactical - EPR programme with deployment of snomed-CT ontology server, WCP & E-forms etc. Tactical controls: Digital element of the strategic programme - Culture to digitise the EPR, our communications, how we do business National Architecture Review - encompassing (NCR /CDR & Sharing arrangements) Coding transformation programme Gaps in controls Scanning time of inpatient activity to digitise the record is at 51 days of maximum clinically safe time of 24-48 hours Quality of paper record and its filing is very poor with audits identifying over 70% of paper records are not maintained to acceptable standards. Digital solutions not yet using snomed-CT/ structurally coded data Information and Technical Standards not being followed with national body favouring document rather than data exchange. Vast amounts of clinical information stored in disparate spreadsheets not visible to central medical record or available to patients or system leaders (including value based healthcare) Digital transcription programme unsupported & unsupported from march 23	Update November 2024: Day forward continues to maintain 48 hour targets. Destruction has started to take place in Williamstown Hub for the CT notes all be it on a small scale, work ongoing to review spread and scale within available resource. No change to risk score.	Digital & Data Committee	15	C3 x L5	9 (C3xL3)	↔	05.06.2021	31.10.2024	15.01.2025
5040	Director of Digital	Central Support Function - Digital & Data	Assistant Director for Data Intelligence, Compliance & Design	Creating Health	Operational: • Core Business • Business Objectives • Projects Including systems and processes, Service /Business interruption	Digital Healthcare Waters (DHICW) interdependencies	18) The Health Board can not integrate new applications into its digital architecture in a timely fashion Then: there could be a detriment to patient care, inefficiencies in care provision and loss in confidence by Health Board staff in the technology provided to them leading to them using alternative software and bespoke systems (including paper based systems) to carry out their duties which are not integrated and major strategic priorities for the organisation (e.g. Bridgend segregation and the deployment of the new Emergency Department system) not being delivered Resulting in: delays in clinical decisions and consequently treatment which may affect clinical outcomes, reduced levels of productivity and thus poorer access to services, staff appetite to work digitally and in accordance with the digital standards required to realise the full strategic benefits of an integrated record and repository not being realised. Other consequences include: 1. Loss of information integrity and accessibility as multiple • copies of clinical records, 2. Failure and delay of digital system deployments (e.g. WEDS) 3. Possible breaches to the GDPR, safeguarding and information	A Hydrad strategic programme group has been established, chaired by the CEO of DHICW to map out how the constraints can be overcome SLAs are in place between DHICW and NHS Wales organisations, however their fulfilment has been exposed by demand pushing the waiting times for developments to start (not complete) to over 12 months Gaps in controls: WG have agreed some funding for the PAS element, however the DHICW IMTF continues to be a top down decision process rather than one being based on HB (User / customer) needs - driven in part by demand overwhelming their capacity (much of which is either Covid born or results from the significant overrun in establishing a minimum viable product to replace CamISc) and numerous critical constraints not continuing to be observed in the system whilst the architecture remains closed. HB carrying viceties in critical areas with no capacity to cover the work from within. As a consequence Emergency to digitise the Emergency Department processes and records has been suspended. Data acquisition from DHICW products is a curious egg, some new APIs are being made available to standards, however latest PAS offering is via de download, presenting challenges to adoption of standards within certain areas. UHB still awaiting availability of access to key HB data such as radiology and tests results.	Update November 2024 - Ethical Healthcare report has been received and is being reviewed. Update on modular EPR to Board is planned for November.	Digital & Data Committee	15	C3xL5	9 (C3xL3)	↔	07.02.2022	31.10.2024	15.01.2025
3337 Linked to RTE Risk 4813 and M&C 4817. Also linked to 4804.	Chief Operating Officer Director of Primary Care and Mental Health Services	Central Support Function: Digital & Data	Lead Infrastructure Architect Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Creating Health	Patient / Staff Public Safety	Lack of a Single Electronic Patient Record in Mental Health Services Loss of Connectivity Care previously reviewed via WCCIS via Mental Health Services	19) Mental Health Services do not have a single integrated clinical information system that captures all patients details. Then: Clinical staff may make a decision based on limited patient information available that could cause harm. Resulting in: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace.	Control measures updated September 2023. 1. A PID has been developed which outlines the processes, resources and timelines sought - this to be discussed in September Programme Board. 2. The Business Case to be refreshed on the back of the PID once approved. It will need to identify additional staff resource required to progress the disaggregation process to bring all CTMHUB staff who currently use WCCIS via local authority over to CTMHUB WCCIS platform. Requires Programme Board approval. 3. Business case to be progressed following Board approval. 4. A new MHLD Care Group risk will be developed relating to the operational mitigations required in the interim to support safe communication and this will be held by the High Quality Clinical Record group, part of the Inpatient Improvement Programme	Update October 2024 - risk reviewed, no change A business case has been put together with another Health Board or bring a single patient record system into the Care Group. The business case has been approved and Welsh Government have agreed funding. A programme board will oversee the implementation.	Quality & Safety Committee	15	C5xL3	6	↔	07.11.2018	29.10.2024	31.12.2024
4691 Linked to RTE Risk 4803, 4795, 3273 and 3019.	Chief Operating Officer	Mental Health Care Group	Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Sustaining Our Future	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /Business interruption	New Mental Health Unit	20) Mental health inpatient environments fall short of the expected design and standards. Then: Care delivered may be constrained by the environment, which is critical to reducing patient frustration and incidents as well as presenting more direct risk as a result of compromised observations. Resulting in: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace and extended lengths of stay.	A Quality Improvement programme in relation to inpatient care has started and a work stream in relation to Safe and Therapeutic Environments has been established with the aim of optimising the patient experience. Inaugural workshop took place on the 26th April. Assistant Director of Strategic Transformation - Mental Health has commenced in post. This new role will lead a range of strategic programmes including recommending a capital business case for a new Mental Health Unit. Annual revisiting of all patient fixture risks and completion of Statement of Needs via Capital process for any fixture risks assessed as needing resolution. All anti fixture works planned for 2022 - 2023 have now been completed. A scoping document case is to be prepared and submitted to WG. Inpatient Improvement Programme established April 2023	Update March 2024 - Still Awaiting a feasibility review on Mental Health inpatient space that will support the mitigation for this risk. Care Group Director engaging with the Capital Team on progressing this at present. No change to risk score at this stage. Update October 2024 - Risk Reviewed no change. Risk will be transferred to new MHLD Service Director when the post holder commences in late November.	Quality & Safety Committee	15	15 (C3xL5)	6 (C3xL2)	↔	15.06.2021	29.10.2024	31.12.2024

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
	Date ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Type	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Heat	Opened	Last Reviewed	Next Review Date
1	5820	Executive Director of Public Health	Public Health - Health Protection	Health Protection Team	Improving Care & Creating Health	Patient / Staff /Public Safety	Potential inability to deliver all elements of the Health Protection Strategic priorities as result of reduced allocation of funding.	IF as a result of the reduced allocation of Health Protection resource the Health Protection Team has insufficient resources to deliver a safe and sustainable service. THEN there may not be sufficient resources to deliver all elements of vaccination and immunisation (which is the first line of defence against infectious disease) in accordance with the NPI. The health board response to infectious disease or environmental hazards will also be significantly hindered and work to address gaps in equity of access will be limited. RESULTING in avoidable harm to patients in vulnerable groups and harm to the public as a result of insufficient health protection interventions delivered. This also poses a reputational risk as a consequence	Governance structure agreed in Health Protection. Health Protection Board established. Recruitment underway to Health Protection structure. A series of planning workshops with partners agreed to review resources available, develop Health Protection strategy and highlight ongoing gaps	A workforce structure has been approved by ELG and work to identify gaps is ongoing which will be reviewed once recruitment is complete. Work with partners is ongoing to reduce inefficiencies and develop A collaborative Health Protection (HP) plan based on all resources available to ensure priorities can be clearly defined and delivered. Wash Government discussions are ongoing with regards to the reduced allocation N/B - Whilst this risk is not scored at a level of 15 and above - the Executive Lead considers this risk to be of a contentious nature that should be escalated to the Board via the Organisational Risk Register. Update November 2024: Risk mitigations and scores reviewed with no change at this stage. This risk will be reviewed in the next 2 months when more recruitment is complete and the Health Protection strategic plan has been circulated more widely. Next review scheduled for the 31.1.2025.	Population Health & Partnerships Committee Quality & Safety Committee	12 Please see note in column J	C&L3	B (C&L2)	↔	01.07.2024	01.11.2024	31.01.2025
36																		

Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	De-escalation Rationale
5669	Director of Digital	Central Support Function - Digital and Data	Service / Business interruption	Increased cost of Citrix Subscription	IF the proposed increase in costs for providing thin client (Citrix) desktops to staff is not affordable or fully funded THEN Some or all of the staff that use Citrix will no longer be able to do so RESULTING IN Staff being unable to access local and national systems Citrix is used by staff to access Virtual Desktops from IGEL thin client devices - 4000 across. These devices only work with Citrix. Staff who access systems using Windows Laptops and PC's will be affected less severely, although many do use Citrix for certain functions. Aside from the CTM Local use and costs for Citrix - National applications that are delivered via Citrix are also in scope of the cost increase, and DHCW have indicated that any costs associated with this are likely to be passed on directly to the organisation.	Renewal costs will increase. Work underway with NHS Wales and Citrix to arrive at the best value licensing on an all Wales basis. CTM Renewal is March 2024, although an interim offer has been made which will take the renewal to December 2024 - allowing all NHS Wales organisations to align their renewals and for negotiations around licensing levels and quantities to be fully understood.	Risk score decreased from a 16 to a 12 as the licensing arrangements have now been finalised and the procurement has been completed. CTMUHB have purchased 3,000 Citrix licenses. The licenses will run for a year, from December 2024 to December 2025. CTMUHB look to significantly reduce its Citrix use over the coming year to reduce/eliminate reliance on Citrix technology. Recommend de-escalating from the Organisational Risk Register to be managed locally by the Digital and Data Directorate.	Digital & Data Committee	12 Risk Score reduced from a 16	4	Update November 2024 - Risk score decreased from a 16 to a 12 as the licensing arrangements have now been finalised and the procurement has been completed. CTMUHB have purchased 3,000 Citrix licenses. The licenses will run for a year, from December 2024 to December 2025. CTMUHB look to significantly reduce its Citrix use over the coming year to reduce/eliminate reliance on Citrix technology. Recommend de-escalating from the Organisational Risk Register to be managed locally by the Digital and Data Directorate.
5730	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety	No Health Board MRI Pacemaker Service	IF there is no MRI pacemaker service THEN patients that require urgent imaging for serious conditions e.g. cauda equina, stroke and Unscheduled Care can not be imaged using the appropriate modality RESULTING IN poor patient outcomes, (life limiting conditions where alternative imaging (CT,US does not answer the clinical question)	Care Group director discussing situation with cardiac team to resource and support this service provision. Escalation to Clinical and Medical Directors as appropriate. Prince Charles Hospital site will offer the service as cardiac physiologist available.	Pacing defib to be purchased - Capital Statement of Need ongoing. Update August 2024 - Defibrillator ordered and should be arriving w/c 26th August 2024. DTPS Care Group have been working on a new policy to allow Patients with a Conditional Cardiac Implantable device to access MRI scans in CTM (which will initially be at Prince Charles Hospital) . This has required considerable work between Radiology, Cardiology and Cardiac Physiology Teams. Care Group Medical Director has been chair of this working group. DTPS Care Group have now pulled together a policy document which is just being finalised with support and help from the appropriate teams. As soon as the defibrillator arrives they will be planning to run the service at PCH within the next fortnight on Monday, Wednesday and Friday afternoons with support of Cardiac Physiology, Cardiologist and Radiology. Whilst they have not had the service consultant Radiologist input has been given to suggest other imaging options. No Harm has been recorded to patients as a result of not having this service at present. Update November 2024 - Update November 2024 - The current service set up the only accepts USC outpatients due to the service only being funded for 3 afternoons per week on one site. There is an ongoing need to expand this service to another site and to allow booking of urgent patients. Ongoing discussions around expansion and funding to accommodate this.	Planning, Performance & Finance Committee Quality & Safety Committee	9 Risk Score reduced from a 16	4	The risk score has been reduced as the MRI service for patients with pacemakers now in place at PCH but limited and does involve transporting patients when service is required. This risk will continue to be managed by the DTPS Care Group.
4152	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety	Back log for Imaging in all modalities / areas and reduced capacity	If: there is a backlog of imaging and reduced capacity Then: waiting lists will continue to increase. Resulting in delay and diagnosis and treatment. Due to the Covid-19 outbreak, all routine imaging has stopped and there is reduced capacity for imaging of USC sand Urgent patients.	Due to the Covid-19 outbreak, all routine imaging was curtailed in line with recommendation for the lockdown periods, resulting in reduced capacity for imaging of Urgent Suspected Cancer (USC) and Urgent patients. It is likely to take many months or even years to get back to a pre-Covid state without additional planned care recovery financial support. However, the Welsh Government (WG) target is to return within the 8-week standard for all patients by March 2024. Cancer waits have been prioritised and are now being undertaken within around 2 weeks with the exception of CT scans which are still around 4 weeks at present.	Update November 2024 - Risk reduced at present as non recurrent Schemes in place which have brought NOUS, MRI and now CT with additional capacity being delivered/ This is dynamic and may increase the risk again when the schemes stop if capacity does not meet demand.	Quality & Safety Committee	12 Risk Score reduced from a 16	4	Update November 2024 - Risk reduced at present as non recurrent Schemes in place which have brought NOUS, MRI and now CT with additional capacity being delivered/ This is dynamic and may increase the risk again when the schemes stop if capacity does not meet demand. This risk will continue to be managed by the DTPS Care Group.
5755	Chief Operating Officer	Improving Care	Environment /Estate/ Infrastructure	Princess of Wales (POW) Air handling unit and electrical infrastructure for Labour ward and Neonatal Unit	If the Air handling unit or the electrical system backups fail for the labour ward and neonatal unit template in POW. Then we do not have assurance that our backup systems will maintain critical equipment including ventilators, anaesthetic machines, pumps etc. and key life preserving equipment during clinical procedures. Resulting in harm to patients and potential for life changing consequences for mothers and babies.	All equipment is being assessed for battery backup. Emergency scenario planning will be arranged with Strategy team as a priority. A Project plan is in place with support from Corporate Planning. Weekly planning meetings held with teams and external stakeholders including WAST, JSS, Network. Neighbouring Health Boards have been informed, meetings between Care Groups arranged. FAQs to staff are out, one to one meetings with affected colleagues taking place, meetings with community midwives / ANC staff underway. FAQs external to women and birthing people are out, drop in sessions underway for any one with any concerns.	Service Director for Children and Family Care Group has confirmed that they now know through the project and deeper assessment of the equipment batteries that they will sustain power for a minimum of 2 hours to give time for emergency electrician to attend. Since the risk was added the Care Group have looked at their contingency plans which currently now would lessen the consequence and impact of the risk as well as the likelihood of occurrence. The Care Group did not have confirmation of these points when the risk was first assessed. On this basis they would reduce the consequence score to 4 from a 5 in terms of the target score. This update will be reflected in the September iteration of the Organisational Risk Register. Risk reviewed and with work underway and the areas decommissioned whilst this is concluded the risk has reduced significantly.	Planning, Performance & Finance Committee Quality & Safety Committee	4 Risk Score reduced from a 16	2	Risk reviewed and with work underway and the areas decommissioned whilst this is concluded the risk has reduced significantly. Weekly meetings continue with all stakeholders are scheduled to review all risks associated with the closure. Risk deescalated as a result of the remedial action underway. This risk will continue to be managed by the DTPS Care Group.

Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	De-escalation Rationale
2808	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Waiting Times/Performance: ND Team	IF: The Neurodevelopment service does not have capacity to achieve the WG assessment target (80% of assessments to commence within 26 weeks of referral) and to follow up patients in a timely way, due to demand exceeding capacity Then: Patients will wait excessive periods to reach a diagnosis and children on medication that require titration and monitoring may not be able to be seen within the appropriate timeframes Resulting in: Delays in appropriate treatments being commenced, delays in accessing support e.g. in school following a diagnosis, delay in being effectively titrated, risks associated with delays in medication monitoring	3.5 wte AHP/Nurses successfully appointed, starting June/July 2024 Demand and capacity modelling completed. Merging of Community and ND waiting lists to enhance capacity has taken place. Capacity available should meet demand following 3.5 wte commencing in post. However, this does not account for the average 20% increase in referrals accepted each year. This also doesn't address the backlog of patients already on W/L. (SBAR developed and presented at OMB seeking 2.0 wte B7 AHP for 2 years to clear backlog. SBAR also submitted for PCR monies) NDIP funding for 24/25 awaiting final agreement (funds to include WLI clinics, additional overtime for A4C staff, medicine costs and ADOS training).	Update August 2024 - Risk reviewed and currently remains at 15. Additional staff have been recruited as part of the Neurodevelopment improvement plan (WG funded), however, from September onward the capacity will meet the current demand. Backlog clearance plans will help us start reducing to below 104 weeks by end of March 2025. Risk will be reviewed again at end of October to update risk score. Update November 2024 - Waiting lists are being managed and reported regularly through the care group OMB and ND improvement board and reported nationally. The team are doing everything within their capability to deliver improvements and are with Welsh Gov support showing an improved trajectory to March 2025.	Quality & Safety Committee	12 Risk Score reduced from a 16	6	Risk reviewed - waiting lists are being managed and reported regularly through the care group OMB and ND improvement board and reported nationally. The team are doing everything within their capability to deliver improvements and are with Welsh Gov support showing an improved trajectory to March 2025. Due to the improved trajectory the likelihood score has been reduced. This risk will continue to be managed by the DTPS Care Group.

	A	B	C	D	E	F	G	H	I	J	K
	Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Month Closed on Org RR	Closure Rationale
1											
2	No risks proposed for closure from the Organisational Risk Register this period.										



Agenda Item

5.2

Audit & Risk Committee

AUDIT RECOMMENDATIONS TRACKER UPDATE REPORT

Dyddiad y Cyfarfod / Date of Meeting	17/12/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Claire Brown, Head of Quality Assurance and Compliance
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance / Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

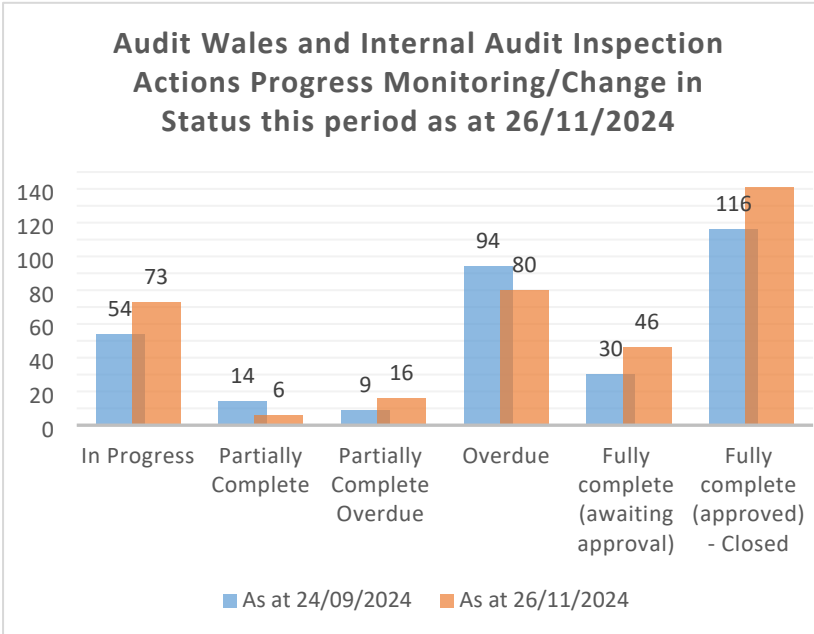
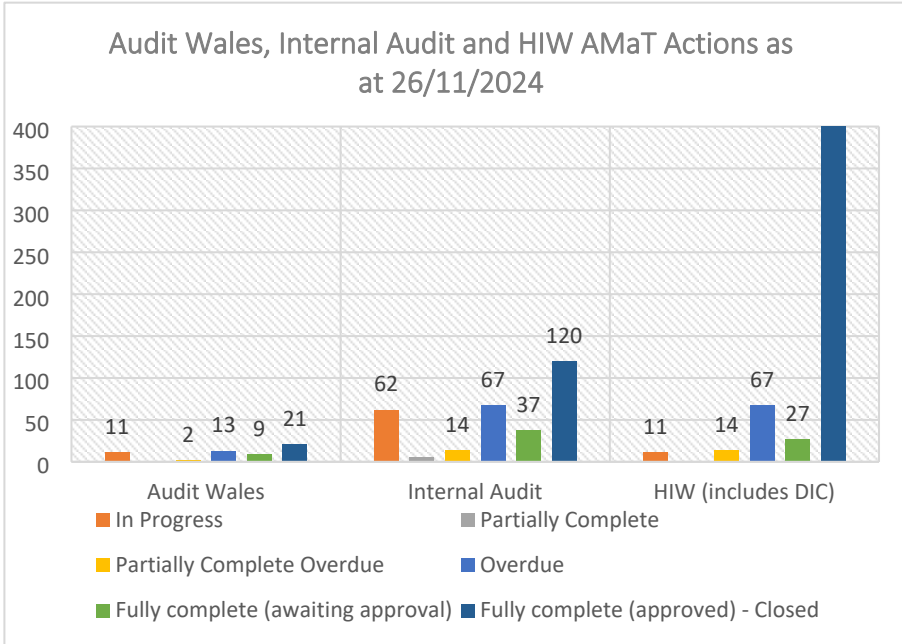
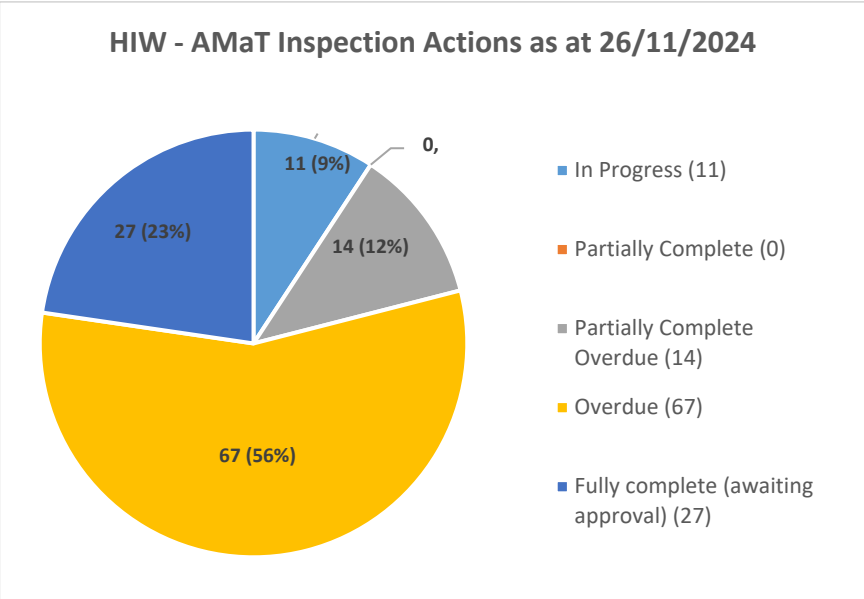
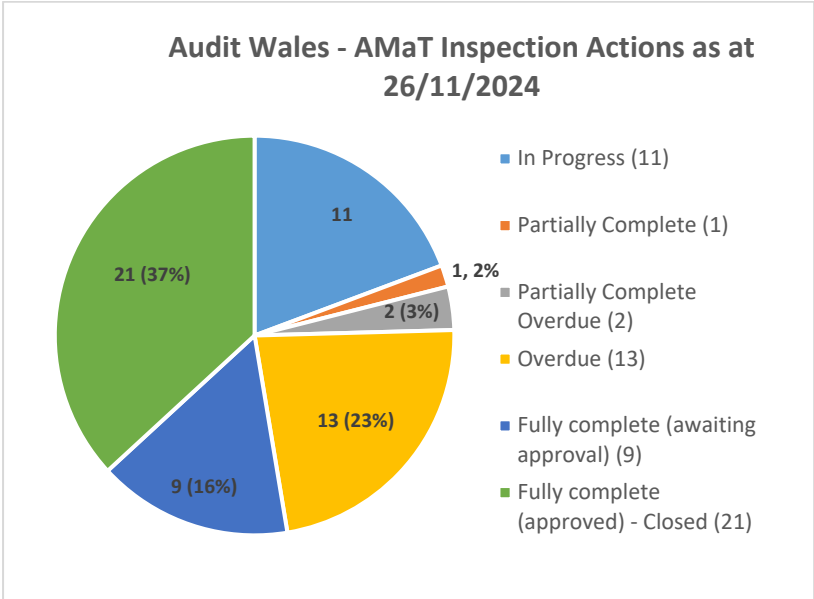
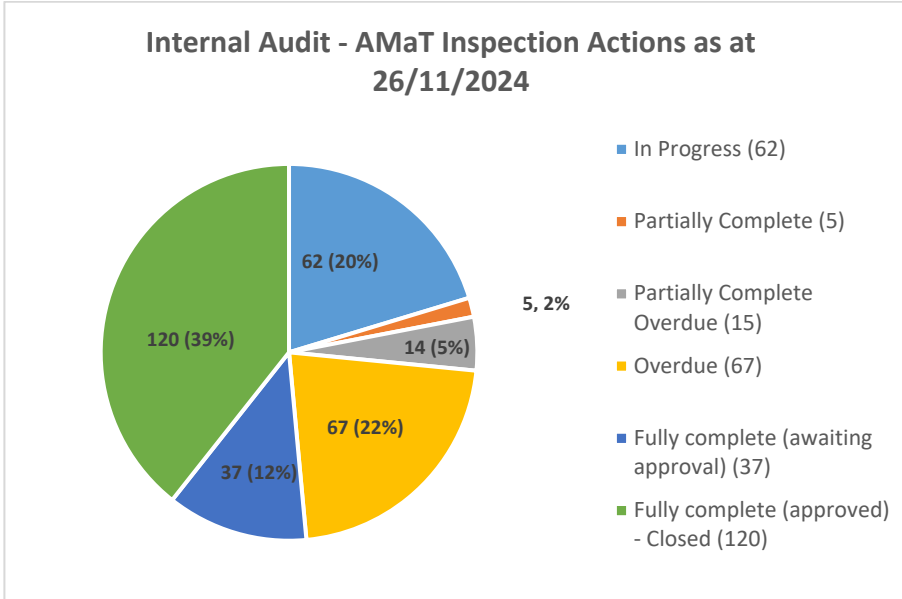
Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Executive Leadership Group	2 nd December 2024	Reviewed and Management Sign Off Received.

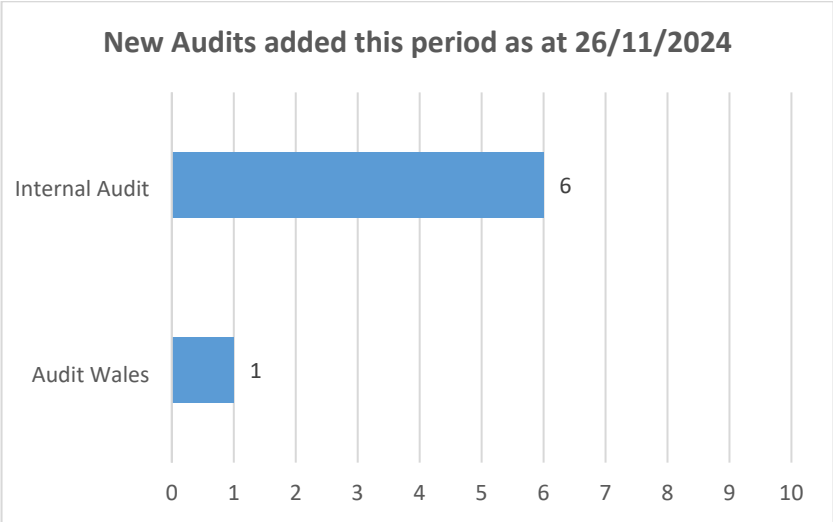
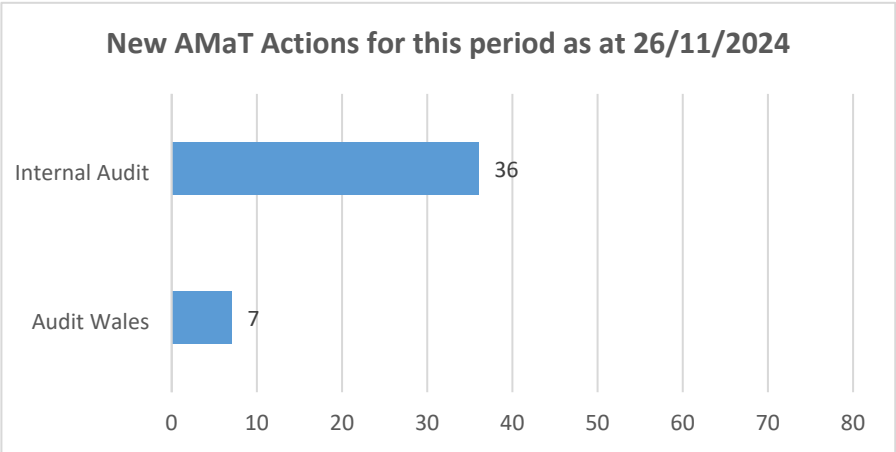
Acronyms / Glossary of Terms	
AMaT	Audit Management and Tracking
HIW	Healthcare Inspectorate Wales

Tracker Dashboard

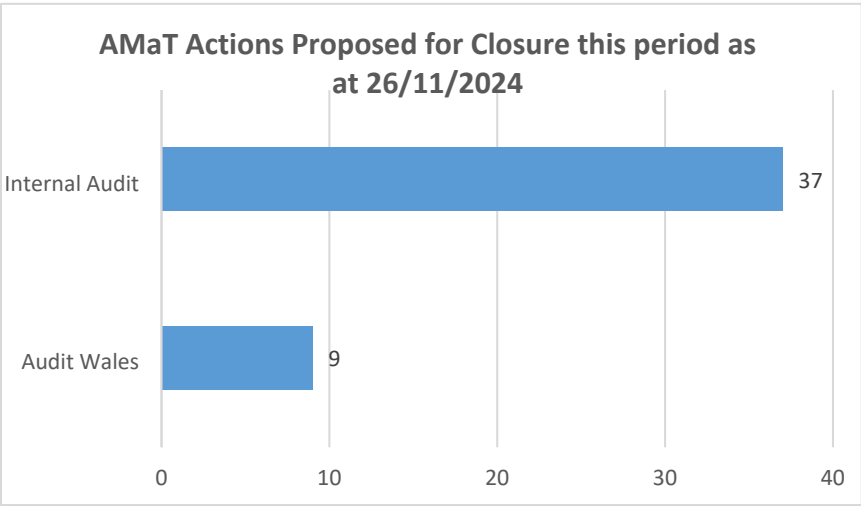
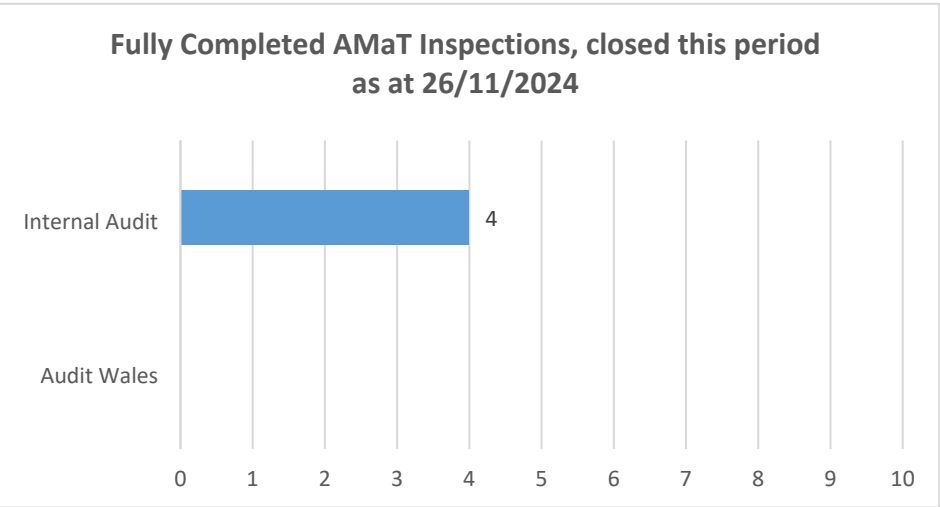
Status: Inspection Actions:



Inspections / Inspection Actions Added:

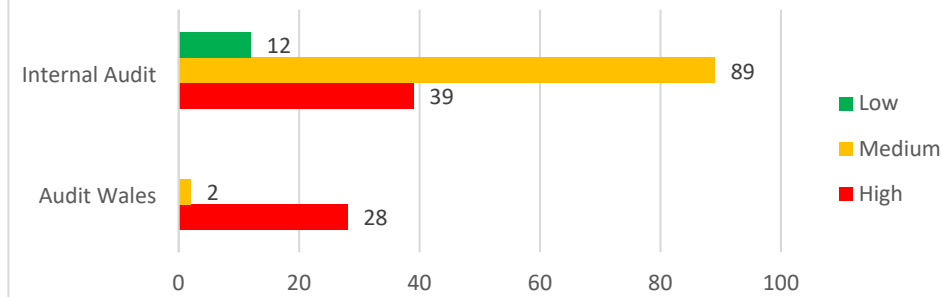


Closed Inspections:

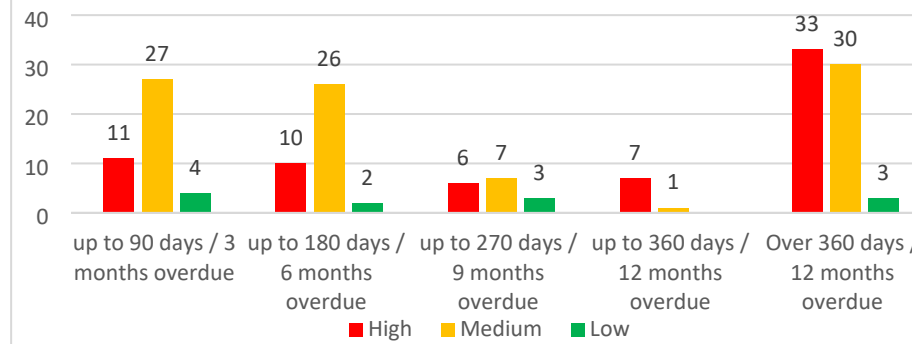


Performance Dashboard

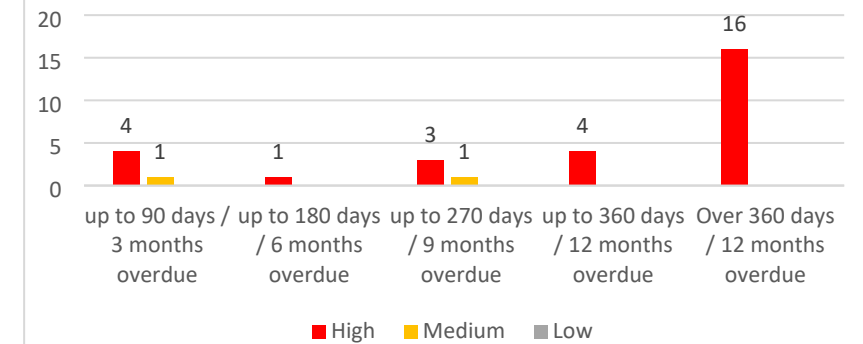
Overall overdue Audit Wales & Internal Audit open Actions (total days overdue from Original Due Date) by Action priority as at 26/11/2024



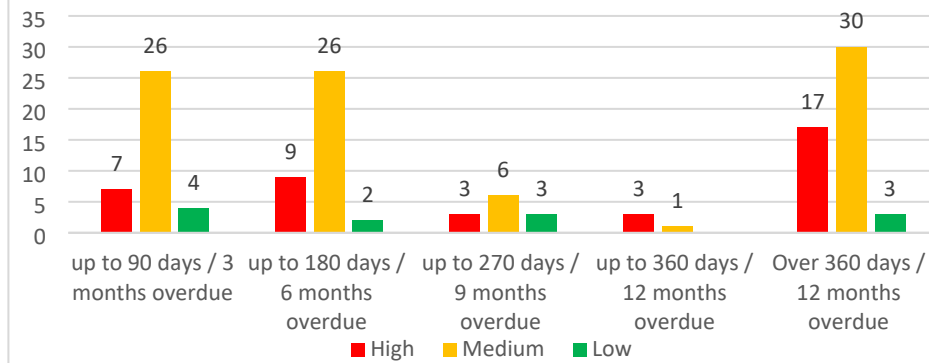
Overall overdue Audit Wales & Internal Audit open Actions (total days overdue from Original Due Date) by Action priority as at 26/11/2024



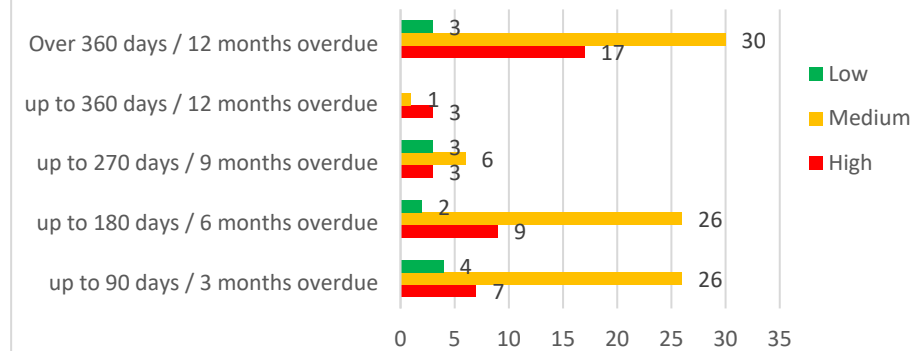
Overall overdue Audit Wales open Actions (total days overdue from Original Due Date) by action priority as at 25/11/2024



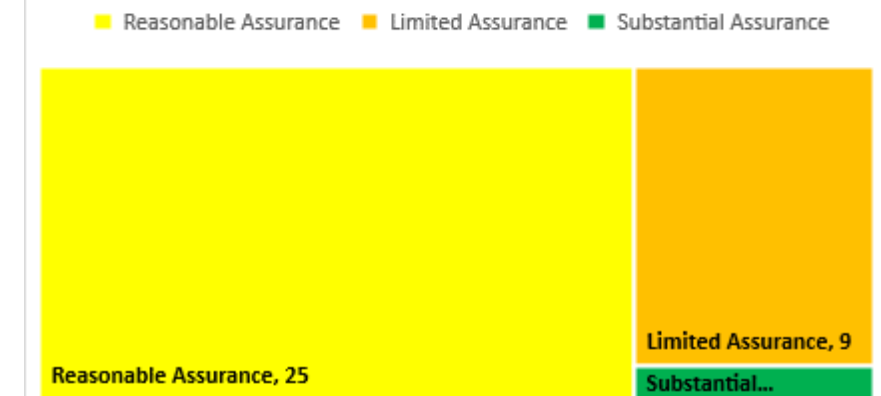
Overall overdue Internal Audit open Actions (total days overdue from Original Due Date) by Action priority as at 26/11/2024



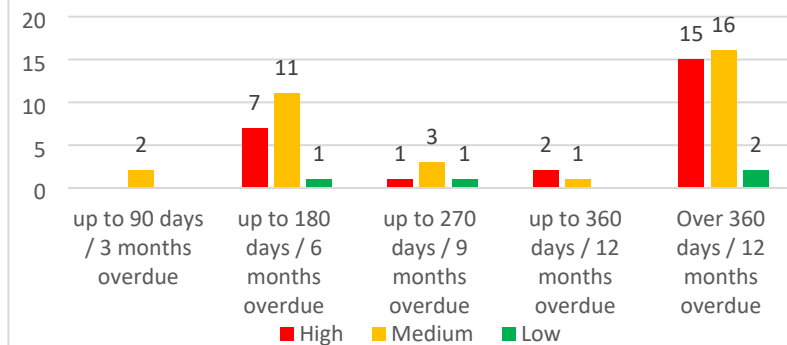
Overall overdue Internal Audit open Actions (total days overdue from Original Due Date) by Action priority as at 26/11/2024



Total AMaT Inspections for Internal Audit as at 26/11/2024 by Assurance Opinion with Actions overdue from Original Date



Limited Assurance only - Overall overdue Internal Audit open Actions (total days overdue from Original Due Date) as at 25/11/2024





1. Background

- 1.1 The main purpose of this report is to present an update to the Audit & Risk Committee on reported progress of audit report recommendations in the revised format following transition to an automated system using the Audit Management and Tracking (AMaT) inspection module.
- 1.2 The scope of this report relates to both internal and external audit review recommendations. Information from HIW included for information only as this is considered at the Quality & Safety Committee.

2. Specific Matters for Consideration

- 2.1 In response to previous feedback from the committee the new dashboard was introduced in the last report to provide the Committee with a more detailed picture in terms of overdue actions and their correlation to a limited assurance or high priority status action. Please note that this data has been populated as overdue from the original due date which differs from calculations within AMaT which takes into account the revised dates.
- 2.2 As indicated in graph 1 of the 'Performance Dashboard' (page 4), there has been an increase in the number of overdue actions since the last report in October 2024, with an additional **16 Medium Priority** actions and **10** further **High Priority** actions which are overdue.
- 2.3 In relation to those actions which have exceeded a 12 months overdue status, graph 2 of the 'Performance Dashboard' (page 4) indicates that there are **30 Medium Priority** and **33 High Priority** recommendations, compared to 26 Medium Priority and 23 High Priority reported in the report received at the October Committee meeting.
- 2.4 There are **15 High Priority** and **16 Medium Priority** actions which are over 12 months passed their due date relating to reviews which were assigned a **Limited Assurance Rating**.
- 2.5 There remains a clear need to re-evaluate these overdue actions to ensure that any achievable open, overdue actions are prioritised and addressed.
- 2.6 A planned, focussed programme of work is in progress with the Executive Team to review all overdue actions within their remit. The Director of Corporate Governance is continuing to liaise with Executive Directors in terms of the need to review overdue recommendations.
- 2.7 Work is ongoing to identify any recommendations which may need to be updated or removed from the tracker to ensure all data being collected and tracked is pertinent, up to date and relevant to the current governance and assurance priorities of CTM. This work continues, involving ongoing discussions with Executive colleagues and Internal Audit as well as regular

meetings with the Business Managers for each Care Group in order to track the progress of ongoing Audit Recommendations.

- 2.8 Progress on this work will be reported to this committee and any recommendations removed will be reported and will receive appropriate approval at the Executive Leadership Group before anything is removed from the system.
- 2.9 Encouragement and highlighting of the timeliness of management responses in accordance to the 15 Day Charter continues to be an increasing priority with greater prominence given within Executive Management Board Meetings.
- 2.10 The current position on the status of recommendation actions can be viewed in *Appendix 1*, with the most recent updates provided in red. System developments continue with the AMaT development team and so the report and tracker continue to be a hybrid approach and continues to require manual manipulation in some areas.
- 2.11 The Quality Assurance and Compliance team have continued to push forward with the transition plan for Care Groups to independently provide all updates directly onto the AMaT system. This approach has been trialled with reporting of HIW updates which has highlighted areas of the system that need to be further developed in order to be able to achieve good governance and provide high levels of assurance. The proposed timescale of 31st March 2025 is proposed for this complete transition over to AMaT for Audit Wales and Internal Audit Reviews.
- 2.12 Engagement on CTM's development requests with the software developers continues and the current development plans are available upon request.
- 2.13 The team continue to collaborate with the Clinical Audit team and the AMaT developers to enhance the functionality of AMaT to suit the purpose within CTM. This work plan has not been included in the report as there is no change from the last meeting however the document is available on request.
- 2.14 **Tracker Updates**

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

6 New Internal Audit Review has been added to the Audit Recommendations Tracker including 36 new actions.

37 Internal Audit recommendations have been completed and **28** are proposed for **CLOSURE**.

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

1 New External Audit Review has been added to the Audit Recommendations Tracker which includes 2 new recommendations.

9 Recommendations are proposed for **CLOSURE**.

Health Inspectorate Wales (HIW) - Reports from Healthcare Inspectorate Wales will be included in brief for noting and observation. The HIW tracker is included at Appendix 3, however, the Committee should note that this was received by the Quality & Safety Committee at its meeting on the 19th November 2024:

2 New agreed Improvement Plans added resulting in **8 New** actions

A significant amount of work has been undertaken during recent months cleansing the HIW data and this has resulted in:

333 Inspection actions **Fully Complete-Closed** and a further **122** actions nearing completion but requiring further evidence. The Head of Quality Assurance and Compliance has been working closely with leads of outstanding actions to retrieve further evidence required to propose complete closure of these actions and these numbers should be reflected in the next Quality and Safety Report in January 2025.

3. Key Risks / Matters for Escalation

- 3.1 The audit tracker will continue to be updated with a targeted focus on actions where the implementation date has passed with reference to the targeted programme of work and the performance dashboard indicating the areas of concern.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies, please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies, please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	Not Applicable
	If more than one applies, please list below:
Dolen i Hwyluswyr Ansawdd	Leadership



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

Impact Assessment		
Ansawdd Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality Have you undertaken a Quality Impact Assessment Screening?	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cydraddoldeb Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Cydraddoldeb? / Equality Have you undertaken an Equality Impact Assessment Screening?	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cyfreithiol / Legal	Yes (Include further detail below)	
	There may be an adverse effect on the organisation if CTMUHB does not fully implement learning and improvements identified as part of Audit arrangements.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau (Pobl / Ariannol) / Resource Impact (People / Financial)	There is no direct impact on resources as a result of the activity outlined in this report.	

5. RECOMMENDATION

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

Inspection	Title	Date of Inspection	Assurance Rating	Recommendations	Actions
Audit Wales/2021/144	Audit Wales Quality Governance Follow Up Review_Audit and Risk Committee Update – CTMUHB_August 2021 (Document reference: 123A2017)	01/08/2021	Not Applicable	7	7
Audit Wales/2021/7	CONFIDENTIAL Audit of Accounts Report Addendum – CTMUHB 2020-21 (Document reference: 2535A2021-22)	01/08/2021	Not Applicable	2	2
Audit Wales/2022/12	Transformational Leadership Programme Board – Baseline Governance Review – CTM Regional Partnership Board 2021-22_August 2022 (Document reference: 2934A2022)	01/08/2022	Not Applicable	5	5
Audit Wales/2023/149	Structured Assessment 2023 – CTMUHB 2023_October 2023 (Document reference: 3920A2023)	01/10/2023	Not Applicable	6	6
Audit Wales/2023/150	CONFIDENTIAL Audit of Accounts Report Addendum – CTMUHB 2022-23_November 2023 (Document reference: 3727A2023)	01/11/2023	Not Applicable	9	9
Audit Wales/2023/18	Structured Assessment 2022 – CTMUHB 2022_February 2023 (Document reference: 3313A2023)	01/02/2023	Not Applicable	8	8
Audit Wales/2023/23	Orthopaedic Services in Wales – Tackling the Waiting List Backlog_Report of the Auditor General for Wales_March 2023	01/03/2023	Not Applicable	3	3
Audit Wales/2024/168	Review of Workforce Planning Arrangements – Cwm Taf Morgannwg University Health Board (Document reference: 4157A2024)	01/02/2024	Not Applicable	6	6
Audit Wales/2024/196	Follow up review: Temporary Closure of the Ysbyty Cwm Cynon Minor Injuries Unit – Cwm Taf Morgannwg University Health Board (Document reference: 4361A2024)	01/07/2024	Not Applicable	1	2
Audit Wales/2024/205	CONFIDENTIAL Audit of Accounts Report Addendum - CTMUHB 2023-24_October 2024 (Document reference: 4395A2024)	01/08/2024	Not Applicable	7	7
Internal Audit/2020/65	Directorate review: Acute Medicine and A&E Directorate_Final Internal Audit Report July 2020 (Review reference: CTMU-1920-23)	29/07/2020	Reasonable	2	2
Internal Audit/2020/74	Medical Equipment and Devices - Follow up Internal Audit Report 2019/20 January 2020 (Review reference: CTMU 1920-45b)	24/01/2020	Reasonable	1	1
Internal Audit/2021/76	Sunnyside Health & Wellbeing Centre_Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03)	06/08/2021	Reasonable	15	15
Internal Audit/2022/161	Continuing Health Care and Funded Nursing Care_Final Internal Audit Report February 2022 (Review reference: CTMUHB-2122-36)	14/02/2022	Reasonable	1	1
Internal Audit/2022/25	Follow-up: Patient Pathway Appointment Management Process_Final Internal Audit Report June 2022 (Review reference: CTM 21/22-15)	15/06/2022	Limited	8	8
Internal Audit/2022/43	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	29/07/2022	Limited	13	13
Internal Audit/2022/67	Radiology Service Review Final Internal Audit Report October 2022 (Review reference: CTMUHB-2223-03)	24/10/2022	Reasonable	5	5
Internal Audit/2022/95	Follow-up: Medical & Dental Rostering_Final Internal Audit Report June 2022 (Review reference: CTM 21/22-31)	15/06/2022	Reasonable	1	1
Internal Audit/2022/97	Medical Records Management_Final Internal Audit Report October 2022 (Review reference: CTMU-2223-06)	10/10/2022	Reasonable	1	1
Internal Audit/2023/100	Welsh Risk Pool Claims_Final Internal Audit Report May 2023 (Review reference: CTMUHB-2223-24)	31/05/2023	Reasonable	3	3
Internal Audit/2023/107	Decontamination_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-25)	08/08/2023	Reasonable	5	5
Internal Audit/2023/113	National Incident Framework_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-05)	08/08/2023	Reasonable	8	8
Internal Audit/2023/117	Performance Reporting – Integrated Performance Report_Internal Audit Report July 2023 (Review reference: CTMUHB-2223-15)	28/07/2023	Reasonable	2	2
Internal Audit/2023/124	Follow-up: Concerns_Final Internal Audit Report May 2023 (Review reference: CTM 22/23-29)	31/05/2023	Reasonable	4	4
Internal Audit/2023/146	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	11/10/2023	Limited	8	8
Internal Audit/2023/148	IT Infrastructure_Final Internal Audit Report October 2023 (Review reference: CTM-2324-19)	09/10/2023	Reasonable	5	5
Internal Audit/2023/37	Arrangements for Managing Service Level Agreements_Final Internal Audit Report June 2023 (Review reference: CTMUHB-2223-17)	06/06/2023	Limited	5	5
Internal Audit/2023/54	Medical Variable Pay – Agency Costs_Final Internal Audit Report February 2023 (Review reference: CTMUHB-2223-12)	06/02/2023	Limited	7	7
Internal Audit/2023/57	Reasonable Offer Process_Internal Audit Report April 2023 (Review reference: CTMUHB-2223-04)	03/04/2023	Limited	4	4
Internal Audit/2023/73	Follow-up: Radiology Workforce_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2324-22)	08/08/2023	Reasonable	4	4
Internal Audit/2024/162	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	06/02/2024	Limited	15	15
Internal Audit/2024/163	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	08/02/2024	Reasonable	11	12
Internal Audit/2024/169	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	11/04/2024	Reasonable	17	18
Internal Audit/2024/170	Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-02)	12/04/2024	Limited	7	7
Internal Audit/2024/171	Decarbonisation Internal Audit Report_April 2024 (Review reference: CTMUHB-2324-13)	09/04/2024	Limited	9	9
Internal Audit/2024/172	Follow-up: Digital Operating Model Final Internal Audit Report_April 2024 (Review reference: CTM-2324-24)	02/04/2024	Reasonable	2	2
Internal Audit/2024/187	Leadership and Management Development Programme Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-01)	06/06/2024	Reasonable	4	7
Internal Audit/2024/188	Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-14)	11/06/2024	Reasonable	5	9
Internal Audit/2024/189	Technical Resilience Final Internal Audit Report_June 2024 (Review reference: CTM-2324-20)	07/06/2024	Reasonable	6	6
Internal Audit/2024/190	Risk Management Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-17)	03/06/2024	Reasonable	9	9
Internal Audit/2024/192	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	04/06/2024	Reasonable	15	27
Internal Audit/2024/195	PCH Redevelopment Programme: Key Performance Objectives Final Internal Audit Report_July 2024 (Review Reference: CTM-SSU-2324-04)	01/07/2024	Reasonable	7	7
Internal Audit/2024/199	Intelligence Led Organisation Final Internal Audit Report_October 2024 (Review reference: CTM-2425-07)	04/10/2024	Reasonable	7	8
Internal Audit/2024/200	Embedding the Quality Framework Final Internal Audit Report_September 2024 (Review reference: CTMUHB-2324-15)	16/09/2024	Reasonable	7	8
Internal Audit/2024/201	Follow-up: Medical Variable Pay – Agency Costs_September 2024 (Review Reference: CTMUHB-2324-23)	16/10/2024	Reasonable	2	5
Internal Audit/2024/202	Follow-Up: Reasonable Offer Final Internal Audit Report - October 2024 (Review Reference -CTM-2324-25)	02/10/2024	Reasonable	4	4

Inspection	Title	Date of Inspection	Assurance Rating	Recommendations	Actions
Internal Audit/2024/203	Follow-up: Patient Pathways Final Internal Audit Report - September 2024 (Review Reference: CTM 23/24-31)	27/09/2024	Limited	9	9
Internal Audit/2024/204	Follow-up: Facilities Governance Arrangements Final Internal Audit Report - October 2024 (Review Reference - CTMUHB 2425-27)	07/10/2024	Substantial	2	2

Audit Recommendations Tracker
AMaT Actions - Status Key

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

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Reference Number	Action	Executive / Inspection Lead	Original Due Date	Current Due Date	Action Rating	Progress Status	Comments/Updates
Audit Wales/2021/144	01/08/2021	Audit Wales Quality Governance Follow Up Review_Audit and Risk Committee Update – CTMUHB_August 2021 (Document reference: 123A2017)	Audit Wales/HW Quality Governance Follow Up Review R3.5 Ensure there is collective responsibility for quality and patient safety across the executive team and clearly defined roles for professional leads: a- Strengthening of the role of the Medical Director and Clinical Directors in relation to quality and patient safety b- Clarify the roles, responsibilities, accountability, and governance in relation to quality and patient safety within the directorates c- Ensure there is sufficient capacity and support, at corporate and directorate level, dedicated to quality and patient safety	Audit Wales/2021/144/MD3/1	Quality metrics capturing a greater breadth of HB services and functions, including population health measures, have been agreed and reviewed at the ILG performance meetings, Quality & Safety Committee and Board. The new measures will utilise, where possible, control limits, targets and trajectories. Once for Wales will support the HB to benchmark against other HBs.	Patient Care and Safety Executive Director of Nursing/Deputy Chief Executive Executive Director of Therapies & Health Science	01.10.2021	31.10.2024	High	Partially complete (Overdue)	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Audit Wales Progress Update - R3 is considered to be partially implemented; remains open. July 2024 Update - CTMUHB has successfully recruited to over 80% of the Clinical Director roles as of March 2024. Four posts remain vacant at present for Pathology, Radiology, Respiratory, and Diabetes and Endocrine, with plans in place to complete recruitment within the next three months. However, in the interim, the relevant Care Group Medical Directors are managing these posts to ensure effective oversight. Emergency Medicine has an interim appointment for a period of six months, with an aim to appoint substantially at the end of that period. Whilst Audit Wales are assured with the plans in place to complete the recruitment process, they are currently unable to close the recommendation until all remaining vacancies have been filled, particularly given the importance of the clinical areas they cover. This recommendation to be noted as partially implemented.
Audit Wales/2021/7	01/08/2021	CONFIDENTIAL Audit of Accounts Report Addendum – CTMUHB 2020-21 (Document reference: 2535A2021-22)	Matter arising 2 - The Health Board should review its governance and procedures in place for the appointment of senior officers, and as part of the review ensure that it fully understands the extent of WG's delegated authority to the Health Board, and importantly, the decisions that WG has not delegated. The Health Board should ensure that minutes, particularly those of the Remuneration Committee, are clear. For example, minutes should make a clear distinction between when the Remuneration Committee has approved (or rejected) a business case; and when it has endorsed (or not endorsed) a business case that then needs the approval of the WG. In respect of retire and return cases, the Health Board should ensure that it has appropriate procedures in place for the consideration and approval/ rejection of business cases. The Health Board should record the process contemporaneously and provide accurate information to the payroll department.	Audit Wales/2021/7/MD2/1	There is a context to the DoTfS delay, for example, which is that the situation was novel, and required Welsh Government banding for a new joint role, which took some time.	People Executive Director for People	31.08.2021	31.05.2024	High	Overdue	Revised Due Date May 2024; Unable to provide a revised date (see July 2024 update) November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - The Welsh Partnership Forum has still not released the All Wales Pension Policy to NHS Wales organisations to approve and implement across their organisation. No date has been confirmed regarding when this policy is due to be released to NHS Wales organisations. The Health Board is unable to take any action until the All Wales Policy has been received, approved and implemented.
Audit Wales/2021/7	01/08/2021	CONFIDENTIAL Audit of Accounts Report Addendum – CTMUHB 2020-21 (Document reference: 2535A2021-22)	Matter arising 8 - The Health Board should perform a restore of the RAM system from backups to confirm that the process works as expected and thereby provide assurance that the system could be recovered in the event of system loss or failure. The Health Board should carry out such testing regularly.	Audit Wales/2021/7/MD3/1	The Capital team will link with the relevant lead in the ICT team to confirm the programme of backups for the RAM system and agree a process and timeframe for checking and testing the backups have recorded properly. This will be actioned early in 21/22 and an agreed programme and process developed moving forward.		07.12.2021	07.12.2021	High	Fully complete (Awaiting approval)	November 2024 Update - The live RAM system was restored to the test system in August 2024. Going forward Finance colleagues have been asked to request a restore of the RAM system every quarter. This audit action can be closed. Matter arising 8 added back to the Tracker as at October 2024. Audit Wales advised at the Audit & Risk Committee on 17th October 2024 that it does not consider that the Health Board has addressed this recommendation.
Audit Wales/2022/12	01/08/2022	Transformational Leadership Programme Board – Baseline Governance Review – CTM Regional Partnership Board 2021-22_August 2022 (Document reference: 2934A2022)	Transformational Leadership Programme Board – Baseline Governance Review R4 Risk Management Our work found areas of risk management that need to be improved, particularly in relation to regional workforce planning. The TLPB should strengthen regional risk management arrangements by improving the identification and prioritisation of shared risks and ensuring mitigating actions are robust and clearly articulated.	Audit Wales/2022/12/MD3/1	Agreed. Within the new governance structure there will be an integrated resources group which will be tasked to develop the risk management framework.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	31.03.2023	31.03.2025	High	In progress	November 2024 Update - Bridgend, Merthyr Tydfil and Rhondda Cynon Taf County Borough Councils and Cwm Taf Morgannwg University Health Board (CTMUHB) have agreed to work together, with other Regional Partnership Board partners, to create an integrated community care system for older people and people living with frailty which is capable of meeting changing and increasing community need. The planned Integrated Community Care System (ICCS) where multidisciplinary teams will work on cluster footprints across the region. The ICCS will be based on two new community pathways - Urgent Community Response and Population Health Management, where the Urgent Response Pathway may be accessed primarily through a Navigation Hub. A new management model - comprising integrated management roles and shared resources, is seen as necessary to deliver integrated services effectively. September 2024 Update - Risk registers maintained and a robust approach is in place for funding programmes. The Housing with Care Funding (HCF) forms a 4-year programme, having begun in FY 22/23 with an annual budget for the first three year of £8,729,000 per annum. This means the fourth year is yet to be confirmed by Welsh Government. Whilst the region progresses into the third year of the programme with a known capital allocation, it does mean a number of large-scale projects which span into FY 25/26 could be at risk due to unknown HCF funding availability, due to construction and completion timelines. Wider than funded programs, the sensitive handling of a new ECC level 4 service, where we are seeking to increase community capacity without carving resources away from social care, demonstrates a maturing approach. We need to embed workforce planning more broadly over the coming months, and this would then provide us with a basis for closing this risk in circa 6 months time. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - Regional Integration Fund plan agreed for 2024/25. A number of projects provided initial 6 months funding to align with any changes required linked to community pathway development. Funding likely to be extended until the end of the financial year. Funding within the wider programme identified to take forward a number of priorities under the children and young peoples board that historically has seen less Rf investment.
Audit Wales/2022/12	01/08/2022	Transformational Leadership Programme Board – Baseline Governance Review – CTM Regional Partnership Board 2021-22_August 2022 (Document reference: 2934A2022)	Transformational Leadership Programme Board – Baseline Governance Review R6 Use of Resources Improving the health and social care outcomes of the region will require efficient and effective use of combined resources. Our work found that there had been some limited examples of pooled budgets and other arrangements for sharing resources. The TLPB needs to explore more innovative ways of sharing and pooling core.	Audit Wales/2022/12/MD6/1	Agreed. The development of the RfF delivery plan is only one funding stream and TLPB recognises that we will need to align core budgets, for example around children with complex needs. This will be addressed through the planning cycle in advance of 2023/24.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	31.03.2023	31.03.2025	High	In progress	November 2024 Update - MOU has been drafted under the provisions of Part 9 of the Social Services and Wellbeing (Wales) Act 2014. • The MOU sets out the ambition of partners to develop a single Regional Partnership Agreement, which will be in place from April 2025 and reviewed annually, for delivery of services within the new community pathways set out in the ICCS. It has been agreed that a Section 33 Agreement is the appropriate vehicle for achieving this. The new RPA will supersede existing legally binding partnership agreements. September 2024 Update - The CTM Regional Partnership plays an essential role in shaping the health and social care system in Wales to respond to changing population need. Better continuity and coordination of care is particularly important in a society where more people are living longer, more people are living from birth with complex health conditions, and there is a significant interplay between physical and growing mental ill health. The development of a regional Memorandum of Understanding and Section 33 Agreement for our Integrated Community Care System provides us with a framework for integrated commissioning and pooled resourcing based on a shared understanding of demand and capacity opportunities and challenges. As we move to the formal agreement of these legal frameworks over the Autumn and Winter we anticipate closing this risk off in 6 months time. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - RfF budgets agreed for 2024/25. Programmes will be realigned in year in line with community pathways modelling.
Audit Wales/2022/12	01/08/2022	Transformational Leadership Programme Board – Baseline Governance Review – CTM Regional Partnership Board 2021-22_August 2022 (Document reference: 2934A2022)	Transformational Leadership Programme Board – Baseline Governance Review R7 Regional workforce planning Like many parts of the public sector, the region is experiencing significant workforce challenges. The TLPB needs to consider how it can facilitate a regional and strategic approach to addressing these challenges and to help it deliver its priorities"	Audit Wales/2022/12/MD7/1	Agreed. Regional workforce development arrangements exist through SCWDP Board workforce development group and work is underway to strengthen links with RPB and Health.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	31.03.2023	31.03.2025	High	In progress	November 2024 Update - Ongoing discussions to expand and strengthen the Social Care Workforce development group to better align with regional integrated pathways developments. September 2024 Update - Integrated Community Care System. We are taking a regional and strategic approach to the development of integrated community pathways. These pathways will be delivered by integrated teams based on a locality footprint. Program plan reviewed regularly by the Partnership Leadership Team and RPB governance. Whilst workforce challenges are an enduring feature of our sector, as we move to the formal agreement of underpinning legal frameworks for our ICCS over the Autumn and Winter we anticipate closing this risk off in 6 months time. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - Review of all RfF funded post has commenced to support urgent and emergency care pathways. As part of development work teams will be reviewed and aligned against the agreed pathways once agreed.
Audit Wales/2023/149	01/10/2023	Structured Assessment 2023 – CTMUHB 2023_October 2023 (Document reference: 3920A2023)	Structured Assessment 2023 R3 Enhancing transparency of committee business Draft committee meeting minutes are produced quickly and reviewed by the relevant chair; however, they are not made publicly available until the papers of the subsequent meeting are published. Furthermore, committee meetings are not livestreamed or recorded for public use. The Health Board, therefore, should consider putting appropriate arrangements in place to ensure the public have timelier access to records of committee meetings as part of its wider efforts to enhance transparency of Board business. (Medium Priority).	Audit Wales/2023/149/MD3/1	The Corporate Governance Team will be reviewing how it can further enhance transparency around its Board Committee Business e.g. sharing a summary of planned business on the website ahead of publication of papers, publishing shared listening and learning videos (linked to R2) etc.	Corporate Governance Director of Corporate Governance/Board Secretary	01.03.2024	30.09.2024	Medium	Fully complete (Awaiting approval)	November 2024 Update - COMPLETE - The Board approved the new approach to Board and Committee business at its formal Board meeting in September 2024. This outlined those Committees where the papers will be made available in public and those that remain closed. Where appropriate Shared Listening and Learning Stories will also be published on the website. Cycles of Business are also received at each Board and Committee meeting and available in the papers which are published on the Health Boards public facing website. Confirmed minutes are also now clearly published. September 2024 Update - The Effective Management of Board Business review which sets out the new approach for Board and Committee Business with effect from 1st January 2025 will be submitted to the Public Board meeting on the 26th September 2024. If approved the updated Terms of Reference and Cycles of Business will be shared on the public facing website which demonstrates the focus at Board and Committees on Shared Listening and Learning and the business which will be received through the Committee structure in 2025. July 2024 Update - this recommendation will be built into the programme of work being undertaken in relation to the Effective Management of Board Business Proposal which will be completed circa July 2024. There is a specific focus in this work on the commitment to openness and transparency. Listening and Learning stories received at the Public Board and Quality & Safety Committee meetings are now shared on the Health Boards website where appropriate to improve transparency.
Audit Wales/2023/149	01/10/2023	Structured Assessment 2023 – CTMUHB 2023_October 2023 (Document reference: 3920A2023)	Structured Assessment 2023 R6 Performance Management Framework The Health Board has appropriate arrangements in place to manage operational performance; however, it lacks a documented performance management framework. In order to enhance its arrangements further, the Health Board should prepare a written framework that clearly sets out roles, responsibilities, and frequency for reviewing performance at service, management, committee, and Board levels (High Priority).	Audit Wales/2023/149/MD6/1	The Health Board has developed a working version of the Performance Framework, however it does require updating to reflect the new organisational structure and the latest Welsh Government performance framework. This activity will be undertaken before 31st December 2023 and presented to the first meeting of the Planning, Performance & Finance Committee in 2024 (currently scheduled for the 27 February 2024), for approval.	Performance Director of Strategy & Transformation (Performance Framework) Chief Operating Officer (Operational Performance) Director of Digital (Performance Information)	01.02.2024	01.02.2024	High	Overdue	November 2024 Update - The performance structure for the IMTP is set out in the reports provided to board. The formal framework document is under review. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - A session is being planned with the Executive Team in April to develop the next stage of the framework. 6 month extension requested. February 2024 Update - This activity will be undertaken before 31st December 2023 and presented to the first meeting of the Planning, Performance & Finance Committee in 2024 (currently scheduled for the 27th February 2024), for approval.
Audit Wales/2023/150	01/11/2023	CONFIDENTIAL Audit of Accounts Report Addendum – CTMUHB 2022-23_November 2023 (Document reference: 3727A2023)	Audit of Accounts Addendum 2022/2023 R3 The Health Board should ensure that its primary-care working papers are clearly cross referenced to the relevant figures within the financial statements. The Health Board should also ensure that, where spreadsheets are the underlying evidence base, all cell values have an appropriate audit trail (typically formula based) and that manually entered figures are used sparingly, when they are the only valid option.	Audit Wales/2023/150/MD3/1	There were changes to the staff preparing the primary care working papers at the end of the financial year, therefore some working papers provided were incorrect at the draft stage. However there was an improvement in the timeliness of providing working papers on the Audit system compared to previous years. The audit team were subsequently able to meet with the team who prepare the primary care figures and agree the figures for the final accounts. The financial accounting team will liaise with the finance officers completing the working papers for primary care to ensure the latest working papers are provided with clear links to information included in the annual accounts.	Finance Executive Director of Finance	01.04.2024	01.04.2024	High	Partially complete (Overdue)	November 2024 Update - Financial Accounts are liaising with the accounting officers responsible for Primary Care to agree mapping of codes to allow full reconciliation to returns. This will be implemented in readiness for the closeout of the 2024/25 accounts. October 2024 Update - Matter arising 3 added back to the Tracker as at October 2024. Audit Wales advised at the Audit & Risk Committee on 17th October 2024 that this remains open noting "...While improvements have been made in this area, we still experienced some difficulty in agreeing the payables accrual for prescribed drugs and appliances. We are aware that there were extenuating circumstances around this issue, relating to loss of key staff and new officers coming on board. We will therefore review this area again during the 2024-25 audit. May 2024 Update - The accounts and WP are now complete, where applicable working papers include links and not hard coded figures. March 2024 Update - This will be actioned for the year end accounts, so will be in place for submission at the beginning of May.
Audit Wales/2023/150	01/11/2023	CONFIDENTIAL Audit of Accounts Report Addendum – CTMUHB 2022-23_November 2023 (Document reference: 3727A2023)	Audit of Accounts Addendum 2022/2023 R5 The Health Board should put arrangements in place to regularly review all the access rights to the Retinue system, to ensure that they are accurate and remain appropriate. Also, the Health Board should obtain formal confirmation from Retinue that it has reviewed its Disaster Recovery Plan and is satisfied that it remains robust. As part of this process the Health Board should also obtain a summary of all changes to the Plan. This confirmation should be obtained at least annually.	Audit Wales/2023/150/MD5/1	The user with inappropriate access was due to an admin error by a member of the Retinue Team. A form has been developed for departments to fill in for anyone with Bridge access. We undertook a review of users when this was highlighted and have scheduled reviews on a bi monthly basis. A new disaster plan has been communicated to Retinue Director and we expect an up to date version jan 2024.	Finance Executive Director of Finance	01.11.2023	01.11.2023	High	Fully complete (Awaiting approval)	February 2024 Update - An update has not been provided against this recommendation on this occasion. New recommendation so no previous updates. November 2024 Update - In terms of the recommendations, below are the actions that are being undertaken: 1. Review of all user access within the systems with the care groups. Implementation of a new/change of user access form for all changes after the review and update of users. Please see emails and current form, although we will be reviewing the form details as well. 2. Disaster Recovery test and evaluation of the plan is to be undertaken during August 24 and results to be sent to the HB. Further testing and review is scheduled for January 25. October 2024 Update - Matter arising 5 added back to the Tracker as at October 2024. Audit Wales advised at the Audit & Risk Committee on 17th October 2024 that this remains open noting "...As part of the 2023-24 audit we have not seen any evidence to suggest that these recommendations have been implemented: i.e. No evidence to confirm that regular checks of user access rights have occurred, to ensure that users have the appropriate levels of access in accordance with their roles And we have not seen an updated disaster recovery plan, or evidence that the Health Board has received one. We will therefore follow up again at our 2024-25 audit....". May 2024 Update - Confirmation from Clare Butcher that new disaster plan has been developed and new user form implemented.
Audit Wales/2023/150	01/11/2023	CONFIDENTIAL Audit of Accounts Report Addendum – CTMUHB 2022-23_November 2023 (Document reference: 3727A2023)	Audit of Accounts Addendum 2022/2023 R7 The Health Board should regularly check its 'Active Users' report to ensure that all live users are set up with the correct access rights, and that any leavers' access has been removed by Digital Health and Care Wales (ie. where requested by the Health Board). Also, the Health Board should document its review of the Welshly 'Inactive Users' report to determine whether any inactive user accounts need to be closed or suspended.	Audit Wales/2023/150/MD7/1	System managers will ensure regular reviews are undertaken	Finance Executive Director of Finance	01.11.2023	01.11.2023	High	Fully complete (Awaiting approval)	November 2024 Update - Evidence has been provided by CT of inactive users being reviewed and removed. October 2024 Update - Matter arising 7 added back to the Tracker as at October 2024. Audit Wales advised at the Audit & Risk Committee on 17th October 2024 that this remains open noting "...As part of the 2023-24 audit we have been provided with verbal assurance that checks are being made, but the checks are not documented. Officers informed us that they will document monthly checks on user access rights and inactive users, which we will follow-up on as part of the 2024-25 Audit. March 2024 Update - This will be an ongoing action which is now in place.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Reference Number	Action	Executive / Inspection Lead	Original Due Date	Current Due Date	Action Rating	Progress Status	Comments/Updates
Audit Wales/2023/150	01/11/2023	CONFIDENTIAL Audit of Accounts Report Addendum – CTMUHB 2022-23_November 2023 (Document reference: 3727A2023)	Audit of Accounts Addendum 2022/2023 R9 The Health Board should document its review of the Healthroster super-user report.	Audit Wales/2023/150/MD9/1	The Health Board will now document its review of the Healthroster super-user report	Finance Executive Director of Finance	01.11.2023	01.11.2023	High	Fully complete (Awaiting approval)	November 2024 Update - CD (E Rostering Lead) provided response "When we met with Welsh Audit the beginning of this financial year it was agreed that we would update the attached document each month with the list of Active Super Users within CTM For Health Roster." - evidence was provided to show completed. October 2024 Update - Matter arising 9 added back to the Tracker as at October 2024. Audit Wales advised at the Audit & Risk Committee on 17th October 2024 that this remains open noting "...At the time of the audit, the Health Board was still not documenting the reviews that were being undertaken, and an approach was agreed with officers that would be implemented immediately. We will therefore review as part of our 2024-25 audit. March 2024 Update - This is an ongoing action that has been agreed to be undertaken.
Audit Wales/2023/18	01/02/2023	Structured Assessment 2022 – CTMUHB 2022_February 2023 (Document reference: 3313A2023)	Structured Assessment 2022 R1 Improving administrative governance arrangements We found opportunities for the Health Board to improve its administrative governance arrangements to enhance public transparency and support Board and committee effectiveness. The Health Board, therefore, should: a) publish the agendas of private Board and committee meetings; b) publish the papers for all public Board, committee, and advisory meetings on its website in a timely manner; c) update report cover sheets to enable authors to better link their reports to the requirements of the Well-being of Future Generations (Wales) Act 2015; and d) update presentation cover sheets to enable authors to summarise the information sufficiently and capture the relevant risks and issues.	Audit Wales/2023/18/MD2/1	a) In the exceptional circumstances where the Health Board is required to hold a Private Board meeting or Board Committee it will endeavour to highlight the agenda items covered on the Public Agenda for transparency. b) Due to capacity constraints within the Corporate Governance Function it is accepted that the timely publishing of papers maybe impacted. Discussions are underway with the Web Development Team to consider if they can provide interim support over the next 3-6 months. c) Cover reports will be reviewed to incorporate requirements of the WBFG Wales Act. d) Presentation cover sheets to be reviewed to ensure authors sufficiently reflect key risks and issues.	Corporate Governance Director of Corporate Governance/Board Secretary	30.10.2023	30.09.2024	High	Fully complete (Awaiting approval)	November 2024 Update - COMPLETE - The Board approved the new approach to Board and Committee business at its formal Board meeting in September 2024. This outlined those Committees where the papers will be made available in public and those that remain closed and the Board approved a variation to its standing orders in this regard. September 2024 - The Effective Management of Board Business review which sets out the new approach for Board and Committee Business with effect from 1st January 2025 will be submitted to the Public Board meeting on the 26th September 2024. If approved this will set out that all Meetings will be published with the exception of those held in closed session and Remuneration & Terms of Service Committee, Organ Donation Sub Committee, Provision of Discharge Sub Committee, Clinical Advisory Group and Local Partnership Forum. July 2024 Update - As reported in May 2024 - Actions a, c and d are completed. Action B update is that as part of the Effective Management of Board Business review underway consideration will be given to the publication of papers received at the Advisory Groups and Sub Committees of the Board. Benchmarking has been done but it is difficult as not all Health Boards are operating the same Advisory Groups or Sub Committee meetings. The Health Board is also introducing two new Sub Committees which need to be taken into consideration. It is therefore proposed that recommendations in this regard are captured in the submission to Board in September for Approval.
Audit Wales/2023/18	01/02/2023	Structured Assessment 2022 – CTMUHB 2022_February 2023 (Document reference: 3313A2023)	Structured Assessment 2022 R3 Strengthening performance management arrangements The Health Board has a number of longstanding performance challenges across many areas in both planned care and urgent and emergency care, resulting in it being escalated to enhanced monitoring from routine arrangements under Welsh Government's Escalation and Intervention Arrangements. The Health Board, therefore, should ensure its performance management and reporting arrangements are appropriately focused on the key challenges it faces in both planned care and urgent and emergency care, especially where performance in those areas is comparatively worse than other Health Boards in Wales.	Audit Wales/2023/18/MD3/1	The Health Board continues to work to improve the Integrated Performance Reporting to the Board. The lay out, content and specifically the narrative throughout the report to Board is constantly being refined and updated to ensure the Board has the right information at the right time. In addition steps have been taken to ensure that the Board Committees receive the performance information relevant to their remit. However the Health Board recognises that given the nature of its business and its complexities that this remains a very large report and it can be challenging to identify the most significant issues. The Health Board is holding a workshop with Board Members in Spring 2023 to develop an approach that enables a greater visibility of the most important indicators whilst still presenting all other metrics in a timely fashion for openness and accountability. Whilst creating opportunities for members to select the "most important indicators" will enable the Board to align measures to strategic priorities etc, the Executive Leads will also draw the Board's attention to areas of concern and/or where performance is comparatively worse than other Health Boards in Wales.	Performance Executive Director of Strategy & Transformation (Performance Framework) Chief Operating Officer (Operational Performance) Director of Digital (Performance Information)	30.09.2023	31.12.2023	High	Overdue	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - A session is being planned with the Executive Team in April to develop the next stage of the framework. 6 month extension requested.
Audit Wales/2023/18	01/02/2023	Structured Assessment 2022 – CTMUHB 2022_February 2023 (Document reference: 3313A2023)	Structured Assessment 2022 R4 Establishing measurable outcomes for strategic priorities Whilst the Health Board has made positive progress in developing a long-term vision, strategic goals, and strategic priorities for the organisation, the new strategy (CTM 2030) lacks clear and measurable outcomes. The Health Board, therefore, should seek to articulate outcomes for each strategic priority, what success would look like, and how it will measure and report progress. In doing so, it should consider the relationship between the goals of the Population Health Strategy and the wider strategic goals and public health 'life course' approach set out in CTM 2030.	Audit Wales/2023/18/MD4/1	We agree that this work needs to progress. The ongoing work of the Strategy Groups and the CTM 2030 steering group is to set out clearly the measurable improvements to be delivered. Most of these relate to pre-existing measures set out in the Quadruple Aims. Each lead for a "strategy chapter" are responsible for identifying the measurable outcomes for their "chapter". In addition, work has already commenced to align the strategy group work to the goals and measures set out within the Population Health Management plan. We will continue to work to ensure that the thread between these aspects is more visible.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation (Performance Framework)	01.09.2023	01.09.2023	High	Fully complete (Awaiting approval)	November 2024 Update - This actions is proposed for closure. Strategy groups have identified high level outcome measures and work is also aligned against population health outcome measures. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - Workforce a key workstream within the urgent and emergency care pathway development programme.
Audit Wales/2023/18	01/02/2023	Structured Assessment 2022 – CTMUHB 2022_February 2023 (Document reference: 3313A2023)	Structured Assessment 2022 R9 Maximising the benefits of digital technologies and solutions There is limited capacity within the Health Board to fully deliver its digital transformation agenda. The Health Board, therefore, should seek to set out in its refreshed Digital Strategy how it intends to overcome staffing and funding challenges to fully exploit the benefits offered by digital technologies and solutions.	Audit Wales/2023/18/MD5/1	The themes identified in the existing Digital Strategy continue to be aligned to the NHS Wales Digital Strategy and are embedded and will continue to evolve with the CTM2030 strategy in relation to digital activity. The Health Board has performed an analysis and identified a minimum set of resources (staff and capital/revenue) required over the next 3 years. Aligned to this work, during 2022 the Health Board completed a functional map of services required from a Digital and Data perspective. The next stage in the process is to align staffing resources to the functions, which will be achieved by following organisational change process. For significant Digital and Data changes (i.e. projects/programmes) the Health Board has developed a process of creating business cases to support service transformation. These business cases indicate the resources (staffing & Infrastructure) required to implement service change and ensure ongoing provision of support services to sustain change. The Health Board is committed to adopting all National Digital developments, where appropriate, and has invested heavily in the deployment of these products across the Health Board. The current strategy is to continue to operate in this manner and ensure it maximises resources efficiently and effectively.	Digital Director of Digital (Performance Information)	31.12.2023	31.12.2023	High	Fully complete (Awaiting approval)	November 2024 Update - The submission of the 3 year IMTP plan will include the Digital & Data Strategic Delivery Plan. This will entail landing existing national programmes, local tactical system deployments and the development of our roadmap for a Modular EPR. Propose to close this audit action - the Digital & Data Strategic Delivery Plan will be monitored by the new Committee Structure - Operational Delivery & Strategic Development. September 2024 Update - An outline case for the next steps in the digital journey was supported at the Board meeting in July. We have been asked to develop a business case to procure a strategic partner for the development of a Modular EPR. July 2024 Update - Digital and the UHB have made a significant investment into developing and increasing the Digital Senior Leadership Team (SLT). This has included developing a cyber security team to face the ever present cyber challenges. An expanded Information Governance team, improving our IG response, as well as Digital Clinical resources, supporting the large number of clinical systems we have. We have also been seen the successful approval of the ePMA business case, this will bring much needed digital transformation to medicine prescribing and well as further increasing our Digital capacity. We also undertook a Board development session in March 2024 to develop a greater awareness and identify potential approaches to Digital Transformation coalescing around a proposed way forward to developing a modular EPR approach. Thinking on this will be furthered in a Board meeting in July 2024."
Audit Wales/2023/18	01/02/2023	Structured Assessment 2022 – CTMUHB 2022_February 2023 (Document reference: 3313A2023)	Structured Assessment 2022 R5 We found opportunities for the Health Board to enhance its arrangements for monitoring the delivery of corporate plans and strategies, and reporting progress to the Board. The Health Board, therefore, should enhance its arrangements by ensuring: a) plans and strategies contain clear summaries of key actions / deliverables, timescales, and measures to support effective monitoring and reporting; b) plans and strategies provide greater detail on which Executive Directors are responsible for the delivery of key actions / deliverables to enable appropriate accountability; and c) reports are aligned to performance reports to enable the Board to assess the extent to which the implementation of key actions / deliverables is having a positive impact on Health Board performance.	Audit Wales/2023/18/MD6/1	a) All plans and strategies will contain an executive summary setting out this information. As set out above, work is ongoing around outcome measures. b) Executive Directors are clear on their responsibilities for delivery so we will ensure this is more visible. c) Reports will be reviewed to ensure they provide the Board with sufficient information to assess the impact of implementation of key actions and deliverables on the Health Board's Performance.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation Director of Digital	30.06.2023	30.06.2023	High	Fully complete (Awaiting approval)	November 2024 Update - By way of follow up to the October 2023 update, parts a, b and c of this action are considered completed and this action is therefore proposed for closure. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - Added back onto the Tracker December 2023. No update has been received on this recommendation. October 2023 Update - a) Recommendation understood and is an ongoing action. The recommended action will be included in all appropriate documents moving forward. Action complete, b) Action complete, c) Recommendation understood and is an ongoing action. The ability to complete this action will be supported by the launch of the revised integrated performance management framework in September 2023. Action complete.
Audit Wales/2023/18	01/02/2023	Structured Assessment 2022 – CTMUHB 2022_February 2023 (Document reference: 3313A2023)	Structured Assessment 2022 R7 Structured Assessment 2022 R7: Whilst the Health Board's financial control procedures are generally effective, we identified opportunities to strengthen some controls and update the information available on the Health Board's website. The Health Board should: a) review the delegated upper financial limit for the Chief Executive; b) ensure there is a clear process in place for the Board to review and approve capital programmes and projects; and c) ensure out-of-date financial control procedures are removed from its website and replaced with the current versions - NOT COMPLETED	Audit Wales/2023/18/MD7/1	a) The Health Board will undertake a review of the Chief Executives upper financial limit. This will form part of the review of the Health Board's Standing Financial Instructions being led by the Head of Corporate Finance. b) Capital approvals are managed through the Executive Capital Management Group (ECMG) which meets monthly and approves all new schemes and adjustments to approved capital schemes. ECMG is chaired by the Director of Finance and the Director of Strategy and Transformation and Chief Operating Officer are also members. Since the removal of the Capital Programme Board the reporting for the capital programme and all business cases are reported through Planning, Performance and Finance Board Committee prior to being reported at the Board. It is proposed that quarterly capital reporting is reinstated through Planning, Performance & Finance (PPF) Committee and to the Board to cover updates on the capital programme and major projects. Business case over £1M will be brought through the PPF and Board Agenda prior to approval to Welsh Government dependent on project progression and Board Agendas. c) A review of all the outdated Financial Control Procedures is underway.	Finance Executive Director of Finance	31.12.2023	31.12.2024	High	Partially complete	November 2024 Update - A number of FCPs have been reviewed and approved by Audit & Risk Committee, including recently Medical Variable Pay and Charitable Funds. All other outstanding FCPs are currently updated and out for review with applicable officers. These will require formal review by finance and other relevant staff before being taken to December's Audit & Risk Committee. We anticipate the majority will be updated by end of year, but there may be a small number that require further review. September 2024 Update - c) 4 FCPs were updated at the August ARC and further FCPs will be reviewed and updated to go to the October ARC. July 2024 Update - A number of FCPs are being brought to August ARC as part of first tranche of updating the FCPs, all others are in line for update by the updated completion date of December 2024.
Audit Wales/2023/23	01/03/2023	Orthopaedic Services in Wales – Tackling the Waiting List Backlog Report of the Auditor General for Wales_March 2023	Review of Orthopaedic Services R3 The Getting it Right First Time reports set out clearly a range of recommendations which will help drive improvements in efficiencies and productivity in orthopaedics at a local level. We recommend that health boards need to: a) ensure they maintain oversight and scrutiny of implementation of the Getting it Right First Time recommendations as part of their governance arrangements; and b) ensure that clear action plans are in place to address the things that get in the way of improvement.	Audit Wales/2023/23/MD3/1	The Health Board will undertake the following in order to maintain oversight and scrutiny and ensure action plans are in place: • Ensure that prehab services are improved by setting up a Prehabilitation Service to ensure patients are medically optimised for surgery. Both digital and face to face options to be considered. • The GIRFT implementation will be included in the reconfiguration programme and updated through the Improving Care Board • Increase the capture of PREMs and PROMs data, digitally captured via MyMobility and through the HB website wherever possible. RGH does not have a system for PROMS or PREMS. Old CTM PCH only had funding and support from Clinical Audit and no funding or support was agreed by the HB. Would need a commitment to roll out MyMobility HB wide • Improve rehabilitation pathways with increased Therapies support. The HB is looking at centralising Trauma and Elective surgery and ensuring the appropriate services are available on these sites. • Implement an Orthogeriatric Service on both trauma sites to ensure management of patient pathways and rehabilitation needs. There will be a focus on early discharges from acute sites. This timing of this will depend upon funding availability. • Introduce a FLS service to prevent repeat fractures – timing will depend upon funding. • Actively consider the provision of a seven day service including Therapies service to ensure earlier discharges and increased throughput. • Consider seven day Theatre working when possible (longer term aim). • Increase clinician engagement • Updated GIRFT action plan to be created with new CD and monitored through the reconfiguration programme. • Weekly Orthopaedic Reconfiguration Group ongoing. All key stakeholders are fully involved.	Planned Care Chief Operating Officer	01.05.2023	01.05.2023	High	Overdue	November 2024 Update - Running "Perfect Month", Reduced LOS for Elective to 1.03 days, Running 4 cases on all day list. Condensed trauma take. Will review before changing, permanently. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 - An update has not been provided against this recommendation on this occasion. October 2023 Update - Work continues in this area as part of the Planned Care Programme and other projects. In particular, the Prehabilitation Service has just been launched and monitoring of the GIRFT work is continuing. The UHB has paused work on the Orthopaedic Reconfiguration paused and is being reviewed alongside the launch of the CTMLUHB Clinical Strategy and alignment to the emerging UHB strategy. Further updates will be available in forthcoming meetings.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Reference Number	Action	Executive / Inspection Lead	Original Due Date	Current Due Date	Action Rating	Progress Status	Comments/Updates
Audit Wales/2023/23	01/03/2023	Orthopaedic Services In Wales – Tackling the Waiting List Backlog Report of the Auditor General for Wales, March 2023	Review of Orthopaedic Services R4 Clinical Musculoskeletal Assessment and Triage Services (CMATS) are having a positive impact on managing demand and providing support. But services are struggling with capacity and are inconsistent in their delivery with examples of duplication of effort where First Contact Practitioners (FCPs) exist. We recommend that health boards need to: a) ensure that local CMATS are appropriately staffed, and at a minimum, reflect previous Welsh Government guidance; and b) ensure that where First Contact Practitioners (FCP) exist, there are clear pathways between FCPs and CMATS to reduce duplication and minimise waits.	Audit Wales/2023/23/MD3/1	The Health Board will undertake the following in order to ensure the recommendations are achieved: • The Facility of a small CMATS team was recognised within physiotherapy. Since the merger with Bridgend the UHB has invested training and development into the band 7 clinical specialist team in order to increase the number of staff working at the advanced practice level, to meet the demand across CTM. • In PCH, CMATS is undertaken via digital referrals (started April 22). Referrals are received centrally and then pooled out within sub specialities, Nurse led, Consultant led and ANPs. • A full workforce and demand and capacity analysis is being undertaken through the regional and local reconfiguration work • The UHB now has FCP clinicians across all GP clusters except Merthyr Cynon and there are clear pathways in place for patients to transition from primary care into secondary care. The clinicians working within the primary care settings are working at advanced practice level.	Planned Care Chief Operating Officer	01.01.2024	01.01.2024	High	Overdue	November 2024 Update - Based on these recommendations and feedback from local stakeholders we have integrated the CMATS service into core services to give greater sustainability and clear pathways for both referrers and patients - with all orthopaedic referrals now being triaged electronically (since October 2022 for old CTM) by a multidisciplinary team which has resulted in reduced time to triage, increased redirection to AHPs (principle of only do what you can only do) and increase in advance and guidance utilised alongside the launch of health pathways. Please note the MCAS service remains under an SLA with SBHUB this the picture for Bridgend is different. Clinicians working within the primary care settings are still working at advanced practice level until 31st March 2025 as per current funding arrangement. Each cluster is currently deciding whether they'd like to continue with their FCP provision into the new financial year. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - An update has not been provided against this recommendation on this occasion. October 2023 Update - Work continues across these areas and a specific update will be available at the next meeting. August 2023 Update - An update has not been provided against this recommendation on this occasion.
Audit Wales/2023/23	01/03/2023	Orthopaedic Services In Wales – Tackling the Waiting List Backlog Report of the Auditor General for Wales, March 2023	Review of Orthopaedic Services R5 There needs to be a greater focus on outcomes across health boards and while people are deteriorating on orthopaedic waiting lists, limited progress has been made by health boards to provide ongoing support and monitor and report harms. We recommend that health boards need to: a) ensure that Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS) are fully rolled out in all orthopaedic services and used to inform decision making both at a service and patient level; b) ensure that local clinical leadership arrangements and performance information are used to identify opportunities for minimising interventions that are unlikely to result in improved outcomes; and c) put arrangements in place to monitor people waiting, provide communication, support and advice when needed, and report openly and honestly, through their existing governance arrangements, the extent to which people are coming to harm whilst waiting for orthopaedic treatment.	Audit Wales/2023/23/MD4/1	The Health Board will undertake the following in order to ensure the recommendations are achieved: • Within POWH, PREMS and PROMs data is currently being captured electronically for all arthroplasty patients and utilising the MyMobility applications AI system, patients with anticipated poorer outcomes are having enhanced Therapies input digitally. There is at present no system for PROMS or PREMS within the “old CT” part of the UHB, with PCH having some help from Clinical Audit. Changes would require a commitment to roll out MyMobility HB wide. • Within POWH, all Arthroplasty patients are enrolled on the MyMobility application to provide prehab for all patients awaiting surgery to try and minimise the harm caused by delays and ensure patients are medically optimised. There is at present no system for PROMS or PREMS within the “old CT” part of the UHB, with PCH having some help from Clinical Audit. Changes would require a commitment to roll out MyMobility HB wide. • Single Clinical Director Leadership required to establish performance structure and review of current services. • Weekly performance reviews that monitor waiting list volumes and actions being taken to address and recover the position • Action plan development with singe CD for performance and governance structure across CTMUHB.	Planned Care Chief Operating Officer	01.04.2024	01.04.2024	High	Overdue	November 2024 Update - CTMUHB is making significant progress in embedding VBHC principles in healthcare delivery. Collection and use of PROMs is key to delivering value based care to inform decision making. Significant progress has been made to secure a new digital PROMs platform which was launched July 2024. Need to establish a baseline status of PROM collection across the Health Board. This will inform on further discussion on Care group priority areas and implementation plans. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion.
Audit Wales/2024/168	01.02.2024	Review of Workforce Planning Arrangements – Cwm Taf Morgannwg University Health Board (Document reference: 4157A2024)	To address the absence of clear workforce plans, the Health Board should prepare sustainable and balanced short-, medium-, and long-term workforce plans with measurable goals and clear timelines aligned to the CTM2030 Strategy. As part of this, the Health Board should ensure that its intent to reconfigure services focusing more on prevention, population health, and digitally enabled health services is appropriately built into long term service workforce design and transformation plans.	Audit Wales/2024/168/MD1/1	Work has begun on the development of the CTM SWP, approach underpinned by the KPMG action plan, next steps are:- • Using workforce data and wider information to develop high level workforce plans by staff group to enable the development of short, medium and long-term goals, with action plans, aligned to CTM 2030, in partnership with key stakeholders. Build into the plans:- • Agreed priorities aligned to the Acute Clinical Services Plan • To agree SWP actions for Llantrisant Health Park • Identify opportunities from regional working and other programmes e.g. Accelerated Cluster Working, Six Goals, HEIW workforce Plans	People Executive Director for People	01.03.2025	01.03.2025	High	In progress	November 2024 Update - Short term workforce plans are developed in CDs with Heads of People. Medium and longer term plans are aligned to Regional working, ACP and LHP. The latter are in progress but not fully developed to establish the medium and long term plans. The workforce shape and supply group is looking at the supply pipelines and where there are gaps. Service plans aligned to the IMTP are in development and will help to shape the workforce demand for the different staff groups, and any potential risks/gaps. Additionally, these will inform the education commissioning, internal education and supervision requirements. The IMTP Education Commissioning first draft to be submitted in Jan 2025. The next meeting of the Workforce Shape and Supply is in December 2024 focussing on the recruitment, retention, education and development of new roles. September 2024 Update - The first meeting of the MDT Shape and Supply Steering Group took place on 4th July. The outcome of the meeting was a workshop with key stakeholders to agree task and finish groups and objectives. This took place on 15th August and the outcomes are to be discussed at the next meeting on 3rd October. The aims of the group are to develop a collective visual of our supply pipelines across all staff groups, e.g. recruitment, student streamlining, training and development and new roles etc. This will enable us to understand our current gaps. Work is also being undertaken to review the Workforce risks on the Risk Register and developing baseline data to support ACP. July 2024 Update - aligned to the actions in 26-30 below to develop the high level plans. Shape and Supply Group developed in July 2024 to discuss and plan to identify key supply pipelines, timescales and numbers across staff groups.
Audit Wales/2024/168	01.02.2024	Review of Workforce Planning Arrangements – Cwm Taf Morgannwg University Health Board (Document reference: 4157A2024)	The Health Board should assess and agree its funded workforce establishment for 2024-25 and then introduce arrangements to update this annually.	Audit Wales/2024/168/MD1/1	• Annual budget setting with Care Groups in place with alignment to Heads of People. • Establishment Control options appraisal underway to consider and agree preferred option to progress.	People Executive Director for People	01.05.2024	01.05.2024	High	Overdue	November 2024 Update - Alignment of finance and workforce data is being finalised for discussions to test the feeds in December 2024. September 2024 Update - Work continues as set out in the July update. Some delays have been incurred due to data errors and system challenges. However, engagement with key stakeholders across People, Finance and medical colleagues has been positive to enable the work once the data and system challenges are addressed. At this point, we are still aiming for the November deadline. July 2024 Update - work still underway with Data/Digital, People and Finance to align ledger with ESR staff in post to identify baseline establishment information. It is anticipated this is will be available early August to inform action plans. Agreed to review medical workforce establishments by November 2024.
Audit Wales/2024/168	01.02.2024	Review of Workforce Planning Arrangements – Cwm Taf Morgannwg University Health Board (Document reference: 4157A2024)	The Health Board should review its operational workforce planning capacity and capability and then ensure it is sufficient to support their operational workforce planning requirements within the new Care Group model.	Audit Wales/2024/168/MD3/1	• Develop SWP skills within People Directorate to promote into the organisation. • Working with Care Groups and Heads of People, assess current SWP capacity and capability. • Explore opportunities to embed SWP methodology in CTM Leadership Development programmes. • Develop workforce planning materials and toolkits to support workforce planning delivery.	People Executive Director for People	01.09.2024	01.09.2024	High	Overdue	November 2024 Update - This action has been slightly delayed due to work needed to support the POW critical incident but will be a priority over the next 2 months. September 2024 Update - Working closely with Heads of People to support the role out of SWP training. An assessment of needs across the organisation is in development and discussions with L&D around SWP training being delivered as part of the Leadership Development Programme are taking place to include once the programme is launched. July 2024 Update - SWP training being reviewed for Care Groups and opportunities to align to Leadership Development Programmes. Resources in development.
Audit Wales/2024/168	01.02.2024	Review of Workforce Planning Arrangements – Cwm Taf Morgannwg University Health Board (Document reference: 4157A2024)	To help determine the extent that the action it is taking to mitigate workforce risks is having an impact, the Health Board should set trajectories and timescales to meet their target risk ratings and more clearly assess the impact of the actions that it is taking.	Audit Wales/2024/168/MD4/1	• Develop a workforce baseline assessment based on risk linked to the UHB risk register to identify key workforce priority areas. • Agree actions, targets and trajectories for improvement with outcome measures. • Agree reporting arrangements and monitor progress (including escalations and improvements) through quarterly reviews of the risk register and at Inspiring People Board to assess any impact of the SWP actions on managing risks.	People Executive Director for People	01.10.2024	01.10.2024	High	Overdue	November 2024 Update - The assessment is in development using the work of the BAF and risk register to inform the workforce risks. This is taking longer due to a number of challenges around data and capacity but is hoped to be in draft by February 2025. September 2024 Update - The risk score for risk 3 of the BAF has been reviewed in accordance with the Risk Domains/ Scoring Matrix, as the original risk score may have been overstated as a 15. The workforce risk remains significant but this reduction places the risk score more appropriately within the risk domains at 14. The risks associated remain high and significant workforce planning work is taking place to reduce the score. Evidence of a reduction in turnover and sickness has been recorded but it too early to say that this is related to any particular action taken but will continue to be monitored. July 2024 Update - Update on SWP at People and Culture on 7 August 2024 using the BAF risk 3 Sufficient workforce to deliver the activity and quality ambitions of the organisation to identify priorities and agree actions for next steps.
Audit Wales/2024/168	01.02.2024	Review of Workforce Planning Arrangements – Cwm Taf Morgannwg University Health Board (Document reference: 4157A2024)	The Health Board needs to reinforce arrangements to both oversee progress and then assess the impact of the recommendations set out in the recent strategic workforce planning review via its People and Culture Committee.	Audit Wales/2024/168/MD5/1	• Assessment of progress and impact of recommendations to be on the agenda for PCC June 2024. • Regular progress updates to the relevant Board Committee.	People Executive Director for People	01.06.2024	01.06.2024	High	Overdue	November 2024 Update - Workforce Planning updates have taken place at PCC and updates will be provided to the new replacement Group and relevant Committees. This is on target. September 2024 Update - An significant SWP update was provided to PCC on 7 August 2024. A progress update will be reported at the next PCC in November 2024. July 2024 Update - Update on SWP at People and Culture on 7 August 2024 using the BAF risk 3 Sufficient workforce to deliver the activity and quality ambitions of the organisation to identify priorities and agree actions for next steps. May 2024 Update - Provide update to PCC in June 2024 and update to Board in July 2024.
Audit Wales/2024/168	01.02.2024	Review of Workforce Planning Arrangements – Cwm Taf Morgannwg University Health Board (Document reference: 4157A2024)	To inform the development of its medium-term plans for workforce redesign and service transformation, the Health Board should use its workforce benchmarking to adopt best workforce practice and workforce models, ensuring similar system conditions, demographics, and population characteristics.	Audit Wales/2024/168/MD6/1	• Development of a horizon scan to support strategic workforce planning and to inform potential changes and/or impact to people/population/services which include: – Census analysis – Population Needs Assessments – Evidenced based practice – Use the benchmarking data and information e.g. HEIW People analytics tools and dashboards/NHS England and wider sources – Case studies and lessons learned – Changes to Policies/Standards, education and training – New roles, advanced and extended practice – Labour market changes and generational changes As part of an overall appraisal in the quality, safety, and patient experience within emergency care services across the HB, the USCG is preparing a report/presentation for the Quality and Safety Committee this financial year.	People Executive Director for People	01.10.2024	01.10.2024	Medium	Overdue	November 2024 Update - The horizon scan is in draft and is anticipated to be finalised in January 2025. September 2024 Update - A draft horizon scan is in development to be ready for October 2024 linked to the work developed by HEIW. July 2024 Update - Plans in place to develop the horizon scan and in progress.
Audit Wales/2024/196	01.07.2024	Follow up review: Temporary Closure of the Ysbyty Cwm Cynon Minor Injuries Unit – Cwm Taf Morgannwg University Health Board (Document reference: 4361A2024)	R4. Enhancing Quality and Safety Committee oversight - Our work has found that despite the full initial disclosure to the Quality and Safety Committee in September 2021, there was no further reporting on any assessment of potential harm, and lessons learned. The Health Board, therefore, should provide an update report to the committee outlining the lessons learned, and confirmation of any outcomes from the work to assess harm.	Audit Wales/2024/196/MD1/1	As part of an overall appraisal in the quality, safety, and patient experience within emergency care services across the HB, the USCG is preparing a report/presentation for the Quality and Safety Committee this financial year.	Patient Care and Safety Executive Director of Nursing/Deputy Chief Executive	31.03.2023	31.01.2025	High	In progress	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - An update will be included as part of the USC Quality and Safety Committee report in November 2024 outlining the lessons learned from the temporary MIU closure and confirmation of any outcomes from the work to assess harm. August 2024 Audit Wales Update - R4 is considered ongoing.
Audit Wales/2024/196	01.07.2024	Follow up review: Temporary Closure of the Ysbyty Cwm Cynon Minor Injuries Unit – Cwm Taf Morgannwg University Health Board (Document reference: 4361A2024)	R4. Enhancing Quality and Safety Committee oversight - Our work has found that despite the full initial disclosure to the Quality and Safety Committee in September 2021, there was no further reporting on any assessment of potential harm, and lessons learned. The Health Board, therefore, should provide an update report to the committee outlining the lessons learned, and confirmation of any outcomes from the work to assess harm.	Audit Wales/2024/196/MD1/2	Furthermore, as part of the ongoing service delivery reviews within the newly established care group model, the USCG will seek to provide a report to the Quality and Safety Committee in full on the Minor Injury Service provision across the HB early in 2023/24.		31.05.2023	31.01.2025	High	In progress	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - A spotlight report on MIU services was provided earlier in the year. Further updates will be included in early 2025. A full review of the MIU service provision across the HB will include an update on some of the future plans relating to Maesteg Hospital. This report will be available for Quality & Safety Committee in early 2025.
Audit Wales/2024/205	01.08.2024	CONFIDENTIAL Audit of Accounts Report Addendum - CTMUHB 2023-24, October 2024 (Document reference: 4395A2024)	Matter arising 1 - While we accepted the use of the additional narrative for the 2023-24 remuneration report, from 2024-25 the Health Board should report the gross total remuneration within the relevant tabulated figures.	Audit Wales/2024/205/MD1/1	Adjusted figures will be used for the 2024/25 accounts.	Finance Executive Director of Finance	30.04.2025	30.04.2025	High	In progress	November 2024 Update - No update as this will be implemented on completion of 2024/25 accounts in April.
Audit Wales/2024/205	01.08.2024	CONFIDENTIAL Audit of Accounts Report Addendum - CTMUHB 2023-24, October 2024 (Document reference: 4395A2024)	Matter arising 2 - The Health Board should ensure that all its pension calculations reflect the Greenbury guidance (which provides templated calculation examples).	Audit Wales/2024/205/MD2/1	This will be actioned in full in the 2024/25 accounts.	Finance Executive Director of Finance	30.04.2025	30.04.2025	High	In progress	November 2024 Update - No update as this will be implemented on completion of 2024/25 accounts in April.
Audit Wales/2024/205	01.08.2024	CONFIDENTIAL Audit of Accounts Report Addendum - CTMUHB 2023-24, October 2024 (Document reference: 4395A2024)	Matter arising 3 - The Health Board should review its procedure for preparing the operating leases note at the financial year-end, and make improvements where required. As part of the review, the Health Board should ensure that management review and sign-off are part of the process.	Audit Wales/2024/205/MD3/1	Due to illness there was an interim arrangement for completing note, the procedure will be improved for future accounts.	Finance Executive Director of Finance	30.04.2025	30.04.2025	High	In progress	November 2024 Update - No update as this will be implemented on completion of 2024/25 accounts in April.
Audit Wales/2024/205	01.08.2024	CONFIDENTIAL Audit of Accounts Report Addendum - CTMUHB 2023-24, October 2024 (Document reference: 4395A2024)	Matter arising 4 - The Joint Commissioning Committee should put in place a robust process to ensure that: • all the necessary declarations of Interests (DoIs) from its senior officers and members are received soon after the financial year-end; • the DoIs are evaluated by officers to establish where an individual has control and / significant influence over a declared organisation; • thereafter and where necessary, officers undertake the relevant checks to the financial ledger to identify all relevant income, expenditure, payables and receivables to be disclosed; and • that all the above is clearly documented for the purpose of officers preparing the accounts and to enable our audit.	Audit Wales/2024/205/MD4/1	As part of the ongoing governance review for the new organisation, revision work on the DOI process for 2024 -2025 financial year has already commenced. The new template, in the agreed format, is being used to ensure that there is clear documentation. This will ensure that the assessment of control or significant interest is complete and that the process will be robust. This will be a joint exercise between finance and governance colleagues to ensure a more comprehensive assessment and to make the financial ledger checks more integrated in the process. As part of the review of governance processes for the new organisation, both new lay members and existing members are being circularised mid year to ensure that all information requirements will be familiar in time for the year end exercise and that it will be fully complete. Regarding the end of year exercise, forms will be given to ICC members following the last ICC meeting of the financial year at the end of March, after one week members and their PA's will be followed up and again after one further week, which will continue in that manner until all forms have been returned.	Finance Executive Director of Finance	17.10.2024	17.10.2024	High	Overdue	November 2024 Update - No update as this will be implemented on completion of 2024/25 accounts in April.

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Audit Wales/2024/205	01.08.2024	CONFIDENTIAL Audit of Accounts Report Addendum - CTMUHB 2023-24_October 2024 (Document reference: 4395A2024)	Matter arising 5 - The Health Board should perform regular (e.g. monthly or quarterly) formal checks of the Prolease users who have access; and remove any users who no longer need access. The Health Board should also review the audit log to determine whether any inappropriate actions have been taken by unknown MRI users, and to promptly investigate any such actions.	Audit Wales/2024/205/MD5/1	There is an All Wales group using Prolease, so this is not fully in control of the Health Board. The group are in discussion with the supplier to establish a report which would show there is no inappropriate access. This work is ongoing.	Finance Executive Director of Finance	31.10.2024	31.10.2024	High	Overdue	November 2024 Update - This is an All Wales system and the health board do not have control of system. Public Health Wales are in discussions with supplier to provide report to show access is not being compromised.
Audit Wales/2024/205	01.08.2024	CONFIDENTIAL Audit of Accounts Report Addendum - CTMUHB 2023-24_October 2024 (Document reference: 4395A2024)	Matter arising 6 - The Health Board should review its current data admin accounts and remove any access from staff who do not need it. This action should include the removal of any duplicate accounts. Also, the Health Board should regularly review (i.e. monthly) its privileged access accounts so that access is maintained only for the appropriate personnel.	Audit Wales/2024/205/MD6/1	All privileged network access accounts are presently being subject to review by the corporate End User Computer Team. Progress on this task will be tracked at the fortnightly EUC NiSCyber review meeting and assured at the Monthly Cyber Security and Availability board. As the reviews identifies issues any accounts, changes will be enforced. An automated process for this cycle is being explored.	Finance Executive Director of Finance	29.11.2024	29.11.2024	High	In progress	November 2024 Update - No update yet, implementation end of this month.
Audit Wales/2024/205	01.08.2024	CONFIDENTIAL Audit of Accounts Report Addendum - CTMUHB 2023-24_October 2024 (Document reference: 4395A2024)	Matter arising 7 - The Health Board should migrate its RAM financial server system to up-to-date and fully supported infrastructure.	Audit Wales/2024/205/MD7/1	Plans have been made by the server team to migrate nearly all 2012 SQL servers onto supported operating infrastructure and operating systems. The date for the migration is pending awaiting confirmation from Finance system admin and the supplier.	Finance Executive Director of Finance	29.11.2024	29.11.2024	High	In progress	November 2024 Update - No update yet, implementation end of this month.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Reference Number	Action	Executive / Inspection Lead	Original Due Date	Current Due Date	Action Rating	Progress Status	Comments/Updates
Internal Audit/2020/65	29/07/2020	Directorate review: Acute Medicine and A&E Directorate_Final Internal Audit Report July 2020 (Review reference: CTMU-1920-23)	Directorate Review Acute Medicine & A&E 13 An inventory of non-capital assets should be developed for each department within the directorate, detailing their assets, which fit under the definition of inventory as detailed within the Financial Control Procedure.	Internal Audit/2020/65/MD1/2	It is accepted that this area needs attention and this will need to be prioritised by the CSG general managers during 2020-21 once supporting staffing structures are in place.	Care Group - Unscheduled Care Chief Operating Officer	01.04.2021	31.07.2024	High	Overdue	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - Position remains the same. This will be picked up with the newly appointed Directorate managers
Internal Audit/2020/65	29/07/2020	Directorate review: Acute Medicine and A&E Directorate_Final Internal Audit Report July 2020 (Review reference: CTMU-1920-23)	Directorate Review Acute Medicine & A&E 04 1. A review of the policies and procedures saved to the intranet should be undertaken to ensure there is a central repository of all documents and all documents that are listed are still relevant, with all out of date policies reviewed and updated where necessary. 2. Where there are common policies across a number of departments, to avoid duplication and possible inconsistencies, consideration should be given to having a set of directorate wide policies with one copy saved and clear information on the lead area for the policy including who is responsible for reviewing and updating the policy."	Internal Audit/2020/65/MD2/1	The review of policies and procedures needs to be undertaken on each acute site and it is acknowledged that this is an area of concern with focussed attention needed over the next 6 months. There also needs to be clear guidance from the ILG on the process for the approval of policies and procedures in the new operating model.	Care Group - Unscheduled Care Chief Operating Officer	01.12.2020	30.04.2024	Medium	Overdue	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - Position remains the same. This will be picked up with the newly appointed Directorate managers
Internal Audit/2020/74	24/01/2020	Medical Equipment and Devices - Follow up Internal Audit Report 2019/20 January 2020 (Review reference: CTMU 1920-45b)	Medical Equipment and Devices Follow Up 03 While we understand that currently, the department does not have the resources to undertake a reconciliation of equipment that has been loaned to wards, consideration should be given to undertaking periodic checks between the equipment available in the library and the equipment recorded as being on loan on the system.	Internal Audit/2020/74/MD1/1	1. Band 2 Equipment library Job Description is now matched – to be 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.	Diagnostics, Therapies, Pharmacies and Specialties (Clinical Engineering) Chief Operating Officer	01.04.2020	31.01.2024	Medium	Partially complete (Overdue)	November 2024 Update - Due to issues with remote access, the completion of re-programming of zones was delayed, but is now in progress. There were also delays with issuing from manufacturer of licences for reader devices activation, now resolved. Supplier to schedule in with ICT a session to enable switch over to new environment. Linux server issue to be resolved by end December 2024. September 2024 Update - IOT infrastructure updated and hand-held scanners now operational in POW. Additional fixed Antenna readers installed @ POW and RGH, re-siting of some antennas @ RGH completed in August 2024. Re-programming of configuration of system since antenna installs to be completed Sept 2024. Server switch over was delayed, due to remote access issues for Linux server and re-submission requirement to DHCW of access requirements. Working with ICT to resolve. Pharmacy will review cylinder tracking functionality once fully operational. Hopeful of completion by end October 2024. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - Switchover to new server environment pending a final data backup and quality assurance software application checks for complete switch over. Await some outstanding quotes for some infrastructure cabling to install hardware purchased as could not be completed last financial year - small amount of capital fund request made for this. Additional server request made to ICT as required for new fixed readers purchased. IOT Wi-Fi @ POW still to be resolved. Data migration and Ktrack 2 app to be completed by July 2024. WG 21-05-2024.
Internal Audit/2021/76	06/08/2021	Sunnyside Health & Wellbeing Centre_Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03)	Sunnyside Health & Wellbeing Centre 18 Management should obtain signed lease agreements with relevant parties at the earliest opportunity.	Internal Audit/2021/76/MD11/1	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.	Capital and Estates Executive Director of Finance	01.01.2022	30.06.2024	Medium	Overdue	November 2024 Update - Lease not yet signed as required updated drawings, no issues anticipated but delayed while the final details are confirmed. September 2024 Update - Lease still with GP for signing - service are working through a few queries. July 2024 Update - Lease is with the GPs for signing. Should be complete by next reporting period.
Internal Audit/2021/76	06/08/2021	Sunnyside Health & Wellbeing Centre_Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03)	Sunnyside Health & Wellbeing Centre 20 Objectives at the business case should be measurable.	Internal Audit/2021/76/MD13/1	The approved business case contained a Benefits Realisation Plan. This will be reviewed to ensure that the benefits are measurable and deliverable.	Capital and Estates Executive Director of Finance	01.01.2022	29.02.2024	Medium	Overdue	November 2024 Update - Unable to complete at November 2024 meeting, will fall to next meeting in January 2025. September 2024 Update - Requested as agenda item for November Project Board. July 2024 Update - no further update. Benefits will be periodically reviewed as part of the Project Board agenda moving forward but have not yet been reviewed.
Internal Audit/2021/76	06/08/2021	Sunnyside Health & Wellbeing Centre_Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03)	Sunnyside Health & Wellbeing Centre 21 Management should review and confirm project objectives based on only measurable outcomes within a Benefits Realisation Plan.	Internal Audit/2021/76/MD14/1	The approved business case contained a Benefits Realisation Plan. This will be reviewed to ensure that the benefits are measurable and deliverable.	Capital and Estates Executive Director of Finance	01.01.2022	29.02.2024	Medium	Overdue	November 2024 Update - Unable to complete at November 2024 meeting, will fall to next meeting in January 2025. September 2024 Update - Requested as agenda item for November Project Board. July 2024 Update - no further update. Benefits will be periodically reviewed as part of the Project Board agenda moving forward but have not yet been reviewed.
Internal Audit/2021/161	14/02/2022	Continuing Health Care and Funded Nursing Care_Final Internal Audit Report February 2022 (Review reference: CTMUHB-2122-36)	CHC and FNC 1.3 The CHC Financial Control Procedure should be reviewed by the finance team in conjunction with the CHC team and updated to reflect current processes and set up within the Health Board.	Internal Audit/2022/161/MD1/1	The Finance Team will review the Financial Control Procedure (FCP) in line with any changes identified in the new CHC Framework. The updated FCP will be an agenda item at the Audit Committee and a further review date agreed. As part of an internal review of CHC we have identified the need for a policy to outline the principles of CHC commissioning and the financial control procedure can be incorporated.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.05.2022	30.04.2024	Medium	Overdue	November 2024 Update - Nursing Team updated FCP on 17.10.24 and have emailed document to Finance Department on 12.11.24 for amendment / approval. September/October 2024 Update - The CHC Nursing and Finance Team have a meeting scheduled for 17 October 2024 to draft the FCP, following the development of the draft document approval of the draft FCP will be sought from finance by no later than 15 November 2024. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - This work will now be reviewed and amended as an action in the forthcoming CHC Board.
Internal Audit/2022/25	15/06/2022	Follow-up: Patient Pathway Appointment Management Process_Final Internal Audit Report June 2022 (Review reference: CTM 21/22-15)	Patient Pathway Appointment Management Process Follow Up 1.3 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.	Internal Audit/2022/25/MD2/1	1.3 ILGs will ensure that they undertake this action.	All Care Groups Chief Operating Officer	01.08.2022	30.04.2024	High	Fully complete (Awaiting approval)	Update October 2024 - Internal Audit have confirmed this item can close as superseded by new recommendations captured in the Follow Up Patient Pathway Report - Inspection Record (Internal Audit/2024/203). September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - Internal Audit has undertaken a review of this Audit and the draft Report is with the COO for comment. The Report includes new recommendations in some areas while others are regarded as completed. It is anticipated that the Report will be signed off in the near future.
Internal Audit/2022/25	15/06/2022	Follow-up: Patient Pathway Appointment Management Process_Final Internal Audit Report June 2022 (Review reference: CTM 21/22-15)	Patient Pathway Appointment Management Process Follow Up 1.5 Given the ongoing problem of outcomes not recorded, management should look to build on the roll out of electronic outcome forms.	Internal Audit/2022/25/MD3/1	1.5 Consideration will be given by ILGs to roll out electronic outcome forms by September 2022	All Care Groups Chief Operating Officer	01.09.2022	30.04.2024	High	Fully complete (Awaiting approval)	Update October 2024 - Internal Audit have advised in their Follow up Patient Pathway Report that this action is now obsolete. The follow up report is captured under inspection record - Internal Audit/2024/203. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - Internal Audit has undertaken a review of this Audit and the draft Report is with the COO for comment. The Report includes new recommendations in some areas while others are regarded as completed. It is anticipated that the Report will be signed off in the near future.
Internal Audit/2022/25	15/06/2022	Follow-up: Patient Pathway Appointment Management Process_Final Internal Audit Report June 2022 (Review reference: CTM 21/22-15)	Patient Pathway Appointment Management Process Follow Up 2.1 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.	Internal Audit/2022/25/MD4/1	2.1 ILGs will work with colleagues in Performance to make sure that this information is available and appropriate.	All Care Groups Chief Operating Officer	01.08.2022	30.04.2024	High	Fully complete (Awaiting approval)	Update October 2024 - Internal Audit have confirmed in their follow up report on Patient Pathways that this action has been taken in line with the recommendation and is considered to be implemented. Follow Up Report is captured under Inspection Record - Internal Audit/2024/203. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - Internal Audit has undertaken a review of this Audit and the draft Report is with the COO for comment. The Report includes new recommendations in some areas while others are regarded as completed. It is anticipated that the Report will be signed off in the near future.
Internal Audit/2022/25	15/06/2022	Follow-up: Patient Pathway Appointment Management Process_Final Internal Audit Report June 2022 (Review reference: CTM 21/22-15)	Patient Pathway Appointment Management Process Follow Up 2.2 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.	Internal Audit/2022/25/MD5/1	2.2 ILGs will work with colleagues in Performance to ensure that the appropriate staff are identified.	All Care Groups Chief Operating Officer	01.08.2022	30.04.2024	High	Fully complete (Awaiting approval)	Update October 2024 - Internal Audit have confirmed in their follow up report on Patient Pathways that this action has been taken in line with the recommendation and is considered to be implemented. Follow Up Report is captured under Inspection Record - Internal Audit/2024/203. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - Internal Audit has undertaken a review of this Audit and the draft Report is with the COO for comment. The Report includes new recommendations in some areas while others are regarded as completed. It is anticipated that the Report will be signed off in the near future.
Internal Audit/2022/25	15/06/2022	Follow-up: Patient Pathway Appointment Management Process_Final Internal Audit Report June 2022 (Review reference: CTM 21/22-15)	Patient Pathway Appointment Management Process Follow Up 2.3 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.	Internal Audit/2022/25/MD6/1	2.3 ILGs will ensure that they undertake this action	All Care Groups Chief Operating Officer	01.08.2022	30.04.2024	High	Fully complete (Awaiting approval)	Update October 2024 - whilst not implemented in the Follow Up Patient Pathway Report (Inspection Record reference Internal Audit/2024/203) notes that this recommendation has been superseded with a new recommendation. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - Internal Audit has undertaken a review of this Audit and the draft Report is with the COO for comment. The Report includes new recommendations in some areas while others are regarded as completed. It is anticipated that the Report will be signed off in the near future.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Reference Number	Action	Executive / Inspection Lead	Original Due Date	Current Due Date	Action Rating	Progress Status	Comments/Updates
Internal Audit/2022/25	15/06/2022	Follow-up: Patient Pathway Appointment Management Process_Final Internal Audit Report June 2022 (Review reference: CTM 21/22-15)	Patient Pathway Appointment Management Process Follow Up 2.4 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.	Internal Audit/2022/25/MD7/1	2.4 ILGs will work with colleagues in Performance to make sure that this information is available and appropriate.	All Care Groups Chief Operating Officer	01.09.2022	30.04.2024	High	Fully complete (Awaiting approval)	Update October 2024 - The Internal Audit Review Follow Up on Patient Pathways (Inspection Record Reference Internal Audit/2024/203) includes the Internal Audit statement that this Action has been taken in line with recommendation / management response and is therefore considered as implemented. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - Internal Audit has undertaken a review of this Audit and the draft Report is with the COO for comment. The Report includes new recommendations in some areas while others are regarded as completed. It is anticipated that the Report will be signed off in the near future.
Internal Audit/2022/25	15/06/2022	Follow-up: Patient Pathway Appointment Management Process_Final Internal Audit Report June 2022 (Review reference: CTM 21/22-15)	Patient Pathway Appointment Management Process Follow Up 3.1 Management should establish if staff in the Rhonddda 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.	Internal Audit/2022/25/MD8/1	3.1 This will be addressed by the ILG with colleagues from Performance	All Care Groups Chief Operating Officer	01.09.2022	30.04.2024	Medium	Fully complete (Awaiting approval)	Update October 2024 - Whilst not implemented the Follow Up Report to Patient Pathways (Inspection Record Internal Audit/2024/203) notes that this action has been superseded by a new recommendation and therefore can be closed. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - Internal Audit has undertaken a review of this Audit and the draft Report is with the COO for comment. The Report includes new recommendations in some areas while others are regarded as completed. It is anticipated that the Report will be signed off in the near future.
Internal Audit/2022/43	29/07/2022	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	POW Theatres Fire Safety Works 3.1 The Health Board should ensure timely completion of contacts.	Internal Audit/2022/43/MD1/1	Agreed – though in this case, due to the bespoke nature of the contract – a single phase business case, this did not align with the national framework contract stages - requiring additional edit prior to issue. Covid also impacted timely return.	Capital and Estates Executive Director of Strategy & Transformation	01.01.2023	31.03.2025	Medium	Fully complete (Awaiting approval)	November 2024 Update - This is now part of the POWH Roof and Compliance Programme and the contract is being signed this week- this can be closed. September 2024 Update - This is in the design stage, will be applicable if business case is approved and we enter into a contract for construction. July 2024 Update - cannot be evidenced until business case approved and contracts signed. May 2024 Update - as per March below, is likely to be in January 2025. March 2024 Update - As per Dec 2023, this is scheduled to be in January 2025. February 2024 - An update has not been provided against this recommendation on this occasion. December 2023 Update - Action to be addressed once there is an approved business case in place - based on current timeline this is scheduled to be January 2025.
Internal Audit/2022/43	29/07/2022	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	POW Theatres Fire Safety Works 4.1 The Health Board should assess the methodology of awarding direct contracts at design and construction projects.	Internal Audit/2022/43/MD2/1	Agreed – we will ensure this at future awards. However, in the early stages of this project, we did not want to contractually commit to the full scheme at the outset, until the position had been appraised.	Capital and Estates Executive Director of Strategy & Transformation	01.01.2023	31.03.2024	Medium	Fully complete (Awaiting approval)	November Update - Now part of POWH Roof & Compliance Programme which was agreed as a direct award due to the Critical Incident with the roof and the urgent timescales. September 2024 Update - As per May 2024 in that the design team was competitively tendered and so will the construction stage if the business case is approved by Welsh Gov. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - to confirm the design team appointment was subject to a competitive process. Construction tenders will also be subject to competitive process.
Internal Audit/2022/43	29/07/2022	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	POW Theatres Fire Safety Works 4.2 The Health Board should confirm how value for money will be assured at the letting of the construction stage award for a Cost Adviser.	Internal Audit/2022/43/MD3/1	Agreed	Capital and Estates Executive Director of Strategy & Transformation	01.08.2022	31.01.2025	Medium	Fully complete (Awaiting approval)	November 2024 Update - part of direct consultant appointments with POWH Roof & Compliance Board, procurement method accepted by NWSSP-SES and W Gov. September 2024 Update - Likely to be Jan 2025 at the earliest. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - as per March below. March 2024 Update - As per Dec 2023, this is likely to be in January 2025. February 2024 - An update has not been provided against this recommendation on this occasion. December 2023 Update - Action to be addressed once there is an approved business case in place - based on current timeline this is scheduled to be January 2025.
Internal Audit/2022/43	29/07/2022	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	POW Theatres Fire Safety Works 4.3 The Health Board should ensure appropriate contractual arrangements are in place for the Cost Adviser.	Internal Audit/2022/43/MD4/1	Agreed	Capital and Estates Executive Director of Strategy & Transformation	01.08.2022	31.01.2025	Medium	In progress	November 2024 Update - part of direct consultant appointments with POWH Roof & Compliance Board, procurement method accepted by NWSSP-SES and W Gov. Contract for consultation in progress. September 2024 Update - Likely to be Jan 2025 at the earliest. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update as per March below. March 2024 Update - As per December 2023. February 2024 Update - An update has not been provided against this recommendation on this occasion. December 2023 Update - Action to be addressed once there is an approved business case in place - based on current timeline this is scheduled to be January 2025.
Internal Audit/2022/43	29/07/2022	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	POW Theatres Fire Safety Works 8.1 Management should ensure appropriate reporting, forecasting and management of project costs, for each project phase, to a project group, accountable for delivery, including overall project reporting of: • contacted sums; • cash flow budgeted to date; • expenditure to date; • forecast out-turn; and • associated variance commentary.	Internal Audit/2022/43/MD6/1	Agreed. However, profiled costs are provided from the Supply Chain Partner. There is formal cost monitoring in terms of performance against funding to ECMG and monthly reviews of capital costs. Further reporting of the formats suggested will follow as appropriate upon review pending scale of the revised proposal.	Capital and Estates Executive Director of Strategy & Transformation	01.08.2022	29.02.2024	Medium	Fully complete (Awaiting approval)	November 2024 Update - This will be reported to the Financial Review Group, then to Programme Board and onto ECMG as per the agreed Terms of Reference for the Programme Board. September 2024 Update - As per May 2024 the only costs on the revised scheme to date are surveys and design team fees and there is no Supply Chain partner as this is now significantly smaller and thus no a longer a DAL scheme. Design team fees to get to tendered costs and BJC submission have been reported to ECMG. The cost profiling will be provided if and when we move into the construction stage. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - A new design team has been appointed, a PO is being issued for their costs and other costs (specialist consultants, surveys etc) are being compiled with an update so far to ECMG on 23 May. Costs will be reported regularly to Project Board and ECMG once they commence being invoiced.
Internal Audit/2022/43	29/07/2022	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	POW Theatres Fire Safety Works 9.1 Pending the outcome of the options appraisal, in the circumstance that Theatres reprovision remains within preferred option, the Project Board should re-assess procurement options to ensure value for money.	Internal Audit/2022/43/MD7/1	Agreed. This will be undertaken at the future procurement.	Capital and Estates Executive Director of Strategy & Transformation	01.01.2023	30.11.2024	Medium	Fully complete (Awaiting approval)	November 2024 Update - No longer applicable. Overtaken by events with POWH roof, Main theatres were vacated during the Critical Incident. September 2024 Update - Procurement of a modular supplier is being linked to the LHP procurement process which is using the relevant framework. Construction costs etc for the FEN works will shortly be competitively tendered and will be reported to Project Board and ECMG. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - as per March below. March 2024 Update - Procurement for modular supplier is under discussion, procurement of a building contractor for works will be by competitive tender to inform the BJC costs, if and when the BJC is approved we can enter into a works contract.
Internal Audit/2022/43	29/07/2022	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	POW Theatres Fire Safety Works 10.1 A costed risk register should be regularly maintained and reported, as applicable to the current project phase.	Internal Audit/2022/43/MD8/1	Agreed	Capital and Estates Executive Director of Strategy & Transformation	01.08.2022	31.01.2025	Medium	In progress	November 2024 Update - will part of the Roof & Compliance Programme, has been requested by NWSSP-SES. September 2024 Update - A risk register is provided but not costed as the scale is significantly smaller than the previous DAL scheme. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - as per March, a new risk register to reflect the new design solution is being compiled, it will be reported to Project Board and be part of the BJC. March 2024 Update - As it is a different way forward for the scheme the risks will be costed as part of the BJC process in Summer 2024.
Internal Audit/2022/43	29/07/2022	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	POW Theatres Fire Safety Works 10.2 Management should actively monitor and report the value of residual risk v remaining contingency.	Internal Audit/2022/43/MD9/1	Agreed	Capital and Estates Executive Director of Strategy & Transformation	01.08.2022	31.01.2025	Medium	In progress	November 2024 Update - will part of the Roof & Compliance Programme, has been requested by NWSSP-SES. September 2024 Update - The contingency applies to the construction stage and will be part of the regular monitoring. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - as reported at March. March 2024 Update - As above will be within BJC process and once contract has commenced.

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Internal Audit/2022/43	29/07/2022	Princess of Wales Theatres: Fire Safety Works, Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	POW Theatres Fire Safety Works 10.3 Risks should be individually assigned to those best placed to control them, with time parameters for action.	Internal Audit/2022/43/MD10/1	Agreed	Capital and Estates Executive Director of Strategy & Transformation	01.08.2022	31.12.2023	Medium	Overdue	November 2024 Update - will part of the Roof & Compliance Programme, has been requested by NWSSP-SES. September 2024 Update - As per May this will be part of the BIC. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - this will be part of the BIC. March 2024 Update - As per Dec 2023, this is likely to be in January 2025. February 2024 Update - An update has not been provided against this recommendation on this occasion. December 2023 Update - Key has been agreeing preferred way forward and pulling together a timeline for the project to present to the fire service , now this has been agreed the risk register will be fully reviewed and updated to address the recommendation.
Internal Audit/2022/43	29/07/2022	Princess of Wales Theatres: Fire Safety Works, Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	POW Theatres Fire Safety Works 10.4 An exception report should be published of targeted risk mitigations not achieved.	Internal Audit/2022/43/MD11/1	Agreed	Capital and Estates Executive Director of Strategy & Transformation	01.08.2022	31.12.2023	Medium	Overdue	November 2024 Update - will be part of regular reporting to Programme Board, could be closed once the reporting is established, first meeting due early Dec 2024. September 2024 Update - As per March 2024 it will be part of regular risk monitoring. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - as per March below. March 2024 Update - Exception reporting will form part of regular risk monitoring.
Internal Audit/2022/43	29/07/2022	Princess of Wales Theatres: Fire Safety Works, Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	POW Theatres Fire Safety Works 2.1 The Health Board should confirm that resource requirements are appropriately assessed utilising a detailed resource schedule at the business case stage.	Internal Audit/2022/43/MD12/1	Agreed. The project has been adequately resourced with two internal officers to date. Formal application for resources would be made at a formal business case, and we will look to make appropriate application at that time.	Capital and Estates Executive Director of Strategy & Transformation	01.01.2023	31.10.2024	Low	Fully complete (Awaiting approval)	November 2024 update - detailed resource schedules regularly received from design team and main contractor on POWH Roof & Compliance Programme. September 2024 Update - As per May 2024 this will be part of the standard BIC cost forms. September 2024 Update - AS per May 2024 this will be part of the standard BIC cost forms. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - internal resource costs will be submitted as part of the BIC cost form, have been adequate to date but now entering a busier phase. March 2024 Update - As per December 2023. February 2024 Update - An update has not been provided against this recommendation on this occasion. December 2023 Update - Preferred option now agreed by the project board and programme updated. Business case is due for submission to WG October 2024. Adequate resources will be factored into the fees requested.
Internal Audit/2022/43	29/07/2022	Princess of Wales Theatres: Fire Safety Works, Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	POW Theatres Fire Safety Works 7.1 The Health Board should obtain advice from NWSSP: Specialist Estates Services in relation to a performance bond for construction works.	Internal Audit/2022/43/MD13/1	Agreed	Capital and Estates Executive Director of Strategy & Transformation	01.08.2022	31.01.2024	Low	Overdue	November 2024 Update - Discussions with NWSSP-SES did not result in a recommendation in the contract, consequently it has not been included. September 2024 Update - This refers to the previous D4L contract but this is no longer in use. Discussions with NWSSP-SES will include whether there's a need for a performance bond with a smaller value contract. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - as the new design team have been appointed this will form part of the discussions with NWSSP-SES on design & tender process in the summer. March 2024 Update - As per Dec 2023. February 2024 Update - An update has not been provided against this recommendation on this occasion. December 2023 Update - This will be discussed with NWSSP in advance of tendering for the works and modular hire.
Internal Audit/2022/67	24/10/2022	Radiology Service Review Final Internal Audit Report October 2022 (Review reference: CTMUHB-2223-03)	Radiology Service Review 12.1 A detailed workforce plan should be developed by the CSG in conjunction with their Workforce Business Partner that incorporates both the current workforce situation, plus longer-term plans in relation to areas such as known retirements.	Internal Audit/2022/67/MD2/1	The Service Group now sits in the Diagnostic and Therapies Care Group since September 2022 and the Care Group Director and Medical Director will work with the teams to advise of the workforce plan required for the IMTP/Annual Plan for 2023/24. On receipt of this advice the Service Group will work with the Workforce Business Partners to articulate the current workforce issues and medium and longer term plans.	Diagnostics, Therapies, Pharmacies & Specialities Chief Operating Officer	30.11.2022	31.12.2023	High	Partially complete (Overdue)	November 2024 Update - Still awaiting confirmation for approval at exec level for CT staffing. The workforce detailed in this paper underpins the Radiology workforce plans. September 2024 Update - NOUS and CT paper partially approved. The staffing element of the CT BC is critical for workforce planning. The team await confirmation of approval at Exec level. July 2024 Update - CT workforce paper and NOUS staffing BC submitted for additional resource. Awaiting formal outcome for both papers. Workforce meeting required following the outcome of the papers to inform next steps.
Internal Audit/2022/95	15/06/2022	Follow-up: Medical & Dental Rostering_Final Internal Audit Report June 2022 (Review reference: CTM 21/22-31)	Medical & Dental Rostering Follow Up Review 3.1 The draft Medics Rostering Policy should be further reviewed to remove any legacy references to the Nursing Rostering Policy. Feedback should then sought from the appropriate groups and approval obtained from the appropriate committee ahead of making the policy available to all relevant staff.	Internal Audit/2022/95/MD1/1	The draft has been reviewed substantially and is now complete. The policy has been submitted to the Medical Workforce Sustainability Group (MWSG) for review. This will be set as an agenda item for the next meeting and then progress through the formal Health Board route to ratification.	People Executive Medical Director Executive Director for People	01.11.2022	30.04.2024	Medium	Partially complete (Overdue)	November 2024 Update - Final comments from the LNC are still awaited. A deadline has been suggested - agreeing the policy at the March 2025 LNC. September 2024 Update - Final comments from the LNC are awaited. July 2024 Update - The policy has now been sent to the LNC for review and will be discussed at the next meeting (10 September 2024).
Internal Audit/2022/97	10/10/2022	Medical Records Management_Final Internal Audit Report October 2022 (Review reference: CTMU-2223-06)	Medical Records Management 1.1 The responsibilities of the Health Records departments across the Health Board should be standardised. Linked to this the procedures operating within each site should be standardised as much as possible, given the limitations imposed by digitisation.	Internal Audit/2022/97/MD1/1	Accept There are challenges to standardising the operational procedures of the Health Records teams due to the variances between the digital systems used within the Princess of Wales and the rest of the Health Board. It should also be noted that some of the Health Records personnel within the Health Board are not under the direct responsibility and accountability of the Director of Digital. The Health Board has devised a programme of work to standardise the PAS in use across the Health Board. This programme is planned until the Autumn of 2024. Process will be aligned as practically possible prior to the completion of the programme.	Digital & Data Director of Digital	01.07.2024	01.09.2025	Medium	In progress	November 2024 Update - Significant disruption to the medical records processes due to the critical incident in POWH and the commencement of the transfer of patients and notes to CTM sites. The Dual PAS systems have historically not been configured to allow for this so a huge amount of work has been undertaken by our records teams to establish and implement new processes for the setting up and tracking on POW notes on CTM PAS and vice versa. POW has not used CTO for digital patients prior to the Critical Incident but as patients from CTM who are digital are now being transferred to POW a user guide for this site has now been created. Increased PAS patients registrations and new SOP's have been implemented and workload continues to increase in line with new operating models. PAS Merger work continues and meetings to explore expedited timelines have been scheduled. September 2024 Update - No significant update this month, work to standardise PAS continues. New proposed due date - 01/09/2025. July 2024 Update - Ongoing work to standardise the PAS continues, as per previous update there are a number of Health Records/ Patient Contact functions that do not sit within core Medical Records. In order to continue the sharing of best practice guidelines across these areas the quarterly Health Records Group is still active, with the most recent meeting being in June. There was a key focus on the CTM process for destruction of records now eligible under the guidelines and the sharing our processes to undertake this work, as well as continued notes storage pressures across all areas that manage health records. A key factor highlighted was the limitation of resourced to be able to start destruction in a timely manner across all area's. We are also starting conversation with Therapy colleagues on the processes we use for management and booking of patients through our centralised Patient Contact teams in Medical Records.
Internal Audit/2023/100	31/05/2023	Welsh Risk Pool Claims_Final Internal Audit Report May 2023 (Review reference: CTMUHB-2223-24)	Welsh Risk Pool 1.1 1.1a Management should reiterate to staff the importance of ensuring accurate data in relation to the closure is captured in Datix for all closed cases. 1.1b Regular monitoring on the 'stages' within Datix should be carried out to ensure compliance and that no 'blanks' are being reported.	Internal Audit/2023/100/MD2/1	1.1a Staff will be reminded of importance in next meeting in respect of closure. A check list will be developed to support staff in the completion of Datix at all stages of process. This information will included in the Standard Operating Procedures for the closing of records. A refresher training session will be provided to the Claims Team in relation to Datix Cymru by the Business Intelligence Team. A monthly audit of closed claims will be undertaken by the Business Intelligence Team. Feedback from this audit will be presented to the Health Board Datix Management and shared with the Claims Team with actions for improvement identified where required. 1.1b In addition a regular (minimum of monthly) data validation exercise and audit of open claims will be completed. Feedback from this exercise will be shared with the Claims Team and recurring issues escalated to the Senior Team.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.06.2023	31.12.2024	Medium	Partially complete	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - Confirmed Claims audit tool developed and report generated. Further feedback is required to implement on a monthly basis. Development of Redress dashboard in progress - anticipated time scale of completion 31.12.24. July 2024 Update - Meeting with BI team in respect of Redress Audit tool has been undertaken. BI team working on redress report and dashboard.
Internal Audit/2023/100	31/05/2023	Welsh Risk Pool Claims_Final Internal Audit Report May 2023 (Review reference: CTMUHB-2223-24)	Welsh Risk Pool 2.2 Management should ensure that staff are aware of accurately recording date information within Datix to allow the calculation of target dates and monitoring.	Internal Audit/2023/100/MD4/1	Staff will be reminded of the importance of accurately recording date information on Datix Cymru and ensuring it is reflected on documents submitted to WRP. The recording of LFER information will be included in the audit and data validation programme described in action 1.1b.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.06.2023	31.12.2024	Medium	Partially complete	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - Confirmed Claims audit tool developed and report generated. Further feedback is required to implement on a monthly basis. Development of Redress dashboard in progress - anticipated time scale of completion 31.12.24. July 2024 Update - Meeting with BI team in respect of Redress Audit tool has been undertaken. BI team working on redress report and dashboard.
Internal Audit/2023/107	08/08/2023	Decontamination_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-25)	Decontamination 1.0 The decontamination policy should be reviewed and updated to reflect the most up to date guidance and practices. The revision should ensure that the updated policy reflects the current decontamination monitoring arrangements, the roles and Responsibilities of Decontamination Officer and the role and purpose of the Local Decontamination Groups. The policy should also reflect the impact of the Health Board's new operating model. Once revised and approved, the policy should be made available to relevant staff.	Internal Audit/2023/107/MD2/1	1a Update the Decontamination of Reusable Medical and Surgical Devices Policy (IPC 27). 1b Present the updated policy to the appropriate oversight committee for ratification. 1c Implementation of the updated policy to include appropriate team briefing and advisory support.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.11.2023	01.11.2023	Medium	Fully complete (Awaiting approval)	Revised Due Date 1a October 2023 Out for Comment / 1b December 2023 to Decontamination Committee/ IPCC March 2024 / 1c March 2024 October 2024 Update - Policy revised and approved through the relevant Committees. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - The policy was approved in the April IPC Committee meeting. The policy has been added to the agenda for the next Operational Board Management meeting for final approval.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Reference Number	Action	Executive / Inspection Lead	Original Due Date	Current Due Date	Action Rating	Progress Status	Comments/Updates
Internal Audit/2023/107	08/08/2023	Decontamination_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-25)	Decontamination 3.0 Arrangements be put in place to ensure that there is a dedicated Microbiologist (Decontamination) in place for Princess of Wales site as soon as practically possible.	Internal Audit/2023/107/MD4/1	3a Escalation to the Deputy Medical Director and escalated to the last IP&C Committee meeting (11/07/23). 3b Multi-stakeholder meeting to discuss the current arrangements with active service level agreements, Public Health Wales and CTM to inform the programme of work required to reach an appropriate substantive outcome. 3c Outcome report and appropriate plan from stakeholder engagement to be presented to IPC Committee meeting.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.10.2023	01.10.2023	Medium	Overdue	Revised Due Date 3a July 2023 / 3b October 2023 / 3c March 2024 October 2024 Update - No further update, there is no decontamination microbiologist lead for POW, the current arrangement only covers RGH and PCH, further discussion needed regarding local arrangements. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - No further update. May 2024 Update - a Consultant has been asked to review the current Service Level Agreement (SLA) for laboratory services and microbiology cover in CTM. The review will take place this year. March 2024 update - Strategic review of IPC service ongoing. Led by Richard Hughes, Deputy Executive Director of Nursing. January 2024 Update - Strategic review of IPC service ongoing. Led by Richard Hughes, Deputy Executive Director of Nursing. December 2023 Update (Date of Review 29/11/23) - Concerns escalated to Deputy Medical Director. The issue was discussed further in the IP&C committee on the 17/10/23. We have been informed that the Consultant cover in POW will form part of the IP&C strategic review. The Deputy Executive Director of Nursing is leading the review. October 2023 Update (Date of Review 04/10/2023) - There is no dedicated Consultant Microbiologist for Decontamination at the Princess of Wales Hospital. This is a requirement for SSD accreditation and will be raised at IPC committee on the 17/10/23. Rationale for revised implementation date - Multi stakeholder meeting to take place in October 2023, outcome report to follow.
Internal Audit/2023/107	08/08/2023	Decontamination_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-25)	Decontamination 5.0 A schedule/programme of independent decontamination audits be implemented to evaluate and assess the decontamination facilities/arrangements across the Health Board. The outcome of these audits be summarised into a report for presentation to the Decontamination Committee so that appropriate actions can be taken.	Internal Audit/2023/107/MD5/1	5a Decontamination audit tools are currently being developed. Three audit tools will be taken to the next Decontamination Committee meeting for approval. Decontamination audit programme to commence. 5b Audit program to review decontamination facilities/arrangements across the Health Board to inform all appropriate future governance.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.06.2024	01.06.2024	Medium	Overdue	October 2024 Update - Denal decontamination audit tool being developed. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - Audit program ongoing. The USS probe decontamination audit tool was agreed in the July Decontamination Committee meeting. There is one remaining audit tool left to be developed; dental services. This will be presented in the next Decontamination Committee meeting (September 2024).
Internal Audit/2023/113	08/08/2023	National Incident Framework_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-05)	National Incident Framework 2.1 The draft training needs analysis should be finalised and staff in Care Groups should be requested to identify who needs to attend incident management training and RCA training. As part of the process of identifying staff training needs, consideration should be given to if refresher training on Datix is required.	Internal Audit/2023/113/MD4/1	A training strategy to be developed which outlines all levels of training in relation to Incident and Concerns Management for different staff groups across the Health Board. This will include a reference to Datix Cymru requirements. Following approval of the Strategy, a training need analysis will be undertaken and a training Programme established.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.11.2023	31.10.2024	Medium	Partially complete (Overdue)	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - Work continues to progress in relation to the development of the training strategy. An outline document has been developed and the action is on track to be completed by the end of the October 2024. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 - A meeting was held on the 01.05.24 to review draft documentation and agree a way forward. Links have been established with Organisational Development colleagues to ensure a collaborative approach alongside Restorative, Just and Learning training programme.
Internal Audit/2023/117	28/07/2023	Performance Reporting – Integrated Performance Report_Internal Audit Report July 2023 (Review reference: CTMUHB-2223-15)	Performance Reporting Integrated Performance Report 2.1 The Standard Operating Procedure for preparing the performance report should be enhanced to fully set out the process for preparing the report. It should include more comprehensive information on how it is determined, which performance measures are to be reported on, how data should be checked for accuracy and completeness and a detailed monthly timetable for production that allows sufficient time for Executive review.	Internal Audit/2023/117/MD2/1	A review of the Standard Operating Procedure will be undertaken to ensure it comprehensively covers the activities required.	Performance Executive Director of Strategy & Transformation, Director of Digital	01.01.2024	30.06.2024	High	Overdue	Revised Due Date - end of Qtr1 2024/25 (30/06/2024) November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - Work continues and is in progress as per January 2024 update. On track for end of June 2024 due date. January 2024 Update - Performance Report continues to iterate - likely to continue into 2024/2025. December 2023 Update - Work Ongoing - Performance Framework being updated by end of December 2023 - proposing to take to January 2024 Board.
Internal Audit/2023/117	28/07/2023	Performance Reporting – Integrated Performance Report_Internal Audit Report July 2023 (Review reference: CTMUHB-2223-15)	Performance Reporting Integrated Performance Report 1.1 The draft performance management framework should be reviewed to ensure: • There is alignment to the most up to date Welsh Government Performance Framework, ensuring all metrics and measures outlined are accurate and there is link the IMTP trajectories required by WG • Greater clarity is provided on how the framework will be applied in practice, including how reporting against metrics will take place. • Listed metrics can be clearly linked to source requirements e.g. WG quadruple aims, other national indicators, internal indicators. • The roles and responsibilities of all Health Board Committees is set out including how those roles relate to one another. • Reference is made to the revised operating model and therefore reporting structure within the Health Board. Following the completion of the review, the framework should be appropriately approved and made available to relevant staff.	Internal Audit/2023/117/MD3/1	The Health Board needs to formalise a Performance Framework. This review will consider the points listed above.	Performance Executive Director of Strategy & Transformation, Director of Digital	01.01.2023	31.12.2024	Medium	In progress	Revised Due Date - Revised Due Date end of Quarter 3 2024-2025 (31.12.2024) November 2024 update - The performance structure for the IMTP is set out in the reports provided to board. The formal framework document is under review. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - A session is being planned with the Executive Team in April to develop the next stage of the framework. 6 month extension requested.
Internal Audit/2023/124	31/05/2023	Follow-up: Concerns_Final Internal Audit Report May 2023 (Review reference: CTM 22/23-29)	Concerns Follow Up Review 3.1 3.1a Once the Concerns Policy and SOP have been finalised, the training needs analysis work should be completed in order to identify the training requirements across the Health Board, including refresher training for those that may have previously completed training on previous policies and processes. 3.1b A training programme should be put in place to deliver the identified concerns training requirement. 3.1c A decision should be made on the best method for capturing concerns training attendance, that allows management the ability to review and monitor attendance going forward.	Internal Audit/2023/124/MD3/1	3.1a Training Needs Analysis to be developed and sent to all Care Groups to identify staff which require training 3.1b Once the training needs analysis has been completed, this will inform the training programme. This will be developed and be an ongoing rolling programme for the Health Board 3.1c Discussions to be held with Learning and Development to ascertain the best method to capture this training on an ongoing basis.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.10.2023	31.10.2024	Medium	Partially complete (Overdue)	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - Work continues to progress in relation to the development of the training strategy. An outline document has been developed and the action is on track to be completed by the end of the October 2024. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 - A meeting was held on the 01.05.24 to review draft documentation and agree a way forward. Links have been established with Organisational Development colleagues to ensure a collaborative approach alongside Restorative, Just and Learning training programme.
Internal Audit/2023/146	11/10/2023	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	Interventions Not Normally Undertaken 1.1 Key staff, especially those listed as the target audience at the start of the INNU policy, should be made aware of the revised policy and its contents. Where necessary, training should be carried out to ensure staff understand the policy and the application of it.	Internal Audit/2023/146/MD1/1	CTMUHB Policy updated and circulated through service groups. Training will be carried out where required across service groups.	Care Group - Planned Care Chief Operating Officer	01.09.2023	01.09.2023	High	Overdue	November 2024 Update - INNU is an area that is being picked up at a national level. CTM are waiting for the outcome of this to inform local policies, procedures and guidance. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - The CTMUHB evolved into the all Wales group with the policy being taken forward. CTMUHB fully engaged in the national INNU review. A national policy is being developed for local implementation. Once we have a policy we will be able to include it in the daily performance reports and weekly meetings.
Internal Audit/2023/146	11/10/2023	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	Interventions Not Normally Undertaken 1.2 A Standard Operation Procedure in relation to INNUs should be developed to provide guidance on consistent application of the INNU policy.	Internal Audit/2023/146/MD2/1	Standard Operating Procedure to be developed as part of the working group and provided to all service groups.	Care Group - Planned Care Chief Operating Officer	01.01.2024	01.01.2024	High	Overdue	November 2024 Update - INNU is an area that is being picked up at a national level. CTM are waiting for the outcome of this to inform local policies, procedures and guidance. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - Once there is an all Wales policy we will be able to locally implement with an SOP. CTMUHB fully engaged in the national INNU review. A national policy is being developed for local implementation. Once we have a policy we will be able to include it in the daily performance reports and weekly meetings.
Internal Audit/2023/146	11/10/2023	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	Interventions not Normally Undertaken 2.0 For those patients where it is deemed that an INNU intervention is necessary, a record, such as a checklist should be retained on their patient file demonstrating that the criteria set out in the INNU policy or within WHSSC guidance has been met. Consideration should be given to the need for an independent check to be made and/or approval to be granted, if it is believed the patient meets the INNU criteria, prior to adding them to a waiting list.	Internal Audit/2023/146/MD3/1	Individual patient funding request panel to be re-established to receive INNU. Intervention requests necessary. Application and outcome to be documented and WPAS to be updated.	Care Group - Planned Care Chief Operating Officer	01.01.2024	01.01.2024	High	Overdue	November 2024 Update - INNU is an area that is being picked up at a national level. CTM are waiting for the outcome of this to inform local policies, procedures and guidance. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2023/146	11/10/2023	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	Interventions not Normally Undertaken 5.1 The monitoring mechanisms set out in the INNU policy should be implemented as soon as possible. Appropriate reports should be produced monthly to monitor INNUs at an operational level which are distributed to all relevant stakeholders. These should include totals by month and by speciality/clinician so that trends and anomalies can be easily spotted and investigated. Sample checks back to patient records should be carried out to confirm all criteria had been met. The use of a checklist as recommended in Matter Arising 2 would aid this process. An appropriate mechanism should be in place for addressing any matters identified, so that corrective action can be promptly taken.	Internal Audit/2023/146/MD4/1	With the establishment of the recording and monitoring mechanism. Monthly reports will be produced with trends and anomalies highlighted. Any matters that require addressing will be via the Care Group with the service performance meeting structures.	Care Group - Planned Care Chief Operating Officer	01.03.2024	01.03.2024	High	Overdue	November 2024 Update - INNU is an area that is being picked up at a national level. CTM are waiting for the outcome of this to inform local policies, procedures and guidance. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2023/146	11/10/2023	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	Interventions not Normally Undertaken 1.3 The policy, and an associated SOP, should provide greater clarity on whether the IPFR process can be used for those interventions that are listed as 'Do Not Do' and the relevant process to follow.	Internal Audit/2023/146/MD5/1	Application of the above actions	Care Group - Planned Care Chief Operating Officer	01.01.2024	01.01.2024	Medium	Overdue	November 2024 Update - INNU is an area that is being picked up at a national level. CTM are waiting for the outcome of this to inform local policies, procedures and guidance. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion.

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Internal Audit/2023/146	11/10/2023	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	Interventions Not Normally Undertaken 4.0 A mechanism should be put in place that will allow the Health Board to monitor if activity has taken place against interventions that are classed as DNDs where no clinical code currently exists and the level of activity against the INNU interventions where no clinical code is recorded.	Internal Audit/2023/146/MD6/1	Data work stream established to look at the recording of INNU's across CTMUHB. An agreed coding and monitoring mechanism to be agreed and implemented.	Care Group - Planned Care Chief Operating Officer	01.03.2024	01.03.2024	Medium	Overdue	November 2024 Update - INNU is an area that is being picked up at a national level. CTM are waiting for the outcome of this to inform local policies, procedures and guidance. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2023/146	11/10/2023	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	Interventions Not Normally Undertaken 5.2 Consideration should be given to the need to periodically report compliance / non-compliance at a relevant level within the Health Board.	Internal Audit/2023/146/MD7/1	Daily report to be added to the performance runs with formal monthly reporting via Planning Performance and Finance.	Care Group - Planned Care Chief Operating Officer	01.03.2024	01.03.2024	Medium	Overdue	November 2024 Update - INNU is an area that is being picked up at a national level. CTM are waiting for the outcome of this to inform local policies, procedures and guidance. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - CTMUHB fully engaged in the national INNU review. A national policy is being developed for local implementation. Once we have a policy we will be able to include it in the daily performance reports and weekly meetings.
Internal Audit/2023/146	11/10/2023	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	Interventions not Normally Undertaken 3.0 The importance of capturing accurate information on patient records should be reiterated to all staff, with the use of alternative names ceasing.	Internal Audit/2023/146/MD8/1	Review and update of waiting list 'holding names' to be undertaken	Care Group - Planned Care Chief Operating Officer	01.03.2024	01.03.2024	Low	Overdue	November 2024 Update - INNU is an area that is being picked up at a national level. CTM are waiting for the outcome of this to inform local policies, procedures and guidance. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - CTMUHB fully engaged in the national INNU review. A national policy is being developed for local implementation. Once we have a policy we will be able to include it in the daily performance reports and weekly meetings.
Internal Audit/2023/148	09/10/2023	IT Infrastructure_Final Internal Audit Report October 2023 (Review reference: CTM-2324-19)	IT Infrastructure 2.1 Older, out of support devices should be removed from use.	Internal Audit/2023/148/MD1/1	Continue to prioritise and review aged assets with a view to replacement, balanced with limited funding sources. Manage and maintain the related risk within the Departmental risk register.	Digital & Data Director of Digital	30.06.2024	30.01.2025	Medium	In progress	November 2024 Update - Work continues to rollout newer Wireless Access points and PCs for the iGael replacement. Further funding is in place via the ePMA project to provide further upgrades to our Wireless Infrastructure. Digital have also submitted a slippage bid to WG valued at £4.4m which covers a range of infrastructure technology. September 2024 Update - A review of current aged assets is underway, this will be prioritised and opportunities for end of year slippage funding will be explored with WG. New Proposed Due Date: This is an ongoing risk - proposed new end date of 30/01/2025. July 2024 Update - For legacy Servers, mitigation continues to be in place to ensure that the cyber risk is low. Work to eradicate/replace typically requires system replacements and a review of the servers in line with the replacement plans is currently being carried out. Programme to rollout endpoint devices requires additional staffing beyond BAU and progress has been minimal.
Internal Audit/2023/148	09/10/2023	IT Infrastructure_Final Internal Audit Report October 2023 (Review reference: CTM-2324-19)	IT Infrastructure 3.1 Documentation should be produced that sets out the processes for: - Managing and configuring Solarwinds; and - Handling of alerts.	Internal Audit/2023/148/MD2/1	The Individual has now left. Management of the SolarWinds platform is now shared across the infrastructure team, although there is no lead and documentation produced is of limited value. Develop the skills and documentation within the team to maximise the use and value of the system for monitoring purposes. Recruit Additional staff in line with the Infrastructure Review resource plan."	Digital & Data Director of Digital	30.06.2024	30.03.2025	Medium	In progress	November 2024 Update - Significant disruption due Critical Incident (CI) at PoW and a shortage of resource has again impacted progress on this activity. Additional recruitment into the team is underway. September 2024 Update - Due to lack of resource/competing priorities minimal progress beyond day to day use and basic maintenance of the system has been made - we are hoping to remedy this by adding additional capacity to the Voice and Data team. New proposed due date 30/03/2025. July 2024 Update - Due to lack of resource/competing priorities minimal progress beyond day to day use and basic maintenance of the system has been made.
Internal Audit/2023/148	09/10/2023	IT Infrastructure_Final Internal Audit Report October 2023 (Review reference: CTM-2324-19)	IT Infrastructure 1.1a Work to complete the register / CMDB should be progressed. Asset information for the Bridgend area should be included and kept up to date.	Internal Audit/2023/148/MD4/1	The Asset manager has been extended to March 2024. They will continue to gather and maintain records of these assets. Service Management tooling and the related CMDB are not in place and a system for this requires investment. A case will be developed to support with the specification, costs and resources required for this.	Digital & Data Director of Digital	31.03.2024	30.09.2024	Low	Overdue	Revised Due Date - end of Qtr. 2 2024/2025 November 2024 Update - A bid for the Armis software has been included in a recent Digital capital slippage bid to WG. We are waiting for feedback on that bid to see if funding for Armis can be included. September 2024 Update - A case has been developed for procuring a system called ARMIS will support with the detailed discovery of all network connected devices on the network. This will also allow for the recording of all asset information in a single database, although progress around making this information, and information already held available to a service desk related CMDB will need to be progressed. July 2024 Update - PoC for Armis (passive scanner for all networked devices including IOT and Media) is underway. This will conclude at the end of July and following that, a recommendation will be made around it's suitability as a register/CMDB will be made, with the case for funding to follow.
Internal Audit/2023/37	06/06/2023	Arrangements for Managing Service Level Agreements_Final Internal Audit Report June 2023 (Review reference: CTMUHB-2223-17)	SLA Arrangements 1.0 To aid the Health Board in achieving more efficient use of resources, a consistent approach for entering into SLA agreements should be adopted. Guidance should be in place to provide clarity on the roles and responsibilities of the central commissioning team in supporting service managers when SLAs are set up. The development of procedures, guidance and templates should be completed, approved and made available to all staff. Communication with staff should take place, to ensure staff are aware of the Health Board's desired approach and prevent the use of localised procedures and approaches that may not comply with the Scheme of Delegation or allow value for money to be achieved.	Internal Audit/2023/37/MD1/1	A project team has been set up to develop the guidance required for development of SLAs. This includes Strategy and Transformation, Finance (Commissioning) leads and will include Procurement and Care Group representatives as the work progresses. This group will: • Develop guidance for the development of SLAs. • Provide templates for SLAs and service specifications. • Ensure all SLAs currently in place are recorded on the register of agreements and have Strategy, Commissioning and Care Group (service) leads. This guidance will be supported by a clear structure of governance supported by meetings with each Care Group to manage and monitor SLAs. Progress already made includes: • A checklist for the development and changes to SLAs has been drafted. • A revised SLA template is being tested for a current SLA development	Commissioning Executive Director of Strategy & Transformation	01.09.2023	30.06.2024	High	Overdue	November 2024 - The Head of Commissioning is facilitating the further review of the SLA checklist. The SLA template is fully revised and in use. The SLA cessation checklist remains in use. Commissioning meetings with care groups are used to facilitate the use of these documents. September 2024 Update - A checklist has been devised for the development of SLAs. There is a checklist for the cessation of SLAs already in place. Both will be reviewed and guidance will be developed following commencement of a Head of Commissioning post in September 2024. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - A service agreement template has been approved for use for 2024-25 agreements. Due to changes to procurement requirements in 2024, staff will require further training to undertake agreements with providers. Training is being organised for Wales NHS teams and spaces for CTMUHB teams have been requested. The process for ceasing arrangements has been reviewed based on NHS service agreement changes and will be supplemented by a process for initiating new agreements. Meetings with each care group occur bi-monthly and provide a mechanism to support setting up, monitoring and ceasing agreements.
Internal Audit/2023/37	06/06/2023	Arrangements for Managing Service Level Agreements_Final Internal Audit Report June 2023 (Review reference: CTMUHB-2223-17)	SLA Arrangements 5.0 Adequate data should be obtained in line with SLA requirements to allow effective performance, quality and financial monitoring of the SLA to take place. The supporting data should be provided in sufficient time before SLA reviews are scheduled to occur so that it can be properly considered at the review. Evidence and supporting data should be retained of the SLA review process.	Internal Audit/2023/37/MD3/1	Please refer to action four above, which confirms that information requirements and review frequency will be determined with Care Groups. The capacity of the Strategy and Transformation team's commissioning function has been a limiting factor in the robust development of processes. A Commissioning Support Officer vacancy is being considered by the organisation's scrutiny panel. This post will lead on organisation of the administration of the register of agreements and the meetings with Care Groups. A Head of Commissioning job description has been developed and has been sent for Agenda for Change banding. This post will be recruited to on a fixed-term basis while the Head of Planning post is vacant due to secondment. Should this role provide successful, every effort will be made to structure the team to retain this function, however this will be dependent upon the team budget.	Commissioning Executive Director of Strategy & Transformation	01.09.2023	30.06.2024	High	Fully complete (Awaiting approval)	November 2024 - All agreements are logged on a corporately held register. Each will have leads allocated and an agreed review frequency. This process will be overseen via commissioning meetings with care groups. September 2024 Update - Regular meetings with all care groups enable monitoring and review of SLAs. There are meetings in place with all health boards which provide services to the health board. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - The regular care group commissioning meetings provide a structure to ensure appropriate review of agreements. A final adjustment to the register of agreements is inclusion of monitoring leads for both planning/ commissioning and care groups.
Internal Audit/2023/37	06/06/2023	Arrangements for Managing Service Level Agreements_Final Internal Audit Report June 2023 (Review reference: CTMUHB-2223-17)	SLA Arrangements 3.0 When SLAs are agreed the documentation should be completed to include the details of the lead contact for the Health Board. SLAs should be signed on behalf of the Health Board as the commissioning body and by the provider before the start of the period to which it applies to confirm agreement with its terms and conditions.	Internal Audit/2023/37/MD4/1	The guidance to be developed, as described in the response to action one will include clarity on processes for signing and storing of agreements.	Commissioning Executive Director of Strategy & Transformation	01.09.2023	30.06.2024	Medium	Overdue	November 24 - Update as per September. The Head of Commissioning is now in post and undertaking further review of guidance. All new agreements will have lead officers allocated. September 2024 Update - A draft checklist has been compiled and a checklist for ceasing SLAs is already in place. Both will be reviewed and guidance developed by the Head of Commissioning, who commenced in post in September 2024. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - Guidance will be finalised when the HB teams complete training on new procurement requirements, however the commissioning meetings with care groups provide a structure to ensure there is support for appropriate sign off and storage of agreements.
Internal Audit/2023/37	06/06/2023	Arrangements for Managing Service Level Agreements_Final Internal Audit Report June 2023 (Review reference: CTMUHB-2223-17)	SLA Arrangements 4.0 SLAs should be reviewed in line with timeframes set out within them and the spreadsheet register kept up to date with renewal dates.	Internal Audit/2023/37/MD5/1	The meetings to be initiated with Care Groups as described in the actions above and the updating of the register of agreements will include the required performance information for each agreement and frequency of reporting, with the officers responsible for review to be identified.	Commissioning Executive Director of Strategy & Transformation	01.09.2023	31.01.2024	Medium	Fully complete (Awaiting approval)	November 2024 - SLAs continue to form part of the commissioning Care Group meetings and external commissioning meetings with providers. This action is considered completed and is proposed for closure. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - Monitoring and review of agreements is a constituent part of the regular commissioning meetings with care groups.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Reference Number	Action	Executive / Inspection Lead	Original Due Date	Current Due Date	Action Rating	Progress Status	Comments/Updates
Internal Audit/2023/54	06.02.2023	Medical Variable Pay – Agency Costs_Final Internal Audit Report February 2023 (Review reference: CTMUHB-2223-12)	Medical Variable Pay 2.1 2.1a The process for using non-direct engaged medical locums should be reviewed to ensure suitable controls, scrutiny, challenge and authorisation is in place going forward. 2.1b The FCP and SOP should be updated to reflect the correct process to be followed, and staff should be made aware of the correct processes and the additional cost implications of using non-direct engaged staff.	Internal Audit/2023/54/MD1/1	2.1a The process around non-direct engagement booking will be fully reviewed. Any identified shortcomings, along with the recommendations of this audit, will be rectified and added to the SOP and FCP. 2.1b Staff will be provided with the new FCP and SOP. They will also be provided with training on how to apply these to this particular part of the audit. The training will be recorded centrally, to ensure every area using the system is up to date with their responsibilities relating to it. Part of this training will be conveying the importance of direct engagement (DE) bookings and the financial benefit to the Health Board.	Medical Directorate and People Executive Medical Director Executive Director for People	01.06.2023	01.06.2023	High	Partially complete (Overdue)	November 2024 Update - The FCP and SOP are currently being revised and will be available on the intranet. A provisional timetable for training will be discussed and agreed. Re-opened October 2024 - Follow Up Report Medical Variable Pay - Agency Costs received by the Audit & Risk Committee on the 17th October. Internal Audit Colleagues consider this item not to be fully complete and therefore it has been re-opened as partially implemented with the residual aspect in relation to updating the Financial Control Procedure. To close this action please indicate which section of the new FCP addresses these points. January 2024 Update - We have now achieved a 98% DE compliance due to the introduced policy. The remaining non-DE are on medium/long term contracts and when they conclude will only be replaced with DE rates. As such we are happy to close this risk/concern down. December 2023 Update - We have now achieved 97% DE across the HB. There are a few remaining non-DEs that were part of agreement before we applied the new rules. These will not be repeated when agreement comes to an end. October 2023 Update - Planned Care, Primary and Community and DT+5 have DE rates of over 98%. The Care Groups that have the most non engaged Doctors are Unscheduled Care and Mental Health. The Unscheduled Care group sent a letter to all agency workers giving them a 6 week period to establish engagement.
Internal Audit/2023/54	06.02.2023	Medical Variable Pay – Agency Costs_Final Internal Audit Report February 2023 (Review reference: CTMUHB-2223-12)	Medical Variable Pay 2.2 The Health Board should resume previous work undertaken with Retinue to encourage agency locums to switch to being directly engaged.	Internal Audit/2023/54/MD2/1	2.2. All current agency workers being used by the organisation will be reviewed for their DE status. Any that are not being engaged through DE will be approached to switch. Retinue will be required to offer up DE candidates in the first instance if available, as well as encourage non-DE agency workers seeking to work in Cwm Taf Morgannwg to switch to DE. This will become a constant process of analysis and identification of non-DE workers in the Health board, which will allow the organisation to target and reduce DE use.	Medical Directorate and People Executive Medical Director Executive Director for People	01.06.2023	01.06.2023	High	Partially complete (Overdue)	November 2024 Update - A meeting is scheduled to take place on 25/11/2024 to discuss this action. Re-opened October 2024 - Internal Audit Report Follow Up Medical Variable Pay - Agency Costs - September 2024 - this inspection stated that Internal Audit did not consider this action to be fully completed. It was concluded that this matter arising should be marked as partially implemented, with the residual aspect in relation to updating the FCP. To close this action please indicate which section of the new FCP addresses these points. December 2023 Update - Completed as Direct Engagement now managed. October 2023 Update - Planned Care, Primary and Community and DT+5 have DE rates of over 98%. The Care Groups that have the most non engaged Doctors are Unscheduled Care and Mental Health. The Unscheduled Care group sent a letter to all agency workers giving them a 6 week period to establish engagement.
Internal Audit/2023/54	06.02.2023	Medical Variable Pay – Agency Costs_Final Internal Audit Report February 2023 (Review reference: CTMUHB-2223-12)	Medical Variable Pay 5.1 Following the implementation of any actions arising from the Medical Productivity Board, the future reporting and monitoring requirements, in relation to medical variable pay, should be agreed and the FCP updated accordingly.	Internal Audit/2023/54/MD3/1	5.1 Finance currently provide comprehensive reports to the Care Groups detailing medical spend. This reporting will continue to happen and any additional requirements recommended by the Medical Productivity Board (MPB) will be added to this financial dataset. The FCP will be updated to reflect the recommendations from the MPB as soon as they are communicated.	Medical Directorate and People Executive Medical Director Executive Director for People	01.06.2023	01.06.2023	High	Partially complete (Overdue)	November 2024 Update - A meeting is scheduled to take place on 25/11/2024 to discuss this action. Reopened October 2024 following the Internal Audit on MVP Agency Costs September 2024 where Internal Audit considered this action to be only partially completed and added the following commentary: "Whilst it has been confirmed that the relevant financial information is being appropriately disseminated, there remains an outstanding requirement to incorporate details of financial monitoring procedures into the revised FCP. We consider this matter arising partially implemented, with the residual aspect in relation to updating the FCP reported under Matter Arising 1." To close this action please indicate which section of the new FCP addresses these points. December 2023 Update - Completed as process now in place for Care Groups to oversee. This is process going forwards. October 2023 Update - Care Groups given monthly spend broken down into DE rates, ADH and locum agency spend. Divided into specialities and Doctor grades so target areas can be then addressed in Medical Productivity Group. Will need to include once rate card is implemented on number of breaches of the rate card and where specific problems are.
Internal Audit/2023/54	06.02.2023	Medical Variable Pay – Agency Costs_Final Internal Audit Report February 2023 (Review reference: CTMUHB-2223-12)	Medical Variable Pay 6.1 6.1a The process for seeking CSG Manager approval to use agency staff to cover roster gaps should be reviewed to ensure that agency use is appropriate. 6.1b The FCP and SOP should be updated to reflect the correct process to be followed.	Internal Audit/2023/54/MD6/1	6.1a A process for authorisation will be clearly defined and communicated via the new FCP and SOP. How to undertake this process and ensure authorisation is gained, will be incorporated into the training provided to all areas using agency staff. 6.1b The recommendations and subsequent processes developed will be included in the FCP and SOP.	Medical Directorate and People Executive Medical Director Executive Director for People	01.08.2023	01.08.2023	High	Partially complete (Overdue)	November 2024 Update - Discussions are taking place regarding further training for staff to ensure correct reasons are entered into the system. A meeting is scheduled to take place on 25/11/2024 to discuss this action. Reopened October 2024 - Internal Audit Report MVP Agency Costs September 2024 advised that Internal Audit considered this action to only be partially completed. The following commentary was concluded in their findings: "The FCP and SOP are yet to be updated to include information on the process for authorisation for the use of agency staff. However, as the process is now undertaken via the Retinue system, we confirmed appropriate manager approval of bookings from our review data relating to bookings for the period October 2023 to March 2024. Conclusion: Whilst the FCP and SOP have not been updated, we were able to evidence booking approvals via the Retinue system. We consider this matter arising partially implemented, with the residual aspect in relation to updating the FCP reported under Matter Arising 1." To close this action please indicate which section of the new FCP addresses these points. December 2023 Update - Rate Card has now been launched. First review due in end of Nov 2023. October 2023 Update - Non Consultant Rate Card has been agreed by Execs. Launch is 19th October. There will be a new governance and reporting system led by both DMDs that the care groups MUST report into if there are any breaches of the rate card. The Care Groups can breach up to 10% of the rate however this must be done in extreme circumstances only. The EMD can only authorise over 10% of the rate.
Internal Audit/2023/54	06.02.2023	Medical Variable Pay – Agency Costs_Final Internal Audit Report February 2023 (Review reference: CTMUHB-2223-12)	4.1 It should be ensured that suitable processes are in place and adhered to for engaging agency staff on a longer-term basis, or for extending any placements thus making them longer term. Prior to authorising longer-term placements, it should be confirmed that recent efforts to recruit into the post have been made and that plans for future recruitment attempts are in place, to prevent ongoing reliance on the agency locum. Where there is a need to extend existing placements, it should be ensured that a review of the current post holder and any alternative agency staff is carried out to ensure the Health Board is achieving value for money and the best fit person is used.	Internal Audit/2023/54/MD7/1	4.1 - The recommendations of this action will be included in the FCP and SOP. Setting out a clear process for extending agency workers placements, that ensure the recommended considerations are taken and recorded, before offering an extension. Training will be provided to all areas on how and when this process is to be used, to ensure the Health Board gets the correct balance between value for money and the correct person for the role.	Medical Directorate and People Executive Medical Director Executive Director for People	31.08.2023	31.08.2023	High	Partially complete (Overdue)	November 2024 Update - A meeting is scheduled to take place on 25/11/2024 to discuss this action. Likely to be rules and plans for looking at data and improvements. Re-opened October 2024 - This action has been entered on AMA7 as the Internal Audit MVP Agency Costs for September 2024 concluded that this item was only partially completed. Internal Audit commented: "The FCP and SOP have not been updated to provide clarity on extending agency worker placements. However, our review of booking data identified that longer-term placements, which represent a minority of engagements, were subject to regular re-approval via the Retinue system. We saw evidence that management have worked to substantively recruit longer term agency staff in some cases. Details of individual longer-term placements are reported to the Audit & Risk committee, and reasons are provided to explain their necessity. Whilst the FCP and SOP have not been updated, work has been carried out by the Health Board to reduce the numbers of longer-term placements. We consider this matter arising partially implemented, with the residual aspect in relation to updating the FCP reported under Matter Arising 1." To close this action please indicate which section of the new FCP addresses these points.
Internal Audit/2023/57	03/04/2023	Reasonable Offer Process_Internal Audit Report April 2023 (Review reference: CTMUHB-2223-04)	Reasonable Offer Process 1.1 As we continue to move away from a pandemic environment, the Health Board should review its approach to the provision of reasonable appointment offers and the subsequent management of waiting lists, in light of any additional WG guidance issued during the course of the pandemic. The Waiting List Management Standard Operating Procedure should be reviewed, updated and appropriately approved. Previous versions of the Waiting List Management Standard Operating Procedure should be removed from the Health Board's intranet site and only the current version published.	Internal Audit/2023/57/MD1/1	Standard Operating Procedures to be reviewed and updated with approval at OMB and Executive Leadership Group. Once approved, the SOP will be published and issued to all booking teams. Previous versions of the SOP will be removed from the intranet and kept in a historical record.	Care Group - Planned Care Chief Operating Officer	30.04.2023	30.04.2024	Medium	Fully complete (Awaiting approval)	Update October 2024 - Internal Audit Review Follow Up: Reasonable Offer received at the Audit & Risk Committee in October 2024. All previous actions have been superseded and replaced with new recommendations captured in the new inspection Report. This action will close and readers are asked to direct to the new inspection report for the latest position. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - SOP updated in 2023. Update to document currently being reviewed as required as currently does not align with Regional working and current organisational structure following OCPs. As described training needs are being highlighted but review for implementation now post OCP phase 2 & 3 aligned with the updated SOP.
Internal Audit/2023/57	03/04/2023	Reasonable Offer Process_Internal Audit Report April 2023 (Review reference: CTMUHB-2223-04)	Reasonable Offer Process 2.3 Consideration should be given to the current approach of having some bookings managed centrally and some managed within specialities, to ensure that the chosen approach does not place the Health Board at greater risk of having inconsistent approaches, errors in application of the RTT rules and over-reliance on key individuals. (We acknowledged that instigating data validation checks will need to take place first to allow relevant information to be available on non-conformance.)	Internal Audit/2023/57/MD2/1	A review of the structures in Bridgend will take place. A plan for an organisational restructure with a standardised approach will be developed.	Care Group - Planned Care Chief Operating Officer	30.06.2023	30.04.2024	Medium	Fully complete (Awaiting approval)	Update October 2024 - Internal Audit Review Follow Up: Reasonable Offer received at the Audit & Risk Committee in October 2024. All previous actions have been superseded and replaced with new recommendations captured in the new inspection Report. This action will close and readers are asked to direct to the new inspection report for the latest position. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - Larger organisational changes are still currently taking place. But a paper has been produced for "consolidation of booking Teams" to move from POW over to CTM (M&R) under Medical Records. Discussions with Sandra McConnell and with Matthew Swardfield confirmed that the "'re-structure'" of the booking teams is still ongoing but a review has been undertaken with a position paper submitted to the COO setting out the approach to the restructure. The paper outlines the proposal to transfer the line management of Princess of Wales Booking Team to come under the same management structure as the rest of the core outpatient booking and medical records in the Health Boards. This is now for Care Groups to agree the next steps of an OCP with the teams across POW site. Meetings have been arranged mid August.
Internal Audit/2023/57	03/04/2023	Reasonable Offer Process_Internal Audit Report April 2023 (Review reference: CTMUHB-2223-04)	Reasonable Offer Process 3.1 The Health Board should perform a training needs assessment of staff responsible for booking appointments and arrange for refresher training on the application of the Waiting List Management SOP/RTT rules, specifically in relation to reasonable offers and the required audit trail within WPAS.	Internal Audit/2023/57/MD3/1	A training needs assessment and compliance sign off will take place post implementation of the agreed SOP. Refresher training to be organised where required for staff identified.	Care Group - Planned Care Chief Operating Officer	01.08.2023	30.04.2024	Medium	Fully complete (Awaiting approval)	Update October 2024 - Internal Audit Review Follow Up: Reasonable Offer received at the Audit & Risk Committee in October 2024. All previous actions have been superseded and replaced with new recommendations captured in the new inspection Report. This action will close and readers are asked to direct to the new inspection report for the latest position. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - SOP updated in 2023. Update to document currently being undertaken and required as currently does not align with Regional working and current organisational structure. As described training needs are being highlighted but review for implementation post OCP phase 2 & 3 aligned with the updated SOP.
Internal Audit/2023/57	03/04/2023	Reasonable Offer Process_Internal Audit Report April 2023 (Review reference: CTMUHB-2223-04)	Reasonable Offer Process 5.1 A review of the approach to data validation to ensure compliance with the Waiting List Management SOP and RTT rules should be undertaken. A pro-active, consistent and independent approach should be adopted regardless of whether the booking has been made by a central booking team or the speciality themselves. The Waiting List Management SOP should be updated to reflect the validation process. Ongoing data validation work should be used to identify trends in errors to allow training to be targeted on certain aspects of the process or to certain teams / specialities. Where there are persistent errors in specialities consideration should be given as to whether it is appropriate for that service to retain managing its own bookings, or if the process should revert to one of the central booking teams.	Internal Audit/2023/57/MD4/1	5.1.1 - Identification of WPAS reports to allow for identification of compliance. 5.1.2 - Development of process to escalate where processes are not being followed consistently, sharing training documents/ SOP to support improvements"	Care Group - Planned Care Chief Operating Officer	01.08.2023	30.04.2024	High	Fully complete (Awaiting approval)	Update October 2024 - Internal Audit Review Follow Up: Reasonable Offer received at the Audit & Risk Committee in October 2024. All previous actions have been superseded and replaced with new recommendations captured in the new inspection Report. This action will close and readers are asked to direct to the new inspection report for the latest position. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - Reports on duplicates and pop ups are available and updated daily. A weekly report on Closed pathways but waiting is circulated to all teams weekly. Validation team in place for stage 1 waiting lists. Service validation continuous. Distribution and access requires update post Phase 2 & 3 of OCP.
Internal Audit/2023/73	08/08/2023	Follow-up: Radiology Workforce_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2324-22)	Radiology Workforce Follow Up Review 5.0 Work should continue to resolve the issues raised with the five Consultant job plans within PoW.	Internal Audit/2023/73/MD5/1	Current compliance POW: • 7 signed off • 1 awaiting 1st sign off • 1 expired but booked – date arranged for 20/09	Diagnostics, Therapies, Pharmacies & Specialities Chief Operating Officer	30.09.2023	31.12.2023	Low	Fully complete (Awaiting approval)	November 2024 Update - Compliance is 86%. 4 Job Planning meetings outstanding. Complete. September 2024 Update - 73% due to 4 new starters in the department who started in this last two weeks. Still issues with Med Staffing teams not sending out notifications to prompt first sign off. A tracker and schedule has been implemented. July 2024 Update - 23 Consultants with an up to date JP. 5 are booked or with a further change needed. 3 to be arranged (1 staff member on LTS). Compliance 79%. 58 emailed all consultants requesting them to 1st sign if they had not.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Reference Number	Action	Executive / Inspection Lead	Original Due Date	Current Due Date	Action Rating	Progress Status	Comments/Updates
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	1.1a A standardised approach to the application of the 4-hour performance clinical exception guidance should be established by the Health Board. 1.1bA comprehensive SOP should be created for use across all sites setting out a standardised approach to the application of the WG guidance on calculating the 4-hour performance target and the use of breach exemptions. The SOP should include details on capturing and recording data in relation to the 4-hour performance target, especially definitions for recording of times, when breach exception codes can be used, the responsibility for inputting data and the validation process. Managers across all sites need to be involved in the process of creating SOP.	Internal Audit/2024/162/MD1/1	Develop standardised approach to application of 4 hour clinical exception to include a pan CTM SOP for application of WG guidance.	Care Group - Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	High	Overdue	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	1.2 A review of the breach reason codes should be carried out to establish a consistent set of codes to be used across all sites. This will allow the Health Board the ability to consistently monitor reasons for patients spending longer than 4 hours in ED and help inform decision making.	Internal Audit/2024/162/MD2/1	Develop a standardised set of codes to be used across all sites.	Care Group - Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	Medium	Overdue	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	2.1Staff should be reminded of the importance of consistently and fully completing CAS cards with all required information. Management should gain an understanding from staff why the summary table as seen on the front of PoW CAS cards is not being completed and determine if it's used could be beneficial for all sites.	Internal Audit/2024/162/MD3/1	Communicate through safety briefings the importance of fully completing CAS Cards and review implementation of summary table across all sites.	Care Group - Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	High	Overdue	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	2.2 The CAS cards at each site should be reviewed with a view to creating a standardised CAS card that explicitly sets out the key information that should be recorded.	Internal Audit/2024/162/MD4/1	Develop standardised CAS card for all sites in conjunction with Clinical Director and Lead Nurse.	Care Group - Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	Medium	Overdue	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	3.1 Acknowledging that two versions of WPAS are in use by the Health Board, were possible a consistent approach to WPAS training should be in place for staff across the sites to ensure data capture is consistent. Once a SOP has been agreed, standard training on the application of the breach exemption and breach reason codes should be provided to relevant staff, along with an overview of the rationale for capturing information.	Internal Audit/2024/162/MD5/1	Ensure standardised approach to training across all ED's, monitor through Directorate Performance Meetings.	Care Group - Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	High	Overdue	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	4.1The importance of clearly and consistently capturing key date and time information on the CAS cards should be reiterated to staff and additional training provided where necessary. The importance of accurately transferring data from the CAS cards to WPAS should be reiterated to staff and additional training provided where necessary.	Internal Audit/2024/162/MD6/1	Ensure standardised approach to training across all ED', monitor through Directorate Performance Meetings.	Care Group - Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	High	Overdue	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	4.2The criteria for determining the treatment complete time should be reviewed with a view to having a consistent definition in place across all sites. Similarly, the approach to applying breach exemption codes, specifically relating the time in the patient's journey when they are applied, should be reviewed to ensure consistency. The agreed approaches should be captured in a SOP.	Internal Audit/2024/162/MD7/1	- Undertake review of treatment complete time and implement consistent definition on all sites. - Ensure breach exemption codes applied consistently, develop SOP and monitor through Directorate Performance Meetings.	Care Group - Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	Medium	Overdue	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	5.1A record should be maintained of the adjustments made including who originally input the data and the error that was rectified. The data should be used to identify staff training requirements.	Internal Audit/2024/162/MD8/1	Implement a standardised approach to capturing any changes to records, monitor through Directorate Performance reviews	Care Group - Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	Medium	Overdue	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	5.2Further work should be undertaken to ensure that those cases adjusted as part of the retrospective validation process are being correctly captured and reported. Consideration should be given to maintaining a record of the WPAS entries that have been adjusted in order to allow spot checks to be performed to confirm the adjustment was correctly captured on the system.	Internal Audit/2024/162/MD9/1	Undertake regular "snapshot" audits to ensure validation is correctly captured and monitor through Directorate Performance reviews.	Care Group - Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	High	Overdue	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	5.3A review of the validation approaches currently in place across the sites should be carried out. It should be clear what the objective of validation work is, and a standard approach applied across site to ensure consistency in reporting.	Internal Audit/2024/162/MD10/1	Review validation approaches across all ED's and implement a standardised approach to reporting.	Care Group - Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	Medium	Overdue	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	5.4A data cleansing exercise should be carried out on the POW outstanding cases spreadsheet. Given the age of some of the entries, it should be determined if validation is worthwhile.	Internal Audit/2024/162/MD11/1	Undertake review of outstanding cases at POW and determine if validation is required	Care Group - Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	Low	Overdue	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	6.1 Weekly senior management team meetings at POW should be reinstated as a forum for discussing ED performance matters including performance against the 4-hour target.	Internal Audit/2024/162/MD12/1	Re-instate weekly SM meetings at POW.	Care Group - Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	Medium	Overdue	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	6.2 Agendas and action logs of all key groups and committees should be retained to support the discussions and decisions made during the meeting and to ensure actions are captured and followed up at subsequent meetings.	Internal Audit/2024/162/MD13/1	Ensure agenda and action logs are retained.	Care Group - Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	Medium	Overdue	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	6.3 Consideration should be given to incorporating site specific data as part of the slide deck taken to the USC Care Group performance meetings to allow more enhanced monitoring and discussion of issues per site.	Internal Audit/2024/162/MD14/1	Site specific slide deck in place, ensure used to underpin discussions.	Care Group - Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	Medium	Overdue	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	6.4Consideration should be given to undertaking more detailed reporting that provides analysis of the data currently presented, such as the proportion of non-breaches that are as a result of clinical exemptions, and the proportion of 'did not wait'. Analysis of the breach reason codes, should be undertaken with the aim of better understanding the causes of patients exceeding the 4-hour target.	Internal Audit/2024/162/MD15/1	Develop a more detailed report to include analysis of breach codes.	Care Group - Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	Medium	Overdue	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/163	08.02.2024	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	1.1Management should ensure that the service catalogue is complete with all required information, and that it is regularly reviewed and updated.	Internal Audit/2024/163/MD1/1	Ensure the Service Catalogue is updated to reflect all of the critical systems in place and complete the additional fields including identifying if the system is locally managed or run by a supplier, and also identify where the system is hosted.	Digital & Data Director of Digital	01.07.2024	01.03.2025	Medium	In progress	November 2024 Update - The Critical Incident (CI) at PoW has disrupted this action. Whilst the Head of Digital Service Management is now in place, they are still covering a number of activities from their old role whilst we recruit and onboard a new Head of Datacentres and Cloud. September 2024 Update - We have now successfully appointed a new Head of Digital Service Management, we will be looking to transfer over responsibilities from mid-October 2024. New proposed due date - 01/03/2025. July 2024 Update - There are further delays to recruitment, it is hoped that recruitment will now start in August.
Internal Audit/2024/163	08.02.2024	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	1.1Management should ensure that the service catalogue is complete with all required information, and that it is regularly reviewed and updated.	Internal Audit/2024/163/MD1/2	Further refine and review the Service Catalogue and extend it to include dependencies of local, national and cloud infrastructure. E.g. The majority of systems are accessed via CTM Managed end user devices so the review should ensure that these common components (such as Citrix, Wireless, LAN and WAN) are reviewed for their resilience and recover ability.	Digital & Data Director of Digital	01.07.2024	01.03.2025	Medium	In progress	November 2024 Update - The Critical Incident (CI) at PoW has disrupted this action. Whilst the Head of Digital Service Management is now in place, they are still covering a number of activities from their old role whilst we recruit and onboard a new Head of Datacentres and Cloud. September 2024 Update - We have now successfully appointed a new Head of Digital Service Management, we will be looking to transfer over responsibilities from mid-October 2024. New proposed due date - 01/03/2025. July 2024 Update - There are further delays to recruitment, it is hoped that recruitment will now start in August.
Internal Audit/2024/163	08.02.2024	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	2.1Management should ensure that knowledge management is progressed through the creation and development of ITIL aligned processes and procedures.	Internal Audit/2024/163/MD2/1	Creation of a Digital Service Management Function. Create a Digital Service Management function as part of current structural review of Digital Delivery. Appoint into the vacant Head of IT Service Management role. Then assess current maturity of ITIL aligned processes and procedures and prioritise development.	Digital & Data Director of Digital	01.10.2024	31.07.2025	Medium	In progress	November 2024 Update - The Critical Incident (CI) at PoW has disrupted this action. Whilst the Head of Digital Service Management is now in place, they are still covering a number of activities from their old role whilst we recruit and onboard a new Head of Datacentres and Cloud. New revised date of 31/07/25. September 2024 Update - We have now successfully appointed a new Head of Digital Service Management, we will be looking to transfer over responsibilities from mid-October 2024. July 2024 Update - There are further delays to recruitment, it is hoped that recruitment will now start in August.

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Internal Audit/2024/163	08.02.2024	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	3.1 Management should establish a defined relationship management framework to align expectations, improve communication and manage risk, and develop relationship metrics to assess their quality, value and impact.	Internal Audit/2024/163/MD3/1	Once a Digital Service Management function has been created (Action 2.1) develop a framework and approach to internal service relationship. This action is predicated on the development of our service catalogue (Action 1.1) as well as an approach to business relationship management (BRM) that will need to span the Digital Delivery, Digital Systems and Digital Intelligence, Compliance & Design.	Digital & Data Director of Digital	01.01.2025	01.01.2025	Medium	In progress	November 2024 Update - The Critical incident (CI) at PoW has disrupted this action. Whilst the Head of Digital Service Management is now in place, they are still covering a number of activities from their old role whilst we recruit and onboard a new Head of Datacentres and Cloud. September 2024 Update - We have now successfully appointed a new Head of Digital Service Management, we will be looking to transfer over responsibilities from mid-October 2024. July 2024 Update - There are further delays to recruitment, it is hoped that recruitment will now start in August.
Internal Audit/2024/163	08.02.2024	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	4.1Management should implement and maintain a single, central register of suppliers and contracts to allow visibility and control over contract data, costs, documentation, action plans and supplier performance data.	Internal Audit/2024/163/MD4/1	Once a Digital Service Management function has been created (Action 2.1) develop a single, central register of suppliers and contracts. This will need co-ordination with our internal Business Admin team, Finance and Procurement.	Digital & Data Director of Digital	01.10.2024	31.07.2025	Medium	In progress	November 2024 Update - The Critical incident (CI) at PoW has disrupted this action. Whilst the Head of Digital Service Management is now in place, they are still covering a number of activities from their old role whilst we recruit and onboard a new Head of Datacentres and Cloud. New revised date of 31/07/25. September 2024 Update - We have now successfully appointed a new Head of Digital Service Management, we will be looking to transfer over responsibilities from mid-October 2024. July 2024 Update - There are further delays to recruitment, it is hoped that recruitment will now start in August.
Internal Audit/2024/163	08.02.2024	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	4.2Management should ensure that an appropriate framework for effective supplier and contract management is developed which allows for clear, planned, and regular activity e.g., measuring and policing supplier performance and active management of contract key dates and milestones.	Internal Audit/2024/163/MD5/1	Creationof a tiered frameworkcategorising high, medium andlow value/importancesuppliers and contracts, and the appropriate level of governance and level of management given to each category.	Digital & Data Director of Digital	01.10.2024	31.07.2025	High	In progress	November 2024 Update - The Critical incident (CI) at PoW has disrupted this action. Whilst the Head of Digital Service Management is now in place, they are still covering a number of activities from their old role whilst we recruit and onboard a new Head of Datacentres and Cloud. New revised date of 31/07/25. September 2024 Update - We have now successfully appointed a new Head of Digital Service Management, we will be looking to transfer over responsibilities from mid-October 2024. July 2024 Update - There are further delays to recruitment, it is hoped that recruitment will now start in August.
Internal Audit/2024/163	08.02.2024	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	4.3 Management should ensure that efficient contract control measures are developed and employed with appropriate oversight, to ensure that suppliers maintain performance and invoices are issued correctly.	Internal Audit/2024/163/MD6/1	This action is closely tied to action 4.2 and the appropriate controls will need to be placed with supplier and contract management framework.	Digital & Data Director of Digital	01.10.2024	31.07.2025	High	In progress	November 2024 Update - The Critical incident (CI) at PoW has disrupted this action. Whilst the Head of Digital Service Management is now in place, they are still covering a number of activities from their old role whilst we recruit and onboard a new Head of Datacentres and Cloud. September 2024 Update - We have now successfully appointed a new Head of Digital Service Management, we will be looking to transfer over responsibilities from mid-October 2024. July 2024 Update - There are further delays to recruitment, it is hoped that recruitment will now start in August.
Internal Audit/2024/163	08.02.2024	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	5.1 Management should ensure that the pre-defined call functionality is expanded to all applicable services, to have a consistent approach to logging calls and more accurate metrics.	Internal Audit/2024/163/MD7/1	This action is dependent on the selection, procurement, and implementation of a new ITSM tool. There is an expectation that ServicePoint is being deprecated by DHCW with the next 12 months. A bid for a new ITSM tool will be placed in the IMTP for 24-25.	Digital & Data Director of Digital	01.04.2025	01.04.2025	Low	In progress	November 2024 Update - The Critical incident (CI) at PoW has disrupted this action. Whilst the Head of Digital Service Management is now in place, they are still covering a number of activities from their old role whilst we recruit and onboard a new Head of Datacentres and Cloud. September 2024 Update - We have now successfully appointed a new Head of Digital Service Management, we will be looking to transfer over responsibilities from mid-October 2024. July 2024 Update - There are further delays to recruitment, it is hoped that recruitment will now start in August.
Internal Audit/2024/163	08.02.2024	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	5.2 Management should ensure that where available, the pre-defined call functionality is used to allow for the accurate recording of details, such as call type and priority.	Internal Audit/2024/163/MD8/1	This action is dependent on the selection, procurement, and implementation of a new ITSM tool. There is an expectation that ServicePoint is being deprecated by DHCW with the next 12 months. A bid for a new ITSM tool will be placed in the IMTP for 24-25	Digital & Data Director of Digital	01.04.2025	01.04.2025	Low	In progress	November 2024 Update - The Critical incident (CI) at PoW has disrupted this action. Whilst the Head of Digital Service Management is now in place, they are still covering a number of activities from their old role whilst we recruit and onboard a new Head of Datacentres and Cloud. September 2024 Update - We have now successfully appointed a new Head of Digital Service Management, we will be looking to transfer over responsibilities from mid-October 2024. July 2024 Update - There are further delays to recruitment, it is hoped that recruitment will now start in August.
Internal Audit/2024/163	08.02.2024	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	5.3Management should ensure that requests such as staff termination forms are accurately logged.	Internal Audit/2024/163/MD9/1	This action is dependent on the selection, procurement, and implementation of a new ITSM tool. There is an expectation that ServicePoint is being deprecated by DHCW with the next 12 months. A bid for a new ITSM tool will be placed in the IMTP for 24-25	Digital & Data Director of Digital	01.04.2025	01.04.2025	Low	In progress	November 2024 Update - The Critical incident (CI) at PoW has disrupted this action. Whilst the Head of Digital Service Management is now in place, they are still covering a number of activities from their old role whilst we recruit and onboard a new Head of Datacentres and Cloud. September 2024 Update - We have now successfully appointed a new Head of Digital Service Management, we will be looking to transfer over responsibilities from mid-October 2024. July 2024 Update - There are further delays to recruitment, it is hoped that recruitment will now start in August.
Internal Audit/2024/163	08.02.2024	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	5.4 Management should ensure that the classifications data held within ServicePoint is reviewed and cleansed of duplications and are configured for all applicable services.	Internal Audit/2024/163/MD10/1	This action is dependent on the selection, procurement, and implementation of a new ITSM tool. There is an expectation that ServicePoint is being deprecated by DHCW with the next 12 months. A bid for a new ITSM tool will be placed in the IMTP for 24-25	Digital & Data Director of Digital	01.04.2025	01.04.2025	Low	In progress	November 2024 Update - The Critical incident (CI) at PoW has disrupted this action. Whilst the Head of Digital Service Management is now in place, they are still covering a number of activities from their old role whilst we recruit and onboard a new Head of Datacentres and Cloud. September 2024 Update - We have now successfully appointed a new Head of Digital Service Management, we will be looking to transfer over responsibilities from mid-October 2024. July 2024 Update - There are further delays to recruitment, it is hoped that recruitment will now start in August.
Internal Audit/2024/163	08.02.2024	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	6.1Management should ensure that a defined problem management process and procedure is finalised, published, and adopted.	Internal Audit/2024/163/MD11/1	Once a Digital Service Management function has been created (Action 2.1) complete process and procedures for Problem Management.	Digital & Data Director of Digital	01.01.2025	01.01.2025	Medium	In progress	November 2024 Update - The Critical incident (CI) at PoW has disrupted this action. Whilst the Head of Digital Service Management is now in place, they are still covering a number of activities from their old role whilst we recruit and onboard a new Head of Datacentres and Cloud. September 2024 Update - We have now successfully appointed a new Head of Digital Service Management, we will be looking to transfer over responsibilities from mid-October 2024. July 2024 Update - There are further delays to recruitment, it is hoped that recruitment will now start in August.
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	1.1b If the existing SOP at YCR is needed following the implementation of all Health Board guidance, it should be reviewed to ensure that it is consistent with the Health Board wide guidance.	Internal Audit/2024/169/MD2/1	Review of YCR SOP to see if still needed.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	01.06.2024	01.06.2024	Medium	Fully complete (Awaiting approval)	November 2024 Update - The YCR SOP supports the implementation of the incident guidance. This SOP was put in place for submission to the Home Office. Health Board wide guidance now in place and will be used. This can be closed. September 2024 Update - The YCR SOP supports the implementation of the incident guidance. YCR Pharmacy team have been asked to review whether this document is still required, and that as part of any update it needs to be consistent with HB guidance. July 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	2.1a A review of authorised signatory lists should take place to ensure they are up to date.	Internal Audit/2024/169/MD4/1	A review of authorised signatory lists will take place to ensure they are up to date.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	01.09.2024	01.09.2024	High	Fully complete (Awaiting approval)	November 2024 Update - Confirmation received from all Heads of Pharmacy. Confirmation received from all Heads of Nursing. Can be closed September 2024 Update - This allocated to Heads of Nursing/Heads of Midwifery for ward areas and Heads of Pharmacy for Pharmacy locations. All pharmacies currently undertaking updating of signatory lists. Royal Glamorgan working on spreadsheet to ensure when sheets need updating. If workable will be rolled out further. Heads of Nursing and Heads of Pharmacy have been asked for an update of progress. July 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	2.1b Management should remind ward and theatre manager that it is their responsibility to inform pharmacy of any amendments that need to be made to authorised signatory lists.	Internal Audit/2024/169/MD5/1	Nursing management to remind ward and theatre manager that it is their responsibility to inform pharmacy of any amendments that need to be made to authorised signatory lists.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	01.05.2024	01.05.2024	High	Fully complete (Awaiting approval)	November 2024 Update - Confirmation received from all Heads of Nursing. Can be closed September 2024 Update - E-mail sent out to heads of nursing to bring this to the attention of the nursing teams in the safe to start meetings. Need confirmation from Heads of Nursing that this has been completed. July 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	2.1c A process should be established for reviewing authorised signatory lists on a periodic basis, for example forming part of the quarterly audit checks that pharmacy undertake at each ward or theatre.	Internal Audit/2024/169/MD6/1	A process will be established for reviewing authorised signatory lists on a periodic basis, for example forming part of the quarterly audit checks that pharmacy undertake at each ward or theatre.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	01.06.2024	01.06.2024	High	Fully complete (Awaiting approval)	November 2024 Update - Can be closed. Pharmacies have started this review and now forms part of the quarterly CD review. September 2024 Update - Pharmacies have started this review and now forms part of the quarterly CD review. July 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	2.1d Pharmacy staff should be reminded of the importance of referring the authorised signatory lists to ensure order have been place by authorised staff.	Internal Audit/2024/169/MD7/1	Pharmacy staff will be reminded of the importance of referring the authorised signatory lists to ensure order have been place by authorised staff.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	01.05.2024	01.05.2024	High	Fully complete (Awaiting approval)	November 2024 Update - Confirmation received from all Heads of Pharmacy. Can be closed. September 2024 Update - Update from Heads of Pharmacy awaited. July 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	2.2 Management should remind ward and theatre staff of the SOP requirements around: • Retaining copies of order books and controlled drugs registers for the required period of 2 years. • The importance clearly signing controlled drugs orders and registers and printing names where required. • Completing all required fields within the order book and the controlled drugs register. Consideration could be given to requiring staff to sign to confirm they have read the SOPs and understood them, as was the practice at on theatre visited.	Internal Audit/2024/169/MD8/1	Nursing management should remind ward and theatre staff of the SOP requirements around: • Retaining copies of order books and controlled drugs registers for the required period of 2 years. • The importance clearly signing controlled drugs orders and registers and printing names where required. • Completing all required fields within the order book and the controlled drugs register. Consideration will be given to requiring staff to sign to confirm they have read the SOPs and understood them, as was the practice at on theatre visited.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	01.05.2024	01.05.2024	Medium	Fully complete (Awaiting approval)	November 2024 Update - Confirmation received from all Heads of Nursing. Can be closed September 2024 Update - Confirmation from Heads of Nursing that this has been completed awaited. July 2024 Update - An update against this recommendation has not been provided on this occasion.

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Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	2.3 Consideration should be given to amending the SOP to: - Require staff to print their name in addition to signing when taking receipt of controlled drugs from pharmacy and when entering the drugs in the controlled drugs register. - Being more explicit in the name used to describe the drug being ordered i.e. manufacturer name or drug name.	Internal Audit/2024/169/MD9/1	During the next review of the procedure, consideration will be given to amending wording to: - Require staff to print their name in addition to signing when taking receipt of controlled drugs from pharmacy and when entering the drugs in the controlled drugs register. - Being more explicit in the name used to describe the drug being ordered i.e. manufacturer name or drug name.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	31.10.2024	31.10.2024	Low	Fully complete (Awaiting approval)	November 2024 Update - has been added to the updated CD procedure which is undergoing scrutiny at present- can be closed off. September 2024 Update - Will be added as part of the CD procedure update. July 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	3.1 Management should ensure staff are reminded that the CD cabinet keys are to be kept separate and unattached to other keys.	Internal Audit/2024/169/MD10/1	Communication to ensure staff are reminded that the CD cabinet keys are to be kept separate and unattached to other keys.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	01.05.2024	01.05.2024	Medium	Fully complete (Awaiting approval)	November 2024 Update - Confirmation received from all Heads of Pharmacy. Confirmation received from all Heads of Nursing. Can be closed. September 2024 Update - This is allocated to Heads of Nursing/Heads of Midwifery for ward areas and Heads of Pharmacy for Pharmacy locations. Heads of Nursing and Heads of Pharmacy have been asked for an update of progress. July 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	4.1b Ward and theatre managers should be reminded that the weekly checklists cover a wider remit than just a count of controlled drugs held, and of the requirement to complete and retain them in line with the SOP.	Internal Audit/2024/169/MD12/1	Ward and theatre managers will be reminded that the weekly checklists cover a wider remit than just a count of controlled drugs held, and of the requirement to complete and retain them in line with the SOP.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	01.05.2024	01.05.2024	Medium	Fully complete (Awaiting approval)	November 2024 Update - This requirement is being reviewed as part of the update of the CD procedure (i.e. the decision of who should be undertaking this check and at what frequency). It is proposed this would form part of the Pharmacy (independent) check so wouldn't require this to be undertaken weekly by the ward [subject to CDAO approval]. This can be closed. September 2024 Update - E-mail sent to Heads of Nursing to disseminate this information in the safe to start meetings. Awaiting confirmation from Heads of Nursing that action is completed. July 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	6.2 To aid the ability to proactively monitor CD related incidents for patterns and trends that could allow targeted training, the Medicines Management team should liaise with the Datix team to establish if there is a way for meaningful data that is quality checked to be extracted from the system. If this is deemed to not be feasible, then consideration should be given to collating the information captured in the quarterly CDLIN highlight reports to allow analysis to take place.	Internal Audit/2024/169/MD15/1	To aid the ability to proactively monitor CD related incidents for patterns and trend that could allow targeted training, the Medicines Management team will liaise with the Datix team to establish if there is a way for meaningful data that is quality checked to be extracted from the system. If this is deemed to not be feasible, then consideration will be given to collating the information captured in the quarterly CDLIN highlight reports to allow analysis to take place.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	01.06.2024	01.06.2024	Medium	Fully complete (Awaiting approval)	November 2024 update- Datix team have provided three dashboards with information. Discussions on going with team to refine how the information can be presented. This information is presented and discussed at the quarterly CDLIN and Medicines Management Quality and Safety Group. This information is also presented by Care Groups at Medication Safety Group. Can be closed. September 2024 Update - Datix team have provided three dashboards with pharmacy information. Discussions on going with team to hone the information required. July 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	6.3 Consideration should be given to reviewing and monitoring the use of controlled drugs distribution across the site. This will support in reviewing patterns, themes, or periodic changes a period.	Internal Audit/2024/169/MD16/1	Consideration will be given to reviewing and monitoring the use of controlled drugs distribution across the site. This will support in reviewing patterns, themes, or periodic changes a period.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	01.05.2024	01.05.2024	Low	Partially complete (Overdue)	November 2024 Update- Meeting took place October 2024 with Chief Pharmacist Medicines Governance. Options to be sent for final decision to CD accountable officer. To be closed. September 2024 Update - process being reviewed, with meeting set for October with CDAO. July 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	7.1 A central electronic record should be retained of those staff that have undertaken Controlled Drugs training and refresher training. Consideration should be given to using ESR for this purpose.	Internal Audit/2024/169/MD17/1	A central electronic record is retained for staff trained since 2020, however consideration will be given to using ESR for this purpose.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	01.09.2024	01.09.2025	Medium	In progress	November 2024 Update- A central electronic record is retained for staff trained since 2020, however consideration will be given to using ESR for this purpose. Request put to ESR team to add this on. This timeframe will need to be revised for completion 1/9/25. September 2024 Update - Request put in to L&D for training to be added to ESR therefore creating an electronic record that ward/theatre managers can access. July 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/170	12.04.2024	Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-02)	1.1a A policy that outlines the Health Board's approach and responsibilities for GI pathways including demand management should be put in place. 1.1b A review of the draft 'Single CTM Colorectal USC Pathway GP Referral Triage' SOP should be carried out, with a view to creating a single SOP that describes the step-by-step process that should be followed to ensure consistency in service delivery across all sites. It should be ensured that the SOP clearly sets out the excepted process to be followed for areas such as GP and internal referrals, the triage and triage process and timeframes for undertaking the various stages in the process. The draft SOP should be agreed at an appropriate level within the Health Board. Where there are variations in service delivery, such as the Nurse Led Rapid Access One Stop Colorectal Clinic based at PCH, then a separate SOP should be formalised for use.	Internal Audit/2024/170/MD1/1	A CTM Standardised LGI SOP to be developed, reviewed and agreed.	Care Group - Planned Care Chief Operating Officer	30.06.2024	30.06.2024	High	Overdue	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/170	12.04.2024	Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-02)	1.2 Specific guidance should be developed and made available in relation to: - GPs outlining the processes relating to general or non-USC GI referrals. - Internal hospital departments in respect of processes to be undertaken for internal GI referrals.	Internal Audit/2024/170/MD2/1	Following completion of the LGI SOP - this will include flow/process charts and referral criteria to support internal and external referral process.	Care Group - Planned Care Chief Operating Officer	30.06.2024	30.06.2024	Medium	Overdue	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/170	12.04.2024	Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-02)	2. Work should continue to explore the feasibility of integrating the WPRS and WCP/WPAS at PCH and RGH sites and negate the need for the current process of printing referrals from one system for scanning into another system. Management should remind staff that referral and triage documentation for cases should be complete, and records saved within WCP/WPAS.	Internal Audit/2024/170/MD3/1	1. Need confirmation for go live date for LGI/Surgery. 2. Set up meeting with Records and Digital Team	Care Group - Planned Care Chief Operating Officer	30.04.2024	30.04.2024	Medium	Overdue	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/170	12.04.2024	Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-02)	3.1 Processes should be implemented to ensure that referrals are efficiently and effectively triaged by clinicians within the shortest reasonable timescale after receipt, to minimise delay risks that could lead to patient harm. This should include the process to be followed where there is the known absence of a clinician. Where there appears to be service areas where triage is not being carried out as timely as others, then a review should be undertaken to understand the cause of this and identify ways of improving service delivery.	Internal Audit/2024/170/MD4/1	1. Complete and roll out new CTM LGI SOP. 2. Produce referral and vetting process in line with SOP.	Care Group - Planned Care Chief Operating Officer	30.09.2024	30.09.2024	Medium	Overdue	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/170	12.04.2024	Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-02)	3.2 Management should review of the paper-based triage process used in a number of service areas to establish if the electronic processes used elsewhere can be rolled out. The use of fully electronic files will negate the need for printing and rescanning of records, meaning files can be traced and accessed, with an electronic record of decision making retained. Where paper triage forms continue to be used, forms should be revised to require the triage clinicians printed name in addition to their signature. Clinicians should be reminded of the importance of signing triage forms once complete to provide a complete record of the decision-making process.	Internal Audit/2024/170/MD5/1	1. Understand go live date for E-Refs for LGI/Surgery. 2. link in with Records/Digital team.	Care Group - Planned Care Chief Operating Officer	30.09.2024	30.09.2024	Medium	Overdue	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/170	12.04.2024	Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-02)	4. Periodic 'peer review' quality assurance exercises should be undertaken by clinicians to ensure consistency in approach to patient referral triage and triage. The review should consider patients that were added to pathways and patients where their case was considered to be an 'inappropriate referral'.	Internal Audit/2024/170/MD6/1	1. To become part of the GI Directorate agenda - date of first meeting to be confirmed. 2. Replicate endoscopy peer review in line with JAG guidelines.	Care Group - Planned Care Chief Operating Officer	30.06.2024	30.06.2024	High	Overdue	November 2024 Update - Gastroenterology/Endoscopy Team to use the afternoon of audit days to hold this meeting, similar to Surgical colleagues. Peer review of referrals to be a standing agenda point as part of this. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/170	12.04.2024	Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-02)	5. There should be a consistent approach to reviewing and monitoring referral and demand activity across the Gastroenterology and Colorectal GI services. This could be supported further by the use of the Medical Records reports that outline delayed and unvetted referrals. Regular reporting at a Care Group level should take place to enable management to effectively review and understand the efficiency of referral throughput and assist with the planning of services. Consideration should be given to other ways in which the data currently collected can be used to identify potential issues in processes and inform decision making to improve service delivery.	Internal Audit/2024/170/MD7/1	1. Imbed new CTM leadership structure. 2. Continue to work with our informatics teams to build purpose dashboards that support D&C and monitoring of productivity and efficiencies.	Care Group - Planned Care Chief Operating Officer	31.12.2024	31.12.2024	Medium	In progress	November 2024 Update - Dashboards are still being worked on, D&C conversations with colleagues ongoing in regards to drill down data. Productivity and efficiencies monitored via SIG KPI data for Gastroenterology. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/171	09.04.2024	Decarbonisation Internal Audit Report_April 2024 (Review reference: CTMUHB-2324-13)	1.1 The terms of reference for the Environmental Sustainability Group should be reviewed in line with the frequency set out in them to ensure they remain current in relation to membership details and reporting arrangements. The review should ensure that there are named representatives for each of the Executive leads with decarbonisation responsibilities.	Internal Audit/2024/171/MD1/1	This recommendation is accepted and the terms of reference for the Environmental Sustainability Group will be updated to reflect this.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	01.07.2024	31.07.2024	Medium	Partially complete (Overdue)	November 2024 Update - Revised ToR has been given to ESG for approval. September 2024 Update - Updated ToR will be submitted to ESG in October for approval and Population Health and Partnerships Committee for ratification. July 2024 Update - The terms of reference were discussed at the July ESG meeting and the audit recommendations will be included in an updated terms of reference document which will go back to the October ESG for approval and then to Population Health and Partnerships Committee for ratification.
Internal Audit/2024/171	09.04.2024	Decarbonisation Internal Audit Report_April 2024 (Review reference: CTMUHB-2324-13)	4.1 To aid the Health Board in identifying the commitment required to meet the WG 2030 Decarbonisation target, an assessment of those initiatives that can be quantified should take place and a costed plan developed and approved in line with organisational governance. Initiatives that cannot be quantified should be recorded as unquantifiable, but with a brief assessment to identify if the investment could be significant or not.	Internal Audit/2024/171/MD5/1	Action will be undertaken to cost appropriate elements of the plan as resources and available information allows. However budgetary constraints are such that it is unlikely that all elements will be affordable and as for 4.2 we will stay in close dialogue with Welsh Government regarding priorities.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	01.03.2025	31.03.2025	High	In progress	November 2024 update - Work is in progress with some assessments of financial requirements complete or underway. September 2024 Update - Work is underway to quantify actions where possible. There are no expected issues meeting delivery timescales. July 2024 Update - This has been added to the workplan of the new sustainability manager.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Reference Number	Action	Executive / Inspection Lead	Original Due Date	Current Due Date	Action Rating	Progress Status	Comments/Updates
Internal Audit/2024/171	09.04.2024	Decarbonisation Internal Audit Report_April 2024 (Review reference: CTMUHB-2324-13)	4.2 For those initiatives that can be quantified, a long-term model for the funding required to support the decarbonisation programme should be developed.	Internal Audit/2024/171/MD6/1	This recommendation needs to be undertaken in partnership with Welsh Government (through Directors of Planning/Directors of Finance channels) as the UHB works within its revenue and capital resource limits. For example, a key component of the UHB's capital planning is maximising access to funds available from Estates Funding Advisory Board for decarbonisation (which provided £0.9m in 23/24). There is a developing consensus that the decarbonisation goals for NHS Wales and those portions of it assigned to the individual health boards cannot be achieved simply by funding decarbonisation projects and initiatives; the carbon savings required are too great. What is needed is for decarbonisation to be considered for each action and activity undertaken by the health boards in their daily operations, as opposed to decarbonisation actions being thought of in isolation. Whilst the Health Board's MTP references decarbonisation as a key priority in the 'Green 2030' section of the document, there is an opportunity to make greater emphasis on it throughout. For example, when discussing the major transformation schemes.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	01.03.2026	31.03.2026	High	In progress	November 2024 update - Work is in progress with some assessments of financial requirements complete or underway. September 2024 Update - Work is underway to review long term funding requirements. There are no expected issues meeting delivery timescales. July 2024 Update - This has been added to the workplan of the new sustainability manager to do in conjunction with the DoP and DoF.
Internal Audit/2024/171	09.04.2024	Decarbonisation Internal Audit Report_April 2024 (Review reference: CTMUHB-2324-13)	5. Carbon impact assessments should form part of the decisions made and actions taken by the Health Board, especially in larger scale transformational projects.	Internal Audit/2024/171/MD7/1	This recommendation is accepted by the Health Board. Work on this recommendation will commence following the recruitment of the Sustainability Manager as this will create additional capacity needed to better understand how this can be enacted systematically across the health board. Environmental Sustainability Group meetings The terms of reference for the ESG state that they are responsible for monitoring progress in implementing the Health Board's DAP. We acknowledge that it would not be practical to review each initiative during these meetings. However, from our review of minutes for the group, it was not clear how the ESG is actively managing and overseeing the progress of implementation of the 30 initiatives it is responsible for that make up the DAP. The DAP is structured around the six Welsh Government workstreams. Highlight reports from three of the six workstreams should be presented at alternate ESG meetings. Whilst we could see regular updates from a number of departments, such as facilities, pharmacy and ICT, these did not clearly align to the workstreams. As such, we were unable to confirm if there was appropriate reporting on the workstreams. Board and Committee reporting Reporting progress against Implementation of the DAP does not appear to be taking place bi-annually, as set out in the ESG terms of reference. Our fieldwork identified one instance of the DAP / monitoring return being submitted to the Population Health and Partnership Committee since returns began in quarter two of 2022/23. The report that we saw used the Welsh Government monitoring return format, so did not include narrative for the reader to gain an overarching view of the position of the Health Board against its targets. Whilst the cover report referred to 'varying degrees of success' and the risks to achievement of the target, there did not appear to be reporting against the Health Board's overall carbon reduction target of 16% by 2025.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	01.03.2025	31.03.2025	Medium	In progress	November 2024 update - In progress but more work required. Decarbonisation has been incorporated into the VBH application process. September 2024 Update - Work has commenced looking at the opportunities to support this action. New governance arrangements are being established which will provide an opportunity to incorporate this recommendation. July 2024 Update - This has been added to the workplan of the new sustainability manager.
Internal Audit/2024/172	02.04.2024	Follow-up: Digital Operating Model Final Internal Audit Report_April 2024 (Review reference: CTM-2324-24)	1.1 Once the organisational governance structures are finalised a steering / ownership structure for digital should be defined.	Internal Audit/2024/172/MD1/1	Accept. The implementation of ePrescribing and the development of a Patient Contact Transformation Programme provides the Health Board with a new way and ownership of delivery for digital and data programmes. It is anticipated (ahead of final confirmation), that both programmes will report into the Improving Care Board and then into Executive Management Board. Discussions are also ongoing with the Chair regarding a greater emphasis at our public board on the Digital Agenda	Digital & Data Director of Digital	31.12.2024	31.12.2024	Medium	In progress	November 2024 Update - The new committees are currently scheduled to begin in January 2025. September 2024 Update - The new committees are currently scheduled to begin in January 2025. July 2024 Update - The review and recommendations for the new governance structures will be going to the Board in September and the implementation date will be agreed then.
Internal Audit/2024/172	02.04.2024	Follow-up: Digital Operating Model Final Internal Audit Report_April 2024 (Review reference: CTM-2324-24)	2.1 The requirement for digital literacy for all staff should be defined and for the Health Board, with the provision of training for staff if required.	Internal Audit/2024/172/MD2/1	Accept With the development of the Digital Transformation function within the digital and data function, roles are being created to support digital literacy, including an assessment of capability. This will be done in collaboration with Digital Communities Wales	Digital & Data Director of Digital	01.10.2024	01.10.2024	Medium	Fully complete (Awaiting approval)	November 2024 Update - The development of our Digital Transformation continues to evolve, including the recruitment of Business Change staff to support Digital Literacy across CTMUHB. We propose that this action can now be closed. September 2024 Update - An outline case for the next steps in the digital journey was supported at the Board meeting in July. We have been asked to develop a business case to procure a strategic partner for the development of a Modular EPR. July 2024 Update - An outline case will be taken to the Board meeting on the 25th July 2024.
Internal Audit/2024/187	06.06.2024	Leadership and Management Development Programme Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-01)	1.1 Short, medium and long-term objectives should be developed that are specific to the leadership and management development programmes.	Internal Audit/2024/187/MD1/1	Short, medium and long-term objectives have been redeveloped and set out in a paper to go to the Executive Leadership Group. This has also been briefed to Care Group Leads at the Care Group Launch Event May 2nd 2024, as well as a series of socialisation meetings detailed in the paper. Actions: • Take leadership paper to Executive Leadership Group for approval of objectives and overall approach. • Re-share objectives with participants of Inspire Cohort 1, as part of launch communications.	People Executive Director for People	31.07.2024	31.07.2024	Medium	Partially complete (Overdue)	November 2024 Update - Inspire cohort 1 participants confirmed and long term objectives communicated via launch communications from COO. Overall leadership approach (i.e. long term objectives) also contained in Leadership Competency Framework and paper. Greater detail of short and medium term objectives to be shared with participants during Module 1 development day, to take place during January 2025. September 2024 Update - Inspire communication plan signed off and participants contacted w/c 16th September 2024. Final draft of the Leadership Competency Framework has been developed which sets out the objectives for all leadership development. July 2024 Update - Leadership Approach paper final draft developed. Consulting Executive Lead to take to the Executive Group. Cohort 1 Inspire participants currently being finalised. Once finalised, coms. plan will be launched to share objectives and programme details.
Internal Audit/2024/187	06.06.2024	Leadership and Management Development Programme Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-01)	1.2 Performance indicators such as the sign-up rate, conversion rate (the number that have registered that go on to start the programme) and the completion rate should be developed for the programmes, and these should be appropriately reported.	Internal Audit/2024/187/MD2/1	These performance indicators were developed for the programmes, although inaccuracies in the data are recognised (as per 2.1a). Actions: • Develop new programme dashboards with HEIW, using functionality in Gwella.	People Executive Director for People	30.11.2024	30.11.2024	Medium	Partially complete	November 2024 Update - All metrics designed and reporting functionality built into programmes. Data to be reported following Module 1 in January 2025. September 2024 Update - Reporting functionality has built into the new Inspire Cohorts, with reporting available once the programme is launched. The reporting will include evaluation data. Reporting will start following the launch of the Discovery Phase, in October 2024. July 2024 Update - Reporting functionality built in to new Inspire Cohorts, with reporting available once programme launched. This will include evaluation data.
Internal Audit/2024/187	06.06.2024	Leadership and Management Development Programme Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-01)	1.2 Performance indicators such as the sign-up rate, conversion rate (the number that have registered that go on to start the programme) and the completion rate should be developed for the programmes, and these should be appropriately reported.	Internal Audit/2024/187/MD2/2	These performance indicators were developed for the programmes, although inaccuracies in the data are recognised (as per 2.1a). Actions: • Report dashboards and programme performance indicators to People and Culture committee.	People Executive Director for People	31.12.2024	31.12.2024	Medium	Partially complete	November 2024 Update - All metrics designed and reporting functionality built into programmes. Data to be reported following Module 1 in January 2025. September 2024 Update - Reports and a dashboard have been designed, but are not yet populated, as the programme has not yet starting. Reports will be presented to the People & Culture Committee, once the programme has started and the reports are available. July 2024 Update - Functionality built in to new Inspire Cohorts, with reporting available once programme launched. Reports will be shared with People & Culture Committee once available.
Internal Audit/2024/187	06.06.2024	Leadership and Management Development Programme Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-01)	2.1a The content of the Leadership Management section of the L&D Monthly Analysis Report should be reviewed to ensure: • Data is accurate. • Information is comprehensive enough to enable readers to clearly understand the number of registrations, active learners and completions for each level of the programme. • Reporting covers all the evaluation criteria that have been set out plus and any future performance indicators that may be set for the programme. 2.1b The Leadership and Management Programmes Evaluation & Impact Report should be prepared on a more frequent basis and presented at the People & Culture Committee to allow greater oversight.	Internal Audit/2024/187/MD3/1	2.1a • As per 1.2, develop new programme dashboards with HEIW, using functionality in Gwella. Ensure inclusion of evaluation data from 2.1b.	People Executive Director for People	30.11.2024	30.11.2024	High	Partially complete	November 2024 Update - New dashboards and an evaluation framework have been designed. These have not been shared due to the programme having not yet started. Following the launch, dashboards and evaluation reports will be compiled and shared. At an appropriate time and once the dataset is big enough, updates and accompanying reports will be shared with the relevant committee. September 2024 Update - The newly developed programme dashboards will be populated, once the programme has started start. A Kirkpatrick evaluation framework has been designed, which will allow this data to be captured in the reports, once available. July 2024 Update - Monthly Analysis Report updated with holding text to clarify that new dashboards are in development (as per R1.2 rows 144 and 145).
Internal Audit/2024/187	06.06.2024	Leadership and Management Development Programme Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-01)	2.1a The content of the Leadership Management section of the L&D Monthly Analysis Report should be reviewed to ensure: • Data is accurate. • Information is comprehensive enough to enable readers to clearly understand the number of registrations, active learners and completions for each level of the programme. • Reporting covers all the evaluation criteria that have been set out plus and any future performance indicators that may be set for the programme. 2.1b The Leadership and Management Programmes Evaluation & Impact Report should be prepared on a more frequent basis and presented at the People & Culture Committee to allow greater oversight.	Internal Audit/2024/187/MD3/2	2.1b • In-line with the relaunch of Inspire, apply HEIW's Kirkpatrick Bronze evaluation framework. This will supersede and replace any previous evaluation methods/ reporting, and will be reported to Inspiring People Board and People and Culture Committee.	People Executive Director for People	30.09.2024	30.09.2024	High	Partially complete (Overdue)	November 2024 Update - New dashboards and an evaluation framework have been designed. These have not been shared due to the programme not having starting yet. Following the launch, dashboards and evaluation reports will be compiled and shared. At appropriate time and once dataset big enough, update and accompanying report will be shared with the relevant committee. September 2024 Update - The newly developed dashboards will be populated, once the programme starts. A Kirkpatrick evaluation framework has been designed, which will allow this data to be captured in reports, once available. July 2024 Update - •Comprehensive Kirkpatrick Bronze Evaluation Framework designed and signed off by HEIW, which includes mechanisms to capture feedback and evaluate performance of the programme. •Framework will be embedded into programme delivery once live. •Full schedule of evaluation reports and feedback sessions contained in framework, the output of which will be shared with People Board/ People and Culture Committee.
Internal Audit/2024/188	11.06.2024	Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-14)	1.1a Management should remind staff of the importance of ensuring that complete and accurate data is input to Datix (see also MA 5 relating to Standard Operating Procedures). 1.1b Regular monitoring should be carried out to ensure compliance.	Internal Audit/2024/188/MD1/1	1.1a Staff have been reminded of the importance of completing Datix. The SOP will be updated to provide guidance to ensure accurate data is recorded. An audit is being developed with support from the BI team to easily identify and monitor accurate data recording.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	30.09.2024	31.12.2024	Medium	In progress	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - Confirmed Claims audit tool developed and report generated. Further feedback is required to implement on a monthly basis. Development of Redress dashboard in progress - anticipated time scale of completion 31.12.24. July 2024 Update - Meeting with BI team in respect of various audits. BI are now developing further audits and dashboards.
Internal Audit/2024/188	11.06.2024	Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-14)	1.1a Management should remind staff of the importance of ensuring that complete and accurate data is input to Datix (see also MA 5 relating to Standard Operating Procedures). 1.1b Regular monitoring should be carried out to ensure compliance.	Internal Audit/2024/188/MD1/2	1.1b Regular monitoring is currently carried as part of the payment approval process. To support regular monitoring, a regular opened and closed cases audit is being developed with support from the BI team.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	30.09.2024	31.12.2024	Medium	In progress	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - Confirmed Claims audit tool developed and report generated. Further feedback is required to implement on a monthly basis. Development of Redress dashboard in progress - anticipated time scale of completion 31.12.24. July 2024 Update - Meeting with BI team in respect of various audits. BI are now developing further audits and dashboards. Staff have been reminded of the importance of data accuracy and the need for saving documents into Datix.
Internal Audit/2024/188	11.06.2024	Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-14)	3.1 Management should continue to remind staff of the importance of working towards the timeframes specified by WRP and should continue to monitor to ensure compliance with this requirement.	Internal Audit/2024/188/MD3/1	Management have implemented weekly Business meetings for the Quality & Safety and Legal Teams, where reporting in respect of LFERs is undertaken to ensure timeframes are met. LFERs are reviewed weekly in the Executive Director Led Patient Safety Meeting. A CMR due report is run monthly by management to ensure CMRs are submitted in a timely manner. A regular opened cases audit is being developed with support from the BI team to facilitate a more thorough check on when a CMR should be triggered.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	30.09.2024	30.09.2025	Medium	In progress	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - Initial stages of the development of a suite of Claims & Redress dashboards and reports are under review by the BI team to support the Legal Services with an audit programme for assurance; this work will include a roll out programme of a number of dashboards & reports. It is anticipated that this will be work in progress over the following 12 months with an anticipation completion date of 30/09/2025. July 2024 Update - LFERs continue to be monitored via Care Group meetings, weekly business meeting and Executive Quality & Safety meeting. CMRs are audited on a weekly basis and is monitored in the Claims weekly meeting. This will be further strengthened with the Legal Services audit programme being developed by the BI team.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Reference Number	Action	Executive / Inspection Lead	Original Due Date	Current Due Date	Action Rating	Progress Status	Comments/Updates
Internal Audit/2024/188	11.06.2024	Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-14)	5.1a The final payment section within the SOP should be reviewed and updated with clear guidance on what constitutes final payment and the process to follow should and invoice be disputed. 5.1b Management should liaise with the Once for Wales task and finish group to determine the outcome of their work on defining the key stages within Datix. The SOPs should be updated accordingly, including the 'closure' section with clear guidance on what the stages are for closed cases in Datix. 5.1c It should be ensured the authorisation details in the SOPs align to the information contained on the various forms. 5.1d All SOPs should be finalised and made available to staff.	Internal Audit/2024/188/MD5/1	5.1a The relevant section of the Standard Operating Procedure (SOP) will be reviewed to ensure that it clearly outlines what constitutes final payment and the process that should be followed if an invoice is disputed. Training will be provided once the SOP has been updated. This action will need to be aligned with the all-Wales approach and completion will be dependent on this.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	30.09.2024	30.09.2024	Medium	Overdue	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - The SOP has been reviewed and is being updated with explanations to outline clearly what constitutes final payment, and the process to be followed if an invoice is disputed. Training will be provided in the Team Meeting taking place on 25 September 2024 to Claims Investigation Officers. July 2024 Update - SOP in process of being reviewed.
Internal Audit/2024/188	11.06.2024	Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-14)	5.1a The final payment section within the SOP should be reviewed and updated with clear guidance on what constitutes final payment and the process to follow should and invoice be disputed. 5.1b Management should liaise with the Once for Wales task and finish group to determine the outcome of their work on defining the key stages within Datix. The SOPs should be updated accordingly, including the 'closure' section with clear guidance on what the stages are for closed cases in Datix. 5.1c It should be ensured the authorisation details in the SOPs align to the information contained on the various forms. 5.1d All SOPs should be finalised and made available to staff.	Internal Audit/2024/188/MD5/2	5.1b Management will attend or delegate staff to the WRP's Task and finish group to ensure the key stages are clearly defined. The SOP will be updated once the work has been finalised.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	31.08.2024	31.08.2024	Medium	Overdue	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - The September WRP Task & Finish Group for Inquest and Claims (to update Key Stage History Fields) was cancelled . We are awaiting a new meeting date to review Key Stage History Fields. Action will remain open until WRP Task & Finish Group updates the Health Board. July 2024 Update - Staff member identified to attend task and finish group.
Internal Audit/2024/188	11.06.2024	Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-14)	5.1a The final payment section within the SOP should be reviewed and updated with clear guidance on what constitutes final payment and the process to follow should and invoice be disputed. 5.1b Management should liaise with the Once for Wales task and finish group to determine the outcome of their work on defining the key stages within Datix. The SOPs should be updated accordingly, including the 'closure' section with clear guidance on what the stages are for closed cases in Datix. 5.1c It should be ensured the authorisation details in the SOPs align to the information contained on the various forms. 5.1d All SOPs should be finalised and made available to staff.	Internal Audit/2024/188/MD5/3	5.1c The SOP will be reviewed and updated to ensure authorisation details align to the information contained in the CMRS. Staff will be informed of the updates at the Legal Services team meeting.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	30.09.2024	30.09.2024	Medium	Overdue	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - Action continues on this recommendation: SOP being reviewed to ensure it aligns with delegated authority for payments. July 2024 Update - SOP in process of being reviewed.
Internal Audit/2024/188	11.06.2024	Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-14)	5.1a The final payment section within the SOP should be reviewed and updated with clear guidance on what constitutes final payment and the process to follow should and invoice be disputed. 5.1b Management should liaise with the Once for Wales task and finish group to determine the outcome of their work on defining the key stages within Datix. The SOPs should be updated accordingly, including the 'closure' section with clear guidance on what the stages are for closed cases in Datix. 5.1c It should be ensured the authorisation details in the SOPs align to the information contained on the various forms. 5.1d All SOPs should be finalised and made available to staff.	Internal Audit/2024/188/MD5/4	5.1d SOPs are available to staff in and accessible in the local drive. Finalization is dependent of ongoing work and updates on from the all-Wales Task and Finish Group and updates to the DCIQ system.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	31.08.2024	31.08.2024	Medium	Overdue	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - Health Board's SOP will be finalised when we receive final update from the September WRP Task & Finish Group for Inquest and Claims (to update stage history fields) was cancelled. We are awaiting a new meeting date to review Key Stage History Fields. Action will remain open until WRP Task & Finish Group updates the Health Board. July 2024 Update - Awaiting SOP updates and update form WRP Task and Finish Group.
Internal Audit/2024/189	07.06.2024	Technical Resilience Final Internal Audit Report_June 2024 (Review reference: CTM-2324-20)	1. Consideration should be given to enabling SRM in order to better facilitate DR to alternate sites.	Internal Audit/2024/189/MD1/1	A review into the use of VSRM will be carried out. Although an automated DR would be optimal, there are a number of scenarios where it would be preferred to have manual intervention into this type of response. This is in part due to some of the other work that would be required to ensure systems were accessible at the DR site such as network addressing.	Digital & Data Director of Digital	30.09.2024	03.03.2025	Low	In progress	November 2024 Update - Recoverpoint is a fit for purpose solution for VMWare replication and we have validated replicas. In order to have full automated site recovery, dependent networking capabilities need to be in place, such as stretched layer 2 networks. Discussions are developing with both Cisco and PSBA on this. September 2024 Update - Further discussion with Cisco lined up for late September. Meeting also kick off held in September with BT/PSBA team around the LANWAN strategy for the Health Board in light of increased reliance on the PSBA and Cloud services. July 2024 Update - The UHB is working with CISCO to design and architect a modern network that supports DR more seamlessly.
Internal Audit/2024/189	07.06.2024	Technical Resilience Final Internal Audit Report_June 2024 (Review reference: CTM-2324-20)	2.1 The Health Board should consider increasing alternate site capacity to enable full service delivery.	Internal Audit/2024/189/MD2/1	Prior to increasing capacity, CTM should complete the system criticality mapping, and therefore have a structure and precedence for systems to be brought back (while noting that certain key infrastructure components need to be present as a foundation – such as DHCP, File, Print and Citrix). Capacity relates to storage in this matter, and by not restoring legacy archive data, the storage requirements may reduce.	Digital & Data Director of Digital	30.09.2024	03.03.2025	Medium	In progress	November 2024 Update - the provision for Disaster recovery is currently being sent replicas of key systems. This will allow a Virtual Machine level recovery. Currently the space available is not a constraint. A review of the next servers (Tier2) to replicate is underway. September 2024 Update - Systems are being categorised and the most critical will be protected and available for quick restoration. Other services will be brought back from backup systems. A schedule and recovery time objectives are being worked up for wider review. July 2024 Update - An assessment has identified that POW has the capacity to enable full service delivery, as such replication of Virtual machines and services is being targeted to the PoW Datacentre.
Internal Audit/2024/189	07.06.2024	Technical Resilience Final Internal Audit Report_June 2024 (Review reference: CTM-2324-20)	3.1 Once the DR site has been provisioned the resilience position should be tested to ensure it operates as anticipated. Going forward resilience should be subject to regular testing, failing over between rooms and across sites to ensure it still operates.	Internal Audit/2024/189/MD3/1	A schedule for end-to-end failover testing will be produced and implemented. This should include a full prioritised recovery of systems and validation by system managers/end users. An ongoing log will be maintained.	Digital & Data Director of Digital	31.12.2024	31.12.2024	Medium	In progress	November 2024 Update - A resource has been aligned to support Disaster Recovery planning. They will also coordinate the testing activities with the respective infrastructure and systems leads. September 2024 Update - A proof of concept has been arranged with BT PSBA to stretch Layer 2 network (VLANs) between PCH and PoW to make this a more seamless operation. July 2024 Update - Replication of Virtual machines from PCH to PoW is being setup to support this.
Internal Audit/2024/189	07.06.2024	Technical Resilience Final Internal Audit Report_June 2024 (Review reference: CTM-2324-20)	4.1 The DR plan should be updated to reflect the new environment. The plan should consider the main types of failure such as IT, power, communications and cover the network infrastructure. • The DR plan should include processes to follow in order to restore services in the event of varying degrees of failure such as: • Failure of site provision of failover instructions, restore priorities; • Failure of rack provision of failover and restore instructions; • Failover of VM restore and restore from backup; and • Failure of system – VM restore / backup restore.	Internal Audit/2024/189/MD4/1	The UHB will establish a prioritised plan, incorporating step by step procedures for the restoration of services following a major incident, under 4 separate scenarios, incorporating the fault domain failures as relevant (site, rack, VM, system). • Cyber impacting affecting CTM network and services • Environment impact affecting CTM network and services (e.g. utility loss, flood or fire) • Loss of DHCW services • Loss of WAN &/or Cloud services (external to NHS Wales hosted services which we access via DHCW, PSBA & internet)	Digital & Data Director of Digital	30.09.2024	30.12.2024	Medium	In progress	November 2024 Update - A resource has been aligned to support Disaster Recovery planning. They have commenced their work with a focus on the overarching DR plan aligned to server hosting. September 2024 Update - For the 'cyber impacting affecting CTM network and services' category ongoing cyber improvement activities are being prioritised. For the 'environment impact affecting CTM network and services (e.g. utility loss, flood or fire)' category this has been alleviated somewhat using PoW as the DR site. Options also being explored to develop the PCH ACTIVE>ACTIVE arrangement into a wider geography - i.e. explore potential of hosting second datacentre outside of the PCH site. For the 'loss of DHCW services' category, mapping of services is progressing through weekly NIS-R CAF Reviews. This activity does requires service management support, and a new Head of Digital Service Management has been appointed. For the 'loss of WAN &/or Cloud services (external to NHS Wales hosted services which we access via DHCW, PSBA & internet)' category discussions scheduled with BT/PSBA that will feed into a LANWAN strategy will address the networking challenges. August 2024 Update - Following discussion at the Audit & Risk Committee (15/08/2024) R4.1 Action was updated (Management response revised). July 2024 Update - New responses have been drafted and are awaiting approval from Internal audit.
Internal Audit/2024/189	07.06.2024	Technical Resilience Final Internal Audit Report_June 2024 (Review reference: CTM-2324-20)	5.1 An assessment of the need for individual service DR plans should be undertaken. Following that detailed DR documentation should be in place, either within the Server DR document, or within individual DR documents for each service which sets out the architecture, and processes to follow in order to restore the service. The DR documentation should explicitly include information on the resilience tier and RTO/RPO and this should be communicated to service leads.	Internal Audit/2024/189/MD5/1	The criticality of systems will be prioritised based on criticality. The exercise to document DR plans for all critical systems as defined by NIS regulations will continue with progress overseen by the Cyber Security Assurance Board. The DR documentation will include information on the resilience tier and RTO/RPO and will be communicated to system managers.	Digital & Data Director of Digital	30.12.2024	30.12.2024	Medium	In progress	November 2024 Update - A resource has been aligned to support Disaster Recovery planning and they will use the output from the System Criticality mapping to ensure that the prioritisation for recovery is set out and communicated agreed. September 2024 Update - Systems are being categorised and the most critical will be protected and available for quick restoration. Other services will be brought back from backup systems. A schedule and recovery time objectives are being worked up for wider review. August 2024 Update - Following discussion at the Audit & Risk Committee (15/08/2024), R5.1 Action was updated (Management response revised). July 2024 Update - New responses have been drafted and are awaiting approval from Internal audit.
Internal Audit/2024/189	07.06.2024	Technical Resilience Final Internal Audit Report_June 2024 (Review reference: CTM-2324-20)	6.1 The services to be restored to alternate sites should be formally defined and a prioritised order for recovery set out. This should be based on a formal assessment of service criticality and risk.	Internal Audit/2024/189/MD6/1	This links to the work being carried out for the NIS Regulations. This will be complete in line with MAIs 2.5.	Digital & Data Director of Digital	30.12.2024	30.12.2024	High	In progress	November 2024 Update - A resource has been aligned to support Disaster Recovery planning and they will use the output from the System Criticality mapping to ensure that the prioritisation for recovery is set out and communicated agreed. September 2024 Update - Systems are being categorised and the most critical will be protected and available for quick restoration. Other services will be brought back from backup systems. A schedule and recovery time objectives are being worked up for wider review. July 2024 Update - New responses have been drafted and are awaiting approval from Internal audit.
Internal Audit/2024/190	03.06.2024	Risk Management Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-17)	2.1a Management should ensure that minutes of the service area and care group governance meetings accurately capture the escalation of risks between the tiers of the risk register.	Internal Audit/2024/190/MD3/1	Risk to be a routine agenda item at the appropriate Care Group/Corporate risk meetings that directs members to consider escalation and note the resolution as part of a decision log. A template will be shared with the leads of the groups to ensure consistency of approach.	Corporate Governance Director of Corporate Governance & Board Secretary	31.07.2024	31.10.2024	Medium	Fully complete (Awaiting approval)	November 2024 Update - COMPLETE - Service to Board Escalation process reviewed following consultation with risk leads and approval by the Operational Management Board and Executive Leadership Group. A document has also been developed which captures the monitoring of risk at a Care Group and Central Directorate level. September 2024 Update - The Assistant Director of Governance & Risk has developed a simplified service to board escalation process for risk which was shared with risk leads in care groups and central directorates on the 10th September for review and comment by the 24th September. If supported the process will be submitted to Operational Management Board for endorsement and then onto Executive Management Board for approval. Revised deadline requested of the 31st October 2024. July 2024 Update - Partially complete - meeting with Care Group risk leads held to agree the approach - further work is needed in this area to simplify the service to board escalation and provide some consistent templates. It is anticipated that this work will go beyond the agreed implementation date of 31.7.2024 and extension to the end of August is requested to allow for a more robust review.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Reference Number	Action	Executive / Inspection Lead	Original Due Date	Current Due Date	Action Rating	Progress Status	Comments/Updates
Internal Audit/2024/190	03.06.2024	Risk Management Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-17)	4.1 Clarity should be provided to Care Groups on the requirements of the risk management policy in relation to where risks of certain scores should be monitored. The information on the level of risk monitoring in the terms of reference for the care group QSRE meetings should align to the risk management policy.	Internal Audit/2024/190/MD6/1	A proposed approach will be shared with Care Groups / Central Functions to ensure a consistent management of this activity is achieved at meetings on the monitoring of risk.	Corporate Governance Director of Corporate Governance & Board Secretary Care Groups Chief Operating Officer	31.07.2024	31.10.2024	Medium	Fully complete (Awaiting approval)	November 2024 Update - COMPLETE - Service to Board Escalation process reviewed following consultation with risk leads and approval by the Operational Management Board and Executive Leadership Group. A document has also been developed which captures the monitoring of risk at a Care Group and Central Directorate level. September 2024 Update - The Assistant Director of Governance & Risk has set out an approach for the monitoring of risks at care group and central directorate level for risks scoring 12 and above. This new approach was shared with risk leads in care groups and central directorates on the 10th September for review and comment by the 24th September. It supported the process will be submitted to Operational Management Board for endorsement and then onto Executive Management Board for approval. Revised deadline requested of the 31st October 2024. July 2024 Update - meeting with Care Group risk leads held to agree the approach - further work is needed in this area to simplify the service to board escalation and provide some consistent templates. It is anticipated that this work will go beyond the agreed implementation date of 31.7.2024 and extension to the end of August is requested.
Internal Audit/2024/190	03.06.2024	Risk Management Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-17)	4.4 Quality and Safety Corporate Directorate The terms of reference for the Quality and Safety Business Team Meeting should finalised as soon as possible, so as to formalise the responsibility in relation to risk register monitoring and the process for escalation or risks. It should be ensured that department risk register is routinely discussed at the Quality and Safety Business Team Meeting with onward reporting and escalation to the Quality and Safety Improvement Meeting where necessary. Minutes or action logs from each meeting should be retained to allow clarity on what was discussed and actions that need acting upon.	Internal Audit/2024/190/MD9/1	The terms of reference for the Quality and Safety Business Team Meeting to be finalised incorporating the monitoring of risk as a routine item. Minutes and decision log reflect action taken.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	31.07.2024	31.08.2024	Medium	Overdue	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - The August Q&S meeting facilitated discussion with regards to the groups remit and discussion with regards to the potential changes to the format of the group in line with the maturing organisational meeting structures therefore, the Quality & Safety team Business meeting Terms of Reference were not included and have been deferred to the agenda for approval at the next meeting which is being held on 15th October 2024 July 2024 Update - The draft Terms of Reference for the weekly Quality & Safety Business meeting have been developed, formal review and approval scheduled for 13 August 2024. Revised due date of the 31.8.2024 proposed.
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	1.1b Up to date terms of reference for each committee and group should be in place and include information such as purpose and remit of the group, frequency of meetings, attendees and quoracy arrangements.	Internal Audit/2024/192/MD1/1	The Terms of Reference for the current established Care Group meetings have been drafted and will be reviewed and amended where required to reflect the audit findings, these will be taken to the relevant meetings for sign off. The Terms of Reference will be saved in the Care Group Teams channel and reviewed annually.	Care Group - Mental Health & Learning Disabilities Chief Operating Officer	31.08.2024	31.08.2024	Medium	Overdue	November 2024 Update - Terms of Reference are ratified or going through ratification for all areas and maintained within the Business, Improvement, Strategy and Commissioning directorate. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - The Terms of Reference have been reviewed and revised and will be taken to the next MH&LD People, Planning, Performance & Finance Meeting on 31.7.24 for final approval.
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	2.1 Consideration should be given to the format of capturing meeting information. Whilst slide decks are a useful platform for presenting information, an appropriate mechanism to capture attendees, key points discussed, decisions made and actions to take forward should be in place.	Internal Audit/2024/192/MD2/1	The Integrated Performance Meetings Terms of Reference will be updated to ensure that key actions and decisions are documented and included for future meetings.	Care Group - Mental Health & Learning Disabilities Chief Operating Officer	31.08.2024	31.08.2024	Medium	Overdue	November 2024 Update - All key fora have action logs and minutes to confirm attendance, and actions are recorded. With new Service Director coming in, governance processes will be reviewed. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - The Terms of Reference have been reviewed and revised and will be taken to the next MH&LD People, Planning, Performance & Finance Meeting on 31.7.24 for final approval. These capture the need to document decisions and actions.
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	6.1 For absence to be properly managed and pay not to be affected, comprehensive and accurate documentation in relation to each episode of sickness should be maintained. Management should ensure that self-certification and return to work forms are fully completed. All periods of absence should be fully covered by self-certification forms or medical certificates.	Internal Audit/2024/192/MD7/1	All Ward Managers and deputies will attend a refresher training session on managing Sickness and Absence in accordance with CTM policy.	Care Group - Mental Health & Learning Disabilities Chief Operating Officer	31.07.2024	31.07.2024	Medium	Overdue	November 2024 Update - complete/continuous now - we have regular workforce meetings to review. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - A list of all appropriate staff has been shared with People Services and a training date is pending.
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	6.1 For absence to be properly managed and pay not to be affected, comprehensive and accurate documentation in relation to each episode of sickness should be maintained. Management should ensure that self-certification and return to work forms are fully completed. All periods of absence should be fully covered by self-certification forms or medical certificates.	Internal Audit/2024/192/MD7/2	A sample audit of 5 staff files will be carried out by the Senior Nurse every 3 months and reported into the Directorate Integrated Performance Meeting Quarterly.	Care Group - Mental Health & Learning Disabilities Chief Operating Officer	31.08.2024	31.08.2024	Medium	Overdue	November 2024 Update - complete/continuous now - we have regular workforce meetings to review September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - Work has commenced and this action is expected to be completed by the target date.
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	6.2 Where periods of absence result in a prompt being breached, appropriate action in line with the Managing Attendance Policy should be taken. Where a manager exercises their discretion and chooses not to undertake an informal or formal warning, this decision should be documented on the individual's file.	Internal Audit/2024/192/MD8/1	All Ward Managers and deputies will attend a refresher training session on managing Sickness and Absence in accordance with CTM policy.	Care Group - Mental Health & Learning Disabilities Chief Operating Officer	31.07.2024	31.07.2024	Medium	Overdue	November 2024 Update - complete/continuous now - we have regular workforce meetings to review September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - A list of all appropriate staff has been shared with People Services and a training date is pending.
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	6.2 Where periods of absence result in a prompt being breached, appropriate action in line with the Managing Attendance Policy should be taken. Where a manager exercises their discretion and chooses not to undertake an informal or formal warning, this decision should be documented on the individual's file.	Internal Audit/2024/192/MD8/2	A sample audit of 5 staff files will be carried out by the Senior Nurse every 3 months and reported into the Directorate QSRE/Performance meeting Quarterly.	Care Group - Mental Health & Learning Disabilities Chief Operating Officer	31.08.2024	31.08.2024	Medium	Overdue	November 2024 Update - complete/continuous now - we have regular workforce meetings to review. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - Work has commenced and this action is expected to be completed by the target date.
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	6.3 Long-term absence should be managed in line with the policy in order to prevent absences being longer than necessary.	Internal Audit/2024/192/MD9/1	All Ward Managers and deputies will attend a refresher training session on managing Sickness and Absence in accordance with CTM policy.	Care Group - Mental Health & Learning Disabilities Chief Operating Officer	31.07.2024	31.07.2024	Low	Overdue	November 2024 Update - complete/continuous now - we have regular workforce meetings to review. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - A list of all appropriate staff has been shared with People Services and a training date is pending.
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	6.3 Long-term absence should be managed in line with the policy in order to prevent absences being longer than necessary.	Internal Audit/2024/192/MD9/2	A sample audit of 5 staff files for sickness absence documentation will be carried out by the Senior Nurse every 3 months and reported into the Directorate QSRE/Performance meeting.	Care Group - Mental Health & Learning Disabilities Chief Operating Officer	31.08.2024	31.08.2024	Low	Overdue	November 2024 Update - complete/continuous now - we have regular workforce meetings to review. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - Work has commenced and this action is expected to be completed by the target date.
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	9 It should be ensured that all staff are provided with the opportunity to undertake their mandatory training Staff. should be reminded that undertaking level one training in the core skills modules is in line with Welsh Government expectations, and that training at higher levels is a Health Board expectation for that role.	Internal Audit/2024/192/MD11/2	The Ward Manager will ensure that time is protected for staff to complete training modules.	Care Group - Mental Health & Learning Disabilities Chief Operating Officer	31.08.2024	31.08.2024	Medium	Overdue	November 2024 Update - training and compliance is reported through our workforce meetings and staff are provided opportunities for core training as well as additional training. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - Work has commenced and this action is expected to be completed by the target date.
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	9 It should be ensured that all staff are provided with the opportunity to undertake their mandatory training Staff. should be reminded that undertaking level one training in the core skills modules is in line with Welsh Government expectations, and that training at higher levels is a Health Board expectation for that role.	Internal Audit/2024/192/MD11/3	A laptop will be made available which can be booked for the purpose of completing e-learning modules	Care Group - Mental Health & Learning Disabilities Chief Operating Officer	31.08.2024	31.08.2024	Medium	Overdue	November 2024 Update - training and compliance is reported through our workforce meetings and staff are provided opportunities for core training as well as additional training. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - Work has commenced and this action is expected to be completed by the target date.
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	9 It should be ensured that all staff are provided with the opportunity to undertake their mandatory training Staff. should be reminded that undertaking level one training in the core skills modules is in line with Welsh Government expectations, and that training at higher levels is a Health Board expectation for that role.	Internal Audit/2024/192/MD11/5	Senior Nurses will review the ESR system and ensure that the correct core skills are allocated to each staff group.	Care Group - Mental Health & Learning Disabilities Chief Operating Officer	31.07.2024	31.07.2024	Medium	Overdue	November 2024 Update - training and compliance is reported through our workforce meetings and staff are provided opportunities for core training as well as additional training. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - Work has commenced and this action is expected to be completed by the target date.
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	10.1 Care should be taken to ensure data is accurately transferred from the worked roster to the Health Roster system on a weekly basis.	Internal Audit/2024/192/MD12/2	A spot check audit of 2 separate weeks of Health Roster will be undertaken by the Senior Nurse which will compare paper roster and the Health Roster system for accuracy. This will be reported at the Directorate QSRE meeting.	Care Group - Mental Health & Learning Disabilities Chief Operating Officer	31.08.2024	31.08.2024	Medium	Overdue	November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - Work has commenced and this action is expected to be completed by the target date.
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	11.1 Consultant job plans should be reviewed and agreed on an annual basis, with planning discussions commencing in enough time to get the plan signed off ahead of the job plan start period.	Internal Audit/2024/192/MD13/1	All substantive inpatient consultant psychiatrists have had their job-planning meeting and all plans have been mutually agreed. The plans are in the process of being inputted to the Allocate system for formal sign off.	Care Group - Mental Health & Learning Disabilities Chief Operating Officer	30.06.2024	30.06.2024	High	Overdue	November 2024 Update - we have experienced issues with the Allocate software and more training on the software is being sought. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - Job planning reviews have been scheduled and are in a process of being completed. This is an ongoing but priority action across the Adult Directorate and the Care Group.
Internal Audit/2024/195	01.07.2024	PCH Redevelopment Programme: Key Performance Objectives Final Internal Audit Report_July 2024 (Review Reference: CTM-SSU-2324-04)	1.2 The current programme funding risks should be noted at the programme risk register.	Internal Audit/2024/195/MD2/1	Noted. The risk presented by the VAT recovery rate matter above will be quantified in the risk register.	Capital and Estates Executive Director of Finance	30.09.2024	30.09.2024	Medium	Fully complete (Awaiting approval)	November 2024 Update - Risk noted in Risk Register (T166 - Potential changes to HMRC rules and recovery) and cost consequence reported in the Level 2 cost report. September 2024 Update - To be incorporated in the next Risk Register update (October)
Internal Audit/2024/195	01.07.2024	PCH Redevelopment Programme: Key Performance Objectives Final Internal Audit Report_July 2024 (Review Reference: CTM-SSU-2324-04)	2.3 The programme risk register should include risks pertaining to the Section 7 design fee, disputed/ withheld fees and the increased cost/ programme associated with the works.	Internal Audit/2024/195/MD5/1	Agreed.	Capital and Estates Executive Director of Finance	30.09.2024	30.09.2024	Medium	Fully complete (Awaiting approval)	November 2024 update - Section 7 design fees dispute resolved. Increased works cost / programme, over-and-above what was indicated in the Programme Business Case, will be the subject of discussion with Welsh Government when the Phase 3 FBC is submitted for approval, and hence not a cost burden to Phase 2 funding levels. September 2024 Update - To be incorporated in the next Risk Register update (October)
Internal Audit/2024/199	04.10.2024	Intelligence Led Organisation Final Internal Audit Report_October 2024 (Review reference: CTM-2425-07_	1.1 The data and AI programme should be reviewed and if necessarily refreshed following the publication of the revised Ministerial Statement of Intent.	Internal Audit/2024/199/MD1/1	The UHB will seek to contribute to the refresh of the Ministerial Statement of Intent on data and AI and the strategic and tactical refresh of the accompanying work programme. We will ensure that the data strategy is refreshed at the appropriate time.	Digital & Data Director of Digital	31.12.2024	31.12.2024	Medium	In progress	November 2024 Update - The UHB is presently contributing to the phase 4 NDR business case which is a key driver for delivery of the data programme for the next 3 years. This is pertinent as WG provides funding for the UHB's data function via the NDR programme and in agreeing to the NDR business case, the UHB will be required to contribute to delivery of these strategic objectives. If the case is agreed, the data programme will be revised accordingly. In regards to AI, there remains an intention to develop an AI strategy and to continue to benefit from the its use. An AI policy has been drafted for wider consideration and processes incorporating training materials have been established to enable staff to benefit from web based generative AI applications (e.g. chatgpt).
Internal Audit/2024/199	04.10.2024	Intelligence Led Organisation Final Internal Audit Report_October 2024 (Review reference: CTM-2425-07_	1.1 The data and AI programme should be reviewed and if necessarily refreshed following the publication of the revised Ministerial Statement of Intent.	Internal Audit/2024/199/MD1/2	It is the intention of the UHB to develop a strategic position and plan for AI over the course of the next 6 months.	Digital & Data Director of Digital	30.04.2025	30.04.2025	Medium	In progress	November 2024 Update - The UHB is presently contributing to the phase 4 NDR business case which is a key driver for delivery of the data programme for the next 3 years. This is pertinent as WG provides funding for the UHB's data function via the NDR programme and in agreeing to the NDR business case, the UHB will be required to contribute to delivery of these strategic objectives. If the case is agreed, the data programme will be revised accordingly. In regards to AI, there remains an intention to develop an AI strategy and to continue to benefit from the its use. An AI policy has been drafted for wider consideration and processes incorporating training materials have been established to enable staff to benefit from web based generative AI applications (e.g. chatgpt).
Internal Audit/2024/199	04.10.2024	Intelligence Led Organisation Final Internal Audit Report_October 2024 (Review reference: CTM-2425-07_	1.2 The Data and AI programme should be refreshed in the event that the Digital Strategy is updated. This should include an organisational wide perspective, noting that the Central Data / Information Team are the professional leads and the organisational aims to improve information use.	Internal Audit/2024/199/MD2/1	In a rapidly developing environment the UHB will endeavour to ensure that our strategic and tactical approach to digital, data and AI, the EHR, patient portal, and other areas align through regular consideration and refresh of our strategic, tactical and operational decision making.	Digital & Data Director of Digital	30.04.2025	30.04.2025	Medium	In progress	November 2024 Update - The UHB is presently contributing to the phase 4 NDR business case which is a key driver for delivery of the data programme for the next 3 years. This is pertinent as WG provides funding for the UHB's data function via the NDR programme and in agreeing to the NDR business case, the UHB will be required to contribute to delivery of these strategic objectives. If the case is agreed, the data programme will be revised accordingly. In regards to AI, there remains an intention to develop an AI strategy and to continue to benefit from the its use. An AI policy has been drafted for wider consideration and processes incorporating training materials have been established to enable staff to benefit from web based generative AI applications (e.g. chatgpt).

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Internal Audit/2024/199	04.10.2024	Intelligence Led Organisation Final Internal Audit Report_October 2024 (Review reference: CTM-2425-07_	3.1 A Data Quality Policy, or statement of intent should be developed that makes clear what good quality data looks like and its characteristic's along with clear expectations and responsibilities of staff.	Internal Audit/2024/199/MD4/1	The UHB will develop and implement a data quality policy, recognising that we anticipate the real improvements to be made when the data becomes available to the staff members who initially made the record and staff members who would use the records to meet the requirements. This availability is dependent upon the open architecture and NDR programmes moving into rapid delivery phases.	Digital & Data Director of Digital	31.01.2025	31.01.2025	Medium	In progress	November 2024 Update - An outline data quality policy has been drafted, however the requirement to maintain services whilst re-roofing POW has resulted in the writing of the policy being postponed. However the requirement for good quality data has been highlighted and far more widely accepted by senior staff across the organisation as a result of the POW incident and it is anticipated that behaviours and attitude towards data quality will have been enhanced.
Internal Audit/2024/199	04.10.2024	Intelligence Led Organisation Final Internal Audit Report_October 2024 (Review reference: CTM-2425-07_	4.1 Consideration should be given to using the IAR process to fully identify data pools and expanding the information held within the IAR.	Internal Audit/2024/199/MD4/1	The UHB will establish a data catalogue in line with Welsh standards as part of a commissioned and funded element of the National Data Resource programme.	Digital & Data Director of Digital	31.03.2027	31.03.2027	Medium	In progress	November 2024 Update - This long term action continues to be pursued, with funding proposed to be set aside to fulfil this task as part of the phase 4 NDR business case.
Internal Audit/2024/199	04.10.2024	Intelligence Led Organisation Final Internal Audit Report_October 2024 (Review reference: CTM-2425-07_	5.1 A Data Governance Framework for the organisation should be defined that sets out the requirements and responsibilities for the identification, aggregation, recording and use of data. This should include requirements for the presentation of information products that comply with good practice.	Internal Audit/2024/199/MD6/1	A data governance framework complimentary to the data quality policy, and incorporating the numerous mandated requirements placed on the UHB will be developed and implemented.	Digital & Data Director of Digital	31.01.2025	31.01.2025	Medium	In progress	November 2024 Update - An outline data governance framework complimentary to the data quality policy has been drafted, however the requirement to maintain services whilst re-roofing POW has resulted in the writing of the policy being postponed. However the requirement for good quality data has been highlighted and far more widely accepted by senior staff across the organisation as a result of the POW incident and it is anticipated that behaviours and attitude towards data quality will have been enhanced.
Internal Audit/2024/199	04.10.2024	Intelligence Led Organisation Final Internal Audit Report_October 2024 (Review reference: CTM-2425-07_	6.1 Training materials on data and its users should be provided, with targeted training provided to key staff tiers.	Internal Audit/2024/199/MD7/1	The organisation will explore core competency training that is presently available across NHS and public sector Wales with the intention of incorporating this into the personal development approach of the organisation.	Digital & Data Director of Digital	31.03.2025	31.03.2025	Medium	In progress	November 2024 Update - Work to be progressed in the first quarter of 2025.
Internal Audit/2024/200	16.09.2024	Embedding the Quality Framework Final Internal Audit Report_September 2024 (Review reference: CTMUHNB-2324-15)	1.1 Management within Children & Families care group should review and update the terms of reference for their QPSE meetings.	Internal Audit/2024/200/MD1/1	We acknowledge the importance of having clear and up-to-date ToRs for our QPSE meetings. We agree that a review and update of these terms of reference is required, to ensure they align with current priorities and best practices of the Children's and Families Care Group. A thorough review of the existing QPSE meeting ToRs will be conducted. Any outdated elements or areas that require enhancement will be made to the ToRs. The ToRs will be reviewed on an annual basis.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	31.12.2024	31.12.2024	Low	In progress	November 2024 Update - An update against this recommendation has not been provided on this occasion. New inspection action added October 2024
Internal Audit/2024/200	16.09.2024	Embedding the Quality Framework Final Internal Audit Report_September 2024 (Review reference: CTMUHNB-2324-15)	1.2a - The quoracy arrangements for the QPSE meetings should be reviewed and made clearer. A review of attendees at the Children & Families QPSE meetings should take place to make efficient use of time, whilst also adhering to any quoracy requirements. 1.2b - Where the Head of Quality and Patient Safety is unable to attend care group QPSE meetings, a representative should attend on their behalf. The ToRs should be updated to provide clarity on the need for representatives to attend meetings, if key members are unable to attend. 1.2c - It should be determined if finance colleagues are required to be in attendance at QPSE meetings. If it is felt they are not required to attend, the ToRs should be updated. However, if it is determined that finance representation is a requirement, care group management should remind their finance representatives of this requirement.	Internal Audit/2024/200/MD2/1	We will conduct a thorough review of the existing ToRs and make the following updates: 1.2a - Clarify the quoracy requirements, specifically defining how many representatives are needed from each service group/area for the meeting to be considered quorate. 1.2b - Update the list of required attendees and specify the need for deputies (especially in relation to the Head of Q&S and deputy) to attend in their absence. 1.2c - The QPSE Group will review whether finance colleagues are required to be in attendance at the QPSE meetings. If it is determined that finance representation is a requirement, the QPSE Chair will: • Remind finance representatives of the requirement to attend, • Emphasise the importance of their participation, • Ensure finance colleagues understand their role within the QPSE meetings.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	30.11.2024	30.11.2024	Medium	In progress	November 2024 Update - An update against this recommendation has not been provided on this occasion. New inspection action added October 2024
Internal Audit/2024/200	16.09.2024	Embedding the Quality Framework Final Internal Audit Report_September 2024 (Review reference: CTMUHNB-2324-15)	2.1 Management should ensure that care groups use the standard slide template provided by the framework. This includes incorporating sections for risk registers, key governance issues, and shared learning.	Internal Audit/2024/200/MD3/1	We acknowledge the importance of consistency and comprehensive reporting in our governance framework. The Corporate Quality & Safety team will review all Care Group QPSE slide templates and/or other methods of reporting, to ensure structures for reporting are consistent and in-line with the standard slide deck template within the Quality and Safety framework. The Corporate Quality & Safety Team will review compliance of the slide templates on a bi-annual basis.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	31.10.2024	31.10.2024	Medium	Overdue	November 2024 Update - An update against this recommendation has not been provided on this occasion. New inspection action added October 2024
Internal Audit/2024/200	16.09.2024	Embedding the Quality Framework Final Internal Audit Report_September 2024 (Review reference: CTMUHNB-2324-15)	2.2 Some CSGs included additional information in their slide deck presentations, such as data on Learning from Event Reports (LFERs), PDR & mandatory training compliance rates and other performance data. If care group management consider this additional information to be beneficial, then consideration should be given to standardising this practice across CSGs and care groups. The slide deck template could be updated to include these sections, ensuring departments present this information in a consistent way.	Internal Audit/2024/200/MD4/1	The Corporate Quality & Safety Team will conduct a review of the additional information currently being included by some CSGs. This review will assess the value and relevance of any additional information and whether, for consistency, this should be included within the standard slide-deck (or other method of structure for reporting).	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	31.12.2024	31.12.2024	Low	In progress	November 2024 Update - An update against this recommendation has not been provided on this occasion. New inspection action added October 2024
Internal Audit/2024/200	16.09.2024	Embedding the Quality Framework Final Internal Audit Report_September 2024 (Review reference: CTMUHNB-2324-15)	3.1 Management should ensure that all Care Groups have a documented assurance framework in place, setting out the assurance activities and structure of the CSGs and Care Group as a whole.	Internal Audit/2024/200/MD5/1	The Corporate Quality & Safety Team will: • conduct a detailed assessment of existing assurance frameworks within each Care Group to identify gaps and areas for improvement; • Develop a standardised assurance framework template that outlines key assurance activities and structures. This will include guidelines on documentation, reporting, and compliance requirements; • Establish a bi-annual monitoring and evaluation process to regularly review the effectiveness of the assurance frameworks. This will include periodic audits and feedback mechanisms to ensure continuous improvement.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	30.11.2024	30.11.2024	Medium	In progress	November 2024 Update - An update against this recommendation has not been provided on this occasion. New inspection action added October 2024
Internal Audit/2024/200	16.09.2024	Embedding the Quality Framework Final Internal Audit Report_September 2024 (Review reference: CTMUHNB-2324-15)	4.1 The annual quality work plans developed by the pathology departments should be updated to include SMART objectives. The approach used by pathology should then be shared wider within the care group and to other care groups as a template for the development of annual quality plans as required by the Quality framework. Progress in implemented the care group level plans should be monitored via the care group QPSE meetings.	Internal Audit/2024/200/MD6/1	The Pathology Department will update their Annual Quality Work Plan to include SMART objectives. Once the Pathology Department Annual Quality Work Plan has been updated, the revised plans will be shared at Care Group QPSE meetings.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	15.10.2024	15.10.2024	High	Overdue	November 2024 Update - An update against this recommendation has not been provided on this occasion. New inspection action added October 2024
Internal Audit/2024/200	16.09.2024	Embedding the Quality Framework Final Internal Audit Report_September 2024 (Review reference: CTMUHNB-2324-15)	4.1 The annual quality work plans developed by the pathology departments should be updated to include SMART objectives. The approach used by pathology should then be shared wider within the care group and to other care groups as a template for the development of annual quality plans as required by the Quality framework. Progress in implemented the care group level plans should be monitored via the care group QPSE meetings.	Internal Audit/2024/200/MD6/2	Templates and guidelines will be distributed to each Care Group QPSE group, who will complete an Annual Quality Work Plan (using SMART objectives). Each Care Group will ensure their QPSE Annual Quality Work Plan aligns with the Health Board's Annual Quality Work Plan. Care Groups will: • Ensure the QPSE Annual Quality Work Plan aligns with the Health Board's overarching Work Plan. • Add quality work plan updates as a standing agenda item at QPSE meetings; • Provide quarterly progress reports on SMART objectives; • Establish a process to escalate any objectives that are off-track; • Conduct an annual review of completed objectives and any lessons learned. * Although we would normally undertake this work immediately, due to the nature of the action a realistic timescale will be 31 December 2024.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	31.12.2024	31.12.2024	High	In progress	November 2024 Update - An update against this recommendation has not been provided on this occasion. New inspection action added October 2024
Internal Audit/2024/200	16.09.2024	Embedding the Quality Framework Final Internal Audit Report_September 2024 (Review reference: CTMUHNB-2324-15)	5.1 Management should review the reporting timeliness for Children & Families to ensure that the data presented is as current as possible to enable more accurate and timely data for decision making.	Internal Audit/2024/200/MD7/1	The Children & Families Care Group will review of the current reporting processes to identify any delays in the reporting timeliness of data, to ensure it is as current as possible.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	31.12.2024	31.12.2024	Low	In progress	November 2024 Update - An update against this recommendation has not been provided on this occasion. New inspection action added October 2024
Internal Audit/2024/201	16.09.2024	Follow-up: Medical Variable Pay – Agency Costs_September 2024 (Review Reference: CTMUHNB-2324-23)	1.1a - The review of the Medical Variable Pay Financial Control Procedure and the Medical Agency Locums Standard Operating Procedure should be completed. Both documents should be updated to reflect the revised organisational structure and the processes and controls that staff should be adhering to when engaging medical agency staff. The review should include: Information on the agreed rate card values and the authorisation process should those values need to be exceeded. Clarity on when non-direct engagement is acceptable and the scrutiny and authorisation process that should be followed. The process for extending agency worker placements. The process for managers to approve the use agency workers to cover roster gaps. 1.1b - Updated copies of the updated FCP and SOP should be accessible to all staff, and staff should be made aware of their existence. 1.1c - Consideration should be given to providing training to relevant staff to raise awareness of the FCP and SOP and ensure staff are clear on the correct processes to be followed.	Internal Audit/2024/201/MD2/1	1.1a It was recognised through the medical workforce programme that greater control and assurance was required hence the need to revise the FCP and SOP. Scrutiny revealed longstanding inconsistencies throughout the Health Board therefore addressing these issues has taken longer than originally anticipated. The investment of time in completing this work is essential to meet our organisational workforce financial controls and assurance. The FCP is being revised in line with the new Care Group structure and the Scheme of Delegation and will be submitted to Audit Committee in October 2024.	Medical Directorate and People Executive Medical Director Executive Director for People	31.10.2024	31.10.2024	High	Overdue	November 2024 Update - A meeting is scheduled to take place on 25/11/2024 to discuss this action. This is linked to original Internal Audit Review 2023/54.
Internal Audit/2024/201	16.09.2024	Follow-up: Medical Variable Pay – Agency Costs_September 2024 (Review Reference: CTMUHNB-2324-23)	1.1a - The review of the Medical Variable Pay Financial Control Procedure and the Medical Agency Locums Standard Operating Procedure should be completed. Both documents should be updated to reflect the revised organisational structure and the processes and controls that staff should be adhering to when engaging medical agency staff. The review should include: Information on the agreed rate card values and the authorisation process should those values need to be exceeded. Clarity on when non-direct engagement is acceptable and the scrutiny and authorisation process that should be followed. The process for extending agency worker placements. The process for managers to approve the use agency workers to cover roster gaps. 1.1b - Updated copies of the updated FCP and SOP should be accessible to all staff, and staff should be made aware of their existence. 1.1c - Consideration should be given to providing training to relevant staff to raise awareness of the FCP and SOP and ensure staff are clear on the correct processes to be followed.	Internal Audit/2024/201/MD2/2	1.1a Contd. The FCP is being revised in line with the new Care Group structure and the Scheme of Delegation and will be submitted to Audit Committee in October 2024. Following this the action is to revise the SOP. (Linked to 1.1a).	Medical Directorate and People Executive Medical Director Executive Director for People	30.11.2024	30.11.2024	High	In progress	November 2024 Update - A meeting is scheduled to take place on 25/11/2024 to discuss this action. Rules and plans for action will be finalised. Linked to Internal Audit /2023/54.
Internal Audit/2024/201	16.09.2024	Follow-up: Medical Variable Pay – Agency Costs_September 2024 (Review Reference: CTMUHNB-2324-23)	1.1a - The review of the Medical Variable Pay Financial Control Procedure and the Medical Agency Locums Standard Operating Procedure should be completed. Both documents should be updated to reflect the revised organisational structure and the processes and controls that staff should be adhering to when engaging medical agency staff. The review should include: Information on the agreed rate card values and the authorisation process should those values need to be exceeded. Clarity on when non-direct engagement is acceptable and the scrutiny and authorisation process that should be followed. The process for extending agency worker placements. The process for managers to approve the use agency workers to cover roster gaps. 1.1b - Updated copies of the updated FCP and SOP should be accessible to all staff, and staff should be made aware of their existence. 1.1c - Consideration should be given to providing training to relevant staff to raise awareness of the FCP and SOP and ensure staff are clear on the correct processes to be followed.	Internal Audit/2024/201/MD2/3	1.1b - The revised SOP and FCP will be available on the Intranet	Medical Directorate and People Executive Medical Director Executive Director for People	31.12.2024	31.12.2024	High	In progress	November 2024 Update - A meeting is scheduled to take place on 25/11/2024 to discuss this action. Linked to Internal Audit/2023/54.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Reference Number	Action	Executive / Inspection Lead	Original Due Date	Current Due Date	Action Rating	Progress Status	Comments/Updates
Internal Audit/2024/201	16.09.2024	Follow-up: Medical Variable Pay – Agency Costs September 2024 (Review Reference: CTMUHB-2324-23)	1.1a - The review of the Medical Variable Pay Financial Control Procedure and the Medical Agency Locums Standard Operating Procedure should be completed. Both documents should be updated to reflect the revised organisational structure and the processes and controls that staff should be adhering to when engaging medical agency staff. The review should include: Information on the agreed rate card values and the authorisation process should those values need to be exceeded. Clarity on when non-direct engagement is acceptable and the scrutiny and authorisation process that should be followed. The process for extending agency worker placements. The process for managers to approve the use agency workers to cover roster gaps. 1.1b - Updated copies of the updated FCP and SOP should be accessible to all staff, and staff should be made aware of their existence. 1.1c - Consideration should be given to providing training to relevant staff to raise awareness of the FCP and SOP and ensure staff are clear on the correct processes to be followed.	Internal Audit/2024/201/MD2/4	1.1c - The training provision timetable will be discussed and agreed at the Medical Workforce Productivity Framework Group.	Medical Directorate and People Executive Medical Director Executive Director for People	31.10.2024	31.10.2024	High	Overdue	November 2024 Update - Discussed at Framework Group meeting on 19/11/2024. Further discussion to take place in meeting scheduled to take place on 25/11/2024, where plans and actions will be finalised. Linked to Internal Audit 2023/54.
Internal Audit/2024/202	02.10.2024	Follow-Up: Reasonable Offer Final Internal Audit Report - October 2024 (Review Reference - CTM-2324-25)	1.1 The review and refresh of the Waiting List Management Standard Operating Procedure should be concluded and be presented to Operational Management Board (OMB) and the Executive Leadership Group (ELG) for final approval.	Internal Audit/2024/202/MD1/1	1.1 To be added to the agenda for Operational Management Board (OMB) following the review and refresh of the Waiting List Management Standard Operating Procedure should be concluded and be presented to OMB and the Executive Leadership Group (ELG) for final approval.	Care Group - Planned Care Chief Operating Officer	30.11.2024	30.11.2024	Low	In progress	November 2024 Update - An update against this recommendation has not been provided on this occasion. New Inspection Action added October 2024.
Internal Audit/2024/202	02.10.2024	Follow-Up: Reasonable Offer Final Internal Audit Report - October 2024 (Review Reference - CTM-2324-25)	2.1 Following completion of changes to the operating model and the merge to one WPAS system, the Health Board should perform a training needs assessment of staff responsible for booking appointments, including the application of the Waiting List Management SOP/RTT rules, specifically in relation to reasonable offers and the required audit trail within WPAS.	Internal Audit/2024/202/MD2/1	2.1 An additional training needs assessment and compliance sign off will take place post WPAS merge in May 2025.	Care Group - Planned Care Chief Operating Officer	31.08.2025	31.08.2025	Medium	In progress	November 2024 Update - An update against this recommendation has not been provided on this occasion. New Inspection Action added October 2024.
Internal Audit/2024/202	02.10.2024	Follow-Up: Reasonable Offer Final Internal Audit Report - October 2024 (Review Reference - CTM-2324-25)	3.1 Management should pursue their original management response of generating WPAS compliance reports as a mechanism to identify staff training requirements.	Internal Audit/2024/202/MD3/1	3.1 Following OCP phase 3, an additional audit of the 'all users with WPAS compliance' report to take place and training arranged for identified staff. Directorates will review and identify where they need training. Monthly Monitoring to enable staff training requirements.	Care Group - Planned Care Chief Operating Officer	31.01.2025	31.01.2025	Low	In progress	November 2024 Update - An update against this recommendation has not been provided on this occasion. New Inspection Action added October 2024.
Internal Audit/2024/202	02.10.2024	Follow-Up: Reasonable Offer Final Internal Audit Report - October 2024 (Review Reference - CTM-2324-25)	4.1 Post-restructure, a full review of the approach to data validation should be undertaken to ensure compliance with the Waiting List Management SOP and RTT rules. The outcome of this work should be used to identify trends in errors to allow training to be targeted on certain aspects of the process or to certain teams / specialities.	Internal Audit/2024/202/MD4/1	4.1 Planned Care to undertake a review of the validation process across CTMUHB. Outcome of review to be shared with the Improving Care Board.	Care Group - Planned Care Chief Operating Officer	31.01.2025	31.01.2025	Medium	In progress	November 2024 Update - An update against this recommendation has not been provided on this occasion. New Inspection Action added October 2024.
Internal Audit/2024/203	27.09.2024	Follow-up: Patient Pathways Final Internal Audit Report - September 2024 (Review Reference: CTM 23/24-31)	1.1a To minimise the number of patients on the 'outpatients not booked' reports, following outpatient appointments, WPAS should be accurately updated in a timely manner. Each speciality should be clear who is responsible for performing this role and ensure relevant staff are aware of their responsibilities.	Internal Audit/2024/203/MD1/1	1.1a Directorates working with admin staff & records department to ensure they are taking back to source and to identify if any training requirements.	All Care Groups Chief Operating Officer	31.01.2025	31.01.2025	High	In progress	November 2024 Update - An update against this recommendation has not been provided on this occasion. New Inspection action added October 2024
Internal Audit/2024/203	27.09.2024	Follow-up: Patient Pathways Final Internal Audit Report - September 2024 (Review Reference: CTM 23/24-31)	1.1b Each speciality should set out who is responsible for actioning 'outcomes not booked' reports. Staff should be made aware of their responsibilities.	Internal Audit/2024/203/MD2/1	1.1b Distribution lists updated to reflect new Directorate structures, will need further updating once vacancies filled. Draft produced and to be sent to PAS team.	All Care Groups Chief Operating Officer	31.10.2025	31.10.2025	High	In progress	November 2024 Update - An update against this recommendation has not been provided on this occasion. New Inspection action added October 2024
Internal Audit/2024/203	27.09.2024	Follow-up: Patient Pathways Final Internal Audit Report - September 2024 (Review Reference: CTM 23/24-31)	1.1c As reports are received each week, speciality managers should ensure they analyse the data to identify trends such as those staff or departments that are continually failing to input outcome data and those staff or department that are facility to rectify errors. Where necessary appropriate action should be taken including the provision of additional training on the WPAS and holding staff to account if they are failing to perform tasks they are responsible for.	Internal Audit/2024/203/MD3/1	1.1c Directorate ops teams continue to validate 'outcomes not booked', next steps to take back to source and work with admin, secretaries and medical records to ensure processes are followed. Any training needs will be highlight to WPAS team for support.	All Care Groups Chief Operating Officer	30.11.2024	30.11.2024	High	In progress	November 2024 Update - An update against this recommendation has not been provided on this occasion. New Inspection action added October 2024
Internal Audit/2024/203	27.09.2024	Follow-up: Patient Pathways Final Internal Audit Report - September 2024 (Review Reference: CTM 23/24-31)	1.2 The wording used in the emails sent by the WPAS team could be further strengthened to ensure those receiving the reports are clear on the implications for patients if the reports are not acted upon and corrective action taken.	Internal Audit/2024/203/MD4/1	1.2 Directorate Managers and Services Managers (new structure) will be included in reporting emails to ensure the correct message is disseminated to the ops teams.	All Care Groups Chief Operating Officer	30.11.2024	30.11.2024	Low	In progress	November 2024 Update - An update against this recommendation has not been provided on this occasion. New Inspection action added October 2024
Internal Audit/2024/203	27.09.2024	Follow-up: Patient Pathways Final Internal Audit Report - September 2024 (Review Reference: CTM 23/24-31)	2.1a Each speciality should set out who is responsible for actioning 'closed pathway' reports when they are received each month. Staff should be made aware of their responsibilities	Internal Audit/2024/203/MD5/1	2.1a Directorate and Directorate Support Managers receive data and actions to be set at local Directorate performance meetings. To be rolled out across all Directorates. Updates are recorded and discussed at weekly Planned Care Weekly Performance Meeting – chaired by Director of Ops.	All Care Groups Chief Operating Officer	30.11.2024	30.11.2024	High	In progress	November 2024 Update - An update against this recommendation has not been provided on this occasion. New Inspection action added October 2024
Internal Audit/2024/203	27.09.2024	Follow-up: Patient Pathways Final Internal Audit Report - September 2024 (Review Reference: CTM 23/24-31)	2.1b To minimise the number of patients incorrectly on closed pathways, as reports are received each month, speciality managers should ensure they analyse the data to identify those departments with high numbers of brought forward cases, and trends such as those staff or departments that are continually failing capture information correctly. Appropriate action should be taken, including the provision of additional training on the WPAS and holding staff to account if they are failing to perform tasks they are responsible for.	Internal Audit/2024/203/MD6/1	2.1b Distribution lists updated to reflect new Directorate structures, will need further updating once vacancies filled. Draft produced and to be sent to PAS team. Directorate ops teams continue to validate 'outcomes not booked', next steps to take back to source and work with admin, secretaries and medical records to ensure processes are followed. Any training needs will be highlight to WPAS team for support.	All Care Groups Chief Operating Officer	31.10.2025	31.10.2025	High	In progress	November 2024 Update - An update against this recommendation has not been provided on this occasion. New Inspection action added October 2024
Internal Audit/2024/203	27.09.2024	Follow-up: Patient Pathways Final Internal Audit Report - September 2024 (Review Reference: CTM 23/24-31)	2.2a The wording used in the emails sent by the WPAS team could be further strengthened to ensure those receiving the reports are clear on the implications for patients if the reports are not acted upon and corrective action taken.	Internal Audit/2024/203/MD7/1	2.2a - Directorate Managers and Services Managers (new structure) will be included in reporting emails to ensure the correct message is disseminated to the ops teams.	All Care Groups Chief Operating Officer	30.11.2024	30.11.2024	Low	In progress	November 2024 Update - An update against this recommendation has not been provided on this occasion. New Inspection action added October 2024
Internal Audit/2024/203	27.09.2024	Follow-up: Patient Pathways Final Internal Audit Report - September 2024 (Review Reference: CTM 23/24-31)	2.2b Consideration should be given to issuing separate 'closed pathways' reports to each speciality, as opposed to one generic report that has to be filtered.	Internal Audit/2024/203/MD8/1	2.2b - New updated distribution lists will ensure correct services and teams are receiving relevant report for their areas/specialities	All Care Groups Chief Operating Officer	31.10.2025	31.10.2025	Low	In progress	November 2024 Update - An update against this recommendation has not been provided on this occasion. New Inspection action added October 2024
Internal Audit/2024/203	27.09.2024	Follow-up: Patient Pathways Final Internal Audit Report - September 2024 (Review Reference: CTM 23/24-31)	3. Those medical secretaries that do not yet have access to QI reporting tool should request access and if necessary, training, in order to be sure monitoring of patients awaiting diagnostic test results can be done in a consistent way across the Health Board, with no restrictions, such as those created by using 'watch lists'.	Internal Audit/2024/203/MD9/1	3. To be discussed and action set with new structure Directorate Managers and ops teams.	All Care Groups Chief Operating Officer	30.11.2024	30.11.2024	Medium	In progress	November 2024 Update - An update against this recommendation has not been provided on this occasion. New Inspection action added October 2024
Internal Audit/2024/204	07.10.2024	Follow-up: Facilities Governance Arrangements Final Internal Audit Report - October 2024 (Review Reference - CTMUHB 2425-27)	2.2 The action cards developed by Facilities could be enhanced to include: - the requirement for staff to record the reasons for the retrospective order within the 'description' box when raising the requisition. -the requirement for approving managers to file/save any relevant supporting documentation, including evidence of quotes, appropriately and in a location that can be accessed by other members of the department.	Internal Audit/2024/204/MD1/1	2.2 The need to update the action cards to reflect the process to be followed for retrospective orders is no longer required due to changes in operating practices. Staff have been informed that they are not permitted to place retrospective orders. Retrospective orders will only be placed in an emergency (outbreak etc.) Only the Director of Facilities or the Performance and Governance Lead, in the absence of the Director, can place a retrospective order, and only in an emergency. Supporting documentation will be given when raising the requisition and the Executive Director of Finance will be informed. The facilities directorate is currently going through a re-structure. A Band 5 procurement manager will be recruited to manage all orders and procurement issues. Unit managers will place orders with the procurement manager. The procurement manager will place all orders on the system/ Catalogue and Oracle. This will negate the need for others to raise orders.	Facilities Chief Operating Officer	17.10.2024	17.10.2024	Low	Fully complete (Awaiting approval)	Update October 2024 - this management action was agreed for closure. Internal Audit Comment: "We acknowledge the revised approach mitigates against the potential risk".
Internal Audit/2024/204	07.10.2024	Follow-up: Facilities Governance Arrangements Final Internal Audit Report - October 2024 (Review Reference - CTMUHB 2425-27)	4. Management should liaise with the Procurement Department resume the regular receipt of the Invoices on Hold reports. Once received it should be ensured that queries are reviewed and resolved as soon as possible	Internal Audit/2024/204/MD2/1	4. Liaison with the procurement department takes place during monthly SLT meetings and Facilities & Procurement Compliance meetings. We have raised the lack of receipt of invoice on hold reports with the procurement lead. This data will now be provided monthly to the Performance Governance lead who will disseminate the relevant parts of the report to the various facilities departments. The department leads will be present at the Facilities & Procurement Compliance meetings where there will be scrutiny of the reports and managers held to account on the actions they have taken to resolve the hold issues. The SLT meetings will have a higher-level overview of facilities as a whole, but focus on hotspot departments if required. The first SLT meeting where invoice on hold data will be presented is due to take place on 03/10/24. At the current time there are just over 1,000 invoices on hold that the facilities team are responsible for actioning. Nearly 200 of these relate to a specific supplier that we intentionally put on hold due to hygiene risks and concerns with quality of supply.	Facilities Chief Operating Officer	31.10.2024	31.10.2024	Medium	Overdue	November 2024 Update - Invoice on hold report has been added to the Facilities - Procurement Compliance Meeting which is held on a bi monthly basis to enable Facilities Senior Managers to review with support from Procurement team. It is recommended that this action is now marked as completed. New inspection action added October 2024.

Code	Title	Date of Inspection	Care Group	DoN Lead	Recommendations	Actions
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/197	HMP Parc Prison - DIC (Case Reference: CA 09791/CRM0006681)	14.08.2024	Primary Care & Community	Lucie Williams, Nurse Director	3	3
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/198	HMP Parc Prison - DIC (Case Reference: RD 06379/CRM0006682)	14.08.2024	Primary Care & Community	Lucie Williams, Nurse Director	5	5
Healthcare Inspectorate Wales (HIW)/2017/141	National review of Ophthalmology Services - report published 2017 - 1st update submitted 2019-follow up update submitted December 2022	30.01.2017	Planned Care	Sharon O'Brien, Nurse Director	22	22
Healthcare Inspectorate Wales (HIW)/2020/139	Quality Check Summary Ysbyty Cwm Rhondda [Ysbyty Cwm Rhondda - Ward A1 (Ref: 20030)]	08.09.2020	Primary Care & Community	Lucie Williams, Nurse Director	2	2
Healthcare Inspectorate Wales (HIW)/2021/135	Quality Check Summary Seren Ward, Royal Glamorgan Hospital [Improvement plan - Seren Ward - Royal Glamorgan Hospital (Ref: 20090)]	20.04.2021	Mental Health & Learning Disabilities	Ana Llewelyn, Nurse Director	1	1
Healthcare Inspectorate Wales (HIW)/2021/137	National Review of Mental Health Crisis Prevention in the Community	30.06.2021	Mental Health & Learning Disabilities	Ana Llewelyn, Nurse Director	17	18
Healthcare Inspectorate Wales (HIW)/2021/138	Quality Check Summary Pinewood House [Pinewood House - Quality Check]	20.07.2021	Mental Health & Learning Disabilities	Ana Llewelyn, Nurse Director	2	2
Healthcare Inspectorate Wales (HIW)/2022/129	HIW & CIW Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital [HIW Improvement Plan Service: Bridgend North CMHT (Maesteg Hospital) (Ref: 3189)]	01.11.2022	Mental Health & Learning Disabilities	Ana Llewelyn, Nurse Director	6	10
Healthcare Inspectorate Wales (HIW)/2022/131	Hospital Inspection (Announced) Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	22.03.2022	Children & Families	Suzanne Hardacre, Director of Midwifery	7	7
Healthcare Inspectorate Wales (HIW)/2022/133	Hospital Inspection Report (Unannounced) Emergency Department, Princess of Wales Hospital [Appendix A - Immediate Improvement Plan - Princess of Wales Emergency Department (Ref: 3326)]	17.10.2022	Unscheduled Care	Emma James, Nurse Director	1	2
Healthcare Inspectorate Wales (HIW)/2022/36	Hospital Inspection Report (Unannounced) Angelton Clinic, Glanrhyd Hospital [Improvement plan Service Angelton Clinic – Glanrhyd Hospital (Ref: 3171)]	14.11.2022	Mental Health & Learning Disabilities	Ana Llewelyn, Nurse Director	5	5
Healthcare Inspectorate Wales (HIW)/2023/130	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	07.03.2023	Mental Health & Learning Disabilities	Ana Llewelyn, Nurse Director	39	180
Healthcare Inspectorate Wales (HIW)/2023/134	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital [Appendix A - Immediate Improvement Plan - PCH, E Dept & C D Unit - 31 July 01 & 02 August 2023 (Ref: 3399)]	31.07.2023	Unscheduled Care	Emma James, Nurse Director	2	2
Healthcare Inspectorate Wales (HIW)/2023/140	HMP Parc Prison	16.05.2023	Primary Care & Community	Lucie Williams, Nurse Director	7	7
Healthcare Inspectorate Wales (HIW)/2023/155	National Review of Patient Flow - a journey through the stroke pathway	07.09.2023	Unscheduled Care	Emma James, Nurse Director	50	50
Healthcare Inspectorate Wales (HIW)/2023/156	Hospital Inspection Report (Unannounced) Paediatric Ward, Princess of Wales Hospital [Appendix C - Princess of Wales Hospital, Paediatric Ward 25 & 26 September 2023 (Ref: 03421)]	25.09.2023	Children & Families	Suzanne Hardacre, Director of Midwifery	2	2
Healthcare Inspectorate Wales (HIW)/2023/157	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	13.11.2023	Mental Health & Learning Disabilities	Ana Llewelyn, Nurse Director	25	26
Healthcare Inspectorate Wales (HIW)/2023/158	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	20.11.2023	Mental Health & Learning Disabilities	Ana Llewelyn, Nurse Director	19	19
Healthcare Inspectorate Wales (HIW)/2023/167	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	31.07.2023	Unscheduled Care	Emma James, Nurse Director	31	36
Healthcare Inspectorate Wales (HIW)/2024/165	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	09.01.2024	Children & Families	Suzanne Hardacre, Director of Midwifery	2	27
Healthcare Inspectorate Wales (HIW)/2024/166	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	09.01.2024	Children & Families	Suzanne Hardacre, Director of Midwifery	14	36
Healthcare Inspectorate Wales (HIW)/2024/184	Appendix A - Ysbyty Cwm Rhondda Ward B2 (Ref: 03467)	11.04.2024	Primary Care & Community	Lucie Williams, Nurse Director	3	3

HIW Inspections Recommendations Tracker
Actions - Status Key

In progress	Inspection action is in the process of being completed and has not yet reached the deadline.
Partially complete	Inspection action is in progress and some of the recommendations have been completed. The deadline has not yet been reached.
Partially complete (Overdue)	Inspection action is in progress and some of the recommendations have been met. The deadline has been reached and is now overdue.
Overdue	Inspection action deadline has been reached and no recommendations have been completed.
Fully complete (Awaiting approval)	Inspection actions have been fully completed and are waiting to be approved to be closed.
Fully complete (Awaiting approval) - Further Evidence Required	Inspection actions are considered to be fully completed and are waiting to be approved to be closed, however, as part of the data cleansing exercise it has been identified that further information/evidence is required to complete closure eg the date of QSRE approval.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Reference Number	Action	Care Group	Original Due Date	Current / Revised Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/197	14.08.2024	HMP Parc Prison - DIC (Case Reference: 09791/CRM005681)	Reception screening for any prisoner with known risks such as significant medical history or substance misuse is undertaken by a qualified nurse, to ensure that any concerns regarding health or risks are recognised and acted upon. Entries in the clinical record is made by a named member of staff and is done so contemporaneously where possible.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/197/M02/1	New admissions are now screened by a qualified nurse. A documentation audit to is to be completed and any issues identified to be reported on the Datix management system.	Primary Care & Community	30.09.2024	30.09.2024	Overdue	October 2024 Update - Added to Tracker as at September 2024 Progress and evidence: Roster to be embedded to evidence RN on duty within admissions. Audit and findings to be embedded.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/197	14.08.2024	HMP Parc Prison - DIC (Case Reference: 09791/CRM005681)	Inter-prison transfers should not be made unless it is clear that a service exists to deliver the health needs of the patient at the appropriate destination, by a confirmed sign off between both prisons heads of healthcare. When arriving at HMP Parc, currently there is no commissioned service for patients with confirmed or suspected ADHD to receive specialist input into care management. CTM/HB commissioners urgently seek to provide a clinical service to HMP Parc that would enable timely assessment and treatment optimisation for prisoners with ADHD.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/197/M02/1	A review of the current processes regarding the inter-prison transfers and the sharing of information between prison healthcare departments to be undertaken in partnership with G&S team. For patients who require ADHD assessments are currently reviewed by mental health services within secondary care. Whilst this is in line with the care provided within Community Services, the team are undertaking a review with Mental Health services to understand any further improvements that could be made to the service. Prison Healthcare Directorate representation included as part of the CTM Regional Neurodivergence Steering and Improvement Board to review current provision and identify work streams to improve services.	Primary Care & Community	31.12.2024	31.12.2024	In progress	October 2024 Update - Added to Tracker as at September 2024 Progress and evidence: Process to be embedded once agreed.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/197	14.08.2024	HMP Parc Prison - DIC (Case Reference: 09791/CRM005681)	CTM/HB commissioners ensure that all contracted services providing any input into the health of the patient are required to maintain records in the main healthcare clinical record system.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/197/M02/1	Email to be sent to all contracted services to remind them of the importance that when providing any input to the health of a patient that all records are maintained with the clinical system. The requirement to add relevant information in the main healthcare clinical record system (System One) to be included in all future SLA and tender documentations. Healthcare Needs Assessment commissioned to provide baseline for service provision and resulting action plan to address identified recommendations.	Primary Care & Community	31.12.2024	31.12.2024	In progress	October 2024 Update - Added to Tracker as at September 2024 Progress and evidence: Email to be embedded. Specific part of contract to be embedded. Needs Assessment to be embedded and evidence.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/198	14.08.2024	HMP Parc Prison - DIC (Case Reference: 06379/CRM005682)	The head of Healthcare should ensure that all prisoners, by the end of second reception screening, have a full set of baseline clinical observations to act as baseline for staff to monitor for changes from the patient normal values. Reception screening should always involve at least one registered health professional undertaking the assessment with the patient. They should arrange clinical audit of compliance against this standard.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/198/M02/1	New admissions are now screened by a qualified nurse. Audit for 15 admissions to be undertaken to ensure that clinical observations have been undertaken. All staff have been informed that baseline observations must be recorded on admission screening. All staff will be issued with written guidance.	Primary Care & Community	30.09.2024	30.09.2024	Overdue	October 2024 Update - Added to Tracker as at September 2024 Progress and evidence: Roster to be embedded. Audit to be embedded. Email to be embedded. Guidance shared to be embedded.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/198	14.08.2024	HMP Parc Prison - DIC (Case Reference: 06379/CRM005682)	Patients with seizures (full loss of consciousness) without an established diagnosis of the cause of seizures should be treated as a clinical emergency by all healthcare staff, and should receive review urgently by a registered medical practitioner. If none is available onsite, then the patient should be referred to hospital for emergency assessment.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/198/M02/1	Emergency medicine training sessions to be devised and provided to ensure that all staff have adequate skills and knowledge to treat clinical emergencies and to identify those who require referral to hospital for an emergency assessment. All staff have been reminded that any patients reporting seizure activity in the absence of a diagnosis of epilepsy must be referred for an urgent GP appointment. All staff have been informed that the GP must be informed of any patients with a diagnosis of epilepsy have any seizure activity. These patients will be reviewed by the practice nurse.	Primary Care & Community	31.10.2024	31.10.2024	In progress	October 2024 Update - Added to Tracker as at September 2024 Progress and evidence: Attendance record for all staff to be embedded. Email to be embedded. Email to be embedded.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/198	14.08.2024	HMP Parc Prison - DIC (Case Reference: 06379/CRM005682)	Healthcare staff should ensure that when reviewing clinical discharge summaries from hospital teams, the information on which they have based their assessment is accurate (for example, in this case, it was incorrect for the consultant neurologist to state this was a single episode of seizure) from the clinical record. These errors or omissions should be alerted to the relevant specialist, so that they can revise the management plan for the patient.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/198/M02/1	Admissions staff to be provided have access to the Welsh Clinical Portal to ensure timely review of discharge summaries. All discharge summaries will be reviewed by a GP and Senior Nurse. The discharge summaries will be checked for accuracy and outstanding actions. Once checked and signed by Senior Nurse and GP they will be scanned onto records. Audit to be undertaken in relation to 10 discharges to ensure all summaries have been checked by the GP and Senior Nurse	Primary Care & Community	31.10.2024	31.10.2024	In progress	October 2024 Update - Added to Tracker as at September 2024 Progress and evidence: Meeting with Digital Health Care Wales with 02/09/24. Audit and findings to be embedded.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/198	14.08.2024	HMP Parc Prison - DIC (Case Reference: 06379/CRM005682)	Where a hospital letter is requesting potential actions if a future event should occur (e.g. 'refer back to my service should a further seizure occur') this should be flagged on the clinical record as an 'alert', so this potential action / request is visible to all staff.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/198/M02/1	Admissions staff to have access to Welsh Clinical Portal to ensure timely review of discharge summaries. All discharge letters will be checked by a Senior Nurse and a GP and any requests for actions to be taken if a future event should occur this will be flagged as an alert on medical records.	Primary Care & Community	31.10.2024	31.10.2024	In progress	October 2024 Update - Added to Tracker as at September 2024 Progress and evidence: Register of staff with dates of access provided to be embedded. Audit in number 3 will evidence the findings.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/198	14.08.2024	HMP Parc Prison - DIC (Case Reference: 06379/CRM005682)	Clinical teams in other services providing care to prisoners (e.g. psychiatry) should clearly document that they have considered the risk of their prescribing recommendations to general practitioners, where those recommendations increase the risk of worsening of other illness (e.g. increasing risk of seizure). Formal letters of referral and assessment need to be conducted between HMP Parc primary care and In-Reach Psychiatry teams, to ensure that all relevant information on the clinical history of the patient is available to both parties (e.g. to ensure that psychiatric colleagues are aware of risk of seizures, and that these colleagues make recommendations for prescribing that clearly document that risk has been considered in their assessment)	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/198/M02/1	Recommendation shared and teams reminded of the importance for enhanced communication and documentation between clinical teams providing care to prisoners at HMP Parc. A task and finish Group to be established to address the recommendation and to improve processes between clinical teams and to identify standardisation for referral and assessment to include patient's clinical history, prescribing recommendations, risk assessment and communication protocols.	Primary Care & Community	30.11.2024	30.11.2024	In progress	October 2024 Update - Added to Tracker as at September 2024 Progress and evidence: Email to be embedded. Findings from the task and finish group to be embedded.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Issues relating to patient referral process. All parties (Welsh Government, NWS, Ophthalmology Planned Care Board and Health Boards) must work together towards the introduction of electronic patient record/referral system from optometrists directly to secondary care.	Healthcare Inspectorate Wales (HIW)/2017/141/M01/1	Roll out of OpenEyes has been delayed nationally. Primary Care have worked with the programme team to provide contact details for all optometrists requiring access/relevant training. Enhanced support has been offered by the HB IT programme and project team to implement OpenEyes, the national electronic patient record/referral system for eye care which will support clearer and integrated working across care settings. A task and finish group has been established, with the clear objective of implementing the system in glaucoma clinics in the NHS hospitals by the end of March 2023. The programme plan is to then implement e-communications (including e-referrals) between primary and secondary care as stage 2 and to roll out to the other sub-specialities in Ophthalmology as stage 3. These are in the local and national plans to be undertaken in the financial year 2023/24. Programme management support has been provided by WG for the 15 months from Jan 2023 to March 2024.	Planned Care	01.03.2023	01.03.2023	Overdue	October 2024 Update - No update has been received against this recommendation action on this occasion. August 2024 Update - this is ongoing, due to delays in national EPR/ERS programme. E-referral software under national tender, CTM contributing to DHCW's national working groups to establish necessary minimum standards of ERS. Primary care optometry M365/NHS email rollout progressing (84% live across HB which will support direct email referral into secondary care (until ERS in place). No recent local progression with EPR rollout beyond glaucoma clinics (see OpenEyes business project manager). await EPR programme updates from DHCW. April 2024 Update - DCHW-led rollout of OpenEyes still delayed, possibility of resourcing tender process. OE contract with CTM in place until at least Jan 2025 (currently only Glaucoma clinics live). CTM OpenEyes Business Project Manager no longer in post (contract not renewed past March 31st), significantly impeding further rollout of OE in hospital sites as no defined support/project management. Use trial of OpenEyes in a glaucoma community optometry practices ongoing. National DCHW-led rollout of e-referrals also delayed, but local work ongoing to establish single inbox for email referrals from primary care into Ophthalmology. Inbox monitoring not being established. Timeline for launch dependent on primary care NHS email roll out below but expected to be live by August 2024. CTM keen to promote roll out of M365 with community optometry practices following successful pilot - provided DCHW with priority list (focusing on practices involved in shared care/WG054) during their rollout of NHS email (rolling out April-Aug).
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	The CCG's National Ophthalmology Review highlighted that some patients felt they had not been provided with sufficient information regarding the reason for their referral. (Patient Referrals - Referral Process) All parties (Welsh Government, NWS, Ophthalmology Planned Care Board and Health Boards) must work together towards the introduction of electronic patient record/referral system from optometrists directly to secondary care.	Healthcare Inspectorate Wales (HIW)/2017/141/M02/1	Primary care has produced and shared patient information on CTM social media platforms to explain changes in patient referrals and enhanced services now being delivered in primary care closer to home. Recent recruitment of additional Optometry Advisor (Jan 23) will support practices to improve communication and referral pathways for patients and will support practices where poor quality referrals are flagged. HES updates on waiting times are shared with practices via SEWNOG to support conversations with patients and manage expectation.	Planned Care	01.04.2024	01.04.2024	Fully complete (awaiting approval) - Further Evidence Awaited	October 2024 Update - No update has been received against this recommendation action on this occasion. August 2024 Update - meeting scheduled with Planned Care Care Group leads to seek confirmation as to when this action was completed. April 2024 Update - EPR/E-referral - see M01/1. Implementation plan for rollover of shared-care services to new WG054 pathways submitted to WG, with cross-sector discussion meeting planned 20/5/24. Once ratified, communications and newsletter to update primary care options on changes will be delivered, as will updated patient service signposting. Dec 23 Completed - new optometry contract phased implementation began Oct 23 2- implementation of EPR across HB remains an ongoing process
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Quality of referrals being sent to rapid access pathway (Patient Referrals - Quality of Referrals) A) Health Boards should consider methods to refine referrals to ensure patients enter the most appropriate care pathway in a timely and efficient manner, avoiding unnecessary visits.	Healthcare Inspectorate Wales (HIW)/2017/141/M03/1	Primary Care (HES) have already established a number of referral refinement schemes within practices in CTM. - Independent Prescribing - Wet AMD - Diabetic Retinopathy - Glaucoma (develop existing service in place)	Planned Care	01.04.2024	01.04.2024	Fully complete (awaiting approval) - Further Evidence Awaited	October 2024 Update - No update has been received against this recommendation action on this occasion. August 2024 Update - meeting scheduled with Planned Care Care Group leads to seek confirmation as to when this action was completed. Completed: all schemes are now established within CTM April 2024 Update - Ongoing pathways continue to monitor under existing shared-care agreements during the WG05 transition phase. Improved data sharing between secondary and primary care re: patient outcomes within these pathways being scoped. Insufficient admin resources within HES team a significant challenge for this. Currently 3 Swift Band 3-5 admin support committed to these pathways (1 Swift Band 3 post vacancy imminent, but recruitment to replace agreed) further admin support necessary to scale up pathways. WG to identify regional Planned Care Board leads to signpost secondary care to potential funding to support WG05 delivery. New HB-wide glaucoma referral refinement pathway being designed, to be live by Oct '24. Dec 23 update Data for these schemes are reviewed monthly on an ongoing basis by the primary/secondary teams and pan HB team/practice meetings are held regularly to review schemes. All schemes will begin to fall under the new optometry contract through phasing in of new contract / WG05 and monitored by primary care.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Quality of referrals being sent to rapid access pathway (Patient Referrals - Quality of Referrals) B) Health Boards should consider providing educational events/material to raise awareness among optometrists and other relevant staff of local referral pathways.	Healthcare Inspectorate Wales (HIW)/2017/141/M04/1	Practices are notified when new local referral pathways are introduced and updates circulated to practices. Optometry newsletter to be produced in primary care and circulated 4 times a year. Accelerated Cluster Development will allow closer working for practices within clusters. CTM to hold first event part 23	Planned Care	01.04.2024	01.04.2024	Fully complete (awaiting approval) - Further Evidence Awaited	October 2024 Update - No update has been received against this recommendation action on this occasion. August 2024 Update - meeting scheduled with Planned Care Care Group leads to seek confirmation as to when this action was completed. April 2024 Update - ACD engagement successful across HB, HB protocol for managing failure to engage being ratified. Local discussion sessions with primary care optometry practices to be delivered once pathway changes finalised over next few months, with newsletter updates. Quarterly ECCG in progress following reinstatement in Dec '23 (next meeting May '24). Monthly cross-sector WG05 planning/implementation meetings between primary & secondary care teams for both Glaucoma and Medical Retina also taking place. Dec 23 update newsletters will continue to be sent to practices via primary care team regarding updates and new referral pathways. There will be ongoing engagement with practices due to the implementation of new contract/WG05 services and communication sent to relevant services re GMS/pharmacy/secondary care on any relevant changes. Most practices are now engaged with ACD under the new contract obligations and work will continue to engage with those practices not yet engaged. HB ECCG will be the platform for primary care to share updates with secondary care on new contract/WG05.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Quality of referrals being sent to rapid access pathway (Patient Referrals - Quality of Referrals) C) Health Boards should ensure feedback is provided to optometrists when required relating to quality of referrals sent to ensure learning.	Healthcare Inspectorate Wales (HIW)/2017/141/M05/1	> 90% of referrals came directly from optometrist with good communication between primary and secondary care. Optometry dept. working with OA developed letter templates to communicate insufficient referral detail to primary care for glaucoma referrals which has improved referral detail.	Planned Care	01.04.2024	01.04.2024	Fully complete (awaiting approval) - Further Evidence Awaited	October 2024 Update - No update has been received against this recommendation action on this occasion. August 2024 Update - meeting scheduled with Planned Care Care Group leads to seek confirmation as to when this action was completed. April 2024 Update - Glaucoma referral refinement pathway to be introduced as above, to further improve referral quality/avoid unnecessary referrals. Dec 23 update the review of quality referrals sent by optometry practices will be an ongoing process
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Lack of feedback provided to optometrists following referral and discharge of patients (Patient Referrals - Communication Following referral) (Discharge patient - Quality of information) A) Health Boards should ensure feedback of diagnosis and a treatment plan is provided to referring optometrists following every referral made to the service, including whether a referral to a low vision service has been made.	Healthcare Inspectorate Wales (HIW)/2017/141/M06/1	Optometrists are copied into all clinic correspondence for new patients when the referral has come from the optometrist in POWH - this will be done across all sites within CTM.	Planned Care	01.04.2024	01.04.2024	Fully complete (awaiting approval) - Further Evidence Awaited	October 2024 Update - No update has been received against this recommendation action on this occasion. August 2024 Update - meeting scheduled with Planned Care Care Group leads to seek confirmation as to when this action was completed. April 2024 Update - Complete. Dec 23 update this is done by the admin staff across the HB in order to ensure that optometrists are kept up to date with patients status within HES. This will be an ongoing process by the service manager to ensure that when a patient is referred by the optometrist that a copy of the clinic correspondence is sent to them for information. All new starters to be informed of the process.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Lack of feedback provided to optometrists following referral and discharge of patients (Patient Referrals - Communication Following referral) (Discharge patient - Quality of information) B) Optometrists must use the appropriate referral form and ensure that their name and practice address are clearly legible.	Healthcare Inspectorate Wales (HIW)/2017/141/M07/1	Primary care to work with HES to identify where this is an issue within practices and provide support via OA to ensure appropriate information is shared in the referral. New recruitment to undertake referral audits to support this. Optometrists contact details are not always clear on the referral form, internal arrangements being made to monitor the quality and individually feedback to the Optometrists via Local Advisor.	Planned Care	01.04.2024	01.04.2024	Fully complete (awaiting approval) - Further Evidence Awaited	October 2024 Update - No update has been received against this recommendation action on this occasion. August 2024 Update - meeting scheduled with Planned Care Care Group leads to seek confirmation as to when this action was completed. Dec 23 update this will be an ongoing process. Optometry Advisors will continue to work with both practices and HES to ensure the submission of high quality referrals. Implementation of the EOR system will also support/improve referral process.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Lack of feedback provided to optometrists following referral and discharge of patients (Patient Referrals - Communication Following referral) (Discharge patient - Quality of information) C) Health boards/Welsh government must ensure that systems are introduced to improve the amount of information available to optometrists in relation to patients who have been discharged from secondary care.	Healthcare Inspectorate Wales (HIW)/2017/141/M08/1	The implementation of Open Eyes will provide optometrists with access to patient information that will promote, simplify and improve the quality of referrals and allow optometrists to have sight of all patient data/results/notes to support management of the patient following discharge.	Planned Care	01.04.2024	01.04.2024	Overdue	October 2024 Update - No update has been received against this recommendation action on this occasion. August 2024 Update - this is ongoing, due to delays in national EPR/ERS programme. April 2024 Update - EPR rollout delays. December 2023 Update (Date of review 12/12/23) - See item 19 what next? By when? By whom?

Healthcare Inspectorate Wales (HIW)/2017/41	30.01.2017	National review of Ophthalmology Services	CHC reports concerns around lack of information provided within secondary care prior to treatment (Patient Referral – Communication following referral) – Health Boards must ensure that patients are provided with adequate information about their condition and proposed care plan prior to any investigation or treatment. This should conform to the principles outlined in GMC guidance on informed consent.	Healthcare Inspectorate Wales (HIW)/2017/41/M09/1	RCD leaflets provided about consent process in pre assessment Information leaflets provided for any eye emergency care Laser information Contact information ECLO services Blepharitis leaflets FFA – information Surgery information leaflets • CMOB: Cosmetic Blepharoplasty • CMOB: Cosmetic Pterosis Surgery • OP01: Cataract Surgery (phacemodification) with Monofocal Intraocular Lens Implant • OP02: Blepharoplasty • OP03: Glaucoma Surgery (Trabeculectomy) • OP04: Retinal Detachment Surgery • OP05: Corneal Transplant Surgery • OP06: Correcting a Squint (child) • OP07: Entropion and Ectropion Repair • OP08: Pterosis Surgery (adult) • OP09: Correcting a Squint (adult) • OP10: Pterosis Surgery (child) • OP11: Intravitreal (Anti-VEGF) injection • OP12: YAG Capsulotomy • OP13: Removing a Chalazion • OP14: LASIK Surgery • OP15: Removal of Pterygium • OP16: LASEK Surgery • OP17: Macular Hole Surgery	Planned Care	01.04.2024	01.04.2024	Fully complete (awaiting approval) - Further Evidence Awaited	October 2024 Update - No update has been received against this recommendation action on this occasion. August 2024 Update - meeting scheduled with Planned Care Group leads to seek confirmation as to when this action was completed. April 2024 Update - Additional SLT (glaucoma laser procedural) leaflet being designed, along with procedure counselling guidelines from Glaucoma consultant team, to improve patient experience and laser clinic flow/efficiency. To be discussed in clinical audit meeting in June. Plan for revised patient education Forum included in business case for potential Glaucoma Diagnostic Hub at YCGHMA. Dec 23 update Date of review: 01/04/2023 What next? The health board has a comprehensive selection of patient information leaflets available. In order to ensure that these meet the needs of our patients, these leaflets need to be well stocked and updated nationally through the EDO programme to ensure that they reflect best practice. Objective to be discussed at directorate meeting to raise awareness to both clinicians and nursing staff about supplying patients with information during their clinical consultations. By when? Weekly review of leaflet stock within clinical area. Objective to be discussed at directorate meeting on 8th August 2023 By whom? Service Manager / Senior Nurse to cascade information to team. Information gathered from the clinical teams regarding what literature is available within the clinical departments. Objective to be discussed at directorate meeting to raise awareness of both clinicians and nursing staff supplying the patients with information during their clinical consultations.
Healthcare Inspectorate Wales (HIW)/2017/41	30.01.2017	National review of Ophthalmology Services	Concerns around set monitoring for follow-up patients (Treatment Timescale – Targets) A) The Welsh Government should ensure that Patient Administration Systems are capable of providing data on clinician recommended follow-up interval and actual follow-up interval by care pathway.	Healthcare Inspectorate Wales (HIW)/2017/41/M010/1	Documents and resource related to FUNB patients are shared between the business information and Directorate Management Team by mean of daily downloads. There are a number of status updates reports to include: Total number waiting Patients past target date Patients with a target date Partial booking PFU Patients with appointments cancelled	Planned Care	01.04.2024	01.04.2024	Overdue	October 2024 Update - No update has been received against this recommendation action on this occasion. August 2024 Update - No update received this period. June 2024 Update - High risk Glaucoma waiting list has been clinically validated and patients identified for face to face appointments in July. All patients will either be seen in clinic or virtually reviewed. Service Manager is responsible for monitoring the whole of the FUNB and this is now also being monitored and discussed in the weekly Friday RTT meetings. December 2023 Update (Date of review: 01/01/24) What next? To continue to monitor the FUNB list across all sub specialities within ophthalmology. By when on a weekly basis By whom service manager
Healthcare Inspectorate Wales (HIW)/2017/41	30.01.2017	National review of Ophthalmology Services	Concerns around set monitoring for follow-up patients (Treatment Timescale – Targets) B) Health Boards must ensure that care is provided for those (new or follow-up patients) with the greatest health need first, making most effective use of all skills and resources available.	Healthcare Inspectorate Wales (HIW)/2017/41/M011/1	Patients on the FUNB and New list are all given a HRF and target date. When booking, clinics the booking office will filter by target date and HRF ensuring that patients are booked into the most appropriate sub-specialty clinic by priority status. However, we continue to hold significant risk with the FUNB cohort and further resource in terms of validation and capacity is required.	Planned Care	01.04.2024	01.04.2024	Overdue	October 2024 Update - No update has been received against this recommendation action on this occasion. August 2024 Update - No update received this period. June 2024 Update - Changes to clinic templates already made to accommodate clinically urgent patients. December 2023 Update - this will need ongoing review by the service manager to ensure that the most clinically urgent patients are booked with priority. <i>Changes review has been commenced, this action is currently undertaken as follows: but will need to be reviewed across all units of the NHS as services are not CDM services</i> October 2024 Update - No update has been received against this recommendation action on this occasion.
Healthcare Inspectorate Wales (HIW)/2017/41	30.01.2017	National review of Ophthalmology Services	Concerns around set monitoring for follow-up patients (Treatment Timescale – Targets) C) Clinical teams must clearly document the follow-up regime selected for each case. This should be applied consistently according to agreed protocols. The patient should be kept informed of any changes to the plan.	Healthcare Inspectorate Wales (HIW)/2017/41/M012/1	Clinic outcome forms are routinely completed for each patient to ensure they are placed on the correct FUNB list immediately following the clinic appointment. The directorate recognises that we continue to have shortfalls in our FUNB monitoring practices. A new management team has been appointed and has identified the current practices fall short of the agreed protocols. A significant review into waiting list management is required to include: Ratio of FUNB capacity to meet demand Extensive validation work to cleanse the FUNB waiting list Duplication of pathways Cross site skills and resource	Planned Care	01.04.2024	01.04.2024	Overdue	October 2024 Update - No update has been received against this recommendation action on this occasion. August 2024 Update - No update received this period. June 2024 Update - Validation both clinically and clerically ongoing for high risk patients initially. December 2023 Update - this work will be ongoing to ensure lists is kept up to date and 'clean' at all times. Ongoing review by the service manager to validated and ensure correct ratios of new and follow patients in all clinic templates.
Healthcare Inspectorate Wales (HIW)/2017/41	30.01.2017	National review of Ophthalmology Services	Lack of incident reporting related to WG patient harm policy A) Health Boards must ensure that there are mechanisms in place to review incident reports to identify potential patterns providing early warning to more serious system failures.	Healthcare Inspectorate Wales (HIW)/2017/41/M013/1	A FUNB Standard Operating Procedure has recently been submitted to the Surgical Safety and Quality Governance group for review and approval, this includes: • Identify adults who have not had an ophthalmology follow up appointment(s) booked in a timely manner • Ensure that National standards for Ophthalmology screening have been met in order to maintain compliance with good clinical practice • To review patient pathway delays and identify the level of harm resulting from avoidable delays. • To identify how much loss of vision represents a loss of function and whether this is as a result of a delay in treatment • To ensure, when harm is established, the application of Putting Things Right Policy and/or Serious incident management process. • To ensure there is an appropriate follow up plan of care in place for each patient reviewed. • To ensure actions are implemented to reduce the risk of a reoccurring delay in the patient's pathway. • To encourage continuous improvement by identifying areas for improvement in FUNB incident reporting.	Planned Care	01.04.2024	01.04.2024	Overdue	October 2024 Update - No update has been received against this recommendation action on this occasion. August 2024 Update - No update received this period. June 2024 - A bespoke harm review team has been set up within the Quality and Safety team consisting of 1 WTE Band 8a project lead and 1 WTE Band 7 clinical investigator funded until March 2025. The team aim to undertake an initial harm review team funding can be extended past March 2024 as the project is still ongoing. Muscular cluster report due by 15/12/2023, good progress being made towards this but absence of the Band 5 FLO support is stalling the work. By when? Closing date TBC for band 5 position. A/w feedback about alternate staffing to support in the short term. CSQM to feedback if funding can be extended and workforce to be reviewed accordingly By whom? Senior Nurse / CSQM December 2023 Update (Date of review: 12/12/2023) - What next? Band 5 1.0 Vacancy not appointed in to - position being re-advertised on Trac. Position escalated to HON and CSQM to look for support in the short term. CSQM to determine if harm review team funding can be extended past March 2024 as the project is still ongoing. Muscular cluster report due by 15/12/2023, good progress being made towards this but absence of the Band 5 FLO support is stalling the work. By when? Closing date TBC for band 5 position. A/w feedback about alternate staffing to support in the short term. CSQM to feedback if funding can be extended further. By when? Interview for band 5 post to take place in the next 2/3/2 CSQM to feedback if funding can be extended and workforce to be reviewed accordingly By whom? Senior Nurse / CSQM September 2023 Update (Date of review: 03/08/2023) - What next? Vacancies for harm review workforce are currently out to advert. An cluster RCA commissioning meeting is to be arranged within the next 2/3/2 regarding the muscular service and the patients who have experienced moderate and above harm as a result of a follow up not being booked By when? to be reviewed in 2/3/2 with update. By whom? Senior Nurse. An SBAR for additional harm review workforce was submitted to Planned care recovery and funding was approved in July 2023 for 2 fixed term positions until the end of March 2024. These positions include 1 WTE Band 7 clinical investigator, 1 WTE band 5 governance support officer / family liaison officer. The workforce will be dedicated to support the legacy open NRI's from 2016-Feb 2022 from RTE, as well as the review all legacy and current open incidents under the Ophthalmology service. The workforce will be supporting any commissioned RCA's and will work closely with the clinical and administration teams in the review of action plans and learning from events. Date of review: 08/11/2023 What next? Band 7 1.0 Vacancy filled with 2 individuals job sharing and fixed term until the end of March 2024. Band 5 Investigation support officer currently shortlisting phase - this role is to act as the FLO for all 2 candidates for interview, date TBC. CSQM to determine if funding can be extended further. By when? Interview for band 5 post to take place in the next 2/3/2 CSQM to feedback if funding can be extended and workforce to be reviewed accordingly By whom? Senior Nurse / CSQM
Healthcare Inspectorate Wales (HIW)/2017/41	30.01.2017	National review of Ophthalmology Services	Lack of capacity/fragility of services of services due to over-reliance on consultants. Issues relating to lack of capacity, recruitment and lack of investment in services. (Treatment - Capacity) A) Health Boards must proactively develop workforce plans which set out to address any shortfalls in the current service capacity and available facilities to mitigate the risks to patient care. These plans should seek to maximise capacity by making most effective use of the skills of medical and non-medical staff available, as well as available space/facilities.	Healthcare Inspectorate Wales (HIW)/2017/41/M014/1	a) CTM has a well established optometry department which has a number of experienced, highly skilled and qualified optometrists working across glaucoma, medical retina, DRSS, unscheduled care, paediatric clinics and specialist contact lenses. Recent expansion of the service to include community optometrists on a seasonal basis which has increased our capacity across these services whilst additionally improving training to community optometrists to in turn reduce referrals and improve referral quality. Hospital based optometry due to start implementing an optometry laser led pathway to improve SLT and laser capacity in the coming months.	Planned Care	01.04.2024	01.04.2024	Overdue	October 2024 Update - No update has been received against this recommendation action on this occasion. August 2024 Update - August 2024 Update - Recruitment in progress for additional permanent non-medical staff to create additional capacity in glaucoma clinics (Band 3 tech, Band 4 tech, Band 8a Optometrist) April 2024 Update - Eye drop institution by unregistered staff in early implementation phase - nursing team signoff complete, in use. Further short term extension of 3 Band 7 (2 x Band 7 Specialist Optometrists) providing significant clinical activity in Medical Retina - extended to 30/4/24 but urgent longer term/permanent extension required to maximise clinic output/booking. MDT GRFT working group on pause following management changes. Longstanding vacancies in Heads of Optometry and Orthoptic services - recruitment strategy in evaluation, as risk to service development without these posts. Further review is required / Action to be removed and replaced with a subsequent agreed action December 2023 Update (Date of review: 12/ 12 /23) - New clinical policy approved to allow for unregistered staff to instill eyedrops, freeing up registered staff for more skilled tasks/faster clinic flow - implementation imminent. Optometry Dept SBAR demonstrating value of workforce & need for expansion completed. Secured fixed term contract extension for 2 seasonal optometrists supporting Medical Retina clinics for next 12/12/23, further extension required to support GRFT process due to start in Dec '23, tasked with evaluating non-med, workforce/skill mix and maintaining use of MDT (to top of clinic). Optometrist role expansion into glaucoma laser delivery successful (training, signoff & SOP complete) - SLT WJ reduced to 12/32, What next? By when? By whom? October 2024 Update - No updates has been received against this recommendation action on this occasion. August 2024 Update - August 2024 Update - AMD referral refinement pathway working well, moving to direct optometrist inter-practice referral 2/2/24 (currently coordinated by hospital team). This will reduce admin burden and shorten turnaround time for patients. April 2024 Update - HES training/consultant mentoring for higher qualifications for community optometrists (to allow them to deliver enhanced services) in progress, with joint co-hosting with Cardiff University. 5 CTM consultants currently agreed to provide mentoring services over 2024/25. HSW funding for administrative placement co-ordinator secured, to be advertised asap. December 2023 Update (Date of review: 12/12/23) - Community optom completed funded academic course successfully, placement pending 2024 (delayed due to consultant workload). Community optom post-grat placements widely delayed due to HES workload/lack of funding - joint collaboration with Cardiff University to co-host placements in 2024, reducing time intensive burden on hospital site. Funding request for admin placement co-ordinator role submitted to HEIW. AMD community scheme live June 2023/23, running well with consultant feedback. What next? By when? By whom?
Healthcare Inspectorate Wales (HIW)/2017/41	30.01.2017	National review of Ophthalmology Services	Lack of capacity/fragility of services of services due to over-reliance on consultants. Issues relating to lack of capacity, recruitment and lack of investment in services. (Treatment - Capacity) B) Health boards must consider ways to work more closely with colleagues from primary care. For example, providing equipment (and training) to optometry practices to allow them to undertake referral refinement and/or assessments on stable patients. This needs to be done in a planned and strategic way under control of the health board.	Healthcare Inspectorate Wales (HIW)/2017/41/M015/1	b) CTM has funded a community optometrist to complete his medical retina higher certificate with a placement in the medical retina service starting in March 2023. We continue to provide independent prescribing, glaucoma certificate and pre-registration placements to community optometrists. An AMD new referral refinement pathway (CAMRDS) is due to be implemented in the coming weeks with in house training of participating local community optometrists. This will allow all new AMD referrals to be triaged in primary care. A DRSS new patient scheme has been implemented over the last few months with low risk DRSS patients reviewed by primary care with additional training. DRSS waiting list has significantly dropped and allowed the majority of DRSS patients to be kept in primary care	Planned Care	01.04.2024	01.04.2024	Overdue	October 2024 Update - No updates has been received against this recommendation action on this occasion. August 2024 Update - August 2024 Update - AMD referral refinement pathway working well, moving to direct optometrist inter-practice referral 2/2/24 (currently coordinated by hospital team). This will reduce admin burden and shorten turnaround time for patients. April 2024 Update - HES training/consultant mentoring for higher qualifications for community optometrists (to allow them to deliver enhanced services) in progress, with joint co-hosting with Cardiff University. 5 CTM consultants currently agreed to provide mentoring services over 2024/25. HSW funding for administrative placement co-ordinator secured, to be advertised asap. December 2023 Update (Date of review: 12/12/23) - Community optom completed funded academic course successfully, placement pending 2024 (delayed due to consultant workload). Community optom post-grat placements widely delayed due to HES workload/lack of funding - joint collaboration with Cardiff University to co-host placements in 2024, reducing time intensive burden on hospital site. Funding request for admin placement co-ordinator role submitted to HEIW. AMD community scheme live June 2023/23, running well with consultant feedback. What next? By when? By whom?
Healthcare Inspectorate Wales (HIW)/2017/41	30.01.2017	National review of Ophthalmology Services	Health boards should learn from the experiences following progress made in other areas (Treatment - Initiatives to improve Capacity) A) Health Boards must ensure that they fully engage with the Ophthalmology Planned Care Board to aid shared learning from/with staff in other areas.	Healthcare Inspectorate Wales (HIW)/2017/41/M016/1	Weekly performance meeting have been arranged between the Clinical Service Group Manager (CSGM) and Interim Director of Planned Care to discuss key performance measures and any ad hoc issues which arise. CSQM from other sites are in attendance for shared learning purposes. Any risks we have assessed in the service is held on the corporate risk register which we update regularly with mitigations to reduce the risks. We also provide regular updates on the above to the Quality, Safety and Risk Group, as well as to the Planned Care Recovery Finance Group and the Joint Executive Team Meetings.	Planned Care	01.04.2024	01.04.2024	Overdue	October 2024 Update - No update has been received against this recommendation action on this occasion. August 2024 Update - No update received this period. April 2024 Update - CD attending national CN meetings, to develop regional strategies/shared learning. December 2023 Update - No update received.
Healthcare Inspectorate Wales (HIW)/2017/41	30.01.2017	National review of Ophthalmology Services	Health Boards should learn from the experiences following progress made in other areas (Treatment - Initiatives to improve Capacity) B) Welsh Government should consider whether there is a need to develop further approaches to encourage shared learning between health boards as well as more integrated methods to address common themes/issues being experienced across Wales. For example, the introduction of non-medical injectors.	Healthcare Inspectorate Wales (HIW)/2017/41/M017/1	WG to answer	Planned Care	01.04.2024	01.04.2024	Overdue	October 2024 Update - No update has been received against this recommendation action on this occasion. August 2024 Update - No further update, complete. Not marked as fully complete as need CSRE sign off. December 2023 Update - No update received.
Healthcare Inspectorate Wales (HIW)/2017/41	30.01.2017	National review of Ophthalmology Services	ECLO – Limited capacity/cover (Service Support Staff – Eye Care Liaison Officer) Health Boards should ensure that there is ECLO for their eye care clinics at all times and consideration should be given as to whether one ECLO is sufficient for the eye care service.	Healthcare Inspectorate Wales (HIW)/2017/41/M018/2	POW – RNIB ECLO coverage 4 days RGH / FCH / YCR – NHS ECLO for RGH, PCH, YCR – coverage 3 days 7 Commissioning issue - ask Elizabeth Beadle	Planned Care	01.04.2024	01.04.2024	Overdue	October 2024 Update - No update has been received against this recommendation action on this occasion. August 2024 Update - No further update, complete. Not marked as fully complete as need CSRE sign off. June 2024 - There are currently 2 ECLO's in CTMUH&S. December 2023 Update - No update received.
Healthcare Inspectorate Wales (HIW)/2017/41	30.01.2017	National review of Ophthalmology Services	Concerns raised by staff in relation to a lack of processes in place to submit comments/suggestions to health board management. (Service Support Staff – Eye Care Liaison Officer) Health Boards must ensure that there are methods in place to allow all staff to raise any concerns/suggestions about improvements to service provision they may have. This process should to ensure that feedback is routinely provided to individuals.	Healthcare Inspectorate Wales (HIW)/2017/41/M019/1	Eye care collab and directorate meeting.	Planned Care	01.04.2024	01.04.2024	Fully complete (awaiting approval)	October 2024 Update - ECGG Meetings now set up on a bi-monthly basis from September 2024. Currently led by the Head of Planning until secretariat is appointed, next one booked for 8th November 2024. Proposed for Closure November 2024 August 2024 Update - meeting scheduled with Planned Care Group leads to seek confirmation as to when this action was completed. April 2024 Update - Regular meetings being held with next meeting set up for August 9th. Complete 01/12/2023 Dec 23 update Date of review: 12 / 12 /23 ECGG re-established as of 1/12/23, regular directorate meetings ongoing What next? By when? By whom?
Healthcare Inspectorate Wales (HIW)/2017/41	30.01.2017	National review of Ophthalmology Services	More clarity required in relation to evolving role of optometrist to enable more effective utilisation of optometrists, Welsh Government must provide clarity to health boards relating to indemnity, resource & finance arrangements, training/qualifications and communication mechanisms.	Healthcare Inspectorate Wales (HIW)/2017/41/M020/1	This appears to be an action required by WGL, though we have answered from a CTM perspective. CTM optometrists are being utilised in multiple areas of ophthalmology such as glaucoma, med retina and corneal specialities and direct WG funding has provided sessional optometrists to work within these areas. Higher level training and qualifications are underway and have been utilised historically and currently. Staff have sourced funding from HEIW in order to gain higher qualifications from The Royal College of Optometrist in order to further develop services (such as the soon to implement optometry led laser service for glaucoma).	Planned Care	01.04.2024	01.04.2024	Overdue	October 2024 Update - No update has been received against this recommendation action on this occasion. August 2024 Update - August 2024 Update - CTM Optometry presented proposal to develop a Welsh Hospital Optometry forum, at CN June '24 which was well supported. Initial planning meeting to develop national subgroup reporting to CN 6/9/24. Heads of Service vacancies (Optometry/Orthoptics) still ongoing. April 2024 Update - CTM Optometry co-authored WGL white paper on role of Hospital Optometry in NHS Wales, with specific recommendations on expanding the Welsh hospital optometry workforce and establishing a Hospital Optometry Forum in Wales. To be presented at CN in May to identify potential resources to implement recommendations nationally, to be followed by local presentation by CTM Optometry at each NHS ECGG over next quarter. To highlight need to develop the workforce across Wales. CTM Optometry collaborated with W&S, HEIW and A&L&M Optometry on development of UK-wide GR options for Optometry. New roles allowing for a defined career progression pathway for optometrists, and more accurate Areas of Work, Occupation Codes and Staff Group approved nationally by NHS Digital in March 2023, to be implemented UK wide in the National Workforce Data Set June 2024. This will allow the optometry workforce to be more accurately captured by ESW across the NHS, aid in recruitment and offset workforce attrition for Hospital Optometry on a national scale. December 2023 Update (Date of review: 12/12/23) - Optometry SBAR detailing need for hospital optometry workforce expansion in size and clinical role completed. Funding secured from HEIW for 3 hospital optometrists to complete Higher Certificate in Medical Retina Qualification (commencing March '24). Optometry led laser service in situ in RGH, successfully fulling laser WJ down. What next? By when? By whom?
Healthcare Inspectorate Wales (HIW)/2017/41	30.01.2017	National review of Ophthalmology Services	Additional utilisation of optometrists is required to increase capacity (HWH&S example) and reduce the burden on secondary care. (Utilisation of optometrists) Health boards should consider additional utilisation of optometrists to increase available capacity and reduce burden on secondary care. Health Board will need to ensure that issues are clarified around indemnity, resource & finance arrangements, training/qualifications and communication mechanisms.	Healthcare Inspectorate Wales (HIW)/2017/41/M021/1	See points above. CTM already utilising both hospital and primary care based optometrists in a range of sub-specialities. Primary care pathways and schemes include IPDS or unscheduled care, Glaucoma community monitoring scheme, AMD referrals refinement and DRSS.	Planned Care	01.04.2024	01.04.2024	Overdue	October 2024 Update - No update has been received against this recommendation action on this occasion. August 2024 Update - Additional 8a optometrist for glaucoma services in recruitment. April 2024 Update - GRFT MDT working group on pause following management changeover. December 2023 Update (Date of Review: 12/12/23) - As above, await outcomes from GRFT MDT workforce working group that will be reviewing the workforce. What next? By when? By whom?
Healthcare Inspectorate Wales (HIW)/2017/41	30.01.2017	National review of Ophthalmology Services	Health boards must ensure that relevant staff engage with the local Eye Care Group. The group should meet regularly and be chaired by a member of the executive team. A key objective is to improve the working relationships between primary and secondary care staff to foster joint working initiatives.	Healthcare Inspectorate Wales (HIW)/2017/41/M022/1	Primary/Secondary care have worked collaboratively to implement shared care pathways in Independent Prescribing/Glaucoma/Wet AMD/Diabetic Retinopathy, work continues to improve and develop these services. Health Board to ensure appropriate representation at local ECGG from a primary care management and clinical perspective/NHS management and clinical team to enable appropriate non-CDM/overnight on actions taken to support reduction of waiting time/ workforces/new pathways/implementation of open eyes/contract reform developments	Planned Care	01.04.2024	01.04.2024	Fully complete (awaiting approval)	October 2024 Update - ECGG Meetings now set up on a bi-monthly basis / in addition service managers to attend weekly optometry progress meeting. By when? Bi-monthly from September 2024 for ECGG & From October for weekly optometry update meetings. By whom? Head of Planning & Partnerships for ECGG until secretariat is appointed. Ophthalmology Service Manager and Directorate Manager for weekly optometry update meetings. Proposed for Closure November 2024 August 2024 Update - meeting scheduled with Planned Care Group leads to seek confirmation as to when this action was completed. April 2024 Update - Good cross-sector representation at ongoing ECGG and local OLG meetings. Dec 23 update - Date of review: 12 / 12 / 23 A shared-care schemes established with frequent cross-sector contact/consultant input/feedback sessions etc. Consultant Connect implemented for Glaucoma scheme (Nov '23) to allow community optoms direct access to Glaucoma team for advice & guidance. ECGG re-established 1/12/23 with good cross-sector collaboration and attendance. HB Optometry Liaison Group long established - continues bi-monthly, with both

Healthcare Inspectorate Wales (HIW)/2020/139	08.09.2020	Quality Check Summary Ydelyr Cwm Rhonda (Ydelyr Cwm Rhonda - Ward A1 (Ref: 20030))	The Health Board should ensure that the escalation procedure is reviewed.	Healthcare Inspectorate Wales (HIW)/2020/139/MCJ/1	A revised Emergency Pressures Escalation Plan has been drafted (9th September 2020) and submitted to the Executive Director of Operations. Once approved, this will be made available on the CTM intranet site.	Primary Care & Community	01.10.2020	01.10.2020	Overdue	October 2024 Update - No update has been received against this recommendation action on this occasion. August 2024 Update - The Emergency Preparedness Resilience and Response Manager is following up with Operational colleagues on the development of the Emergency Pressures Escalation Procedure. Draft version is developed and confirmation of approval is being sought. Once confirmed this action will be marked as closed.
Healthcare Inspectorate Wales (HIW)/2021/135	20.04.2021	Quality Check Summary Seren Ward, Royal Glamorgan Hospital (Improvement plan - Seren Ward - Royal Glamorgan Hospital (Ref: 20000))	The health board must ensure that compliance with mandatory training is completed and kept up to date. Additionally, a process needs to be put in place to ensure future compliance with mandatory training.	Healthcare Inspectorate Wales (HIW)/2021/135/MCJ/1	80% of applicable staff groups will be fully compliant with mandatory training in PMVA, L1/LB1 and Fire training. Progress towards this target and future training compliance rates will be managed using ESR and monitored through line management arrangements. Deviation from the proposed improvement trajectory and failure to maintain the target levels of compliance will be escalated at Clinical Service Group Performance Review meetings. Mandatory training compliance to be included as a standing agenda item during line management sessions. Compliance to be reported on and monitored in the Clinical Service Group (CSG) Workforce and Organisational Development meeting and I/G Performance Review meeting.	Mental Health & Learning Disabilities	10.08.2021	10.07.2021	Partially complete (Overdue)	October 2024 Update - Closed - developed mandatory training monitoring as part of discharge review August 2024 - Ongoing monitoring via the MHLD Care Group in relation to compliance Partially Complete. + Training plan was integrated with Inspectorcy for 85 % compliance by 10 July 2021. At time of reporting - (10/07/21) compliance is April 21 July 21 IL1 6% ↑ 64% IL2 0% ↑ 38% PMVA - Adult C 20% ↑ 23% PMVA Mod A/B 41% ↑ 87% PMVA Mod C 8% ↑ 67% Fire 50% ↑ 87% Covid risk assessment 46% ↑ 80% + PMVA mod A/B/C is time intensive training (8 hours per person) and clinical pressures have delayed completion. Additional pay has been used to release capacity to ensure 85 % compliance by 10th August 2021. + BLS attendance has been impacted by availability of training sessions with ward based model now established to address + BLS training sessions are now being delivered in a more timely manner. October 2024 Update - Remains open to discuss at next CSRE August 2024 - MHLD has one outstanding action to be discussed at next CSRE in September 2024. June 2024 Update - Partially complete, but with outstanding work. Complete by August 2024. Action updated as at May 2024 - An initial meeting was set up between MH and PC AMD to discuss this but meeting did not take place. Ongoing communication between MHL&LD MD and PC MD is in place to establish which existing forum this work can best sit to ensure action. Mitigating Actions Dedicated lithium and disorganise clinics are in place across adult and older adult CMHTs that have a consistent standard and ensure follow-up for patients who do not attend. There is an offer of physical health monitoring in all adult and older adult CMHTs. Improving the physical health of people with severe and enduring mental health problems is a priority of the MHL&LD Care group, and a Physical Health Monitoring Group reporting through CSRE governance structures is in place. April 2024 Update - Partially complete, but with outstanding work. Complete by August 2024.
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	Health boards must ensure that clear processes are in place to ensure that physical health assessments and monitoring is undertaken for relevant patients under the Mental Health (Wales) Measure 2010.	Healthcare Inspectorate Wales (HIW)/2021/137/MCJ/1	Working group to be established between Primary Care and mental Health to ensure clear understanding of responsibilities for delivery of Physical Health checks with agreed process	Mental Health & Learning Disabilities	01.11.2024	01.11.2024	Partially complete	October 2024 Update - No update against this recommendation action has been received on this occasion. October 2023 Update (Date of Review: 20/10/2023) - Further to discussions with the Head of Mental Health Nursing it has been advised that that the CNO principles do not apply to Mental Health Rehabilitation areas. We will however continue to monitor our staffing levels on a daily basis and redeploy staff as necessary to ensure there are safe staffing levels at all times. October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - Remains open to discuss at next CSRE June 2024 Update - Partially complete, but with outstanding work. Complete by August 2024. Action updated as at May 2024 - An initial meeting was set up between MH and PC AMD to discuss this but meeting did not take place. Ongoing communication between MHL&LD MD and PC MD is in place to establish which existing forum this work can best sit to ensure action. Mitigating Actions Dedicated lithium and disorganise clinics are in place across adult and older adult CMHTs that have a consistent standard and ensure follow-up for patients who do not attend. There is an offer of physical health monitoring in all adult and older adult CMHTs. Improving the physical health of people with severe and enduring mental health problems is a priority of the MHL&LD Care group, and a Physical Health Monitoring Group reporting through CSRE governance structures is in place. April 2024 Update - Partially complete, but with outstanding work. Complete by August 2024.
Healthcare Inspectorate Wales (HIW)/2021/138	20.07.2021	Quality Check Summary Pinewood House (Pinewood House - Quality Check)	The health board must provide assurance on how it will meet principle nine outlined by the Chief Nursing Officer for Wales for at least two registered nurses to be rostered every shift, or if determined as not necessary, that there must be the ability to deploy a second registered nurse without delay.	Healthcare Inspectorate Wales (HIW)/2021/138/MCJ/1	Undertake a review of the night time staffing resource across the rehabilitation service in CTM and develop an options appraisal to address the risk of one registrant by night.	Mental Health & Learning Disabilities	30.11.2021	30.11.2021	Overdue	October 2024 Update - No update against this recommendation action has been received on this occasion. October 2023 Update (Date of Review: 20/10/2023) - Further to discussions with the Head of Mental Health Nursing it has been advised that that the CNO principles do not apply to Mental Health Rehabilitation areas. We will however continue to monitor our staffing levels on a daily basis and redeploy staff as necessary to ensure there are safe staffing levels at all times. October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - Remains overdue October 2023 Update (Date of Review: 14/10/2023) - It has been agreed with the Senior Nurse and Ward Managers that the following actions will be undertaken immediately to start addressing the training compliance with support from the L&D department 1) Review hierarchy lists; 2) Ensure Group alignment numbers are correct; 3) Look at appropriate required compliance and accurate records and L&D department will take forward to the subject experts on teams' behalf. Regular meetings with new L&D representatives to address and correct the issues associated with core mandatory training compliance.
Healthcare Inspectorate Wales (HIW)/2021/138	20.07.2021	Quality Check Summary Pinewood House (Pinewood House - Quality Check)	The health board must provide assurance of its plans to ensure all staff are fully compliant with their mandatory training as soon as possible.	Healthcare Inspectorate Wales (HIW)/2021/138/MCJ/1	Review all core competencies across the rehab service, with an improvement plan for 85% compliance.	Mental Health & Learning Disabilities	30.11.2021	30.11.2021	Overdue	October 2024 Update - No update against this recommendation action has been received on this occasion. October 2023 Update (Date of Review: 20/10/2023) - Further to discussions with the Head of Mental Health Nursing it has been advised that that the CNO principles do not apply to Mental Health Rehabilitation areas. We will however continue to monitor our staffing levels on a daily basis and redeploy staff as necessary to ensure there are safe staffing levels at all times. October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - Remains overdue October 2023 Update (Date of Review: 14/10/2023) - It has been agreed with the Senior Nurse and Ward Managers that the following actions will be undertaken immediately to start addressing the training compliance with support from the L&D department 1) Review hierarchy lists; 2) Ensure Group alignment numbers are correct; 3) Look at appropriate required compliance and accurate records and L&D department will take forward to the subject experts on teams' behalf. Regular meetings with new L&D representatives to address and correct the issues associated with core mandatory training compliance.
Healthcare Inspectorate Wales (HIW)/2022/129	01.11.2022	HIW & CWJ Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital (HIW Improvement Plan Service: Bridgend North CMHT (Maesteg Hospital) (Ref: 3189))	The health board must implement a signing in and out book to ensure an appropriate audit trail of medication stock.	Healthcare Inspectorate Wales (HIW)/2022/129/MCJ/1	Spot checks to be completed by the Senior Nurse to monitor compliance	Mental Health & Learning Disabilities	28.04.2023	28.04.2023	Fully complete (Awaiting approval)	October 2024 Update - CSRE date of approval April 2024 Proposed for Closure November 2024 The completion of this action was pre care group reconfiguration and the MHL&LD are providing confirmation of the closure sign off at the relevant CSRE meeting.
Healthcare Inspectorate Wales (HIW)/2022/129	01.11.2022	HIW & CWJ Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital (HIW Improvement Plan Service: Bridgend North CMHT (Maesteg Hospital) (Ref: 3189))	The health board must implement a signing in and out book to ensure an appropriate audit trail of medication stock.	Healthcare Inspectorate Wales (HIW)/2022/129/MCJ/2	Audit of medication to take place. CTMDH&H Homecare visited the team on 20th January 2023 and they have agreed to attend the CMHT monthly for three months and then three monthly to audit and help with stock management checks. The home care team only audit Polar Speed medication (ability and Paliperidone). For all other depot medication staff who order these medication will audit at the same time.	Mental Health & Learning Disabilities	28.04.2023	28.04.2023	Fully complete (Awaiting approval)	October 2024 Update - CSRE date of approval April 2024 Proposed for Closure November 2024 The completion of this action was pre care group reconfiguration and the MHL&LD are providing confirmation of the closure sign off at the relevant CSRE meeting.
Healthcare Inspectorate Wales (HIW)/2022/129	01.11.2022	HIW & CWJ Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital (HIW Improvement Plan Service: Bridgend North CMHT (Maesteg Hospital) (Ref: 3189))	The health board must ensure that substantive medical staff are appointed as far as possible to ensure continuity of care.	Healthcare Inspectorate Wales (HIW)/2022/129/MCJ/1	The health board will continue in its attempts to recruit substantively into the consultant post. This is against a background of higher demand for posts than the supply of senior medical staff to fill them.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	October 2024 Update - CSRE date of approval April 2024 Proposed for Closure November 2024 The completion of this action was pre care group reconfiguration and the MHL&LD are providing confirmation of the closure sign off at the relevant CSRE meeting.
Healthcare Inspectorate Wales (HIW)/2022/129	01.11.2022	HIW & CWJ Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital (HIW Improvement Plan Service: Bridgend North CMHT (Maesteg Hospital) (Ref: 3189))	The health board and local authority should reflect on comments from staff relating to access to care documents and systems	Healthcare Inspectorate Wales (HIW)/2022/129/MCJ/1	This is reviewed in monthly performance review meetings with the Senior Team which includes a table on the status on all medical positions in the locality. Progress on recruitment is discussed and there is a focus on having Royal College of Psychiatry Approved Job Descriptions ready for advertisement should a vacancy appear.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	October 2024 Update - CSRE date of approval April 2024 Proposed for Closure November 2024 The completion of this action was pre care group reconfiguration and the MHL&LD are providing confirmation of the closure sign off at the relevant CSRE meeting.
Healthcare Inspectorate Wales (HIW)/2022/129	01.11.2022	HIW & CWJ Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital (HIW Improvement Plan Service: Bridgend North CMHT (Maesteg Hospital) (Ref: 3189))	The health board and local authority should reflect on comments from staff relating to access to care documents and systems	Healthcare Inspectorate Wales (HIW)/2022/129/MCJ/2	A business case for WCCDS implementation has been written and requires Executive sign off for funding. The Mental Health Care Group have allocated a Project Manager.	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	October 2024 Update - CSRE date of approval April 2024 The completion of this action was pre care group reconfiguration and the MHL&LD are providing confirmation of the closure sign off at the relevant CSRE meeting.
Healthcare Inspectorate Wales (HIW)/2022/129	01.11.2022	HIW & CWJ Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital (HIW Improvement Plan Service: Bridgend North CMHT (Maesteg Hospital) (Ref: 3189))	The health board must ensure that medical staff complete all safeguarding related refresher training in a timely manner	Healthcare Inspectorate Wales (HIW)/2022/129/MCJ/1	All medical staff to attend 'Safeguarding People' Day	Mental Health & Learning Disabilities	28.04.2023	28.04.2023	Overdue	October 2024 Update - An update against this recommendation action has not been received on this occasion. August 2024 Update - remains overdue Medical staff booked in to attend 'Safeguarding People' Consented, answered through CSRE October 2024 Update - CSRE date of approval April 2024 Proposed for Closure November 2024 The completion of this action was pre care group reconfiguration and the MHL&LD are providing confirmation of the closure sign off at the relevant CSRE meeting.
Healthcare Inspectorate Wales (HIW)/2022/129	01.11.2022	HIW & CWJ Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital (HIW Improvement Plan Service: Bridgend North CMHT (Maesteg Hospital) (Ref: 3189))	The health board must ensure that Community Treatment Order (CTO) documentation contains all of the required detail	Healthcare Inspectorate Wales (HIW)/2022/129/MCJ/1	The MHA team propose to develop an audit tool for CTO MHA statutory documentation and to conduct a CTM wide audit of detention papers for those patients subject to a Community Treatment Order. Compliance will be monitored through our CSRE meetings	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	October 2024 Update - CSRE date of approval April 2024 Proposed for Closure November 2024 The completion of this action was pre care group reconfiguration and the MHL&LD are providing confirmation of the closure sign off at the relevant CSRE meeting.
Healthcare Inspectorate Wales (HIW)/2022/129	01.11.2022	HIW & CWJ Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital (HIW Improvement Plan Service: Bridgend North CMHT (Maesteg Hospital) (Ref: 3189))	The health board must ensure that Community Treatment Order (CTO) documentation contains all of the required detail	Healthcare Inspectorate Wales (HIW)/2022/129/MCJ/2	We have asked our MHA provider and South Wales Advocacy to obtain feedback on our service from patients on a community treatment order (CTO). The MHA team and South Wales Advocacy are working collaboratively to develop a questionnaire. The health boards MHA operational group and Mental health act monitoring committee will be kept up to date on progress.	Mental Health & Learning Disabilities	28.04.2023	28.04.2023	Fully complete (Awaiting approval)	October 2024 Update - CSRE date of approval April 2024 Proposed for Closure November 2024 The completion of this action was pre care group reconfiguration and the MHL&LD are providing confirmation of the closure sign off at the relevant CSRE meeting.
Healthcare Inspectorate Wales (HIW)/2022/129	01.11.2022	HIW & CWJ Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital (HIW Improvement Plan Service: Bridgend North CMHT (Maesteg Hospital) (Ref: 3189))	The health board and local authority should reflect on the staff feedback comments provided in this report	Healthcare Inspectorate Wales (HIW)/2022/129/MCJ/1	A deliver session has been arranged to reflect on the HIW inspection and feedback comments provided in the report.	Mental Health & Learning Disabilities	21.02.2023	21.02.2023	Fully complete (Awaiting approval)	October 2024 Update - CSRE date of approval April 2024 Proposed for Closure November 2024 The completion of this action was pre care group reconfiguration and the MHL&LD are providing confirmation of the closure sign off at the relevant CSRE meeting.
Healthcare Inspectorate Wales (HIW)/2022/129	01.11.2022	HIW & CWJ Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital (HIW Improvement Plan Service: Bridgend North CMHT (Maesteg Hospital) (Ref: 3189))	The health board and local authority should reflect on the staff feedback comments provided in this report	Healthcare Inspectorate Wales (HIW)/2022/129/MCJ/2	The inspection findings will also form part of our local CSRE meetings standard agenda to maintain monitoring of the review	Mental Health & Learning Disabilities	28.04.2023	28.04.2023	Fully complete (Awaiting approval)	October 2024 Update - CSRE date of approval April 2024 Proposed for Closure November 2024 The completion of this action was pre care group reconfiguration and the MHL&LD are providing confirmation of the closure sign off at the relevant CSRE meeting.
Healthcare Inspectorate Wales (HIW)/2022/131	22.03.2022	Hospital Inspection (Announced) Princess of Wales Hospital - Maternity Services (Appendix C - POW Maternity Unit (Ref: 21233))	The health board should consider consultant job plans that formally allocate a separate consultant to supervise the neonatal section lists and gynae/obstetrics work.	Healthcare Inspectorate Wales (HIW)/2022/131/MCJ/1	Business case under development for separate maternity elective theatre case lists to be established. Once finalised will be submitted through Integrated Locality Group structure for consideration.	Children & Families	01.08.2022	01.09.2023	Overdue	October 2024 Update - An update against this recommendation action has not been received on this occasion. August 2024 Update - Business Case currently on hold as from early September 2024, there will be a temporary closure of the maternity and neonatal units at Princess of Wales Hospital (POWH) to allow for essential maintenance works on both units. This action will be revisited in January 2025. September 2023 Update - new consultant appointments enable 2 sessions of elective work to be staffed by consultant obstetricians. Awaiting 1st consultant to agree job plan 18.09.23 to commence one session a week, moving to 2 session in January 2025.
Healthcare Inspectorate Wales (HIW)/2022/131	22.03.2022	Hospital Inspection (Announced) Princess of Wales Hospital - Maternity Services (Appendix C - POW Maternity Unit (Ref: 21233))	Risk assessments are undertaken and recorded in patient records. Medical discussion and decisions are accurately recorded in patient records.	Healthcare Inspectorate Wales (HIW)/2022/131/MCJ/1	The specific areas of risk assessment, medical discussions and decisions will be added to the record keeping audit and all service medical staff to participate in this annual audit to drive multi professional improvement in this area.	Children & Families	01.08.2022	01.08.2022	Overdue	October 2024 Update - An update against this recommendation action has not been received on this occasion. August 2024 Update - Update requested from the Medical Director in the Children and Family Care Group. September Update (Date of Review: 08/09/23) - email sent to Medical Director of care group for advice on how to progress this recommendation.
Healthcare Inspectorate Wales (HIW)/2022/131	22.03.2022	Hospital Inspection (Announced) Princess of Wales Hospital - Maternity Services (Appendix C - POW Maternity Unit (Ref: 21233))	The Health Board must ensure that additional welfare support is available for KIT staff.	Healthcare Inspectorate Wales (HIW)/2022/131/MCJ/1	Workforce team asked for specific resources for KIT staff going forward.	Children & Families	01.06.2022	01.10.2023	Overdue	October 2024 Update - An update against this recommendation action has not been received on this occasion. August 2024 Update - KIT update to be taken to next Care Group Workforce meeting on the 28th August and the Local Partnership Forum. September Update (Date of Review: 08/09/23) - email sent to care group's People's Services Lead to advice on progress with this recommendation.
Healthcare Inspectorate Wales (HIW)/2022/131	22.03.2022	Hospital Inspection (Announced) Princess of Wales Hospital - Maternity Services (Appendix C - POW Maternity Unit (Ref: 21233))	The Health Board must ensure that: The backlog of incidents are cleared and consideration of further funding should continue.	Healthcare Inspectorate Wales (HIW)/2022/131/MCJ/1	Incident backlog due to be closed by 31.5.22. Service agreed targets all incidents managed and closed within 3 months - using Data action tracker for ongoing work.	Children & Families	01.06.2022	01.10.2023	Partially complete (Overdue)	October 2024 Update - An update against this recommendation action has not been received on this occasion. August 2024 Update - Children & Family Care Group just completing a review of the governance arrangements in line with the new incident management framework. Outcome of will be presented to the Maternity and Neonatal Safety Board in September 2024 with an implementation plan. The new arrangements will ensure proportionate review and learning. September 2023 Update - incident report monitored by executive team. Timely review and closure for moderate harm and above incidents but low and no harm process requires further reviewing and dedicated allocation of time.
Healthcare Inspectorate Wales (HIW)/2022/133	17.10.2022	Hospital Inspection Report (Unannounced) Emergency Department, Princess of Wales Hospital (Appendix A - Immediate Improvement Plan - Princess of Wales Emergency Department (Ref: 33246))	The health board must ensure that checks are completed and logged at all times, and that there are robust mechanisms in place to identify and rectify when checks are not completed or logged.	Healthcare Inspectorate Wales (HIW)/2022/133/MCJ/1	Plan to work with corporate nursing team to review options of creating a digital solution for audit surveillance and daily checks to further improve oversight of status.	Unscheduled Care	01.02.2023	01.02.2023	Overdue	October 2024 Update - An update against this recommendation action has not been received on this occasion. August 2024 Update - The USC Care Group are finalising the last AMAT audit for the three Emergency Departments', this will be achieved by Oct 2024 as needs to go through existing governance process' for sign off prior to use. June 2024 Update - We have progressed towards standardised audits on AMAT across the three sites, the ED audit report remains outstanding however we anticipate this will be in place within the next 8 weeks and will provide an update when achieved. July 2023 Update - Working across CTM to ensure standardised audits are implemented.
Healthcare Inspectorate Wales (HIW)/2022/133	17.10.2022	Hospital Inspection Report (Unannounced) Emergency Department, Princess of Wales Hospital (Appendix A - Immediate Improvement Plan - Princess of Wales Emergency Department (Ref: 33246))	The health board must ensure that checks are completed and logged at all times, and that there are robust mechanisms in place to identify and rectify when checks are not completed or logged.	Healthcare Inspectorate Wales (HIW)/2022/133/MCJ/2	Work with Care Group Directors of Nursing and Midwifery and Heads of Nursing across the three acute sites and community hospital sites in establishing a consistent model of surveillance and checking practice.	Unscheduled Care	01.12.2023	01.12.2023	Overdue	October 2024 Update - An update against this recommendation action has not been received on this occasion. August 2024 Update - The USC Care Group are finalising the last AMAT audit for the three Emergency Departments', this will be achieved by Oct 2024 as needs to go through existing governance process' for sign off prior to use. June 2024 Update - We have progressed towards standardised audits on AMAT across the three sites, the ED audit report remains outstanding however we anticipate this will be in place within the next 8 weeks and will provide an update when achieved.
Healthcare Inspectorate Wales (HIW)/2022/36	14.11.2022	Hospital Inspection Report (Unannounced) Angelon Clinic, Glanhyd Hospital (Appendix C - Improvement plan Service Angelon Clinic - Glanhyd Hospital (Ref: 31711))	The health board must ensure that restraints are recorded in patient records and that patient's notes are updated.	Healthcare Inspectorate Wales (HIW)/2022/36/MCJ/1	Data to be submitted and written account of restraint to be documented in patient notes. Restraint forms to be completed and uploaded to Datix. Compliance to be monitored through monthly nursing notes audits, ward manager meetings and Quality, Safety, Risk and Experience Group meeting.	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	October 2024 Update - CSRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHL&LD are providing confirmation of the closure sign off at the relevant CSRE meeting.
Healthcare Inspectorate Wales (HIW)/2022/36	14.11.2022	Hospital Inspection Report (Unannounced) Angelon Clinic, Glanhyd Hospital (Appendix C - Improvement plan Service Angelon Clinic - Glanhyd Hospital (Ref: 31711))	The health board must ensure that all staff are confident in how to deal with a safeguarding referral.	Healthcare Inspectorate Wales (HIW)/2022/36/MCJ/1	80% compliance to be achieved for Level 2 and Level 3 Safeguarding Training. Safeguarding to be a standard agenda item in staff meetings to reiterate the process. Safeguarding referral process to be clearly visible in nursing office on both wards.	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	October 2024 Update - CSRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHL&LD are providing confirmation of the closure sign off at the relevant CSRE meeting.
Healthcare Inspectorate Wales (HIW)/2022/36	14.11.2022	Hospital Inspection Report (Unannounced) Angelon Clinic, Glanhyd Hospital (Appendix C - Improvement plan Service Angelon Clinic - Glanhyd Hospital (Ref: 31711))	The health board must ensure that patients' risks are regularly updated and recorded in patient records.	Healthcare Inspectorate Wales (HIW)/2022/36/MCJ/1	This will be monitored in the Quality, Safety, Risk and Experience Group meeting and closed after 6 months if compliance is maintained and standards upheld.	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	October 2024 Update - CSRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHL&LD are providing confirmation of the closure sign off at the relevant CSRE meeting.
Healthcare Inspectorate Wales (HIW)/2022/36	14.11.2022	Hospital Inspection Report (Unannounced) Angelon Clinic, Glanhyd Hospital (Appendix C - Improvement plan Service Angelon Clinic - Glanhyd Hospital (Ref: 31711))	The health board must ensure that outcome measures are clearly recorded in patient records.	Healthcare Inspectorate Wales (HIW)/2022/36/MCJ/1	Older Peoples Inpatient Mental Health Service Outcome Measures implementation group to be progressed to identify appropriate outcome measure tool which can then be implemented and embedded into the service, in line with the national work led by Improvement Cymru.	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	October 2024 Update - CSRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHL&LD are providing confirmation of the closure sign off at the relevant CSRE meeting.
Healthcare Inspectorate Wales (HIW)/2022/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 1 The health board must ensure that full and comprehensive mental health assessments and physical health assessments are always being completed in a timely manner, in line with the Mental Health (Wales) Measure 2010 under the Mental Health Act 1983.	Healthcare Inspectorate Wales (HIW)/2022/130/MCJ/3	On completion agreed pathway will be communicated to all Nursing and Medical staff across all Mental Health services using the care Group "Communication and Learning Framework" as detailed in Recommendation 40	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	October 2024 Update - CSRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHL&LD are providing confirmation of the closure sign off at the relevant CSRE meeting.
Healthcare Inspectorate Wales (HIW)/2022/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 1 The health board must ensure that full and comprehensive mental health assessments and physical health assessments are always being completed in a timely manner, in line with the Mental Health (Wales) Measure 2010 under the Mental Health Act 1983.	Healthcare Inspectorate Wales (HIW)/2022/130/MCJ/4	Completion of mental health and physical health checks will be added to the Admission Pathway for all inpatient wards.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	October 2024 Update - CSRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHL&LD are providing confirmation of the closure sign off at the relevant CSRE meeting.

Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 2 The health board must ensure that when staff complete patient risk assessments, the method should reflect the requirements set out within national guidance.	Healthcare Inspectorate Wales (HIW)/2023/130/MQ2/2	All staff who are expected to complete clinical risk assessment will receive training in WARIN (nationally recognised) risk assessment and formulation.	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 2 The health board must ensure that when staff complete patient risk assessments, the method should reflect the requirements set out within national guidance.	Healthcare Inspectorate Wales (HIW)/2023/130/MQ2/5	Compliance will be reported monthly by the CIP Lead and monitored through the Risk Steering Group. An initial demand and capacity exercise has been completed, with external training provision through Spring 2023. Present compliance is at 85.5% (from 35.5% in Feb 2023) with a trajectory of 80% by end of June 23. There is a programme of ongoing WARIN training delivered by a cohort of clinical trainers. This programme has been developed to ensure that there is capacity to deliver against 100% of anticipated demand annually.	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 2 The health board must ensure that when staff complete patient risk assessments, the method should reflect the requirements set out within national guidance.	Healthcare Inspectorate Wales (HIW)/2023/130/MQ2/6	Inpatient units will review paper and electronic archives and systems and remove all risk documentation other than the HB approved Clinical Risk Formulation and Management Plan.	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 2 The health board must ensure that when staff complete patient risk assessments, the method should reflect the requirements set out within national guidance.	Healthcare Inspectorate Wales (HIW)/2023/130/MQ2/7	Evidence of routine compliance will be shown through the weekly Ward Manager Audit, which contains a review of risk assessment documentation of a sample of patient records. Mental Health Ward Assurance audits will be added to the Health Board electronic audit system.	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 3 The health board must ensure that mental capacity assessments are undertaken by relevant staff, which reflect the criteria set within the relevant legislation and national guidance.	Healthcare Inspectorate Wales (HIW)/2023/130/MQ3/2	The inpatient multi-disciplinary team have developed a formal template for documentation of patient reviews and multidisciplinary discussions. This formalises the necessity to routinely record the MDT opinion of the person's capacity and any need for full Mental Capacity Assessment using the approved Health Board Framework. This will be implemented across the Care Group.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 3 The health board must ensure that mental capacity assessments are undertaken by relevant staff, which reflect the criteria set within the relevant legislation and national guidance.	Healthcare Inspectorate Wales (HIW)/2023/130/MQ3/3	Evidence of routine compliance will be shown through the weekly Ward Manager Audit, which contains a review of MDT documentation of a sample of patient records.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 3 The health board must ensure that mental capacity assessments are undertaken by relevant staff, which reflect the criteria set within the relevant legislation and national guidance.	Healthcare Inspectorate Wales (HIW)/2023/130/MQ3/7	Audit data will be reported/escalated through Care Group Governance Framework	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 3 The health board must ensure that mental capacity assessments are undertaken by relevant staff, which reflect the criteria set within the relevant legislation and national guidance.	Healthcare Inspectorate Wales (HIW)/2023/130/MQ3/9	Each clinical area (inpatient and community) will have designated training board/information space for the sharing of learning / local audit/ educational resource, with specific information (bulletins/posters) relating to the right of the carer under the Social Services and Wellbeing Act.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 5 The health board must ensure that patient care and treatment plans: a) Reflect the requirements set out within the Mental Health (Wales) Measure 2010; b) Are routinely updated and dated following review or update, to allow for the identification of relevant staff members.	Healthcare Inspectorate Wales (HIW)/2023/130/MQ5/1	Inpatient units have reviewed paper and electronic archives and systems and removed all care planning documentation other than the HB Inpatient Management Plan and Care and Treatment Planning (CTP)	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 5 The health board must ensure that patient care and treatment plans: a) Reflect the requirements set out within the Mental Health (Wales) Measure 2010; b) Are routinely updated and dated following review or update, to allow for the identification of relevant staff members.	Healthcare Inspectorate Wales (HIW)/2023/130/MQ5/2	The standards around signing reviewed and completed Care and Treatment Plans which are outlined in the HB Care and Treatment Plan (CTP) Policy will be communicated to all appropriate staff through ward training boards and daily safety briefings.	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 5 The health board must ensure that patient care and treatment plans: a) Reflect the requirements set out within the Mental Health (Wales) Measure 2010; b) Are routinely updated and dated following review or update, to allow for the identification of relevant staff members.	Healthcare Inspectorate Wales (HIW)/2023/130/MQ5/3	The CIP audit tool has been reviewed, digitised and added to "Audit management and Tracking (AMAT)" process. A 6 monthly audit programme is underway as a pilot with roll out from July 2023.	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 5 The health board must ensure that patient care and treatment plans: a) Reflect the requirements set out within the Mental Health (Wales) Measure 2010; b) Are routinely updated and dated following review or update, to allow for the identification of relevant staff members.	Healthcare Inspectorate Wales (HIW)/2023/130/MQ5/4	Evidence of routine compliance will be shown by adding audit of this standard to the weekly Ward Manager Audit. Initial review will be of all admissions for no less than one month or until compliance, and weekly sample of admissions going forward.	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 5 The health board must ensure that patient care and treatment plans: a) Reflect the requirements set out within the Mental Health (Wales) Measure 2010; b) Are routinely updated and dated following review or update, to allow for the identification of relevant staff members.	Healthcare Inspectorate Wales (HIW)/2023/130/MQ5/5	Effectiveness of implementation will be evident in audit outcomes and compliance with national reportable KPI. These are monitored through the monthly Integrated Performance meeting chaired by the Care group Service Director and informed by the "Performance Scorecard" that is produced monthly by the MH Performance team.	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 6 The health board should review the ward round structure and arrangements in place, to ensure that sufficient time is permitted to adequately discuss all patients.	Healthcare Inspectorate Wales (HIW)/2023/130/MQ6/1	A review of ward round arrangements across the Health Board will be undertaken. This will include Consultation with patients and carers Consultation with the multi-disciplinary team Benchmarking with other mental health services	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 6 The health board should review the ward round structure and arrangements in place, to ensure that sufficient time is permitted to adequately discuss all patients.	Healthcare Inspectorate Wales (HIW)/2023/130/MQ6/2	Standards for ward round arrangements will be developed, communicated and implemented across the Care Group. These arrangements will be shared with all staff through Communication and Learning Framework (Recommendation 40). Audit of the process will be fed back to teams and any remedial action will reinforce compliance	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 7 The health board must ensure that arrangements are in place to enable prompt communication and information sharing between inpatient and community teams during the discharge process.	Healthcare Inspectorate Wales (HIW)/2023/130/MQ7/1	The Safe Discharge Workstream will develop standardised discharge communication processes across the Care Group.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 7 The health board must ensure that arrangements are in place to enable prompt communication and information sharing between inpatient and community teams during the discharge process.	Healthcare Inspectorate Wales (HIW)/2023/130/MQ7/2	In acknowledgement of the significant work programme that is required across CTM to return it to a position of delivering consistently high quality Mental Health services, a Quality Improvement Programme has been implemented to ensure whole service engagement and consistency of approach across the Health Board.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 7 The health board must ensure that arrangements are in place to enable prompt communication and information sharing between inpatient and community teams during the discharge process.	Healthcare Inspectorate Wales (HIW)/2023/130/MQ7/3	The Improvement Programme is led at Care Group level by the Director of Nursing, with six distinct workstreams within the "High Quality Inpatient Care" sub programme. Each led at a Senior level (Lead Nurse or equivalent), with an overarching aim to ensure that all action, change and improvement will be consistently and universally implemented across CTM.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 8 The health board must ensure that all relevant staff complete appropriate training for timely and effective communication and information sharing relating to the discharge process.	Healthcare Inspectorate Wales (HIW)/2023/130/MQ8/1	A review of ESR function and recording of mandatory and MH specific training within the MH care group and has developed a universal spreadsheet to enable accurate and consistent reporting of compliance. This was completed in March 2023.	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 8 The health board must ensure that all relevant staff complete appropriate training for timely and effective communication and information sharing relating to the discharge process.	Healthcare Inspectorate Wales (HIW)/2023/130/MQ8/2	Subsequently the care group has rolled out a local training record that will enable accurate reporting of the range of mandatory and MH specific training.	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 8 The health board must ensure that all relevant staff complete appropriate training for timely and effective communication and information sharing relating to the discharge process.	Healthcare Inspectorate Wales (HIW)/2023/130/MQ8/7	This will also enable reporting of training compliance through monthly Integrated Performance meeting chaired by the Care group Service Director.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 8 The health board must ensure that all relevant staff complete appropriate training for timely and effective communication and information sharing relating to the discharge process.	Healthcare Inspectorate Wales (HIW)/2023/130/MQ8/8	The care group is developing a Service Improvement Team (SIT) the service lead of which will gather intelligence from the wider Audit programme, unmet need process, wider learning and staff feedback through PDR to develop a training needs analysis (TNA).	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 9 The health board must ensure that minutes are completed for inpatient MDT meetings. This is to ensure an accurate record of attendance, key discussion points and agreed actions are available to all staff.	Healthcare Inspectorate Wales (HIW)/2023/130/MQ9/1	4.4 Ensure that arrangements are in place to maintain comprehensive records following formal MDT meetings, discharge planning meetings or others relating to patient care, and ensure these are shared and reviewed by relevant staff.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 9 The health board must ensure that minutes are completed for inpatient MDT meetings. This is to ensure an accurate record of attendance, key discussion points and agreed actions are available to all staff.	Healthcare Inspectorate Wales (HIW)/2023/130/MQ9/2	As part of the ward round and multi-disciplinary review (Recommendation number 6) the Safe Discharge Workstream will develop standardised approaches for recording multi-disciplinary meetings across the Care Group.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 9 The health board must ensure that minutes are completed for inpatient MDT meetings. This is to ensure an accurate record of attendance, key discussion points and agreed actions are available to all staff.	Healthcare Inspectorate Wales (HIW)/2023/130/MQ9/5	The Safe Discharge Workstream have agreed standards for format of content of ward round and MDT meeting to record attendance, key discussion points and agreed actions, an agreed template for recording this in the patient notes, and storage and access arrangements for all involved professional across CTM.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 9 The health board must ensure that minutes are completed for inpatient MDT meetings. This is to ensure an accurate record of attendance, key discussion points and agreed actions are available to all staff.	Healthcare Inspectorate Wales (HIW)/2023/130/MQ9/6	As a mitigation for the multiple record system that are still in place across the CTM Mental Health service the Safe Discharge Workstream has developed a matrix for clinical team (staff access - "who accesses what system for what purpose") for all systems across the mental health service. This informs all clinical staff of how to access patient clinical risk and discharge planning, information both in and out of hours describes mitigants and escalation.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 11 The health board must ensure that patients and, where appropriate, their family, carer and/or advocate are able to provide their views to inform inpatient care and discharge planning. These views and any subsequent actions should be recorded within the patients' notes.	Healthcare Inspectorate Wales (HIW)/2023/130/MQ10/1	As part of the ward round and multi-disciplinary review (Recommendation number 6) the Safe Discharge Workstream will develop standardised approaches for ensuring that family, carer and/or advocate views are documented across the Care Group.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 11 The health board must ensure that patients and, where appropriate, their family, carer and/or advocate are able to provide their views to inform inpatient care and discharge planning. These views and any subsequent actions should be recorded within the patients' notes.	Healthcare Inspectorate Wales (HIW)/2023/130/MQ10/2	In acknowledgement of the significant work programme that is required across CTM to return it to a position of delivering consistently high quality Mental Health services, a Quality Improvement Programme has been implemented to ensure whole service engagement and consistency of approach across the Health Board. The Improvement Programme is led at Care Group level by the Director of Nursing, with six distinct workstreams within the "High Quality Inpatient Care" sub programme. Each led at a Senior level (Lead Nurse or equivalent), with an overarching aim to ensure that all action, change and improvement will be consistently and universally implemented across CTM. This consistency of approach will be further reinforced with the imminent reorganisation of the MH Care group to provide Senior leadership and Governance structures that have responsibility for the delivery of all inpatient care across CTM.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 13 The health board must ensure that patient records are routinely being updated by staff, to detail what, when and to whom information is being shared with as part of the discharge process.	Healthcare Inspectorate Wales (HIW)/2023/130/MQ12/1	As part of recommendation 7 the Safe Discharge Workstream will develop standardised discharge recording and communication processes across the Care Group.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 14 The health board must ensure arrangements are in place to mitigate against the risks associated with expedited patient discharges, ensuring that timely information is shared with relevant community teams.	Healthcare Inspectorate Wales (HIW)/2023/130/MQ13/1	The oversight of this recommendation will be via the Safe Discharge Workstream. The workstream will define an expedited discharge and develop a procedure for management of expedited discharges to ensure: An Offer of Home Treatment following discharge Formal communication with the Community Mental Health Team by ward manager Those identified as expedited will be escalated to the Clinical Service Group Senior Management Team for scrutiny and learning Review of process and decision making for each case	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 14 The health board must ensure arrangements are in place to mitigate against the risks associated with expedited patient discharges, ensuring that timely information is shared with relevant community teams.	Healthcare Inspectorate Wales (HIW)/2023/130/MQ13/2	The care group will audit all cases who are considered to have been subject to "expedited discharge" using standards agreed within the procedure.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 14 The health board must ensure arrangements are in place to mitigate against the risks associated with expedited patient discharges, ensuring that timely information is shared with relevant community teams.	Healthcare Inspectorate Wales (HIW)/2023/130/MQ13/3	Compliance/noncompliance will be formally reported at CSG QGRE (with any variation over time noted) and reported/escalated through Care Group Governance Framework.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 16 The health board should consider the benefits of reinstating the huddle meetings to help manage the issues with patient flow in and out of the inpatient units.	Healthcare Inspectorate Wales (HIW)/2023/130/MQ15/1	The oversight of this recommendation will be via the Access and Alternatives to Admission Workstream. See response to recommendation 15	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 19 The health board must continue to provide HIW with updates on the plans to implement the unified patient clinical records system. This must also include consideration for its inpatient and community services for Child and Adolescent Mental Health Services across the health board.	Healthcare Inspectorate Wales (HIW)/2023/130/MQ18/1	The Executive and Board are committed to the implementation of a unified electronic record system for the Mental Health and Learning Disabilities Care Group, which includes Child and Adolescent Mental Health Services.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Overdue	October 2024 Update - Currently in process of drafting a local business case for CTM/HB to move rapidly with our own procurement process to obtain the single clinical record. August 2024 Update - This remains on going.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 19 The health board must continue to provide HIW with updates on the plans to implement the unified patient clinical records system. This must also include consideration for its inpatient and community services for Child and Adolescent Mental Health Services across the health board.	Healthcare Inspectorate Wales (HIW)/2023/130/MQ18/2	A business case has been developed and endorsed by the Executive. There are however challenges with the preferred national system. The Health Board is working closely with Digital Health and Care Wales and other Health Boards as part of the review of the national strategic programme for the Welsh Community Care Information System. The outcome of this review will influence timescales for WCCS implementation for the Health Board. A CTM/HB WCCS Workshop is scheduled for 15th June 23 led by MHLd Service Director. CTM/HB WCCS Programme Board to start from 26th July 23 chaired by the Deputy Chief Operations Officer and Executive Director for Digital. A WCCS Operational Group will start in July/August 23 chaired by MHLd Service Director and IT Digital Senior manager. WCCS Implementation Plan timescales for MHLd to be refreshed and presented to WCCS workshop on 15th June 23.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 19 The health board must continue to provide HIW with updates on the plans to implement the unified patient clinical records system. This must also include consideration for its inpatient and community services for Child and Adolescent Mental Health Services across the health board.	Healthcare Inspectorate Wales (HIW)/2023/130/MQ18/3	As a mitigation for the multiple record system that are still in place across the CTM Mental Health service the Safe Discharge Workstream has developed a matrix for clinical team (staff access - "who accesses what system for what purpose") for all systems across the mental health service. This informs all clinical staff of how to access patient clinical risk and discharge planning, information both in and out of hours describes mitigants and escalation.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
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Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 20 The health board must implement actions to mitigate against risks associated with staff access to clinical records in different teams to patient information in a timely manner.	Healthcare Inspectorate Wales (HIW)/2023/130/M020/2	In alignment with the Access and Admission Workstream and Safe Discharge Workstream drivers, process mapping has been undertaken and flow diagrams regarding passing patient information between CMHT and Inpatient for admission and discharge have been completed and shared across the MHLd Care Group.	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 21 The health board must ensure that discharge letters provide sufficient information to patients and where appropriate family or carers, to help manage patient care following discharge. Where applicable, this should include information on the patient's rights to self-refer to the service, in line with the Mental Health (Wales) Measure 2010	Healthcare Inspectorate Wales (HIW)/2023/130/M020/1	"This element of recommendation 21 has been addressed as part of the immediate assurance action plan: 4.1.1 Review discharge letter template, to ensure they provide sufficient information to patients and other key staff to support a patient following discharge and help maintain their safety and wellbeing"	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	Recommendation overdue ratification at Inpatient Improvement Board on 21/11/2023 October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 21 The health board must ensure that discharge letters provide sufficient information to patients and where appropriate family or carers, to help manage patient care following discharge. Where applicable, this should include information on the patient's rights to self-refer to the service, in line with the Mental Health (Wales) Measure 2010	Healthcare Inspectorate Wales (HIW)/2023/130/M020/2	Aligned with recommendation 6 and recommendation 11 the Safe Discharge Workstream will ensure that there is a standardised approach to communication with patients and where appropriate their family or carers.	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 21 The health board must ensure that discharge letters provide sufficient information to patients and where appropriate family or carers, to help manage patient care following discharge. Where applicable, this should include information on the patient's rights to self-refer to the service, in line with the Mental Health (Wales) Measure 2010	Healthcare Inspectorate Wales (HIW)/2023/130/M020/5	In acknowledgement of the significant work programme that is required across CTM to return it to a position of delivering consistently high quality Mental Health services, a Quality Improvement Programme has been implemented to ensure whole service engagement and consistency of approach across the Health Board. The Improvement Programme is led at Care Group level by the Director of Nursing, with six distinct workstreams within the "High Quality Inpatient Care" sub programme. Each is led at a Senior level (Lead Nurse or equivalent), with an overarching aim to ensure that all action, change and improvement will be consistently and universally implemented across CTM. This consistency of approach will be further reinforced with the imminent reorganisation of the MH Care group to provide Senior leadership and Governance structures that have responsibility for the delivery of all Inpatient care across CTM.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting. Reorganisation of the MHLd Care group in progress
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 21 The health board must ensure that discharge letters provide sufficient information to patients and where appropriate family or carers, to help manage patient care following discharge. Where applicable, this should include information on the patient's rights to self-refer to the service, in line with the Mental Health (Wales) Measure 2010	Healthcare Inspectorate Wales (HIW)/2023/130/M020/5	In alignment with the Work undertaken by the high quality records workstream, the Inpatient units are now using a uniform template for electronic discharge letters and recording, storage and creation if also uniform. This has also been adapted for OA Services to ensure parity across inpatients and CMHTs.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 21 The health board must ensure that discharge letters provide sufficient information to patients and where appropriate family or carers, to help manage patient care following discharge. Where applicable, this should include information on the patient's rights to self-refer to the service, in line with the Mental Health (Wales) Measure 2010	Healthcare Inspectorate Wales (HIW)/2023/130/M020/6	As a mitigation for the multiple record system that are still in place across the CTM Mental Health service the Safe Discharge Workstream has developed a matrix for clinical team /staff access. ("Who accesses what system for what purpose") for all systems across the mental health service. This informs all clinical staff of how to access patient clinical risk and discharge planning, information both in and out of hours describes mitigations and escalation	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 23 The health board must ensure that discharge summaries are completed and sent out to the patients' GP and other relevant services involved in the post discharge care and treatment, within a week of the discharge	Healthcare Inspectorate Wales (HIW)/2023/130/M020/1	The oversight of this recommendation will be via the Ward Assurance Group. This standard is explicit within the Health Board Procedure (MH40) standard and is monitored through a process audit of all discharges within 24 hours (ward manager) and bi weekly document review (Senior Nurse). This audit will be included in the Health Board electronic audit tool	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 24 The health board must ensure that patients are followed up within three days post discharge from mental health units, in line with national guidance	Healthcare Inspectorate Wales (HIW)/2023/130/M023/2	This standard is explicit within the Health Board Discharge Procedure (MH46) standards.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval - Further Evidence Available)	October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 24 The health board must ensure that patients are followed up within three days post discharge from mental health units, in line with national guidance	Healthcare Inspectorate Wales (HIW)/2023/130/M023/2	The High Quality Clinical Records Workstream will provide solutions for the monitoring of discharge follow up by community teams using different record systems.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 25 The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	Healthcare Inspectorate Wales (HIW)/2023/130/M034/8	The inpatient units have developed staffing escalation processes to ensure effective support to those staff who have responsibility for safe staff decision making on a shift by shift basis. These will be reviewed to ensure a consistency of approach across all inpatient units.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 25 The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	Healthcare Inspectorate Wales (HIW)/2023/130/M034/9	A review of nursing establishments across the inpatient units is underway. This will be informed by present best practice guidance and the principles that have been developed by the ongoing All Wales Mental Health Nurse staffing programme.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	Recommendation overdue ratification at Inpatient Improvement Board on 21/11/2023 October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 25 The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	Healthcare Inspectorate Wales (HIW)/2023/130/M034/10	Alternative approaches to recruitment and retention will be explored including: •Recruitment events •Skill mix review •Exploration of Band 4 roles •Overseas recruitment •MHdM facilitated cross training solutions	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	Recommendation overdue ratification at Inpatient Improvement Board on 21/11/2023 October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 25 The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	Healthcare Inspectorate Wales (HIW)/2023/130/M034/11	The care group will monitor staffing, recruitment and retention issues and the effectiveness of the approaches detailed through a monthly Nursing Staffing and Workforce meeting.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 25 The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	Healthcare Inspectorate Wales (HIW)/2023/130/M034/12	Workforce issues such as vacancies and sickness are reported, by clinical service group at monthly integrated performance meeting	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	Recommendation overdue ratification at Inpatient Improvement Board on 21/11/2023 October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 26 The health board should undertake a community workforce capacity and demand review, to ensure relevant community teams are sufficiently resourced to manage their patient caseloads.	Healthcare Inspectorate Wales (HIW)/2023/130/M025/1	"The oversight of this recommendation will be via the Care Group Strategic Transformation Board. The health board will undertake a demand and capacity review of the community teams and will consider: •Utilisation of local resources •Thresholds for access to community teams •Caseload numbers and acuity •Skill mix •Mental health workforce"	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting. Recommendation notified as completed by the Inpatient Improvement Board on 17/10/2023
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 26 The health board should undertake a community workforce capacity and demand review, to ensure relevant community teams are sufficiently resourced to manage their patient caseloads.	Healthcare Inspectorate Wales (HIW)/2023/130/M025/2	The demand and capacity review will include engagement with staff working within community teams within the health board, as staff experience, engagement and feedback is an essential part of a compassionate leadership approach to service review.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 27 The health board must provide an update on the status of the Merthyr Cymru CHRT assessment facilities within PCH.	Healthcare Inspectorate Wales (HIW)/2023/130/M026/5	The current room has been stripped of furniture points as far as is reasonably practicable but is not an anti-ligature environment so is reliant on risk assessment and observation of the patient.	Mental Health & Learning Disabilities	30.09.2023	30.09.2023	Fully complete (Awaiting approval)	Recommendation notified as completed by the Inpatient Improvement Board on 22/10/2023 October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 27 The health board must provide an update on the status of the Merthyr Cymru CHRT assessment facilities within PCH.	Healthcare Inspectorate Wales (HIW)/2023/130/M026/4	Hand held panic alarms have been ordered and will be delivered to Crisis Team w/c 12th June 23	Mental Health & Learning Disabilities	30.09.2023	30.09.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 27 The health board must provide an update on the status of the Merthyr Cymru CHRT assessment facilities within PCH.	Healthcare Inspectorate Wales (HIW)/2023/130/M026/5	The Care Group is working closely with colleagues at Prince Charles Hospital as part of the estates planning processes and an update on substantive arrangements for unscheduled/crisis assessment will be provide to HIW assessment 30 Sept 2024.	Mental Health & Learning Disabilities	30.09.2023	30.09.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 28 The health board must ensure communication arrangements are embedded, to allow for essential sharing of information between teams regarding patient care and treatment planning during the hospital stay and after discharge.	Healthcare Inspectorate Wales (HIW)/2023/130/M027/1	As a mitigation for the multiple record system that are still in place across the CTM Mental Health service the Safe Discharge Workstream has developed a matrix for clinical team /staff access. ("Who accesses what system for what purpose") for all systems across the mental health service. This informs all clinical staff of how to access patient clinical risk and discharge planning, information both in and out of hours describes mitigations and escalation	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	Status relates to the substantive recommendations for unscheduled/crisis assessment in PCH October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 28 The health board must ensure communication arrangements are embedded, to allow for essential sharing of information between teams regarding patient care and treatment planning during the hospital stay and after discharge.	Healthcare Inspectorate Wales (HIW)/2023/130/M027/2	In alignment with the Access and Admission Workstream and Safe Discharge Workstream drivers, process mapping has been undertaken and flow diagrams regarding passing patient information between CMHT and Inpatient for admission and discharge have been completed and shared across the MHLd Care Group.	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 28 The health board must ensure communication arrangements are embedded, to allow for essential sharing of information between teams regarding patient care and treatment planning during the hospital stay and after discharge.	Healthcare Inspectorate Wales (HIW)/2023/130/M027/3	In acknowledgement of the significant work programme that is required across CTM to return it to a position of delivering consistently high quality Mental Health services, a Quality Improvement Programme has been implemented to ensure whole service engagement and consistency of approach across the Health Board.	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 28 The health board must ensure communication arrangements are embedded, to allow for essential sharing of information between teams regarding patient care and treatment planning during the hospital stay and after discharge.	Healthcare Inspectorate Wales (HIW)/2023/130/M027/4	The Improvement Programme is led at Care Group level by the Director of Nursing, with six distinct workstreams within the "High Quality Inpatient Care" sub programme. Each is led at a Senior level (Lead Nurse or equivalent), with an overarching aim to ensure that all action, change and improvement will be consistently and universally implemented across CTM.	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 28 The health board must ensure communication arrangements are embedded, to allow for essential sharing of information between teams regarding patient care and treatment planning during the hospital stay and after discharge.	Healthcare Inspectorate Wales (HIW)/2023/130/M027/5	This consistency of approach will be further reinforced with the imminent reorganisation of the MH Care group to provide Senior leadership and Governance structures that have responsibility for the delivery of all Inpatient care across CTM.	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting. February 2024 - Reorganisation of MHLd Care Groups has commenced with shadow directorates from 01/02/2024.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 29 The health board must take action to ensure there is sufficient medical capacity across all mental health teams.	Healthcare Inspectorate Wales (HIW)/2023/130/M028/2	The care group Medical Director is leading on the development and progress of a Medical Workforce Productivity Committee with the purpose of developing a pan care group medical workforce plan to ensure the delivery of safe high quality care. "This programme of work is focusing on: •Medical recruitment •Medical retention •Design of new roles •Monitoring of job planning"	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	December 2023 Update - Reorganisation of the MHLd Care Groups underway October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 29 The health board must take action to ensure there is sufficient medical capacity across all mental health teams.	Healthcare Inspectorate Wales (HIW)/2023/130/M028/3	"Medical Workforce Productivity Group is now established with CTM wide membership and terms of reference agreed and following first meeting in May 2023. Workstreams agreed for Recruitment and retention •Upgraded care •Diverse workforce and vacancy rates aligned as the initial Outcome measures"	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 29 The health board must take action to ensure there is sufficient medical capacity across all mental health teams.	Healthcare Inspectorate Wales (HIW)/2023/130/M028/5	The care group will monitor staffing, recruitment and retention issues and the effectiveness of the approaches detailed through a monthly Medical Staffing and Workforce meeting.	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 29 The health board must take action to ensure there is sufficient medical capacity across all mental health teams.	Healthcare Inspectorate Wales (HIW)/2023/130/M028/6	Workforce issues such as vacancies and sickness are reported, by clinical service group at monthly integrated performance meeting	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval - Further Evidence Available)	October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 31 The health board must consider the need to undertake a review of the capacity and demand of the mental health therapy services, and whether the establishment is correct to meet the demand.	Healthcare Inspectorate Wales (HIW)/2023/130/M030/5	The remaining demand and capacity review will include engagement with staff working with each of the Therapy disciplines, as staff experience, engagement and feedback is an essential part of a compassionate leadership approach to service review. This review will conclude in the development of a MH Therapy workforce proposal for consideration.	Mental Health & Learning Disabilities	31.03.2024	31.03.2024	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 31 The health board must consider the need to undertake a review of the capacity and demand of the mental health therapy services, and whether the establishment is correct to meet the demand.	Healthcare Inspectorate Wales (HIW)/2023/130/M030/10	ASP and psychological therapies in acute services have a long tradition of offering training placements to clinical psychology trainees, counselling psychology trainees, art psychotherapy trainees and psychology undergraduate yearlong placements students. This has created additional capacity to ensure a tiered approach to working with people in acute care. This additional capacity has enabled more patients to be offered protocol based psychological interventions.	Mental Health & Learning Disabilities	31.03.2024	31.03.2024	Fully complete (Awaiting approval)	February 2024 Update - Consultant Clinical Psychologist is leading on this action from a psychological therapies perspective and the recommendation is on track to be completed by 31/03/2024 October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 31 The health board must consider the need to undertake a review of the capacity and demand of the mental health therapy services, and whether the establishment is correct to meet the demand.	Healthcare Inspectorate Wales (HIW)/2023/130/M030/11	For the wider nursing team training on Companionate Care, and Psychologically Informed Practice has been arranged and delivered to the RMN and HCA workforce in acute services, while further training is being planned and commissioned with a third sector provider to deliver ASIST suicide prevention training to the workforce by October 31 2023.	Mental Health & Learning Disabilities	31.03.2024	31.03.2024	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 32 The health board must consider the staff feedback highlighted in this report and consider undertaking a training needs analysis for inpatient and community staff, to identify any training gaps and help ensure all staff have the appropriate knowledge and skills to effectively undertake their role.	Healthcare Inspectorate Wales (HIW)/2023/130/M031/2	In addition to the care learning skills for mental health staff and informed by the outcome of the wider in-patient improvement workstreams a full training needs analysis will be completed to identify further opportunities for skills development.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 32 The health board must consider the staff feedback highlighted in this report and consider undertaking a training needs analysis for inpatient and community staff, to identify any training gaps and help ensure all staff have the appropriate knowledge and skills to effectively undertake their role.	Healthcare Inspectorate Wales (HIW)/2023/130/M031/4	In light of the scale of improvement required, in addition to the organisational mandatory and statutory training requirement, the Mental Health care group are focusing only on a core set of Mental Health specific skills including WARMR, CTF and PMAA training, and any Mental Health Act /statutory training that is immediately identified through on going learning.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 32 The health board must consider the staff feedback highlighted in this report and consider undertaking a training needs analysis for inpatient and community staff, to identify any training gaps and help ensure all staff have the appropriate knowledge and skills to effectively undertake their role.	Healthcare Inspectorate Wales (HIW)/2023/130/M031/6	The Care Group will focus on increased compliance within time 31 August 2023 report, but outside this will review the fuller training needs analysis this in 12 months time (31 May 2025) with a fuller understanding of the issues from the inpatient improvement work stream.	Mental Health & Learning Disabilities	31.08.2023	31.05.2024	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 33 The health board must ensure that all staff across the mental health services are aware of how to access support, and that timely access to occupational health and well-being support is available to staff when required.	Healthcare Inspectorate Wales (HIW)/2023/130/M032/2	"The Care Group will: •Establish a programme of Wellbeing Activities in each team to work as champions for this agenda. •Implement the learning from the Ty Lladur and Maternity Services improvement work on staff engagement •Work with people services and occupational health to determine backlogs to assess service and possible mitigations •Develop mechanisms to demonstrate appreciation and celebrate success •Seek to understand the most common staff distress and welfare solutions"	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	October 2024 Update - QGRE date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QGRE meeting.
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Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 36 The health board must provide HIW with an update on the progress of the ongoing work to review and update the mental health service policies and procedures, and when the health board wide documents will be implemented. This must include how this will be shared with all staff across the mental health services as a whole.	Healthcare Inspectorate Wales (HIW)/2023/130/MO35/1	The oversight for this recommendation will be via the Policies Group. The newly established Policy Review group will have an operational scope to: •Review & RAG of all existing MH Policies to establish priorities rating •Develop a policies plan with objectives for addressing the backlog •To progress for sign off at Care Group level •Maintenance of a register of policies for review Following agreement of ToT at April 2023 Care Group Quality Safety Risk and Experience Group.	Mental Health & Learning Disabilities	01.06.2024	01.06.2024	Overdue	October 2024 Update - remains ongoing, to discuss further at QSR. August 2024 Update - •21 policies in date (up from 16 in July). •6 pending ratification, awaiting comments by 2nd Sept, I will then progress. •36 under review (17 have elapsed completion dates from June/July to Sept/Oct/Nov 24) as below: June 2024 Update - Though all policies and procedures are now under review by the expert groups, the changes caused by the restructure is causing added complication as teams and services are moved and merged across locally (ie @ MH Liaison SOP). February 2024 Update - Remains in progress December 2023 Update - The HB has revised its process for the ratification of policies which will lead to more timely ratification and will enable all policies and procedures to be ratified by 01/06/24. There are 39 agreed MH policies/procedures. These have been prioritised for updates. The Mental Health Policy Review group will monitor this review schedule at each meeting. In the interim the Mental Health Policy group has directed the clinical teams to work with the most current version each Clinical policy. October 2024 Update - 21 policies up to date, 31 under review, 12 awaiting approval. August 2024 Update - •21 policies in date (up from 16 in July). •6 pending ratification, awaiting comments by 2nd Sept, I will then progress. •36 under review (17 have elapsed completion dates from June/July to Sept/Oct/Nov 24) as below:
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 36 The health board must provide HIW with an update on the progress of the ongoing work to review and update the mental health service policies and procedures, and when the health board wide documents will be implemented. This must include how this will be shared with all staff across the mental health services as a whole.	Healthcare Inspectorate Wales (HIW)/2023/130/MO35/2	Mental health policies will follow the agreed organisational process for ratification. All MH specific policies were reviewed by 1 June 2023 and of the 49 MH specific policies - Review underway 4 in date and agreed 32. With an agreement that those that require updating will be completed by 1st June 2024. The 32 expired policies have been prioritised with consideration of patient safety, present best practice and clinical impact and a review schedule has been developed with this in mind. The Mental Health Policy group will monitor this review schedule at each meeting through an agenda item. In the interim the Mental Health Policy group has directed the clinical teams to work with the most current version each Clinical policy. On completion agreed policies will be communicated to all Nursing and Medical staff across all Mental Health services using the Care Group "Communication and Learning Framework" recommendation All current and ratified policies will be live on the Mental Health Policies page on the staff internet site SharePoint.	Mental Health & Learning Disabilities	01.06.2024	01.06.2024	Overdue	October 2024 Update - 21 policies up to date, 31 under review, 12 awaiting approval. August 2024 Update - •21 policies in date (up from 16 in July). •6 pending ratification, awaiting comments by 2nd Sept, I will then progress. •36 under review (17 have elapsed completion dates from June/July to Sept/Oct/Nov 24) as below:
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 37 The health board must ensure that risk registers are reviewed, and that consideration is given to risk identification and risk management processes. This must include ensuring staff that key staff are adequately trained in identifying risks and their management.	Healthcare Inspectorate Wales (HIW)/2023/130/MO36/1	The oversight of risk registers will be dualled via the Care Group Quality Safety Risk and Experience Group and the Performance, Planning and Finance Group. Accountability for the management of risk registers at Clinical Service Group will be via operational leaders.	Mental health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval) - Further Evidence Awaited	October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QSR meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 37 The health board must ensure that risk registers are reviewed, and that consideration is given to risk identification and risk management processes. This must include ensuring staff that key staff are adequately trained in identifying risks and their management.	Healthcare Inspectorate Wales (HIW)/2023/130/MO36/2	The organisational risk register includes risk with a score of over 15. The organisational risk register has been reviewed across the Health Board. Aggregate workforce shortage and training risks are included for CTM. Specific Mental Health risks including clinical records and environmental risks are recorded on the organisational risk register. Risk registers with scores over 12 are monitored at Care Group level via Quality Safety Risk and Experience Group - (see Appendix 1 for governance arrangements), and all other risks are monitored via the Clinical Service group performance arrangements. The Head of Quality and Safety will lead an operational care group governance meeting to monitor compliance with Putting Things Right, action plans and risk review timescales. Agenda item in performance meeting at senior nurse level in order to encourage escalation and culture of owning risks and mitigation at local level.	Mental Health & Learning Disabilities	30.11.2024	30.11.2024	Fully complete (Awaiting approval) - Further Evidence Awaited	October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QSR meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 38 The health board must consider how it can audit the process in place for social worker identified incidents, which are documented within Datix, and that feedback, learning and actions are shared with them as applicable.	Healthcare Inspectorate Wales (HIW)/2023/130/MO37/1	The oversight for this recommendation will be via the Quality, Safety, Risk and Experience Group. The Mental Health Governance lead will establish a working group with the Lead Nurses and Local Authority heads of service to develop a mechanism for multi-agency incident reporting.	Mental Health & Learning Disabilities	30.06.2023	31.10.2024	In progress	October 2024 Update - Completed. August 2024 Update - No update received this period. February 2024 Update - Update from Business Intelligence Team that they have explored ways for a social worker to be able to access the incident module of Datix, however a solution has not been found. Action agreed: SOP to be developed to describe the process for feedback, learning and actions to be shared with social workers as applicable. Previous Update - The Mental Health Care Group is exploring a way for social workers to be able to report incidents directly through Datix with the Health Board Governance Team and ICT team. This has been delayed by issues with allowing non MH personnel access to MH and NHS systems and organisational changes to the CTM governance and Data teams. In the meantime, a process for reporting and feeding back
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 39 The health board must ensure that any staff who report incidents via Datix are provided with feedback, including any actions taken and learning identified.	Healthcare Inspectorate Wales (HIW)/2023/130/MO37/2	"The oversight for this recommendation will be via the Quality, Safety, Risk and Experience Group. Following rollout of new 'Datixweb' functionality, data reviews cannot be closed without providing the reporter with feedback. Monitoring of incident closures will be via the Quality, Safety, Risk and Experience Group."	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	October 2024 Update - QSR date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QSR meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 40 The health board must ensure that there is a process in place to share learning or actions identified following incidents are cascaded across all teams within its mental health services.	Healthcare Inspectorate Wales (HIW)/2023/130/MO39/1	"The oversight for this recommendation will be via the Quality, Safety, Risk and Experience Group. The Mental Health Care Group will develop a Communication and Learning Framework that entails: •A Standard operational Policy for cascade/escalation of information Ward/Board/Ward (attached Appendix 6) •Monthly Quality, Safety, Risk and Experience (QSRE) meetings where learning is shared between all Clinical Service group (CSG) senior teams •Monthly CSG QSRE for escalation and dissemination of wider learning by Senior Nurses and MDT. Monthly "Clinical Lead" meetings for escalation and dissemination of wider learning to ward managers and Team leaders •Monthly team ward meetings for escalation and dissemination of wider learning, and sharing of local Quality Improvement and audit information. This will be an universally agreed meeting with action points noted. •7 minute briefing (LASER) used as a mechanism to share learning in team/ward meetings; safety briefings on wards, and to individual staff email accounts. •Each clinical area (inpatient and community) will have designated training board/information space for the sharing of learning / local audit/ educational resource •Quarterly Post Grad learning Sessions to enable Multi-disciplinary Shared learning	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	October 2024 Update - QSR date of approval November 2023. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QSR meeting.
Healthcare Inspectorate Wales (HIW)/2023/134	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix A- Immediate Improvement Plan, 31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken: • to improve mandatory staff training compliance in respect of resuscitation training • to promote patient safety in the interim until compliance has improved	Healthcare Inspectorate Wales (HIW)/2023/134/MO2/1	Cwm Taf University Health Board acknowledges that compliance for mandatory resuscitation training is not where we want it to be in order that Patient Care and Safety can be assured in the event of a patient collapse - Current Training Compliance- ED •Registered Nurse ALS compliance is currently 38.24% and HCWS BLS is 2.78% as demonstrated in attached training needs analysis. •An As Senior Nurse for Professional Education has been appointed (July 2022) as part of the new ED Workforce Model agreed following the HIW review in September 2021. •A Training Needs Analysis has been undertaken and a Study Plan has been developed for all Registered Nurses and HCWS. Registered Nurses-the Resuscitation Team have agreed to undertake bespoke ALS and PLS training monthly with 12 spaces being allocated monthly HCWS's - the Resuscitation Team have agreed to undertake bespoke BLS training monthly for ED -8 spaces As an interim measure to ensure patient safety until compliance has improved the senior nurse for ED will have oversight of the roster to provide assurance that each area has an ALS trained nurse on shift. CDU - Registered Nurse ALS currently 70.6% this should also translate to BLS being achieved at 70.6% which was a data entry error not to be immediately rectified by the resuscitation team via ESR. There are only 5 further nurses requiring training in order to meet 100%. Training is in line with the PCR process "Have your Conversation", training compliance is aligned to the Agenda for Change process.	Unscheduled Care	01.11.2023	30.06.2024	Partially complete (Overdue)	October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - CDU BLS - 94%, ALS 40%, ED BLS - 80% ALS 65% (CDU Clinical Decisions Unit (BLS) Basic Life Support (ALS) Immediate Life Support (ED) Emergency Department (BLS) Basic Life Support (ALS) Advanced Life Support.) February 2024 Update - CDU compliance 65.40% (PML), BLS 68% and ED compliance 85.43.75%, BLS 76%. It is important to note the RM's undertake ALS training and therefore BLS is not required - ESR Mandatory Training requires updating. Please note there has been 10 new New Starters in the last 6 weeks, hence reducing the compliance rate - there is a plan to improve. Partially Completed - review date June 2024 (new recruitment has reduced trajectory of compliance as described). Previous Update - 65% compliance aim November 2023 with 100% compliance February 2024.
Healthcare Inspectorate Wales (HIW)/2023/140	18.05.2023	HMP Parc Prison	HMP Parc Prison should ensure that there is a robust mechanism to ensure that drug monitoring bloods are organised in a timely fashion especially for immunosuppressant drugs.	Healthcare Inspectorate Wales (HIW)/2023/140/MO2/1	A review of the current GP management process to be undertaken. To implement a robust process ensuring that bloods required due to drug monitoring are undertaken in a timely manner and results are reviewed appropriately.	Primary Care & Community	31.08.2023	31.08.2023	Partially complete (Overdue)	October 2024 Update - Discussion with Head of Healthcare within HMP Parc, chair email sent to GP contractors to request update on process with implementation of recommendation. September 2024 Update - email sent from head of Health care to GP contractors August 2024 - ongoing with Pharmacy lead and GP in HMP Parc
Healthcare Inspectorate Wales (HIW)/2023/140	18.05.2023	HMP Parc Prison	HMP Parc Healthcare must ensure that all medication recommended is supplied.	Healthcare Inspectorate Wales (HIW)/2023/140/MO7/1	A work stream to understand the correct process to and develop robust process to ensure recommended medication is supplied. This will include flow chart to be drafted and implemented with a process how staff/ patients access medication in a timely manner. Implementation of critical medication policy. Any process developed will need to consider all stages, pharmacy from the perspective of supply and staff on the wings for administration. Consideration needed regarding prescribing as it may be that in some circumstances an interim prescription for an alternative formulation etc may be required.	Primary Care & Community	31.08.2023	31.08.2023	Partially complete (Overdue)	October 2024 Update - No update against this recommendation action has been received on this occasion. September 2023 Update - No update received August 2024 Update - Ongoing with Pharmacy lead and GP in HMP Parc.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient: Flow - a journey through the stroke pathway	Health boards should engage with each other, to learn from the good patient education practices taking place across Wales. This could help the shared learning with themselves and with GP practices in their localities, to educate patients of the risks for a stroke, to help reduce the number of strokes across Wales.	Healthcare Inspectorate Wales (HIW)/2023/155/MO1/1	CTM UHB continues to work in partnership with Cardiff and Vale UHB in the Regional Network for stroke services and have collaborated on cross-health board workshops to share and learn from good practice for service development, including patient education. The Health Board will continue to engage in the national network for stroke to ensure that we work together with other Health Boards across Wales to develop and share good practice and learning for the benefit of our patients and teams. We continue in our GP Practices to target patients at increased risk of stroke and we continue to build on this as part of CTM0302 and our Acute Clinical Services Plan. Governance and reporting have been refreshed and strengthened, with learning fed back through the CTM UHB Stroke Operational Group and Stroke Performance Board into the Stroke Strategy Group for implementation across the Health Board area.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - This work is ongoing and forms part of long term engagement and partnership working via the stroke programme board. Revised Due Date - Ongoing across 2024/25 Ongoing across 2023/24
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient: Flow - a journey through the stroke pathway	Public Health Wales should consider the development and promotion of a national campaign to raise stroke awareness and its prevention in Wales alongside its Act FAST campaign. This should include raising awareness of stroke prevention within Black and minority ethnic communities and the impact of health inequalities and socio-economic deprivation.	Healthcare Inspectorate Wales (HIW)/2023/155/MO2/1	This action is led by PHW however, CTM UHB will continue to engage with PHW, the Stroke Association, and other Health Boards through the national network in order to support the development and implementation of a campaign by PHW. Updates will feed through to the CTM UHB Stroke Strategy Group to ensure continued support.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - "This action is led by PHW however, CTM UHB will continue to engage with PHW, the Stroke Association, and other Health Boards through the national network in order to support the development and implementation of a campaign by PHW. Updates will feed through to the CTM UHB Stroke Strategy Group to ensure continued support. Revised Due Date - Ongoing across 2024/25 Ongoing across 2023/24
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient: Flow - a journey through the stroke pathway	Health boards and PHW should work closely with Black and minority ethnic communities and people affected by socio-economic deprivation, to understand the specific issues they face with their increased risk of stroke and in accessing preventative care and ensure ongoing engagement with them to support better health outcomes.	Healthcare Inspectorate Wales (HIW)/2023/155/MO3/1	CTM UHB will continue to engage with PHW and Health Boards across Wales through the national network to support a co-ordinated approach to effective engagement with Black and minority ethnic communities and people affected by socio-economic deprivation, to understand the specific issues they face. Listening to all our communities and increased engagement is a key part of the CTM UHB Organisational Strategy Action Plan.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - "CTM UHB will continue to engage with PHW and Health Boards across Wales through the national network to support a co-ordinated approach to effective engagement with Black and minority ethnic communities and people affected by socio-economic deprivation, to understand the specific issues they face. Listening to all our communities and increased engagement is a key part of the CTM UHB Organisational Strategy Action Plan." Revised Due Date - Ongoing across 2024/25 Ongoing across 2023/24
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient: Flow - a journey through the stroke pathway	Health boards must communicate with each other to establish the good practices taking place in place in some hospitals for the robust management of patient flow. This includes the implementation of effective action plans to manage daily discharges, which remain active throughout the day, and in planning for subsequent days.	Healthcare Inspectorate Wales (HIW)/2023/155/MO4/1	Significant work is ongoing to ensure the robust management of patient flow. Each site has a well-established daily Safe2Start meeting which provides assurance around site based escalation, staffing, patient safety and clinical priorities. The meeting allows the identification of clinical priorities, including stroke patients, and time frames for movement to appropriate inpatient beds. All patient flow constraints are discussed and risk is shared across the acute inpatient wards and community sites in order to balance risk within the Emergency Department. This remains an action-focused meeting with clear ownership and delivery prior to the afternoon meeting. As part of this work, under the 4 Goals national programme, the Safe2Start template has been revised to include SAFER, Red/Green and both internal and external delay metrics. There was a delay in launching the new template due to access required into SAFECARE to display nurse staffing levels, this is being worked through by informatics colleagues with the new template expected to be completed and implemented by November 2024. We have introduced Electronic Whiteboards on every ward that track each stage of discharge and highlights any blockages in the process. This information is an integrated tool across health and social care partners. As part of this work, we have also developed Optimize, a programme of work under the national equals programme to focus on value added care for patients, including a multi-professional approach to patient flow and Discharge to Recover then Assess (D2RA) pathways.	Unscheduled Care	01.11.2023	01.11.2023	Overdue	October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - This work is ongoing and forms the central part of the stroke programme board - this is discussed in every other Q&S committee as part of the board updates.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient: Flow - a journey through the stroke pathway	Health boards must review and consider timelier processes of prescribing take home medication and obtaining this promptly from pharmacy to minimise discharge delays. This should include planning well in advance of the scheduled time for discharge (such as the day before).	Healthcare Inspectorate Wales (HIW)/2023/155/MO6/1	CTM UHB is aware that consideration needs to be given to dedicated specialist pharmacist support as part of our review of the Stroke Pathway. The Pharmacy Team are involved in conversations to improve communication regarding estimated dates of discharge and full MDT involvement/Use of eWhiteboards, which includes planning the day before for potential discharges. Pharmacy colleagues are also part of the site based Safe2Start meetings, so they are aware of potential discharges across the acute sites early to prevent potential delays.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - CTM UHB is aware that consideration needs to be given to dedicated specialist pharmacist support as part of our review of the Stroke Pathway. The Pharmacy Team are involved in conversations to improve communication regarding estimated dates of discharge and full MDT involvement/Use of eWhiteboards, which includes planning the day before for potential discharges. Pharmacy colleagues are also part of the site based Safe2Start meetings, so they are aware of potential discharges across the acute sites early to prevent potential delays.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient: Flow - a journey through the stroke pathway	Health boards should consider the benefits of dedicated 'discharge phlebotomy slots' for managing the necessary blood tests, to assist with effective and timelier discharge.	Healthcare Inspectorate Wales (HIW)/2023/155/MO7/1	Currently, there is a variation in the service provided across the CTM UHB footprint. In Princess of Wales Hospital, phlebotomy is provided through an S&A with Swansea Bay UHB. Prince Charles and Royal Glamorgan Hospitals' phlebotomy services are provided through CTM UHB. Further conversations will take place through the Stroke Programme Board/Operational Group to ascertain the feasibility of starting. Robust data would be required to evidence the implementation of this action which as yet we do not have and so this has not yet been progressed.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - This action is not being progressed as - Currently, there is variation in the service provided across the CTM UHB footprint. In Princess of Wales Hospital, phlebotomy is provided through an S&A with Swansea Bay UHB. Prince Charles and Royal Glamorgan Hospitals' phlebotomy services are provided through CTM UHB. Further conversations will take place through the Stroke Programme Board/Operational Group to ascertain the feasibility of starting. Robust data would be required to evidence the implementation of this action which as yet we do not have and so this has not yet been progressed. Ongoing 2024/25
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient: Flow - a journey through the stroke pathway	Health boards must consider the benefits of Implementing Cymru's Real Time Demand Capacity methodology, and whether this would have a positive impact to implement (or to pilot) within all hospitals to help manage timelier patient flow.	Healthcare Inspectorate Wales (HIW)/2023/155/MO8/1	Within Prince Charles Hospital there was a trial of the RTDC model with some positive effect supported by Improvement Cyntu. There is a national move towards the North Bristol Trust model of continuous flow, which has been explored by the USC Group as an option which may have a positive impact on patient flow. We are currently collaborating with NHS xcel colleagues on the roll out of this, with the site planned for proof of concept being Royal Glamorgan. In order to undertake this piece of work, we need to understand the breakdown of our specialty demand and so informatics colleagues are supporting this piece of work which will be developed as an improvement project once relevant data is available.	Unscheduled Care	01.02.2024	31.12.2024	In progress	October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - we remain in collaboration with the NHS exec on this however as an organisation we do not yet have predicted demand modelling available to us which constrains our ability to progress this work.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient: Flow - a journey through the stroke pathway	Health boards should reflect on their patient flow processes and consider whether improvements can be made with predictive methodology for demand in each of their hospital sites, such as with medical and surgical admissions.	Healthcare Inspectorate Wales (HIW)/2023/155/MO9/1	CTM UHB has significant experience of using predictive methods to enhance patient and system outcomes. In building on this as part of the development of an USC Dashboard, which is now embedded for operational use, and the future development of an ED Electronic Whiteboard/Viewer, there is the ability to start to inform the USC leadership team around their predicted demand. Later developments will allow the breakdown of this into specialty and also to further explore surgical demand data. The Health Board continues to build on its use of data to enhance the provision of business intelligence on offer at all levels of the organisation, in order to scrutinise the demand and flow of patients through the system. These additional developments have been built into the Informatics MTP proposals for 2024/2025.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	October 2024 Update - No update against this recommendation action has been received on this occasion. Revised Due Date - In 2024/25 timescale dependent on resource availability Timescale in 2023/24 exact timescale dependent on resource availability August 2024 Update - CTM UHB has significant experience of using predictive methods to enhance patient and system outcomes. In building on this as part of the development of an USC Dashboard, which is now embedded for operational use, and the future development of an ED Electronic Whiteboard/Viewer, there is the ability to start to inform the USC leadership team around their predicted demand. Later developments will allow the breakdown of this into specialty and also to further explore surgical demand data. The Health Board continues to build on its use of data to enhance the provision of business intelligence on offer at all levels of the organisation, in order to scrutinise the demand and flow of patients through the system. These additional developments have been built into the Informatics MTP proposals for 2024/2025.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient: Flow - a journey through the stroke pathway	Health boards should consider whether a daily senior nursing/ clinical oversight for each directorate could be implemented to facilitate clinical issues with flow. This may help ensure staff are making timely progress to discharge patients, challenge medical staff to undertake key tasks where necessary, and help expedite any outstanding clinical patient needs. In addition, to commence planning for patient discharge on subsequent days.	Healthcare Inspectorate Wales (HIW)/2023/155/MO10/1	See also response to Rec 5. Within the USC Group and under the umbrella of the national 4 Goals programme, there is a significant focus on patient flow, aligned to SAFER, Red/Green and R&G patient, right time, within work stream 3. Part of this work includes the implementation of a standardised process around board and ward rounds, with senior nursing and clinical teams having direct involvement with information relating to internal and external delays as part of this being captured on an electronic whiteboard which feeds into the afternoon Safe2Start site based meeting. This piece of work is ongoing and focuses of value added care. This work is ongoing and in large scale intervention with a detailed project plan and timescale for implementation that are supported via Executive Board.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - a proposal has been shared with the board for extension of the CHS workforce with Senior nurse oversight. This requires resource allocation. November launch. Full implementation 24-25

Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient: Flow - a journey through the stroke pathway	Health boards and WAST should engage with people to better understand the barriers to them accessing, or choosing, from the range of healthcare services available in Wales. Once the barriers are understood, this in turn, could be used to influence service design.	Healthcare Inspectorate Wales (HIW)/2023/155/MD11/1	Listening to our communities and understanding their experiences is a key part of the CTM UHB Organisational Strategy Action Plan. As part of CTM2030 and our Acute Clinical Services Plan there will be multiple opportunities to engage with our communities in order to influence service design.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	October 2024 update - No update against this recommendation action has been received on this occasion. August 2024 Update - Listening to our communities and understanding their experiences is a key part of the CTM UHB Organisational Strategy Action Plan. As part of CTM2030 and our Acute Clinical Services Plan there will be multiple opportunities to engage with our communities in order to influence service design.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient: Flow - a journey through the stroke pathway	Health boards should seek assurance that their MHA and ED departments ensure all reception staff have received up to date Act FAST training, and they are competent with this. In addition, that appropriate escalation process is in place if a receptionist is or is not sure a patient may be suffering with a stroke.	Healthcare Inspectorate Wales (HIW)/2023/155/MD12/1	Due to significant changes within CTM in relation to a large scale OCP process with multiple changes to staff groups and lines of reporting the review of current training in relation to Act FAST training, and they are competent with this, is scheduled to start in the next month with an aim for completion by September. There is also a national e-triage system being implemented which may prevent the need for this in future, as stroke symptoms are built in as part of 'red flagging' leading to an appropriate clinical triage category for patients who are symptomatic of a stroke.	Unscheduled Care	01.10.2024	01.10.2024	Overdue	October 2024 update - No update against this recommendation action has been received on this occasion. August 2024 Update - This work remains a focus and is part of ongoing discussions as programme board. Due to significant changes within CTM in relation to a large scale OCP process with multiple changes to staff groups and lines of reporting the review of current training in relation to Act FAST training has not yet taken place. This is scheduled to start in the next month with an aim for completion by September. There is also a national e-triage system being implemented which may prevent the need for this in future, as stroke symptoms are built in as part of 'red flagging' leading to an appropriate clinical triage category for patients who are symptomatic of a stroke. Reviewed Review - August 2024. Ongoing implementation. Review March 2024
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient: Flow - a journey through the stroke pathway	WAST and all health boards must work collaboratively to identify a consistent approach to ensure handover of stroke patients is made within the Welsh Government 15-minute target. This is to ensure that time critical investigations and treatment are undertaken promptly.	Healthcare Inspectorate Wales (HIW)/2023/155/MD13/1	Collaborative working with WAST continues as part of the CTM UHB Stroke Programme Board/Stroke Operational Group to collaboratively identify and implement a consistent pathway for stroke patients, both confirmed and query arriving at our emergency departments. In addition, we are currently reviewing our nurse specialist provision in order to create capacity to better support the early handover of stroke patients and transfer directly to time critical investigations.	Unscheduled Care	01.10.2024	31.03.2025	In progress	October 2024 update - No update against this recommendation action has been received on this occasion. August 2024 Update - collaborative work with WAST in relation to patient pathways is ongoing.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient: Flow - a journey through the stroke pathway	Welsh Government should work collaboratively with WAST, health boards and social care providers to evaluate and strengthen the current processes in place to improve flow through health and care systems, with a concerted focus on the analysis of flow, the bottlenecks impeding flow and the issues with achieving timely discharge.	Healthcare Inspectorate Wales (HIW)/2023/155/MD14/1	This action remains ongoing as stroke and flow performance indicators continue to form part of regular performance meetings with Welsh Government, resulting in scrutiny and discussion. In addition, CTM UHB is working with the NHS Wales Executive Performance and Assurance Directorate regarding stroke performance and the nation review of self-presenters. Recently reviewed data (as per below "table removed for AMAT purposes"), shows a decrease in patients self-presenting to CTM for Stroke, which in theory should enable a more efficient stroke pathway across PoW and PCH where we have stroke provision.	Unscheduled Care	01.10.2024	01.10.2024	Overdue	October 2024 update - No update against this recommendation action has been received on this occasion. August 2024 Update - This action remains ongoing as stroke and flow performance indicators continue to form part of regular performance meetings with Welsh Government, resulting in scrutiny and discussion. In addition, CTM UHB is working with the NHS Wales Executive Performance and Assurance Directorate regarding stroke performance and the nation review of self-presenters. Recently reviewed data (as per below "table removed for AMAT purposes"), shows a decrease in patients self-presenting to CTM for Stroke, which in theory should enable a more efficient stroke pathway across PoW and PCH where we have stroke provision.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient: Flow - a journey through the stroke pathway	Health boards must ensure that ED staff undertake the triage of patients within the 15 minute target time. Where this has not been possible, it should be clearly documented 'why not' within the patient's clinical record.	Healthcare Inspectorate Wales (HIW)/2023/155/MD15/1	Triage within 15 minutes is a national tier one target and quality metric that we always strive to achieve. If not possible, additional resource is allocated to mitigate where possible. Any delays in triage is captured via ED huddles and site management patient safety reports, which are escalated to the Flow Manager of the day and the Escal call to explore mitigation and actions to reduce any delays. Implementation of e-triage will minimise delays as patients will self-triage and be clinically prioritised following this. If triage times are starting to escalate then additional nursing resource is allocated to support.	Unscheduled Care	01.10.2024	01.10.2024	Overdue	October 2024 update - No update against this recommendation action has been received on this occasion. August 2024 Update - Triage within 15 minutes is a national tier one target and quality metric that we always strive to achieve. If not possible, additional resource is allocated to mitigate where possible. Any delays in triage is captured via ED huddles and site management patient safety reports, which are escalated to the Flow Manager of the day and the Escal call to explore mitigations and actions to reduce any delays. Implementation of e-triage will minimise delays as patients will self-triage and be clinically prioritised following this. If triage times are starting to escalate then additional nursing resource is allocated to support.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient: Flow - a journey through the stroke pathway	Health boards must ensure that medical staff who carry the beep for stroke alerts recognise the urgency of both thrombolysis and non-thrombolysis stroke calls. A patient may still be symptomatic whilst out of the thrombolysis window but may still be within the thrombectomy time frame. This is particularly important if a referral tertiary centre is relatively close to the ED.	Healthcare Inspectorate Wales (HIW)/2023/155/MD16/1	Significant work is ongoing within CTM UHB to review the clinical workforce required to review stroke patients within the ED. Work continues to ensure we have the right workforce with the right skills and attributes to support early recognition and treatment of stroke. Patients eligible for thrombectomy are described in the thrombectomy pathway, which forms part of teaching given to junior doctors and the stroke CNS team who carry the beep for stroke alerts. The Unscheduled Care Group have developed a case for change to create additional ACP capacity to support urgent stroke alerts and more timely progress through the stroke pathway.	Unscheduled Care	01.01.2025	01.01.2025	In progress	October 2024 update - No update against this recommendation action has been received on this occasion. August 2024 Update - Case submitted to Board in January 2024 and rejected - Significant work is ongoing within CTM UHB to review the clinical workforce required to review stroke patients within the ED. Work continues to ensure we have the right workforce with the right skills and attributes to support early recognition and treatment of stroke. Patients eligible for thrombectomy are described in the thrombectomy pathway, which forms part of teaching given to junior doctors and the stroke CNS team who carry the beep for stroke alerts. The Unscheduled Care Group have developed a case for change to create additional ACP capacity to support urgent stroke alerts and more timely progress through the stroke pathway.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient: Flow - a journey through the stroke pathway	Health boards should review the provision of the CNS or AMP stroke specialist service at each acute site and consider how they can maximise their availability throughout the stroke service.	Healthcare Inspectorate Wales (HIW)/2023/155/MD17/1	Within CTM, a review of the CNS Stroke workforce has been undertaken with recommendations made to significantly increase the workforce but it is recognised that this requires significant additional resource. This paper has been refreshed to allow ACP workforce over extended hours to support early recognition and treatment of stroke patients. Ongoing workforce modernisation is underway to ensure we have the right workforce with the right skills and attributes looking after our patients.	Unscheduled Care	01.01.2025	01.01.2025	In progress	October 2024 update - No update against this recommendation action has been received on this occasion. August 2024 Update - case submitted to board in January 2024 - Within CTM, a review of the CNS Stroke workforce has been undertaken with recommendations made to significantly increase the workforce but it is recognised that this requires significant additional resource. This paper has been refreshed to develop an ACP workforce over extended hours to support early recognition and treatment of stroke patients. Ongoing workforce modernisation is underway to ensure we have the right workforce with the right skills and attributes looking after our patients.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient: Flow - a journey through the stroke pathway	Health boards should ensure that EDs track and monitor all patients arriving at hospital with a suspected stroke (by ambulance and self-presenting), to drive improvement on assessment times, so people can commence on the stroke pathway in a timely manner.	Healthcare Inspectorate Wales (HIW)/2023/155/MD18/1	Work is underway to develop a patient alert system embedded in the Electronic White Board that will allow stroke wards to track and monitor suspected stroke patients from the Emergency Department. This is in an early development phase and development and progress is monitored via the 6 Goals Programme Board.	Unscheduled Care	01.01.2025	01.01.2025	In progress	October 2024 update - No update against this recommendation action has been received on this occasion. August 2024 Update - remains ongoing with digital team - Work is underway to develop a patient alert system embedded in the Electronic White Board that will allow stroke wards to track and monitor suspected stroke patients from the Emergency Department. This is in an early development phase and development and progress is monitored via the 6 Goals Programme Board.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient: Flow - a journey through the stroke pathway	Health boards must ensure that all relevant staff within EDs are trained and are competent to use the ROSIER assessment tool. In addition, that staff are consistently using a validated tool, such as ROSIER, to enable prompt differentiation with strokes or stroke mimics, such as TIA.	Healthcare Inspectorate Wales (HIW)/2023/155/MD19/1	Work is ongoing within the USC Group to streamline processes and ensure the domains of quality are met across the organisation, with a focus on equity of treatment and patient outcomes. There is a case being developed to ensure compliance with the ROSIER assessment tool. This will ensure compliance with the ROSIER assessment tool.	Unscheduled Care	01.10.2024	31.03.2025	In progress	October 2024 update - No update against this recommendation action has been received on this occasion. August 2024 Update - This remains a priority - Work is ongoing within the USC Group to streamline processes and ensure the domains of quality are met across the organisation, with a focus on equity of treatment and patient outcomes. There is a comprehensive stroke pathway that are working to replicate on other sites working in collaboration with stroke teams and other relevant stakeholders to support standardisation where possible to ensure compliance with the ROSIER assessment tool.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient: Flow - a journey through the stroke pathway	Health boards must ensure that ED staff fully and clearly complete the clinical diagnostic assessment tool for stroke	Healthcare Inspectorate Wales (HIW)/2023/155/MD20/1	As part of ongoing work within the USC Group, actions are being developed to streamline processes and ensure the domains of quality are consistently met, with a focus on equity of treatment and patient outcomes. There is a comprehensive stroke pathway that are working to replicate on other sites working in collaboration with stroke teams and other relevant stakeholders to support standardisation where possible to ensure compliance with the ROSIER assessment tool.	Unscheduled Care	01.10.2024	31.03.2025	In progress	October 2024 update - No update against this recommendation action has been received on this occasion. August 2024 Update - USC Care Group continue to work towards equity across our sites and this forms part of stroke programme board discussions.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient: Flow - a journey through the stroke pathway	Health boards must ensure that the reason for delayed brain imaging is monitored and analysed for possible stroke patients to ensure scans are completed in a timely manner in line with NICE guidance.	Healthcare Inspectorate Wales (HIW)/2023/155/MD21/1	The work of the CTM UHB Stroke Operational Group is ongoing in its analysis of the stroke pathway through from arrival at hospital front door to discharge. All branches are reviewed to identify learning and any associated actions. The work of the group will include implementation of processes to monitor delays in the pathway for scans and actions to address.	Unscheduled Care	01.01.2024	01.01.2024	Overdue	October 2024 update - No update against this recommendation action has been received on this occasion. August 2024 Update - This work is continuous - The work of the CTM UHB Stroke Operational Group is ongoing in its analysis of the stroke pathway through from arrival at hospital front door to discharge. All branches are reviewed to identify learning and any associated actions. The work of the group will include implementation of processes to monitor delays in the pathway for scans and actions to address.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient: Flow - a journey through the stroke pathway	Health boards must ensure that all possible stroke patients who are clinically appropriate for thrombolysis, receive treatment in a timely manner.	Healthcare Inspectorate Wales (HIW)/2023/155/MD22/1	Within CTM UHB stroke pathway, all patients presenting inside of the thrombolysis window (Code 1 stroke) are to be reviewed by the medical registrar, Stroke CNS and Stroke Consultant on arrival. In hours, the target is to administer thrombolysis within the 45 minute guideline. There are delays out of hours due to waiting for Everlight to report CT scans. Work is ongoing to develop a more robust stroke Consultant rota with other Health Board colleagues and discussions are ongoing around resuming the regional Stroke Consultant rota. This would enable us to avoid Everlight delays by stat reporting by the stroke Consultants.	Unscheduled Care	01.10.2024	01.10.2024	Overdue	October 2024 update - No update against this recommendation action has been received on this occasion. August 2024 Update - USC Care Group continue to explore regional solutions however this remains multifaceted and complex - Within CTM UHB stroke pathway, all patients presenting inside of the thrombolysis window (Code 1 stroke) are to be reviewed by the medical registrar, Stroke CNS and Stroke Consultant on arrival. In hours, the target is to administer thrombolysis within the 45 minute guideline. There are delays out of hours due to waiting for Everlight to report CT scans. Work is ongoing to develop a more robust stroke Consultant rota with other Health Board colleagues and discussions are ongoing around resuming the regional Stroke Consultant rota. This would enable us to avoid Everlight delays by stat reporting by the stroke Consultants.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient: Flow - a journey through the stroke pathway	Health boards must explore the options available to improve the process for prioritising stroke patient admissions to acute stroke wards within the four-hour target, to help maximise their clinical outcome.	Healthcare Inspectorate Wales (HIW)/2023/155/MD23/1	As part of the Stroke Programme Board/Stroke Operational Group, there is ongoing transformation work around patient flow and prioritisation of stroke patients to meet the 4 hour target. This is a key improvement metric within CTM UHB and work will continue around exploring more extensive ring-fencing of beds, early identification, and pull of patients from the Emergency Department. This work needs to be supported by workforce modernisation, digital enablers and resource allocation. A task and finish group has delivered a single pathway for patients self-presenting at HGH to transfer to the Stroke unit at PCH this is continuously monitored and reviewed as required.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	October 2024 update - No update against this recommendation action has been received on this occasion. August 2024 Update - This work is ongoing as well as a focus as part of the recent 'reset forthright' - As part of the Stroke Programme Board/Stroke Operational Group, there is ongoing transformation work around patient flow and prioritisation of stroke patients to meet the 4 hour target. This is a key improvement metric within CTM UHB and work will continue around exploring more extensive ring-fencing of beds, early identification, and pull of patients from the Emergency Department. This work needs to be supported by workforce modernisation, digital enablers and resource allocation. A task and finish group has delivered a single pathway for patients self-presenting at HGH to transfer to the Stroke unit at PCH this is continuously monitored and reviewed as required.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient: Flow - a journey through the stroke pathway	Ring fenced stroke beds are frequently used for non-stroke patients, which may impact on a new stroke admission to ED. Therefore, health boards must explore how a ring fenced stroke bed can be maintained, to help ensure the best outcome for a stroke patient following their arrival at ED.	Healthcare Inspectorate Wales (HIW)/2023/155/MD29/1	As above, this continues to be a priority for CTM UHB, with non-stroke patients identified via a ward/board round, inputted into the electronic white board, and moved to the appropriate inpatient area. Ring-fenced capacity is identified at the twice daily cross site bed meetings and forms part of the out of hours and weekend planning cycle of the HB. Work is underway to better understand the risks/benefits of more extensive ring-fencing of stroke beds.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	October 2024 update - No update against this recommendation action has been received on this occasion. August 2024 Update - This continues to be a priority - As above, this continues to be a priority for CTM UHB, with non-stroke patients identified via a ward/board round, inputted into the electronic white board, and moved to the appropriate inpatient area. Ring-fenced capacity is identified at the twice daily cross site bed meetings and forms part of the out of hours and weekend planning cycle of the HB. Work is underway to better understand the risks/benefits of more extensive ring-fencing of stroke beds.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient: Flow - a journey through the stroke pathway	Health boards must review their therapies staffing models to ensure there are sufficient resources and staff in place to adequately manage the rehabilitation and recovery of stroke patients in line with NICE guidance.	Healthcare Inspectorate Wales (HIW)/2023/155/MD31/1	Current therapies workforce data is being captured, with a review of therapy workforce provision to explore the best models for therapy provision. This is linked to recommendation 38 regarding need for funded 7 day service. In order to achieved this, a case for resource to expand ESD is being developed.	Unscheduled Care	01.01.2024	01.01.2024	Overdue	October 2024 update - No update against this recommendation action has been received on this occasion. August 2024 Update - Current therapies workforce data is being captured, with a review of therapy workforce provision to explore the best models for therapy provision. This is linked to recommendation 38 regarding need for funded 7 day service. In order to achieved this, a case for resource to expand ESD is being developed.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient: Flow - a journey through the stroke pathway	Health boards must consider the need for psychological support for people with stroke, and that adequately trained staff can provide this support to help effectively manage patient recovery.	Healthcare Inspectorate Wales (HIW)/2023/155/MD32/1	This service is fragile in CTM UHB and historical funding was for the north of the CTM footprint only, excluding Bridgend. The national withdrawal of the funding for the Community Neurorehabilitation service combined with maternity leave for a senior psychologist has led to the temporary cessation of the neuropsychology service to ESD patients within CTM. The Health Board remains committed to the ongoing development of the stroke pathway and consideration will be given to this aspect of the service as part of any redeployment/investment opportunities.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	October 2024 update - No update against this recommendation action has been received on this occasion. August 2024 Update - This remains ongoing - This service is fragile in CTM UHB and historical funding was for the north of the CTM footprint only, excluding Bridgend. The national withdrawal of the funding for the Community Neurorehabilitation service combined with maternity leave for a senior psychologist has led to the temporary cessation of the neuropsychology service to ESD patients within CTM. The Health Board remains committed to the ongoing development of the stroke pathway and consideration will be given to this aspect of the service as part of any redeployment/investment opportunities.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient: Flow - a journey through the stroke pathway	Health boards must consider introducing the provision of sufficient seven-day therapies services to comply with NICE guidance, to help improve patient flow by supporting a seven-day discharge for patients, and to help meet targets as highlighted within SNAAP.	Healthcare Inspectorate Wales (HIW)/2023/155/MD33/1	CTM UHB currently offers a 5 day clinical model. A 7 day clinical model remains the ambition for the health board but requires identification of significant financial resource. This is linked to the response to recommendation 36. The Health Board remains committed to the ongoing development of the stroke pathway and consideration will be given to this aspect of the service as part of any redeployment/investment opportunities.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	October 2024 update - No update against this recommendation action has been received on this occasion. August 2024 Update - This remains ongoing - CTM UHB currently offers a 5 day clinical model. A 7 day clinical model remains the ambition for the health board but requires identification of significant financial resource. This is linked to the response to recommendation 36. The Health Board remains committed to the ongoing development of the stroke pathway and consideration will be given to this aspect of the service as part of any redeployment/investment opportunities.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient: Flow - a journey through the stroke pathway	Health boards must ensure that stroke rehabilitation environments are appropriate and are adequate to meet the needs of patients.	Healthcare Inspectorate Wales (HIW)/2023/155/MD34/1	Risk assessments have been submitted as part of the Health Board stroke action plan. Current rehabilitation space is sub-optimal and review of the stroke pathway includes detailed consideration of the environment and we are actively exploring options to address this. This action has been recognised as a risk and is regularly reviewed.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	October 2024 update - No update against this recommendation action has been received on this occasion. August 2024 Update - we continue to review this as a risk - Risk assessments have been submitted as part of the Health Board stroke action plan. Current rehabilitation space is sub-optimal and review of the stroke pathway includes detailed consideration of the environment and we are actively exploring options to address this. This action has been recognised as a risk and is regularly reviewed.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient: Flow - a journey through the stroke pathway	Health boards must work collaboratively with social workers and social care providers to ensure that delays in arranging or holding Best Interest Meetings are minimised, to ensure timely and effective hospital discharge for patients to improve flow.	Healthcare Inspectorate Wales (HIW)/2023/155/MD39/1	As part of the DORA improvement programme, a task and finish group was set up to improve delays in the overall Mental Capacity Act process, including Best Interest Meetings and associated Court of Protection proceedings. A training programme has been rolled out across social care and the Health Board. Delays are monitored through FIMB and escalated as previously outlined. Timescales have been collaboratively agreed across health and social care of a 21 day maximum assessment period for Pathway 3 patients, which include MCA processes.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	October 2024 update - No update against this recommendation action has been received on this occasion. August 2024 Update - significant work ongoing under the optimise project to address MCA challenges with supported intervention from Head of nursing to maintain training and standards on other sites.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient: Flow - a journey through the stroke pathway	Health boards must develop and strengthen Home First services and social care to benefit the people who need this across Wales, and to help manage the issues with patient flow through health and social care systems.	Healthcare Inspectorate Wales (HIW)/2023/155/MD40/1	Implementation of DORA in CTM UHB has widely promoted the increase of Home First pathways. Awareness and engagement sessions have been held with nearly 500 staff. Key questions to increase uptake for Pathway 1 are included on board round guidance as well as guidance on selection of pathway. We continue to monitor the volume of Home First pathways, with a balance to bed board pathways with the trend shown below "table removed for AMAT purposes".	Unscheduled Care	01.04.2024	01.04.2024	Overdue	October 2024 update - No update against this recommendation action has been received on this occasion. August 2024 Update - This is ongoing - Implementation of DORA in CTM UHB has widely promoted the increase of Home First pathways. Awareness and engagement sessions have been held with nearly 500 staff. Key questions to increase uptake for Pathway 1 are included on board round guidance as well as guidance on selection of pathway. We continue to monitor the volume of Home First pathways, with a balance to bed board pathways with the trend shown below "table removed for AMAT purposes".
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient: Flow - a journey through the stroke pathway	Welsh Government, health boards and local authorities must work collaboratively to consider the options of improving the accessibility to care in the community, such as domiciliary care.	Healthcare Inspectorate Wales (HIW)/2023/155/MD41/1	A targeted improvement plan has been created through the Integrated Discharge Delivery Board that also reports directly in the GGLUEC board, the Integrated Adults and then into the Regional Partnership Board. Specific improvement has been identified for accessibility for intermediate care, domiciliary care and care homes. This action plan escalates activity highlighted through the market stability statement published by the region.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	October 2024 update - No update against this recommendation action has been received on this occasion. August 2024 Update - This is ongoing but being prioritised - "A targeted improvement plan has been created through the Integrated Discharge Delivery Board that also reports directly in the GGLUEC board, the Integrated Adults and then into the Regional Partnership Board. Specific improvement has been identified for accessibility for intermediate care, domiciliary care and care homes. This action plan escalates activity highlighted through the market stability statement published by the region.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient: Flow - a journey through the stroke pathway	A PaCD action plan addressing community delays has been collaboratively agreed with all partners. A work programme in line with WG guidance for Enhanced Community Care has been set up under an Integrated Director.	Healthcare Inspectorate Wales (HIW)/2023/155/MD42/1	The USC group continue to review inpatient bed base and patient flow to better understand the requirement for discharge lounges. Planned/predicted discharges are identified through the cross site bed meetings, in addition they form part of the out of hours and weekend planning cycle. There is a discharge lounge in place in POW and we are exploring the feasibility of further discharge lounges on the other two sites, recognising that capital and revenue investment would be required.	Unscheduled Care	01.01.2024	01.01.2024	Overdue	October 2024 update - No update against this recommendation action has been received on this occasion. August 2024 Update - This remains ongoing and requires capital funds - The USC group continue to review inpatient bed base and patient flow to better understand the requirement for discharge lounges. Planned/predicted discharges are identified through the cross site bed meetings, in addition they form part of the out of hours and weekend planning cycle. There is a discharge lounge in place in POW and we are exploring the feasibility of further discharge lounges on the other two sites, recognising that capital and revenue investment would be required.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient: Flow - a journey through the stroke pathway	Health board must identify the hospital sites that do not have a discharge lounge service and should consider the benefits of implementing this service on improving patient care.	Healthcare Inspectorate Wales (HIW)/2023/155/MD43/1	As above, the USC group continue to review inpatient bed base and patient flow to better understand the requirement for discharge lounges across our sites. Planned/predicted discharges are identified through the cross site bed meetings and form part of the out of hours and weekend planning cycle. There is a discharge lounge in place in POW and we are exploring the feasibility of further discharge lounges on the other two sites, recognising that capital and revenue investment would be required.	Unscheduled Care	01.01.2024	01.01.2024	Overdue	October 2024 update - No update against this recommendation action has been received on this occasion. August 2024 Update - As above, the USC group continue to review inpatient bed base and patient flow to better understand the requirement for discharge lounges across our sites. Planned/predicted discharges are identified through the cross site bed meetings and form part of the out of hours and weekend planning cycle. There is a discharge lounge in place in POW and we are exploring the feasibility of further discharge lounges on the other two sites, recognising that capital and revenue investment would be required.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient: Flow - a journey through the stroke pathway	Health boards must assure themselves that ward staff are promptly declaring a fully completed patient discharge within the electronic patient systems once they have left the ward. This is to enable patient flow managers to see that a bed is become available, to help manage timely patient flow.	Healthcare Inspectorate Wales (HIW)/2023/155/MD44/1	The electronic Whiteboard developed under the 6 Goals programme allows the site management team to see when a discharge has completed. As part of ongoing improvement to the system, there is an ambition for future versions to include a 'push report' that would notify the site team that a patient has been discharged.	Unscheduled Care	01.10.2024	01.10.2024	Overdue	October 2024 update - No update against this recommendation action has been received on this occasion. August 2024 Update - This work is ongoing with digital colleagues - The electronic Whiteboard developed under the 6 Goals programme allows the site management team to see when a discharge has completed. As part of ongoing improvement to the system, there is an ambition for future versions to include a 'push report' that would notify the site team that a patient has been discharged.
Healthcare Inspectorate Wales (HIW)/2023/156	25.09.2023	Hospital Inspection Report (Unannounced) Paediatric Ward, Princess of Wales Hospital (Appendix C - Princess of Wales Hospital, Paediatric Ward 25 & 26 September 2023 (Ref: 03451))	The health board should display information on healthy eating and smoking cessation.	Healthcare Inspectorate Wales (HIW)/2023/156/MD2/1	Health promotion board on display on Childrens ward. Healthy diet and smoking risks, with signposting for additional advice and support will be added to the health promotion board.	Children & Families	31.12.2023	31.08.2024	Overdue	October 2024 update - No update against this recommendation action has been received on this occasion. August 2024 Update - refurbishment of area now complete. Awaiting display boards and once in situ this action will be completed. May 2024 Update - The above iteration was actioned December 2023 - However the childrens ward is currently undergoing refurbishment of the painting and decorating in the area new display boards are being purchased and the Health promotion elements of the action will be a priority on completion of the estates works. New timescales added.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angellion Clinic, Glanrhydd Hospital (Ref: 03445)	The hospital communal gardens areas must be tidied and maintained to provide a more pleasant and appealing environment for patients.	Healthcare Inspectorate Wales (HIW)/2023/157/MSU/1	The facilities department have a schedule for garden maintenance works within Angellion Clinic. This will be carried out in the Spring where plants and bulbs will be planted. The Angellion team have also been working closely with the third sector organisation Mental Health Matters who have and will continue to support the maintenance and gardening. This will also provide an opportunity for the patients to be involved in a therapeutic activity.	Mental Health & Learning Disabilities	01.04.2024	01.04.2024	Fully complete (awaiting approval)	December 2023 Update - In progress 12/12/23 - Doctors have been assigned poster presentation for health promotion. Nursing staff completed this action Dec 2023. Health promotion boards on smoking cessation and health actions contained on the health promotion board 21.2.2024 October 2024 Update - QSRF date of approval June 2024. Proposed for Closure November 2024 August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QSRF meeting. Action updated as at May 2024 - Completed 30/05/2024, see Appendix 8
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angellion Clinic, Glanrhydd Hospital (Ref: 03445)	The health board should ensure the provision of gym and exercise equipment to support patient health promotion and improvement.	Healthcare Inspectorate Wales (HIW)/2023/157/MSU/1	Angellion Clinic has a dedicated Physiotherapist. We have identified an area within Angellion Clinic to be used to support physical exercise, patient health and promotion. Appropriate equipment has been identified and is in place.	Mental Health & Learning Disabilities	28.12.2023	28.12.2023	Fully complete (awaiting approval) - Further Evidence Awaited	October 2024 update - No update against this recommendation action has been received on this occasion. August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QSRF meeting. Completed 28/12/2023 See Appendix 2
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angellion Clinic, Glanrhydd Hospital (Ref: 03445)	The health board should consider reinstating the hospital's dedicated wheelchair accessible vehicle to promote timely patient care.	Healthcare Inspectorate Wales (HIW)/2023/157/MSU/1	Angellion Clinic has always had access to a wheelchair accessible vehicle however unfortunately it was involved in an accident and wasn't repairable, a replacement is on order.	Mental Health & Learning Disabilities	28.12.2023	28.12.2023	Fully complete (awaiting approval) - Further Evidence Awaited	October 2024 update - No update against this recommendation action has been received on this occasion. August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QSRF meeting. Completed 28/12/2023 See Appendix 2

Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angellton Clinic, Glanrhyd Hospital (Ref: 03445)	The health board must undertake measures to improve mandatory Welsh language training compliance.	Healthcare Inspectorate Wales (HIW)/2023/157/MC4/1	Welsh Language Awareness training levels to reach a minimum of 85% whilst working toward 100% Ward 1 is currently 100% Ward 2 is currently 78.5%	Mental Health & Learning Disabilities	01.01.2024	01.01.2024	Fully complete (Awaiting approval) - Further Evidence Awaited	October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QSR meeting. April 2024 Update - Ward 1= 92% Ward 2=91.18% Previous Update - In Progress Estimated date for completion January 2024 See Appendix 4
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angellton Clinic, Glanrhyd Hospital (Ref: 03445)	The health board must ensure that hospital systems and processes can be suitably filtered to extract ward specific data to support effective supervision, governance oversight and shared learning.	Healthcare Inspectorate Wales (HIW)/2023/158/MC24/1	The incident management system Datix Cloud IQ can be filtered down to show specific data relating to areas, incident type and severity. The Head of Nursing is working with the Patient Care and Safety Business Intelligence officer to ensure all Lead Nurse, Senior Nurse and ward Managers have access to and training on Datix dashboards.	Mental Health & Learning Disabilities	31.01.2024	10.07.2024	Overdue	October 2024 Update - Requiring updates to national system. August 2024 Update - The HnN is working with the Business Intelligence Manager in the Patient Care and Safety team on the development of a Quality Dashboard, the mapping of the new Care Group structure is complete and we are awaiting implementation. June 2024 Update - Working with Corporate and Patient Care Safety to align DATIX to new structure. Action updated as at May 2024 - Update 10/05/2024 The Head of Nursing continues to work with the Datix team regarding this action. The new care group structures have created some delay. Revised completion date set for 10/07/2024. April 2024 Update - In progress. Work is ongoing between the head of nursing and the Datix team. Previous Update - In Progress Due for completion end of Jan 2024
Healthcare Inspectorate Wales (HIW)/2023/158	20.11.2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board should review the shared bedrooms and consider updating the rooms to allow patients the privacy of their own room.	Healthcare Inspectorate Wales (HIW)/2023/158/MD1/1	The Health Board has reviewed the current ward environment. With consideration of the ward footprint, clinical need and bed capacity within the Adult Mental Health Directorate it is not possible at present to provide a fully single bedroom inpatient provision. To mitigate potential impact of the present arrangements the nursing teams ensure that all shared rooms are single sex, with identified curtained private space for each person. The specific need for single rooms is identified at point of admission/assessment, with consideration of individual need i.e., gender, sexual orientation, or physical need/risk, and care plan developed as required. The nursing team identify patients who wish to have shared rooms e.g. for company. If requested, an individual room will be provided when available and if there is no other	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval) - Further Evidence Awaited	October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QSR meeting. Completed
Healthcare Inspectorate Wales (HIW)/2023/158	20.11.2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board should consider the gender balance of staff and ensure that there are enough male staff present on each shift.	Healthcare Inspectorate Wales (HIW)/2023/158/MD1/1	The Health Board undertakes a fair and equitable recruitment process, in order to ensure that all staff are employed based on the qualities, values, skills and the experience they demonstrate during recruitment. It is, of course, not lawful to discriminate or make such decisions based on gender. The Royal Glamorgan Hospital (RGH) Senior Nursing team work across adult and older persons wards and will support each ward to ensure that there is an optimal skill, and when possible, gender mix. All shift requirements are monitored at the daily staffing "huddle" to identify particular issues and ensure that safety needs are adequately met i.e. that there are adequate Prevention and Management of Violence and Aggression (PMVA) trained staff on shift. Daily Huddle Documentation; Evidence 1 There is opportunity to alter staff skill and when necessary, gender mix to address needs of an individual e.g. if patient is sexually disturbed or targeting staff due to gender, in extremes the Senior Nursing team can call on staff from across the care group i.e. Princess of Wales and CAMHS Mental Health wards, and there have been examples of	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval) - Further Evidence Awaited	October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QSR meeting. Completed
Healthcare Inspectorate Wales (HIW)/2023/158	20.11.2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board must ensure a more robust application of the health boards no smoking policy and the framework supporting it.	Healthcare Inspectorate Wales (HIW)/2023/158/MD3/1	It is a priority of the Health Board to support the communities we work with to make positive decisions about their health, and we maintain a commitment to support all patients and staff to give up smoking. Since the "Smoke-free Premises and Vehicles (Wales) Regulations 2020" came into force in the Mental Health Unit (MHU) in September 2022, smoking on there has been prohibited. Following implementation, the significant challenges this presented to individuals who found smoking cessation measures to be ineffective or unwelcome were noted, and after discussion with staff and patients the Mental Health Smoking Cessation group agreed that in the RGH MHU unit we would create small designated outside smoking areas for restricted use. This seemed to be well received by the patient group, but following an anonymous concern being raised with the Health Inspectorate Wales in summer 2023, this arrangement was halted while the measures were reviewed. Following presentation of a mitigating paper to the Health Board Executive Leadership Group, a "Derogation in compliance" was agreed for a period of six months while the Mental Health Care Group develop options for a permanent solution across all Mental Health sites. It is recognised by the Health Board that this temporarily contravenes the Smoke-free Premises and Vehicles (Wales) Regulations 2020. Mental Health Directorate Smoking Mitigation Paper; Evidence 1.1 Practically, on the RGH MHU, this means that there is an availability of managed smoking sessions at designated times in a space within the footprint of the MHU on the patio/terrace directly off the ward corridor. This an arrangement that is clearly documented within the care plan of all patients who identify this as being their wish following smoking cessation assessment. The conditions and restrictions of the designated smoking area are made clear to all patients and signposted across the wards. Ash trays are being purchased for designated smoking area, there is a bin currently in place as an alternative. Patio Photos; Evidence 2 Patio Photos; Evidence 3	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval) - Further Evidence Awaited	October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QSR meeting. Completed
Healthcare Inspectorate Wales (HIW)/2023/158	20.11.2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board must ensure that a full review is undertaken on the appropriateness and reliability of the current personal alarm systems used.	Healthcare Inspectorate Wales (HIW)/2023/158/MD5/1	There is ongoing discussion within the patient community groups around smoking arrangements and support for the patient groups of self-regulation of cleanliness of such. At time of the HW inspection (November 2023) there was an Standard Operating Procedure (SOP) in place that directed that a dual personal alarm system was in place on the RGH MHU for all clinical staff. This was due to a recent increase in the frequency of incidents whereby the panic alarm failed to activate when tested. MHU Dual Alarm SOP; Evidence 6 A full diagnostic review of the "all call" system was undertaken in November 2023, with the system noted to be returned to a serviceable and operational state. This issue however remains on the Directorate Risk Register for the immediate future and incidents of alarm failure will be reviewed and reported via the Datix system. The SOP also remains in place on the MHU. A review of any action failures will be undertaken by the MHU Inpatient Senior Nurse and Assistant Directorate Manager for inpatient services for discussion at Directorate Quality Safety Risk and Experience meeting (QSR) in June 2024. Subsequently a decision will be made by the Adult Mental Health Senior Leadership Team as to whether the Safe System of working for a dual alarm system can be stepped	Mental Health & Learning Disabilities	30.06.2024	30.06.2024	Overdue	October 2024 Update - Completed, approved in QSR. Evidence to follow. August 2024 Update - Update requested. June 2024 Update - Update due in August 2024.
Healthcare Inspectorate Wales (HIW)/2023/158	20.11.2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board must address the environmental issues and resolve them in a prompt and timely manner.	Healthcare Inspectorate Wales (HIW)/2023/158/MD6/1	The ward 22 damaged chair, with exposed foam filling which is not compliant with the relevant legislation has been condemned and removed with a temporary replacement now in place. A specialist furniture manufacturer has provided a quotation for new seating within the interview room and a Statement of Need submitted. Ward 22 Interview Room Photo; Evidence 7 Psychiatric Intensive Care Unit (PICU) missing ceiling tiles have now been replaced. PICU Ceiling Photo; Evidence 8 Water damaged ceiling tiles in the Ward 22 office have all been replaced. There remain 6 water damaged tiles between the lounge & dining room awaiting replacement which have been logged with Estates Department. These have been prioritised by Estates as non-urgent, as they are considered decorative rather than safety sensitive, and the progress on replacement is monitored weekly by the Inpatient Deputy Directorate manager Ward 22 Ceiling Photo; Evidence 9 Ward 22 Ceiling Photo; Evidence 10 After consultation with a specialist furniture manufacturer the Inpatient Senior Nurse confirmed the suitability of the dining chairs currently in place in Ward 22. The dining room chairs are multipurpose and need to be moved between dining room and lounge for group discussions/activities and therefore need to be of a manageable weight. The Adult Mental Health Senior Leadership Team acknowledged that the weight of the current chair would allow them to be picked up and potentially brandished as a weapon, however this risk would not be completely eradicated unless the chairs were of a weight that would disadvantage patients with mobility restrictions and potentially increase risk of injury to staff when moving for cleaning purposes. The nursing team mitigate risk of furniture being used in this way through individual risk assessment and maintaining observation of these areas when in use. Ward 21 bedroom rails and privacy curtains have been replaced. Ward 21 Curtain Photo; Evidence 11 There are long standing difficulties with inadequacy of wastewater/ sewage capacity within the RGH MHU site. As a result, the PICU Extra Care Area (ECA) utilises a Sani flo macerator system to move waste from ECA to the main sewage system. This can result in issues when foreign objects are placed in toilet in ECA. Groundwork investigations report that a permanent solution to connect ECA to main sewage system would require extensive excavation works with significant capital spend	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval) - Further Evidence Awaited	October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QSR meeting. Completed
Healthcare Inspectorate Wales (HIW)/2023/158	20.11.2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board must ensure that COSHH equipment is stored correctly.	Healthcare Inspectorate Wales (HIW)/2023/158/MD7/1	All wards on the MHU have flammable lockers where all laundry detergents are stored. It is the responsibility of all Health Board staff to be aware of and undertake their responsibilities when using COSHH materials. The Inpatient Senior Nurse has emailed a reminder to all staff including HCSW about COSHH and requirement re storage. Standards for storage of COSHH materials; Evidence 13 Checks on the environment are undertaken by ward managers as part of weekly environmental checks (Ward Managers Assurance Audit) and matters of concern addressed Following the HW Review in November 2023, all medication cabinets across the MHU were inspected and no further out of date medications were found.	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval) - Further Evidence Awaited	October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QSR meeting. Completed
Healthcare Inspectorate Wales (HIW)/2023/158	20.11.2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board must ensure that out of date medication is disposed of appropriately.	Healthcare Inspectorate Wales (HIW)/2023/158/MD8/1	Review of all medication dates and returns to pharmacy is monitored through the "Ward Managers Assurance Audit" which is undertaken weekly and monitored by the Inpatient Senior Nurse. Ward Managers Assurance Audit; Evidence 14 The Mental Health Ward Assurance Group are undertaking a process of digitising this audit. The Inpatient Senior Nurse reports Audit outcomes to Directorate Quality Safety Risk and Experience meeting (QSR) which will enable the assurance group and action dates to be reviewed. Inpatient Senior Nurse and Mental Health pharmacist will revisit the role of pharmacist technician to ensure that review of MARS charts will be included in their routine checks. An email has been sent by the Clinical Director to all medical team to reaffirm the documentation standards required on clerking and renewing medication. A sample of MARS charts are reviewed through the "Ward Managers Assurance Audit" which is undertaken weekly and monitored by the Inpatient Senior Nurse. Ward Managers Assurance Audit; Evidence 15 The Mental Health Ward Assurance Group are undertaking a process of digitising this audit. The Inpatient Senior Nurse reports Audit outcomes to Directorate Quality Safety Risk and Experience meeting (QSR) which will enable the assurance group and action dates to be reviewed.	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval) - Further Evidence Awaited	October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QSR meeting. Completed
Healthcare Inspectorate Wales (HIW)/2023/158	20.11.2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board must ensure that MAR charts are fully completed.	Healthcare Inspectorate Wales (HIW)/2023/158/MD9/1	A sample of MARS charts are reviewed through the "Ward Managers Assurance Audit" which is undertaken weekly and monitored by the Inpatient Senior Nurse. Ward Managers Assurance Audit; Evidence 15 The Mental Health Ward Assurance Group are undertaking a process of digitising this audit. The Inpatient Senior Nurse reports Audit outcomes to Directorate Quality Safety Risk and Experience meeting (QSR) which will enable the assurance group and action dates to be reviewed.	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval) - Further Evidence Awaited	October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QSR meeting. Completed
Healthcare Inspectorate Wales (HIW)/2023/158	20.11.2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board must ensure that staff comply with the health board policies and guidance on safe and secure storage of medication trolleys and how they are stored on the wards and in clinical rooms.	Healthcare Inspectorate Wales (HIW)/2023/158/MD10/1	Reminder email from Senior Nurse reminding staff of agreed standard Safe Storage of medication; Evidence 16 Security arrangements of medication trolley are reviewed through the "Ward Managers Assurance Audit" which is undertaken monthly and monitored by the Inpatient Senior Nurse. The Mental Health Ward Assurance Group are undertaking a process of digitising this audit. The Inpatient Senior Nurse reports Audit outcomes to Directorate Quality Safety Risk and Experience meeting (QSR) which will enable the assurance group and action dates to be reviewed.	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval) - Further Evidence Awaited	October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QSR meeting. Completed
Healthcare Inspectorate Wales (HIW)/2023/158	20.11.2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board must ensure that there are more variety of choices for patients with specific dietary requirements.	Healthcare Inspectorate Wales (HIW)/2023/158/MD12/1	The Health Board Catering Service works with clinical teams to adapt the patient menus to patient specific requirements. The present patient menu changed in September 2023 to a two-week rolling menu which replaced an 'a la carte' style menu. The new menu was reviewed by the All Wales dieticians and assessed for compliance with the Catering and Nutrition Standards. The Inpatient Nursing team seek feedback from patients via the Inpatient Community Group and "Have Your Say" suggestion boxes (which are regularly monitored). This feedback informs discussions with the wider service i.e. Catering and outstanding issues can be escalated to the Adult Mental Health Senior Leadership Team. The Catering Service are undertaking a process of digitising this audit. The Inpatient Senior Nurse reports Audit outcomes to Directorate Quality Safety Risk and Experience meeting (QSR) which will enable the assurance group and action dates to be reviewed.	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval) - Further Evidence Awaited	October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QSR meeting. Completed
Healthcare Inspectorate Wales (HIW)/2023/158	20.11.2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board must review staffing levels to ensure they meet the demands of the patient group.	Healthcare Inspectorate Wales (HIW)/2023/158/MD15/1	The Mental Health Head of Nursing has recently concluded a thorough nursing establishment review that has considered levels of acuity and demand across the Mental Health Inpatient units. This review acknowledged the changing picture of inpatient work and environments since the last Mental Health Inpatient staffing review in 2017 and recognised the challenges of maintaining a motivated and engaged workforce when pressures within these clinical settings are increasing. Using principles drawn from All Wales Mental Health Workforce on the implementation of the Nurse Staffing Levels Act, the report makes recommendations about amendments to skill mix and enhancement of Nursing leadership roles the better to improve opportunities for recruitment and particularly staff retention. The Staffing review report will be presented to the Mental Health Nursing Workforce meeting on 25 January 2024, for consideration by Director of Nursing on subsequent actions. Considerations of staffing levels day to day are a core role of the Ward Managers and Senior Nurse, with all shift requirements monitored initially at the daily staffing "huddle" to identify particular issues and ensure that safety needs are adequately met i.e. that there are adequate staff on shift. Review of clinical need is a dynamic process that involves all members of the Nursing team, and staffing levels are increased in response to increased levels of acuity e.g. 1:1 patient observations to maintain safety or a need for intensive personal care. At this time, there is an organisational acknowledgement of the particular challenges to recruitment of unregistered nurses into Mental Health posts and as a result the Health Board embargo on the use of agency Health Care Support Workers, has been temporarily relaxed for the Mental Health Directorate. While there is a high degree of acuity around the use of staff in addition to substantive staff, with appropriate evidence and rationale in place, a request for additional bank	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval) - Further Evidence Awaited	October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QSR meeting. Completed

Healthcare Inspectorate Wales (HIW)/2023/158	20.11.2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 0344)	The health board must ensure that staff vacancies are filled, and future initiatives are explored to encourage recruitment into the hospital.	Healthcare Inspectorate Wales (HIW)/2023/158/MD16/1	Recruitment of band 5 registered nurses remains a challenge and the HB is taking steps to ensure that all vacancies are being filled. The recently completed nursing establishment review has been considered by the Care Group Senior Leadership Team who are currently exploring the financial implications and opportunities of the recommendations. The Head of Nursing is leading on the development of a recruitment and retention plan, which includes actions such as working closely with the local universities to maximise local resources, facilitating major construction works to remove and as part of this further applications for Welsh Government funding are being explored to support significant changes to the EU footprint. This will facilitate improved patient clinical areas allowing for improved patient and staff experience.	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (awaiting approval - Further Evidence Awaited)	October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLd are providing confirmation of the closure sign off at the relevant QSRK meeting.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with an update on the plans to reconfigure the EU footprint to address the environmental and operational challenges identified within the Ambulatory Care area.	Healthcare Inspectorate Wales (HIW)/2023/167/MD5/4		Unscheduled Care	01.06.2024	31.12.2024	In progress	October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - capital work ongoing - PCH is currently in the process of major construction works to remove and as part of this further applications for Welsh Government funding are being explored to support significant changes to the EU footprint. This will facilitate improved patient clinical areas allowing for improved patient and staff experience.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with an update on the plans to reconfigure the EU footprint to address the environmental and operational challenges identified within the Ambulatory Care area.	Healthcare Inspectorate Wales (HIW)/2023/167/MD5/6	CTM has implemented a pre-emptive transfer and boarding process to support patient flow, sharing the risk across inpatient areas allowing the de-escalation of risk held in ambulatory care. This reinforces that patient flow is a team approach across the site.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - work ongoing
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with an update on the plans to reconfigure the EU footprint to address the environmental and operational challenges identified within the Ambulatory Care area.	Healthcare Inspectorate Wales (HIW)/2023/167/MD5/7	We are awaiting capital works to progress to take down a wall partially of the large non-clinical area with the Ambulatory Care Area-this will facilitate improved observation of patients within the area to ensure patient care and safety.	Unscheduled Care	01.09.2023	01.09.2023	Overdue	Awaiting date from Welsh Government following a successful bid for funding. This will supply an extra toilet and showering facilities. October 2024 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with an update on the systems in place to improve patient flow through the ED.	Healthcare Inspectorate Wales (HIW)/2023/167/MD11/1	We are currently reviewing through large organisational change, the operational structures that will be key to patient flow and ensure senior leadership is present on site and can CTM Health Board. Through the 6 goals programme work we are progressing improved patient flow as this is a multi-professional/whole system approach involving our local Authority colleagues. The E White Board has been introduced across the organisation and this is key to patient flow and implementation of RedGreen as a quality metric for patient care. This will increase bed capacity through more efficient and sustainable processes where we explore value added time, measure internal and external delays and focus on marginal gains in length of stay. Consequently, this will improve flow through ED. As part of this work the senior team are also exploring the continuous flow model to review if this would be suitable for roll out across CTM. The ED Team use the Myrdyn IT system which is monitored by the responsible teams and reviewed as part of the ED Patient Safety Huddles. When it is identified that Triage Times are beginning to increase, there are internal escalation processes in place to ensure timely support and assessment of patients which additional staff being deployed to support. The ED Clinician Team will adopt a Rapid Assessment and Triage (RAT) model to support any delays in triage, hence there will be senior assessment and crowding at the front door of patients. EU has recently recruited 2.8 vte Patient Flow Coordinators to support timely patient flow and escalation of patient flow delays. The UIC group have developed updated Escalation Cards to support actions and provide assurances that ambulance delays are avoided. There are rigorous escalations in place, and when any patient is delayed over 4 hours an internal investigation is undertaken to provide	Unscheduled Care	01.03.2024	01.03.2024	Overdue	October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - part of ongoing capital plans - We are awaiting capital works to progress to take down a wall partially of the large non-clinical area with the Ambulatory Care Area-this will facilitate improved observation of patients within the area to ensure patient care and safety. This work continues to progress via the Optimise Project which formally reports into 6 goals programme board and onto NHS Executive colleagues.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to improve staff compliance with Departmental Fire Safety (ED) and Mental Capacity and DoLS (CDU) training.	Healthcare Inspectorate Wales (HIW)/2023/167/MD13/1	The Senior Nurse for Professional Education is key to progressing this agenda in EU and maintaining a database of training compliance and has developed a training needs analysis template. A plethora of study days, and protected study time for the inclusion of mandatory training and recovery of face to face study time has been provided. Ongoing training dates are in place with an improving picture which is monitored by the Nurse Director at bi-monthly workforce meeting. The Fire Officer has been undertaking bespoke training sessions for the PCH site weekly to improve compliance as part of the resetting post Covid-19 pandemic where training was unavailable as of Aug 23 fire training for staff is as follows: ED-RN 72.85% HC3W 84% CDU-RN 97.50% HC3W 58.33%	Unscheduled Care	01.04.2024	01.04.2024	Overdue	October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - There are monthly workforce meetings chaired by the director of nursing to review workforce metrics and as part of this training compliance is reviewed with all areas required to achieve 85% or above within the next 3 months. ED MCA now 77% and fire 85% Monthly training offered to staff for fire, Violence and Aggression and DoLS. Compliance with Fire training and Mental Capacity continues to improve. CDU - MCA training compliance is 77% and Fire is 86%. ED MCA compliance is 96% and Fire is 79%. MCA overall compliance is reduced as a result of a number of newly recruited Registered Nurses and Health Care Support Workers, yet to complete training. There are monthly workforce meetings chaired by the director of nursing to review workforce metrics and as part of this training compliance is reviewed with all areas required to achieve 85% or above within the next 3 months.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with assurance Violence and Aggression, Mental Capacity and DoLS training compliance is effectively tracked for the EU.	Healthcare Inspectorate Wales (HIW)/2023/167/MD13/2	Monthly mandatory training study days and reports now include V & A, DoLS, medications management, safeguarding and MCA training and compliance. Mandatory training compliance is monitored during the 4 weekly Workforce and Business meetings, trends are monitored for improvements, where there is deterioration action plans are required. V&A compliance is recorded on the Mandatory Training database held by the Senior Nurse for professional Education.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - There are monthly workforce meetings chaired by the director of nursing to review workforce metrics and as part of this training compliance is reviewed with all areas required to achieve 85% or above within the next 3 months. CDU fire is 100% Monthly training offered to staff for fire, Violence and Aggression and DoLS. Compliance with Fire training and Mental Capacity continues to improve. CDU - MCA training compliance is 77% and Fire is 86%. There are monthly workforce meetings chaired by the director of nursing to review workforce metrics and as part of this training compliance is reviewed with all areas required to achieve 85% or above within the
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix B Immediate Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 0360)	Midwifery staffing levels on night shift The health board are required to provide HIW with details of how it will ensure there are sufficient numbers of suitably qualified and trained staff on every night shift within the maternity service.	Healthcare Inspectorate Wales (HIW)/2024/165/MD1/7	g)Working with finance colleagues to develop a new model for obstetric theatre nursing (releasing midwifery time).	Children & Families	01.02.2024	01.02.2024	Partially complete (Overdue)	October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 - activity underway with finance colleagues but pace of progress has been impacted by the temporary closure of the maternity and neonatal units at Princess of Wales Hospital (PWH). Commenced September 2023. Due for completion February 2024.
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix B Immediate Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 0360)	Midwifery staffing levels on night shift The health board are required to provide HIW with details of how it will ensure there are sufficient numbers of suitably qualified and trained staff on every night shift within the maternity service.	Healthcare Inspectorate Wales (HIW)/2024/165/MD1/9	j)Review safe care tool to ensure that red flags according to NICE safe staffing 2015 are included in the tool.	Children & Families	31.01.2024	31.01.2024	Partially complete (Overdue)	A meeting took place with the lead nurse for Perioperative services and Finance to explore the feasibility for perioperative services to cover emergency and elective theatres 24/7. costs did not align with evidence. This decision is now being reviewed to ensure subject to the time and the first instance, with assistance being assessed for May 2024. October 2024 Update - No update against this recommendation action has been received on this occasion.
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix B Immediate Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 0360)	Midwifery staffing levels on night shift The health board are required to provide HIW with details of how it will ensure there are sufficient numbers of suitably qualified and trained staff on every night shift within the maternity service.	Healthcare Inspectorate Wales (HIW)/2024/165/MD1/10	j)Work with the Corporate Communications department to develop a Comms Recruitment strategy to demonstrate the benefits to attract staff to work in CTM UHB.	Children & Families	29.02.2024	29.02.2024	Partially complete (Overdue)	August 2024 Update - need to be reviewed at Care Group Workforce Meeting on the 28th August to monitor implementation. Review of safe care tool has been undertaken to ensure that red flags according to NICE safe staffing 2015 are included in the tool
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix B Immediate Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 0360)	Midwifery staffing levels on night shift The health board are required to provide HIW with details of how it will ensure there are sufficient numbers of suitably qualified and trained staff on every night shift within the maternity service.	Healthcare Inspectorate Wales (HIW)/2024/165/MD1/17	q)The team are working with the wider Health Board initiative to ensure maternity services are included as part of 'Safe to Start'.	Children & Families	12.01.2024	12.01.2024	Partially complete (Overdue)	October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 - included in 'safe to start' meetings and working with the corporate team to ensure the mat neo template is fit for purpose.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 0360)	Midwifery staffing levels on night shift The health board are required to provide HIW with details of how it will ensure there are sufficient numbers of suitably qualified and trained staff on every night shift within the maternity service.	Healthcare Inspectorate Wales (HIW)/2024/166/MD3/1	There are dedicated infant feeding co-ordinators in place across the perinatal services who are working together toward BFI accreditation. The service is currently undertaking a number of audits in readiness for re-assessment which is infant feeding experience is positive. The service has implemented a feeding voice partnership.	Children & Families	01.05.2024	01.05.2024	Partially complete (Overdue)	October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - In response to a recent positive inspection audit there are a few actions underway. Accreditation being sought in the next couple of months.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 0360)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary.	Healthcare Inspectorate Wales (HIW)/2024/166/MD11/6	Working with finance colleagues to develop a new model for obstetric theatre nursing (releasing midwifery time).	Children & Families	01.03.2024	01.03.2024	Overdue	October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - activity underway with finance colleagues but pace of progress has been impacted by the temporary closure of the maternity and neonatal units at Princess of Wales Hospital (PWH)
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 0360)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary.	Healthcare Inspectorate Wales (HIW)/2024/166/MD11/8	Review safe care tool to ensure that red flags according to NICE safe staffing 2015 are included in the tool	Children & Families	31.01.2024	31.01.2024	Overdue	October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - need to be reviewed at Care Group Workforce Meeting on the 28th August to monitor implementation.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 0360)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary.	Healthcare Inspectorate Wales (HIW)/2024/166/MD11/9	Work with the Corporate Communications department to develop a Comms Recruitment strategy to demonstrate the benefits of attracting staff to CTM UHB.	Children & Families	29.02.2024	29.02.2024	Partially complete (Overdue)	October 2024 Update - Update 11/9/24 Filing of staff has commenced, currently on hold due to pressures due to PWH temporary closure. August 2024 Update - Work underway in conjunction with the recruitment and retention lead including developing a short video as part of an attraction campaign. There will be a focus on the PCH site.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 0360)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary.	Healthcare Inspectorate Wales (HIW)/2024/166/MD11/16	The team are working with the wider Health Board initiative to ensure maternity services are included as part of 'Safe to Start'.	Children & Families	12.01.2024	12.01.2024	Partially complete (Overdue)	October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 - included in 'safe to start' meetings and working with the corporate team to ensure the mat neo template is fit for purpose.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 0360)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary.	Healthcare Inspectorate Wales (HIW)/2024/166/MD12/1	Operational and specialist midwives are rostered to support clinical activity.	Children & Families	01.03.2024	01.03.2024	Fully complete (awaiting approval)	October 2024 Update - Update 9/24 Agency and bank has been utilised since the inspection to supplement the roster. Rolling advert on trac for midwifery recruitment 17 NCM's have been recruited commencing work in September. August 2024 Update - Update requested from Children and Family Care Group.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 0360)	Datix reporting The health board should undertake a review of the processes for reviewing incidents. The reviewing team should include clinicians and practitioners with the appropriate experience and expertise.	Healthcare Inspectorate Wales (HIW)/2024/166/MD13/1	All moderate and above are reviewed by the MOT and SMDT. A review of all no and low level incidents is underway to explore any emerging themes, trends and ensure that the service is addressing any concern / incident in a robust manner. A wider review of governance process is underway to ensure that there is sustainability and assurance in accordance with the Duty of Quality and Maternity and Neonatal Assurance Escalation Framework. The review was discussed in the Maternity and Neonatal Safety Board in February 2024, the outcome of this work and any recommendations will be reviewed at the Maternity and Neonatal Safety Board in April 2024.	Children & Families	01.04.2024	01.04.2024	Partially complete (Overdue)	October 2024 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - Children & Family Care Group just completing a review of the governance arrangements in line with the new incident management framework. Outcome of will be presented to the Maternity and Neonatal Safety Board in September 2024 with an implementation plan. The new arrangements will ensure proportionate review and learning.
Healthcare Inspectorate Wales (HIW)/2024/184	11.04.2024	Appendix A Immediate Improvement Plan_Tydyty Cem Rhonda Ward B3_11-12 April 2024 (Ref: 03467)	Provide HIW with details of the action taken to ensure a call bell system is put in place as soon as possible.	Healthcare Inspectorate Wales (HIW)/2024/184/MD1/1	Discussion with operational estates manager who has confirmed funding has been agreed to replace the system and a plan is in place to replace.	Primary Care & Community	30.06.2024	30.06.2024	Fully complete (awaiting approval)	October 2024 Update - Call bell system replaced August 2024. Proposed for Closure November 2024 August 2024 Update - Installation date agreed for 27th August.
Healthcare Inspectorate Wales (HIW)/2024/184	11.04.2024	Appendix A Immediate Improvement Plan_Tydyty Cem Rhonda Ward B3_11-12 April 2024 (Ref: 03467)	In the interim, provide HIW with details of a robust system where patients are checked regularly to ensure they are safe, and their needs are met.	Healthcare Inspectorate Wales (HIW)/2024/184/MD1/1	Risk assessment in place to provide assurance on reducing the risk of patient needs not being met.	Primary Care & Community	30.06.2024	30.06.2024	Fully complete (awaiting approval)	October 2024 Update - Completed and ongoing monitoring until new call bell system is in place. Proposed for Closure November 2024 August 2024 Update - partially completed, ongoing monitoring of actions implemented until new call bell system is in place.

Cwm Taf Morgannwg University Health Board

Audit & Risk Committee Internal Audit Progress Report

December 2024

NWSSP Audit and Assurance Services

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Appendix A – Tables showing detailed progress against audit plans



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Disclaimer notice - please note

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

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

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

1 Introduction

- 1.1 This progress report provides the Audit & Risk Committee (the 'Committee') with the current position of the work undertaken by Internal Audit as at 10 December 2024. This report provides information on the status of progress of our reviews.
- 1.2 We report the progress made to date against individual assignments along with details regarding the delivery of the plans and any required updates.

2 Reports Issued

- 2.1 Since the October meeting of the Committee four reports have been finalised, two report are in draft, and we have ongoing fieldwork in relation to eleven reviews, which includes one review for the Joint Commissioning Committee (JCC). A summary of the position of the finalised reports, including a summary of number of recommendations, is provided below in Table 1.

Table 1 – Summary of finalised reports

Assignments	High	Medium	Low	Total	Assurance rating
PCH Validation of Management Actions	-	-	-	0	Substantial
Charitable funds	-	4	-	4	Reasonable
Additional medical pay	6	4	-	10	Limited
JCC – Mental Health quality assurance process	-	1	-	1	Reasonable

3 Delivering the Plan

- 3.1 Our work in 2024/25 is ongoing. The detail of our work is included in appendix A to this report.

4 Performance reporting

4.1 We monitor aspects of the Internal Audit service and report this information in our annual report. Our agreed performance indicators, as at the time of this progress report, are set out in table 2 below:

Table 2 – Performance Indicators 2024/25

Indicator	Status	Actual	Target	Red	Amber	Green
Report turnaround: time from fieldwork completion to draft reporting [10 days]	Green	89% (8/9)	95%	v>20%	10%<v ≤20%	v≤10 %
Report turnaround: time taken for management response to draft report [15 days per Internal Audit Charter]	Green	71% (5/7)	80%	v>20%	10%<v ≤20%	v≤10 %
Report turnaround: time from management response to issue of final report [10 days]	Green	100% (7/7)	95%	v>20%	10%<v ≤20%	v≤10 %

5 Feedback

5.1 A post audit questionnaire is issued to the key health board staff that we have worked with alongside our final report. This is one of our ways of getting feedback on the audit process so that we can look to make improvements. So far, this year to date, we have issued six feedback questionnaires and received feedback in relation to three reviews. We note two questionnaires have only recently been issued.

6 Other activity

Joint Commissioning Committee (JCC)

6.1 We have agreed a programme of work for 2024/25 with officers of the JCC (Appendix A – Table 3). We have finalised one report and have ongoing fieldwork for our second review.

Meetings

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

6.3 We also regularly observe the Board and committees of the Board to help ensure we have an understanding and gain valuable insight into the activity of the organisation.

New Global Internal Audit Standards

6.4 In January 2025 new Global Internal Audit Standards (GIAS) will become effective. The body that sets Internal Audit Standards for UK Public Sector Organisations, the UK Public Sector Internal Audit Standards Advisory Board (the IASAB), has

determined that the new Standards will apply to Public Sector audits from 1 April 2025 to align with the financial year. As the new Standards have been developed to apply to all sectors, the IASAB will be producing a practice note setting out any sector specific interpretations or other material needed to make them suitable for UK public sector use.

- 6.5 The new GIAS requirements seek to elevate internal audit practice in five domains that cover the profession's purpose, ethics and professionalism, governance, management and performance.
- 6.6 We are currently undertaking preparatory work to understand the impact of the new GIAS on our work, and to ensure that we can appropriately apply these standards from 1 April 2025.
- 6.7 At this point we do not anticipate that there will be many changes needed to our audit approach. However, one potential change is around how we monitor and evidence the implementation of agreed management actions.
- 6.8 We will update the Committee at the next meeting if we identify that any other changes are needed to our approach.

Appendix A – Programme of work**Table 3: Status of reports included in annual opinion for 2023/24 as draft**

Plan Ref.	Review	Rating	Status	Notes
4	Estates condition	Limited	Draft	Part of all Wales review - Updated draft report issued 18.10.23. Following management feedback, updated report issued 23.07.24. Some feedback on low priority recs received, but not everything.

Table 4: 2024/25 Core programme of work for Q1-Q4

Plan Ref.	Review	Rating	Review period	Planned AC	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
-	Embedding the quality framework - Brought forward from 2023/24	Reasonable	-	Oct	Final	Y	N	-
T07	Information provision – Intelligence led organisation	Reasonable	Q1	Oct	Final	Y	Y	-
T27	Follow up – Facilities governance arrangements	Substantial	Q1	Oct	Final	Y	Y	-
-	PCH Validation of Management Actions	Substantial	Q2	Dec	Final	Y	Y	-
T20	Charitable funds	Reasonable	Q2	~~Oct~~ Dec	Final	Y	N	-
T16	Additional medical pay	Limited	Q1	~~Oct~~ Dec	Final	Y	Y	-
T19	Energy management	Reasonable	Q2	~~Oct~~ Dec	Draft	Y	-	Draft report issued 7.11.24
T10	Duty of candour	Reasonable	Q1	~~Oct~~ Feb	Draft	N	-	Fieldwork and draft report complete – Cross checking findings with WRP national team.

Plan Ref.	Review	Rating	Review period	Planned AC	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
T17	Medical job planning	-	Q2	~~Oct~~ Feb	Drafting	-	-	Fieldwork complete. Have been delays due to Audit.
T23	Regional integration fund	-	~~Q2~~ Q3	~~Oct~~ Feb	Drafting	-	-	Fieldwork complete. Drafting report.
T33	Follow up – SLA arrangements	-	Q2	~~Oct~~ -Feb	Drafting	-	-	Management request to delay start until Autumn due to new staff members. Fieldwork complete.
-	PCH – Supply chain partner management	-	-	~~Oct~~ Feb	WIP	-	-	Waiting for information to complete. Additional sampling.
T18	Capital systems	-	Q2	~~Oct~~ Feb	WIP	-	-	Fieldwork started July. Paused while waiting for information.
T31	Follow up – Financial savings	-	Q1	~~Oct~~ Feb	WIP	-	-	Fieldwork started July. Delayed due to annual leave on both sides. Now delays due to Audit.
T22	Vaccination policy implementation	-	Q2	~~Oct~~ Feb	WIP	-	-	Engagement delays.

Plan Ref.	Review	Rating	Review period	Planned AC	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
T28	Follow up – Performance management – 4-hour target	-	Q2	~~Oct~~ Feb	WIP	-	-	Delays getting meetings/responses.
T15	New PDR process	-	Q1	~~Oct~~ Feb	WIP	-	-	Management request November start.
T02	Cancer tracking process	-	Q3	Feb	WIP	-	-	Fieldwork started 05.12.24.
T08	Digital benefits realisation	-	Q4	May	Planned	-	-	Brief agreed.
T01	New care group model	-	~~Q2~~ -Q4	~~Dec~~ June	Planning	-	-	Initial discussion planned for September, but met early November. Agreed move to Q4.
T03	Elective care criteria	-	Q3	Feb	Planning	-	-	Initial discussion planned for September. CTM cancelled meeting, rescheduled to November. Detailed planning in January.
T04	End of life care management	-	Q3	Feb	Planning	-	-	Initial discussion planned for September. CTM cancelled meeting, rescheduled to early

Plan Ref.	Review	Rating	Review period	Planned AC	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
								October, now November. Detailed planning in January.
T09	Continuing Health Care	-	Q3-Q4	May	Planning	-	-	Planning meeting in November. Focus has changed to three-part review with electronic whiteboards first.
T12	Ensuring quality when commissioning care services	-	Q3	Feb	Planning	-	-	Had initial meeting November – Now to meet with nursing.
T21	Core financial systems	-	Q3	Feb	Planning	-	-	Scoping meeting on 11.10.24. Awaiting information.
T24	Stroke	-	Q3	Feb	Planning	-	-	-
T05	Discharge planning	-	Q4	May	-	-	-	-
T06	Primary care	-	Q4	May	-	-	-	-
T13	Service user experience	-	Q4	May	Planning	-	-	Agreed planning meeting in January.
T14	Welsh Risk Pool	-	Q4	May	-	-	-	-
T26	Risk management	-	Q4	May	-	-	-	-

Plan Ref.	Review	Rating	Review period	Planned AC	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
T09	Clinical coding	-	Q3	Feb	Defer	-	-	DHCW has recently undertaken work and reported in this area.
T29	Follow up - INNU	-	Q2	Feb	Propose defer	-	-	Brief agreed. Has been delayed due to all Wales working group – Likely defer to 2025/26.
T25	Llantrisant Health Park	-	-	-	Propose defer	-	-	Project has had gateway review in year, so propose to undertake audit in early 2025/26.

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

Ref.	Review	Rating	Status	Notes
1	Mental Health quality assurance process	Reasonable	Final	-
2	Governance systems	-	WIP	Fieldwork started 11.12.24
3	Financial systems	-	Planning	Scoping meeting 19.11.24
4	Traumatic stress Wales	-	Planning	JCC requested additional advisory review

Energy Management

Final Internal Audit Report

2024/25

Cwm Taf Morgannwg University Health Board



Reasonable Assurance

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Review Reference

CTMUHB-SSU-2425-19

Fieldwork

July - September 2024

Executive Sign Off

12 December 2024

Audit Committee

17 December 2024

Executive Lead

Sally May

Head of Internal Audit

Huw Richards

Deputy Head of Internal Audit

Eifion Jones

Executive Summary

Purpose

Noting rising costs of energy, effective management and control of energy costs has been risk assessed as an area of potential benefit for audit.

Overview

The UHB's energy consumption represents 12% of the NHS Wales total, with costs of £4.5m for gas and £7.5m for electricity reported for 2023/24.

Energy is procured centrally on behalf of NHS Wales by NWSSP: Procurement Services, with new contractual arrangements in place from October 2023.

Appropriate governance arrangements were observed, including an experienced Energy Team, reporting into the Environment & Sustainability governance structure.

The Energy Team had established robust systems for data capture, validation and payments: ensuring that management received comprehensive, accurate and timely data for review.

The University Health Board (UHB) being aware of the limitations of the current Building Management Systems (BMS) in place had commissioned consulting engineers to conduct an independent overview of the BMS systems across the organisation; the findings of which will inform strategic decision-making and will be considered when submitting applications for future funding including the refit scheme.

The move to the new NHS Wales energy contract in 2023 has caused national disruption. This included difficulties in providing accurate energy forecasts to participating organisations, and additional resource required within the Energy Team to resolve account queries. Recognising the robust data processes operated at Cwm Taf Morgannwg UHB, the impact of the national issues had not been as significant as seen elsewhere.

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

- The findings of the BMS report would benefit from a wider exposure within the UHB
- Benchmarking with similar Hospitals across other NHS Wales Health Boards
- The conducting of site walk-arounds as recommended by HTM07-02 Encode (Part A section 3.5)
- Consideration of additional energy risks for inclusion on the Estate's Risk Register.

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

Scope & Assurance Summary

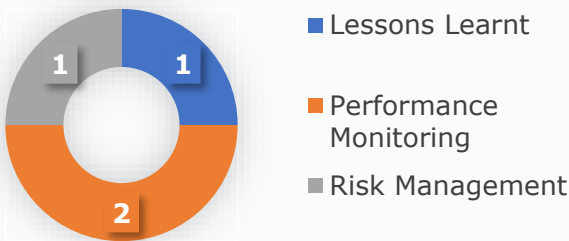
Objectives		Related Findings	Assurance
1	Governance - Assurance that key roles had been assigned and responsibilities of key staff were understood. An appropriate forum had been assigned with responsibility and accountability for overseeing Energy efficiency/ consumption.		Substantial
2	Contract- Recognising the national contracts in place, to obtain assurance that the Health Board obligations under the national contract arrangements were fully understood and applied.		Substantial
3	Data Capture – To ensure that appropriate systems were in place to capture data on energy consumption in a timely manner.		Substantial

4	Data Validation – To confirm adequate checks were undertaken to verify the quality/ reliability of the data – with any anomalies fully investigated.		Substantial
5	Monitoring and Reporting - To review internal / external monitoring and reporting arrangements, to ensure that anomalies were understood, benchmarking was undertaken where appropriate, and any resulting management action was appropriately tracked.	1,2,3	Reasonable
6	Energy Awareness - That appropriate training had been established for general and key energy staff focused on increasing awareness of obligations and requirements. Assessment of any other initiatives established to increase awareness e.g. intranet pages, staff circulars, team briefings etc.		Substantial
7	Payments - Energy related billing was verified, authorised, and processed in accordance with contractual payment terms.		Substantial
8	Risk Management - A review of the systems and controls in place to manage energy-related risks, and assurance that risks were escalated as appropriate – to include evaluation of risk mitigation strategies, ensuring compliance with regulations, and addressing any risk exposure.	4	Reasonable

Management Actions



Themes



Risk Types

Quality or Safety Issues

Financial Loss

Findings & Agreed Action Plan

Objective 1: Governance Arrangements	Substantial
Overview / Summary of Observations	
Key roles/responsibilities required to deliver the energy management function had been clearly defined, including the Head of Assets, Governance and Technical Services along with an Energy/Carbon Project Manager and Energy Support Officer. Between them they fulfilled many obligations, such as attending and engaging in Welsh Energy Operational Group (WEOG) Group meetings, liaising with energy suppliers, collating and analysing energy consumption data, and providing reports on usage for both internal stakeholders and external bodies, including NWSSP: Specialist Estates Services and the Welsh Government. The Energy/Carbon Project Manager chaired the Energy Compliance Group forum which has a broad Energy based agenda including Energy Scorecard updates. Energy performance was reported to the Environmental Management System Group meetings, these meetings incorporated a broad environmental/decarbonisation led agenda. Particularly relevant to this review was the inclusion of the Energy Team report as a standing agenda item. The UHB's Environmental Sustainability Group (ESG) oversaw the delivery of the UHB's Decarbonisation Action Plan (DAP). The Terms of Reference for the ESG defined the group's role and responsibilities, linked to decarbonisation. Energy related themes fed into this via the various DAP actions related to reducing energy consumption.	

Objective 2: Contracts	Substantial
Overview / Summary of Observations	
In October 2023, the UHB entered the new all-Wales NHS energy contract with Crown Commercial Services (CCS), managed by NWSSP: Procurement Services. This change in contractual arrangements was due to the existing supplier exiting the market, citing volatility since 2021. Two new central governance forums were initiated to oversee the introduction of the new contractual arrangements: - Welsh Energy Group (WEG) – Responsible for the strategy for energy procurement and determining basket choices from the CCS framework. Membership included Directors of Finance representing each organisation. - Welsh Energy Operational Group (WEOG) – Responsible for establishing a common model for supplier management. Membership included operational energy and finance colleagues from member organisations. Internal Audit reviewed these arrangements in January 2024, determining Substantial Assurance. The implementation of the new CCS contract has seen issues across NHS Wales, both in the closure of the previous supplier's accounts and the commencement of relationships with the new gas and electricity suppliers appointed under the CCS framework. These difficulties have impacted all NHS organisations, to varying degrees, e.g. the availability of accurate data (forecasting and validation of invoices) and input of additional resource to resolve issues. Handover issues were addressed centrally by WEOG. CTMUHB has been effectively represented at WEG and WEOG gatherings, supported by documented evidence displaying robust engagement during these sessions.	

Objective 3: Data Capture

Substantial

Overview / Summary of Observations

The UHB utilised the Team Sigma energy management system to validate supplier invoices reconciling with captured energy data, including manual meter readings, Automatic Meter Reads (AMR).

A robust programme of monthly manual meter readings operated across the estate, supplemented by AMR data from half-hourly meters on the larger sites.

Audit testing from a sample of two sites, between October 2023 and April 2024, found all data to have been input correctly to Team Sigma, and in a timely manner.

Whilst recognising the above process provides the UHB with a comprehensive, timely and accurate data set, and has ensured a degree of protection from the impact of the contract handover issues experienced by some other NHS Wales organisations (see *Contracts* objective), it was manually intensive with a heightened risk of transposition error. The Energy team have identified a few opportunities for improved efficiency, e.g. through increased provision of AMRs, and introducing electronic data transfer processes.

However, the UHB advised that on evaluating the potential Team Sigma software additions it was considered that these did not provide a value for money solution. With respect to an increase in AMR's the UHB have been in dialogue with the energy supplier both directly and indirectly through the WEOG group, with an expectation that this will be addressed.

Noting some UHB premises were leased to third parties including both public, private sector and NHS organisations, the UHB had an established process to recharge utility costs in an agreed apportioned manner.

Objective 4: Data Validation

Substantial

Overview / Summary of Observations

The Team Sigma energy management system incorporates built-in data validation tools, using parameters determined by the Energy Team. Validation takes place for a range of data inputs, e.g. meter readings and unit rates. The process to be followed being formally documented within the UHBs standard operating procedures.

Monthly report outputs from the system are also reviewed for unexpected variances, which may indicate inaccurate data entry. This process is discussed further in the *Monitoring and Reporting* objective.

Sample audit testing identified no occurrences of data input error, in either meter readings or invoice data.

The UHB also demonstrated a robust authorisation process for the approval of utility invoices prior to their submission to NWSSP for payment.

Overview / Summary of Observations

The audit included site visits to the Royal Glamorgan Hospital and the Princess of Wales Hospital to assess for any visible instances of energy inefficiency. Generally, good practice was observed at both sites.

All locations, including clinics, were monitored by the Building Management System (BMS), although not monitored continuously. However, in the case of temperature critical areas such as path labs, out of hours alerts would be triggered where required.

While no issues were found with the BMS systems at the audit, it was evident that other sites required upgrade to their systems for effective control as noted within the expert review commissioned by the UHB. BMS system upgrades are currently being funded as EFAB projects. Additionally, it is part of the REFIT programme (expected within HLA & IGP).

Energy data was entered into the Estates & Facilities Performance Management System (EFPMS), shared across NHS Wales by NWSSP: Specialist Estates Services (SES), which could facilitate performance benchmarking against similar facilities. However, for effective benchmarking, the UHB would need clarity on consumption factors, including extended facility usage, increased medical technology usage in theatres, or new equipment installations like MRI scanners.

Without a high proportion of sub-metering, it remains difficult for the Energy Team to determine any reasons behind site-wide changes in consumption.

Key Findings	Risk & Impact	Agreed Management Action
1 BMS The UHB has been proactive in looking to better understand the limitations of their existing BMS. An independent review was carried out in June 2022 by an independent firm of Consulting Engineers detailed several recommendations and areas for improvement (some outside the scope of any refit funding). These included: • Observations in respect of the ability of the UHB to react to alarms on the system at the Princess of Wales Hospital. • The report goes on to recommend that the UHB could address this and other legacy BMS oversight issues with the appointment of at "least 1 Whole Time Equivalent (WTE) Health Board wide BMS manager" along with "two off BMS Technicians to ensure that all equipment is correctly serviced". Noting the revenue implications of this especially in the current financial climate the report author suggests that if the "team were only able to achieve a conservative 3% reduction on every site in utilities, at the current predicted energy spend of £15M, this would represent a £450K annual saving. The findings of the report would benefit from a wider exposure within the UHB. In so doing ensuring that any decisions made	The UHB fails to address the wider findings of the BMS report, in so doing missing an opportunity to deliver longer term financial benefits in an era of growing austerity.	Proposed Management Action: Findings of the report have been shared with the Environmental Steering Group Actions to employ additional BMS staff previously reported at the Green Group and the Environmental Steering Group and been included in the UHB's Decarbonisation Action Plan (DAP) and included in the Environmental Management Plan Objectives and Targets. The UHB is working towards a standardised BMS system across the UHB, as per the recommendations of the BMS study completed by CTM Estates. Veolia have included audits of the BMS system as part of the ReFit High Level Assessment. Veolia are currently conducting a high-level assessment of BMS systems across the Estates, which will feed into an investment grade proposal for BMS repairs and upgrades as identified. Specialist contractors are employed across the Estate to maintain the standards of BMS systems operation and control. CTM Estates will share the findings of the BMS report again with the Environmental Steering Group and the Green Group.

	may address not only those themes that can be addressed by refit monies, but also changes that can be made in the short-term utilising existing BMS architecture. This should highlight any limitations and agreed mitigating arrangements.		Expected Evidence of Implementation: Evidence of Veolia HLA and IGP BMS related works Evidence of BMS contracts Minutes from Environmental Steering Group and copy of BMS summary presentation.
	Theme: Lessons Learnt	Medium Priority Control Operation	Officer: Head of Assets, Governance and Technical Services Estates Date: March-2025
2	Site walk arounds During the site visits it was observed that there were several stand-alone fans in offices, resulting in energy inefficiencies. Conducting the twice-yearly site walk-arounds as recommended by HTM07-02 Encode offer management first hand observation of where energy is being used and presenting an opportunity to raise the profile of energy awareness with Health Board colleagues. Alternatively, the rationale/ risks for derogating from the HTM should be reported and approved by an appropriate forum.	Visible matters of energy inefficiency are not identified/ addressed.	Proposed Management Action: CTM Estates will raise the proposal for twice-yearly site walk-arounds at the next Environmental Steering Group meeting. Decision by the group to implement or derogate from the recommendation to be recorded in minutes and action plan.
	Theme: Performance Monitoring	Medium Priority Control Operation	Expected Evidence of Implementation: Environmental Steering Group meeting minutes and associated actions. Officer: Head of Assets, Governance and Technical Services Estates Date: March-2025
3	Benchmarking The UHB submitted energy data annually via the national NHS Wales Estates & Facilities Performance Management System (EFPMS) system – this requirement was recently changed to all sites over 500m². NWSSP: Specialist Estates Services (SES) advise that, whilst benchmarking dashboards haven't been published in recent years, raw EFPMS data has been shared with all NHS Wales organisations, which would facilitate internal data review and benchmarking against other Health Boards.	Available performance data is not utilised to aid the UHB's benchmarking activities. Areas for improvement are not identified or appropriately prioritised.	Proposed Management Action: The UHB has all Wales benchmarking information from NWSSP for previous years and CTM properties perform well above benchmark in these reports. A CTMUHB Benchmarking exercise for properties above 500m2 is scheduled for Q4 of 2024-25 once the data has been provided to CTM by NWSSP-SES
	Theme: Performance Monitoring	Medium Priority Control Operation	Expected Evidence of Implementation: Officer: Head of Assets, Governance and Technical Services Estates Date: March-2025

Objective 6: Energy Awareness

Substantial

Overview / Summary of Observations

Encode (HTM 07-02 - Encode - Part A - Policy and Management 2015) addresses energy awareness, including motivating stakeholders (section 3.11) and emphasises developing an energy behaviour modification campaign.

Energy awareness previously focused solely on “energy,” but now encompasses decarbonisation and climate change as part of the broader decarbonisation agenda. Given the national emphasis on decarbonisation, this was overseen by a programme board and was audited separately earlier in 2024. While the energy team contributed, they were not responsible for implementing any associated actions.

Although, as noted activity in this area was now delivered as part of the decarbonisation agenda, the Energy Team did provide supporting documentation demonstrating initiatives and activities/materials aimed at raising awareness.

The Energy Team has gained from professional qualifications in energy management and vocational training provided on the energy management software package used by the UHB. Additionally, there was substantial evidence demonstrating the broader UHB staff groups completion of ESR training that includes energy within a wider environmental module.

The UHB has established a green team with initiatives focused on enhancing the visibility of decarbonisation (energy reduction) within CTMUHB, supported by webpages on the UHB intranet site.

Objective 7: Payments

Substantial

Overview / Summary of Observations

The audit sample testing observed strong processes in place for invoice review, data entry and validation managed by the Energy Team. The UHB’s Utility Invoice Validation procedure documented the associated process to be applied.

Compliance with the procedure was observed at the audit testing with all sampled invoices confirmed to have been accurately recorded within the organisation’s energy software. Each received invoice was verified before being submitted to Accounts Payable for payment.

Individual invoices were processed against an annual call-off purchase order recorded in Oracle at the start of the year, aligned with projected energy costs.

The audit found that no overdue payment fees were incurred during the review period, as invoices were promptly processed and forwarded to Accounts Payable within a few days of receipt.

Overview / Summary of Observations

The UHB's Board Assurance Framework incorporating Strategic level risks, as reported to the Board in March 2024, was reviewed for any reference to energy risks. The following were noted:

- Risk 09- Fulfilling environmental and social duties and ambitions, this overarching risk picks up on the achieving the net zero targets and the strategic measures adopted to achieve this including the decarbonisation action plan and the UHB’s central strategy CTM2030. This risk was assessed as having a risk rating of ‘16’ with an acknowledgement that current financial environment challenges threaten the pace of change.
- Risk 03 - Financial revenue resource risk, may contain some element of energy costs, though not explicitly detailed (currently scored 8).

Energy risks that could affect the DAP were reported to and overseen by the Environment Sustainability Group.

The Energy Team outlined that key financial risks were managed through monthly Finance meetings – where issues such as cost pressures and late payments are discussed. Additionally, the Head of Finance attended the WEOG meetings.

Recognising the above, other energy-based risks were not being considered or recorded within a directorate risk register.

Key Findings		Risk & Impact	Agreed Management Action
4	Energy Risk Reporting It was recognised that risks pertinent to energy management measures were captured as part of the decarbonisation governance process. Additionally, there was narrative provided within the Health Board’s risk register recognising energy related issues that were contributing to an assessed high-risk rating in respect of the UHB estate. However, several energy management related risks had been noted and discussed that may warrant formal assessment, including: 1. The new All-Wales energy contract, which continued to cause disruption to process and available data – potentially impacting billing; 2. Energy cost going forward; and 3. The Decarbonisation Strategy action to remove all Combined Heat and Power (CHP) units by 2030. Whilst this aims to reduce carbon emissions, electricity costs are significantly higher than gas, which is expected to	If not identified and assessed, risks may not be appropriately managed.	Proposed Management Action: Energy compliance risks are fed through to the Environmental Steering Group. Energy finance risks are fed through to the Finance Department and included in the Estates IMTP Intermediate Medium-Term Plan. 1. Risks associated with the All-Wales energy contract are reported through the Estates IMTP. 2. Energy cost risks “going forward” will continue to be recorded through the Estates IMTP. 3. Loss of CHP plant by 2030 will be recorded through the Estates long term financial plan. Risks associated with lifecycle and condition of energy related plant and equipment such as CHP and biomass boilers, is and will continue to be reported through the directorate risk register. Expected Evidence of Implementation: Estates IMTP risks

	increase the UHB's grid consumption and associated cost. All financial and non-financial risks should be recorded within the directorate risk register – to include proposed mitigating action.	Medium Priority	Officer: Head of Assets, Governance and Technical Services Estates Date: March-2025
	Theme: Risk Management		

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

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

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

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

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Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.



Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives Final Internal Audit Report

December 2024

Cwm Taf Morgannwg University Health Board

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Review reference:	CTMUHB-24/25-09
Report status:	Final
Fieldwork commencement:	16 August 2024
Fieldwork completion:	14 October 2024
Debrief meeting:	14 November 2024
Draft report issued:	12 November 2024 Revised draft 6 December 2024
Management response received:	29 November 2024 and 10 December 2024
Final report issued:	10 December 2024
Auditors:	Elizabeth Vincent – Principal Auditor Emma Samways – Deputy Head of Internal Audit
Executive sign-off:	Dom Hurford – Executive Medical Director
Distribution:	Anthony Gibson – Deputy Medical Director, Acute Services Esther Flavell – Assistant Medical Director, Workforce Nicholas Price – Senior HR Manager, Medical Workforce
Committee:	Audit & Risk Committee



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement

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

Disclaimer notice - please note

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Executive Summary

Purpose

To review the systems and controls in place within the Health Board for the management of additional duty hours payments and waiting list management payments to medical staff.

Overview

The significant matters which require management attention include:

- The need for a detailed procedure notes to support the consistent application of the recently approved Financial Control Procedure.
- Reviewing the rate approval hierarchy set up in Patchwork.
- Minimising the retrospective creation of shifts, especially where they are for known vacancies in the establishment.
- Monitoring longer shifts set up to ensure correctly set up both for the hours worked and they type of shift (hourly or on-call).
- Ensuring the appropriate use of WLI session bookings.

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

Report Opinion

Limited



More significant matters require management attention.
Moderate impact on residual risk exposure until resolved.

Assurance summary¹

Objectives	Assurance
1 Policies and procedures	Reasonable
2 Additional Duty Hours (ADH) bookings	Limited
3 Breaks during shifts	Reasonable
4 Waiting List Initiative (WLI) bookings	Unsatisfactory
5 Monitoring and reporting	Limited

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Lack of operating procedures	1	Design	High
2	Use of direct manager bookings	2	Operation	Medium
3	Rate escalations approvals	2	Design	High
4	Longer shifts	2	Operation	High
5	Reason codes	2	Operation	Medium
6	Retrospective shifts	2	Operation	High
7	Removal of breaks	3	Operation	Medium
8	Shifts paid without timesheets input by employee	3	Operation	Medium
9	Use of Waiting List Initiative shifts	4	Operation	High
10	Monitoring activity	5	Operation	High

1. Introduction

- 1.1 Our audit of additional medical pay – Additional Duty Hours (ADH) and Waiting List Initiatives (WLI) was completed in line with the 2024/25 Internal Audit Plan for Cwm Taf Morgannwg University Health Board (the 'Health Board').
- 1.2 For the last six months of 2022/23, the average monthly spend on ADHs was £1.25m, which rose to £1.83m per month for the last six months of 2023/24. Over the last year, spend on WLIs was on average £0.2m per month.
- 1.3 In recent years, through its contract with Retinue Solutions¹, the Health Board has introduced the Patchwork App. This platform identifies unfilled shifts so that medical bank staff can book to work these additional duty hours. In September 2023 and June 2024, the Health Board launched rate cards for non-consultant and consultant grade staff, respectively. These aim to standardise the rates paid to medical staff for ADHs, not just across the Health Board, but also more widely with other local health boards. ADH shifts should be booked as 'hourly' shifts in the Patchwork system.
- 1.4 WLIs are agreed additional sessions/clinics that are undertaken to specifically address waiting list challenges. Consultant grade staff receive additional pay to undertake these sessions. WLI work should be booked as 'sessional' shifts in the Patchwork system.
- 1.5 Our previous audit work has reviewed the controls in place in relation to medical agency staff. As such, we did not look at medical variable pay agency costs in this review. Our most recent report on this was taken to the October 2024 Audit and Risk committee meeting.
- 1.6 The potential risks considered in this review were as follows:
 - Additional costs and pressures on the Health Board where agreed pay rates are not being used.
 - Inappropriate or unauthorised payments made at higher rates.

2. Detailed Audit Findings

Objective 1: There are policies and procedures in place setting out the Health Board's expectations and the process to be followed in relation to the use of ADHs and WLIs.

- 2.1 At the time of our fieldwork both the Financial Control Procedure (FCP) and the Standard Operating Procedure (SOP) covering the use of agency staff, additional duty hours (ADHs) and Waiting List Initiatives (WLIs) had passed their review dates. We saw an updated FCP being taken to the October 2024 Audit and Risk Committee for approval. We understand that work on the SOP is ongoing, but at

¹ Since November 2018 the Health Board has had a contract with Retinue Solutions who act on behalf of the Health Board to source medical agency staff. Patchwork Health is an on-line booking system for medical bank staff that has been developed in partnership with Retinue Solutions.

the time of our fieldwork there is not up to date SOP for staff to use. **(Matter Arising 1)**

- 2.2 Papers in relation to the introduction of the consultant rate card and proposed changes to the WLI process were taken to the May 2024 Executive Leadership Group (ELG) meeting and the July 2024 Operational Management Board (OMB) meeting, respectively. In August 2024 an email was sent to senior management providing clarification on the use of the rate cards and WLIs. This information was to provide some clarity in the absence of an up-to-date SOP. However, it appears that not all relevant staff are aware of the email guidance and the correct processes to be followed. For example, we saw that sessional bookings continue to be used for non-WLI work. **(Matter Arising 1)**
- 2.3 The revised FCP is high level and appears to incorporate information agreed in the recent WLI and consultant rate card papers and email. Our fieldwork identified parts of the process where the FCP is silent. For example, the maximum allowable time following a shift when a staff member can input their time sheet into Patchwork for approval and payment, and the circumstances when retrospective shifts can be created and the process and timeframe for this. **(Matter Arising 1)**
- 2.4 We have also seen flow charts created by Retinue to support staff using the Patchwork system. One has been incorporated into the FCP, although it is not clear if it applies to agency bookings, ADHs, or both. Other flow charts, such as the process for block bookings, or bookings that are made outside of normal working hours, are not included in guidance documentation. **(Matter Arising 1)**
- 2.5 Patchwork app user training is provided by Retinue, but there does not appear to be a training record. **(Matter Arising 1)**

Conclusion:

- 2.6 The Health Board's policies and procedures in relation to variable pay have not been updated for a number of years and more recent *ad hoc* guidance has not been disseminated to relevant staff. Whilst there is now an updated FCP, more granular guidance is needed to ensure consistent approaches are in place. We have provided **Reasonable Assurance** against this objective.

Objective 2: ADH bookings and payments are managed through the Patchwork App and are in line with agreed rate cards, with appropriate authorisation should rates need to be exceeded.

- 2.7 Bookings for ADH shifts are managed through the Patchwork system. Managers and rota co-ordinators have 'manager-level' access to the app that is specific to their department and allows them to submit a bank worker request. There are three types of shifts that can be requested: hourly (ADHs), sessional (WLIs) and on-call. Hourly and on-call shifts are based on the agreed rate card, and rates cannot be edited within the system without approval. Sessional shift rates can be adjusted by those staff with permissions such as Service Managers, Clinical Directors. (See objective 4 for more detail in relation to sessional / WLI shifts).

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- 2.8 Once a shift has been added to Patchwork, there are three ways staff can be booked into the shifts.
- Worker Application: Staff apply to do an advertised shift, and the department reviews and approves the application.
 - Instant Booking: Staff with pre-approval by the department or central HR, can book shifts directly without applying for them. The department are notified once the worker is booked.
 - Manager Booking: A manager can directly assign a staff member to a shift, and they receive a notification confirming the booking.
- 2.9 We looked at hourly, sessional and on-call shifts that were booked and worked in August 2024. We identified that 87% of the 2,903 shifts in August were 'manager bookings', meaning that they were directly assigned to a specific individual when created in Patchwork and the application process has been by-passed. Direct manager booking can be used for bank workers without computer access, particularly in areas such as estates and facilities, but medical staff shifts should not follow this route. For transparency, the 'worker application' route should be followed to ensure shifts are properly advertised so all relevant staff have the opportunity to apply. **(Matter Arising 2)**
- 2.10 Where shifts cannot be filled at the agreed rate card value, a rate escalation process takes place. At the time of our fieldwork within Patchwork, shifts with rates up to 25% above the rate card required approval from the Care Group Directors, and over 25% by the Medical Director. However, we identified that all rate escalation authorisers were able to approve both escalation rates. We also note that the list of authorisers appeared to be out of date, as a number of the identified staff had left the organisation. **(Matter Arising 3)**
- 2.11 The updated FCP has different authorisation levels, which will need to be reflected in the Patchwork app. **(Matter Arising 3)**
- 2.12 2,104 of the shifts that were created within Patchwork for August 2024, were hourly (ADH) shifts. We identified 28 shifts (6 consultant and 22 non-consultant) that were paid above their retrospective rate card, but all escalated rates were approved appropriately. The remaining 2,076 shifts were all paid in line with agreed rates.
- 2.13 However, our analysis of the 2,104 hourly shifts for August identified that 170 were shifts that were more than 12 hours, six were for 24 hours, and nine for 23 hours. We believe some of these are miscoded and should be 'on call' shifts and not hourly shifts. However, other shifts appear to be for excessive hours within a 24-hour period and do relate to ADH work. We are unclear why these long shifts have been created, but if worked, they may create a risk relating to patient safety and staff wellbeing. **(Matter Arising 4)**
- 2.14 Shifts created in the system require a 'reason' code. August's data shows 21 different 'reason' codes were used for the 2,104 hourly shifts created. The 'establishment vacancies' code was used for 1,554 (74%) of the shifts. We
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understand that there is no monthly monitoring of the number of shifts generated by a Care Group, or of the 'reason' codes used. As such, there are no checks to confirm that there are establishment vacancies where this reason is used. **(Matter Arising 5)**

- 2.15 We identified that 426/2,104 (20%) of the hourly shifts that were generated in August were created in Patchwork after the shift was worked. 68% of these were input more than two days after the shift. We also saw instances of shifts input up to one month after being worked. Furthermore, the reason code of 'establishment vacancies' was used 265 times (62%) when creating these retrospective shifts. If the shifts were required to cover known vacancies in a department's establishment, these shifts should be raised in advance of being worked, and not retrospectively. **(Matter Arising 6)**
- 2.16 7/426 retrospective hourly shifts were above the rate card values. While these had been appropriately authorised, this was after the shift had been completed. When shifts are input retrospectively, rates above the agreed rate cards are not challenged as the work has already taken place. **(Matter Arising 6)**
- 2.17 It is unclear why shifts are not booked in advance. Retinue has a process in place for out of hours bookings, but it appears to be rarely used. There is no information in relation to this in the FCP and as noted above, there is not an SOP in place. **(Matter Arising 6)**
- 2.18 Within Patchwork, to improve booking efficiency, shifts can be block booked, such as creating a block of shifts for a number of days or weeks at a time. We note that only 13 of the 2,903 shifts worked in August were part of a block booking. They were linked to four separate block bookings that had originally been created in April 2024. However, when we reviewed the data relating to the individual bookings, we note four individuals who on average each worked 28 shifts during the month. All of which had been input as separate shifts and not as a block booking. We looked back to June and July's data and note the same pattern. Had the block booking function in Patchwork been used this would have streamlined the administrative process for creating these shifts. Also setting up block bookings and advertising them through the app can help attract long-term bank workers and visibility in the recruitment process. **(See Matter Arising 1)**
- 2.19 Our further analysis of the four members of staff identified as working high numbers of shifts during June to August, established that whilst these shifts were for ADH work, all had been created in Patchwork as sessional shifts (WLIs), and all were paid rates above the agreed rate card. **(See Matter Arising 9)**

Conclusion:

- 2.20 The Patchwork app is used for the booking and payment approval of hourly (ADH) shifts, and when used correctly, we have seen adherence to the agreed rate cards and appropriate approval when exceeded. However, there remain issues that need to be addressed, including not properly advertising shifts, creating excessively long shift, retrospective input of shifts, inaccurate use of reason codes for shifts, and

coding shifts to other types of work where rates are not restricted. We have provided **Limited Assurance** against this objective.

Objective 3: Working Time Regulations are followed, with staff taking required breaks during their shifts.

- 2.21 By law, workers are entitled to a break of at least 20 minutes if they work six or more hours in a day. There is a function within Patchwork that automatically deducts break time from hourly shifts created in the app if the shift is at least six hours long. However, 'on call' or 'sessional' shifts are not automatically adjusted for breaks.
- 2.22 Our testing of hourly shifts created and worked in August identified 86/1,043 shifts which were in excess of six hours and had no break included when the shift was set up. As such, it appears that the break had been 'removed' when the shift was created on the system. **(Matter Arising 7)**
- 2.23 Following completion of a shift, the member of staff can amend the shift start or end times if they differed to the actual shift worked and can remove the breaks if they were unable to take them. This allows that time to then be paid for. Reasons have to be provided, with changes flagged to authorising managers. For August, we only identified 26 shifts where the break was removed by the worker after the shift had been worked. Each of these had a brief explanation for the removal and were then approved for payment.
- 2.24 At the time of our fieldwork, 203 of August shifts had either not had a timesheet input by the worker, or the timesheet had not been approved for payment. There is no guidance in respect of the time to complete these tasks. Furthermore, we identified that 159 (5%) of the paid shifts had been processed without an electronic timesheet being submitted by the employee. Instead, the timesheet had been input by the rota co-ordinator. Input of own timesheets by employees is a key control as it acts as the confirmation by the individual of the hours they worked. **(Matter Arising 8)**

Conclusion

- 2.25 The Patchwork app now has the automatic break function turned on, meaning for hourly shifts a break will be deducted in line with working time regulations. However, there remains instances where breaks are being removed when the shifts are being created and when shifts are being worked and no break taken. Ongoing monitoring of these occurrences should take place. We have provided **Reasonable Assurance** against his objective.

Objective 4: WLI payments are only used for activities that are part of an appropriately authorised and planned WLI programme.

- 2.26 The June 2024 WLI position paper established a common process and set of rules for WLI activity across all specialities. As the budget for WLIs sits with the Chief Operating Officer (COO) the paper requires WLI activity to be approved by the COO or deputy COO.

- 2.27 We understand that care groups submitted planned care recovery plans and bids to the COO for additional funding to support a number of WLIs. While we saw a list of the approved bids, we did not see more detailed bid information from the specialities or the number of WLI sessions approved. Approved WLI information provided by finance, included information about specialities that were not on the original list we received from the COO. The lack of clarity around the approved WLI schemes, the specialities they relate to, the level of activity agreed, and timeframes has meant that we were unable to confirm that the WLI payments made in August 2024 related to agreed schemes. **(Matter Arising 9)**
- 2.28 Our analysis of data from the Patchwork app for August 2024 identified 591 sessional (WLIs). Like hourly shifts, a 'reason' code is attributed when the shift is input in Patchwork. Only 160 (27%) of the WLI shifts were coded against the 'waiting list' reason code. For 292 (49%) the 'establishment vacancy' reason code was used, and a further 65 (11%) were coded as 'annual leave'. The WLI position paper states that WLIs are to be used to address waiting lists with an excessive length of waiting time, and not for other activity. **(Matter Arising 9)**
- 2.29 We also understand that WLI sessions should only apply to consultants; however, in August, 144 sessional shifts were allocated to junior medical staff grades. **(Matter Arising 9)**
- 2.30 We are aware that other health boards using the Patchwork app have set up WLI sessions with the agreed consultant rate for WLI work input as an hourly rate. Whilst this approach was initially introduced in the Health Board, it was subsequently removed. The rate field is now a free text box for sessional work, which means that any rate can be entered when creating these shifts. Recently, changes have been made to the system to restrict who can create sessional shifts, though we understand budget holders can still delegate this responsibility to an administrator or rota coordinator. While these sessions undergo a sign-off and payment approval process, there is no verification to ensure the entered rate is accurate, and there is no escalation of higher rates in the same way there is for hourly sessions. **(Matter Arising 9)**
- 2.31 We were unable to confirm the agreed WLI session rate was being appropriately applied due to the inconsistent ways these shifts are being created in Patchwork. We saw that the duration of the sessional shifts varied significantly, ranging from 2 hours to 24 hours. Additionally, because sessional shifts allow free-text entry, it was unclear whether the costs were being recorded as a total cost for the shift or on an hourly basis. The set up of shifts in this manner will also make it difficult for management to easily monitor rates of pay. **(Matter Arising 9)**
- 2.32 Of the 591 sessional shifts, 209 (35%) were input into Patchwork retrospectively. Of these, 77% were input more than two-days after being worked, with the highest being 35 days after the shift was worked. The correct management of retrospective shift entries is crucial to avoid an inaccurate financial position. **(See Matter Arising 6)**

Conclusion:

- 2.33 Whilst recent guidance has been issued in relation to the use of WLI sessions, it is clear from our testing that activity other than waiting list work is inappropriately coded to these sessions, impacting the ability to properly monitor WLI work. Where sessions may be for WLI work, we have been unable to confirm the work related to approved WLI bids. We have provided **Unsatisfactory Assurance** against this objective.

Objective 5 Monitoring, reporting and scrutiny of ADH and WLI usage takes place at appropriate levels within the Health Board.

- 2.34 The Medical Workforce Productivity Programme Board (MWPP) is one of six programmes within the Value and Effectiveness (V&E) portfolio. The V&E Board meet monthly and report into the ELG/Transformation Board which is chaired by the Chief Executive.
- 2.35 The MWPP receives highlight reports from the Performance and Escalation Group (PEG). Part of the PEG's responsibility is to scrutinise performance and provide assurance over the delivery of the strategic objectives and operation plans in relation to ADH, agency spend, and rate cards.
- 2.36 Our review of May to July 2024 PEG papers confirmed that this scrutiny is taking place. We saw data in relation to medical and dental variable spend and more specific data on shifts approved above the rate card. Each month, a deep dive is conducted for two of the Care Groups. Risk and escalation issues for the MWPP board are also discussed. We understand that Retinue provide monthly reports to care groups each month.
- 2.37 While we saw evidence of monitoring at PEG meetings, additional areas also require focus, such as the use of retrospective shifts and the approval of out of hours shifts, reason codes, shifts of longer length, and use of the 'manager booking' approach. In addition, the PEG does not appear to monitor WLI sessions. We understand that there is weekly monitoring of WLI activity by the Director of Operations for Planned Care and the Care Groups, but we did not see evidence of these meetings. **(Matter Arising 10)**
- 2.38 We discussed the monitoring of costs relating to ADH and WLI work with the finance team. Finance identified that the volume of retrospective shifts impacts on the monthly accrual, and more importantly, the Health Board's year-end financial position. Finance highlighted that in August, more than £100k was added to the accrual which related to shifts work in March – July 2024. This had an adverse impact on the monthly position, which was simply down to shifts not being added to Patchwork prior to them being worked. **(See Matter Arising 6)**

Conclusion:

- 2.39 We saw evidence of limited monthly monitoring at a care group level taking place at the monthly PEG meeting but saw no WLI monitoring. However, given the data available in the Patchwork app, more detailed scrutiny should take place to identify non-compliance with the FCP and agreed processes. We have provided **Limited Assurance** against this objective.

Appendix A: Management Action Plan

Matter Arising 1: Lack of up-to-date operating procedures (Design)	Potential Impact
At the time of our fieldwork both the Financial Control Procedure (FCP) and the Standard Operating Procedure (SOP) covering the use of agency staff, additional duty hours (ADHs) and Waiting List Initiatives (WLIs) had passed their review dates. While an updated FCP was taken to the October 2024 Audit and Risk Committee for approval, work on the SOP is ongoing, so there is not up to date SOP for staff to use. Management have produced a high-level paper outlining proposed changes to the WLI process and the introduction of a consultant rate card. Whilst this information has been disseminated to Care Group management, not all staff have seen the information. Detailed, step-by-step guidance on processing shifts within the system has not yet been provided. Retinue have created a number of flow charts to help staff use the Patchwork system, but only one of these has been included in the Health Board guidance. Our testing identified inconsistencies in the use of ADHs and WLIs, which emphasises the need for detailed operating procedures. For example: • Retrospective bookings including use of the Retinue out of hours service to reduce such bookings. • Booking of longer length shifts • Timeframes for input and authorisation of timesheets and approval for payment. • WLI / sessional shift activity Training on using the Patchwork app, along with the process maps, is provided by Retinue when the app is downloaded. However, it remains unclear when the last training session was offered or whether staff are aware of the user guide and process maps.	If detailed operating procedures or guidance notes are not in place, the principles set out in the FCP may not be adhered to. Inconsistent practices in place across departments.
Recommendations	Priority
1.1 An updated Standard Operating Procedure (SOP) should be developed, setting out a consistent approach to the application of the Financial Control Procedure.	High

	The SOP should incorporate all relevant information from recently issued guidance on WLI usage and rate cards. Where appropriate it should include the flow charts developed by Retinue. Management should also ensure that the findings of this report are used to identifying other areas where clear processes need to be defined, such as: • Timeframe for entering shifts into Patchwork (e.g. within one week of the shift being worked) and timeframes for approval for payment. • Situations when the creation of shifts retrospectively is acceptable and how the Retinue out of hours service should be used to minimise the need for creating retrospective shift on the system. • When WLI / sessional shifts can be created, and the grade of staff they can be used for. • Definitions of the 'reason' codes and guidance of when they can be used.		
1.2	Once an SOP has been developed: • It should be made accessible to staff via the intranet pages and consideration given to having links to it within the Patchwork app. • Staff should be made aware of its existence. • Consideration given to running training events or overview sessions for key areas to be discussed and allow staff to raise queries.	Medium	
Agreed Management Actions		Target Date	Responsible Officer
1.1	The FCP will be updated to reflect the changes in the audit. The SOP will be finalised to include the points raised in the audit and will align to the FCP. Controls will be reviewed with Retinue to align to the FCP and SOP. Reporting and monitoring of retrospective shifts, WLIs usage and reason codes will be discussed at MWPP: PEG	Jan 2025 Feb 2025 Feb 2025 Mar 2025	Asst. Director of SWP Asst. Director of SWP Asst. Director of SWP Deputy Medical Directors

1.2	Once the FCP and SOP are agreed, both will be made accessible to all and training will be organised.	Mar 2025	Asst. Director of SWP

Matter Arising 2: Direct manager booking (Operation)		Potential Impact
We reviewed data of hourly, on call, and sessional medical shifts for August 2024. We identified that for shifts created in the Patchwork system, 87% were directly assigned to a specific worker by the rota co-ordinator/manager bypassing the system's standard 'worker application' process. These direct manager bookings are intended to be used for bank workers who do not have easy access to a computer to apply for available shifts. Medical staff bookings should follow the 'worker application' route. This practice undermines the proper use of the system to source staff and removes transparency in the booking process as shifts are not openly advertised, denying other eligible staff the opportunity to work the shift.		Lack of transparency in the booking process if shifts are not properly advertised and open to relevant staff to apply for. Inability to achieve value for money if additional hours are not properly advertised.
Recommendations		Priority
2.1	Management should minimise the use of direct bookings within the Patchwork app and encourage managers and rota coordinators to book shifts via the worker application route. To do this: - Rota coordinators and managers should be reminded of the various booking approaches and the circumstances when each can or should be used. The importance of an open and transparent process should also be reiterated. Where necessary refresher training on use of the system should be provided. - Guidance documentation (a SOP) should contain information on the various booking approaches and the circumstances when each can or should be used.	Medium
2.2	Management should implement regular monitoring of booking practices, generating reports to track the use of direct bookings versus the worker system application. Deviations from the established process should be flagged and addressed promptly.	Medium

Agreed Management Actions		Target Date	Responsible Officer
2.1	A reminder on the appropriate booking approaches and when to be used will be shared with rota co-ordinators and managers.	Feb 2025	Asst. Director of SWP
	The SOP will confirm the appropriate booking approaches and when they should be used.	Feb 2025	Asst. Director of SWP
2.2	Monitoring of booking practices will be undertaken monthly and reported to MWPP: PEG.	Mar 2025	Deputy Medical Directors
	Accountability for identifying and reporting deviations will be clarified to address promptly.	Mar 2025	AMD for Medical Workforce

Matter Arising 3: Rate escalation approvals (Design)		Potential Impact	
The approval hierarchy set up in Patchwork for rate escalation approvals is tiered. Shifts priced at up to 25% above the rate card can be approved by care group directors, while shifts more than 25% above the rate card require the Medical Director approval. However, we identified that all authorisers have the same approval level, meaning the tiered structure control process is not operating within Patchwork. We acknowledge that the recently revised FCP has reduced the percentage margins for the tiered authorisation, so revision to levels within Patchwork should align to these new percentages. Additionally, the list of Patchwork authorisers is out of date and does not appear to have been revised for some time. Several of the staff listed have left the organisation or changed roles, so individuals listed may not have the appropriate authority to approve shifts. This could lead to improper approvals and a lack of oversight in managing rate exceptions.		Inappropriate approval of rates. Inconsistent approaches to rate approvals.	
Recommendation		Priority	
3	The tiered rate escalation approval system within Patchwork should be reviewed to ensure: - Limits are set up that align to the revised FCP. - Authorisers are set up in groups that align to their approval level, with no authorisers being able to approve at both below 10% escalated rates and above escalated rates. Rate approvers should also not be the same staff who can authorise timesheets for payment. - Only current and relevant staff are set up with authorisation access. Periodic reviews of rate authorisers and their access should take place to ensure appropriateness.	High	
Agreed Management Action		Target Date	Responsible Officer
3	The alignment of the process between People and Retinue has been addressed.	Dec 2024	Asst. Director of SWP

A review of the authorisation process commenced before the audit and evidence sent to the auditor. The authorisation rate within Retinue has been corrected to 10% instead of 25%. A review of authorisers will be undertaken and updated within the Retinue and Patchwork systems.	Dec 2024	Asst. Director of SWP
	Feb 2025	Asst. Director of SWP

Matter Arising 4: Long shifts (Operation)		Potential Impact
Our analysis of the 2,104 hourly shifts booked and worked in August 2024 showed 170 were over 12 hours long. Of these, 15 were recorded in Patchwork as being for shifts of either 23 or 24 hours. We were unable to determine if staff had worked these long shifts or if the shifts had been created to provide a larger payment equivalent to a higher hourly rate. If staff have worked long hours this may create a risk relating to patient safety and staff wellbeing. We also noted instances where the narrative information for these bookings suggested that some relate to 'on call' shifts and have been miscoded as hourly shifts.		Patient safety and quality impacted if staff work excessive shifts. Staff wellbeing impacted if they are required to work excessive shifts.
Recommendation		Priority
4	Management should undertake monthly reviews of Patchwork data to identify shift bookings that are considered excessive, such as greater than 12 hours. A further analysis by care group and directorate would help to target areas where long shifts are being recorded. Appropriate action should be taken to ensure: • Patient safety and staff wellbeing are not being compromised. • Ensuring that higher equivalent hourly rates are not paid by paying for longer shifts. • Staff are reminded to properly code shifts to ensure correct rates are paid and accurate information is captured in the system. Where excessive shift lengths continue, the Health Board could liaise with Patchwork to establish if controls can be included in the system that requires additional authorisation for shifts above a certain length.	High

Agreed Management Action		Target Date	Responsible Officer
4	The SOP will confirm the approach to working long shifts and the appropriate reason codes.	Feb 2025	Asst. Director of SWP
	A process to periodically review of long shifts by CG will be initiated	Feb 2025	Asst. Director of SWP
	Control options will be discussed with Retinue (Patchwork) regarding long shifts to establish what is possible	Feb 2025	Asst. Director of SWP
	Monitoring long shifts will reported at MWPP:PEG	Mar 2025	Deputy Medical Directors

Matter Arising 5: Use and monitoring of reason codes (Operation)		Potential Impact
Each shift created within Patchwork is assigned a 'reason' code to explain why the shift is necessary. In August 2024, a total of 21 different reason codes were used when booking the 2,104 hourly shifts. The most frequent reason code used was 'establishment vacancies' which accounted for 1,554 (74%) of the shifts. This suggests a more reactive approach to filling gaps in rotas and workforce management rather an approach that may address the underlying vacancies. We also identified that there is no monitoring or analysis of the reason codes used. As such, it is unclear if all of the shifts in August 2024 recorded as establishment vacancies could be reconciled to a vacancy within the respective department.		Inaccurate capture of data meaning inaccurate reporting and ability to interrogate data.
Recommendations		Priority
5.1	Evaluate the existing reason codes to ensure they all remain relevant and accurately reflect the needs of the organisation. Simplifying and standardising the reasons could streamline the process and improve clarity in data reporting.	Medium
5.2	In order to ensure accurate data is captured and available for future analysis, management should include the reason codes, and a description of when they should be used, within the user guidance. Staff should be reminded of the importance of selecting the correct reason code for a shift. This will enhance the accuracy of data collection and reporting, aiding in more effective decision-making.	Medium
5.3	Management should produce and analyse periodic reports on the level of use of reason codes for hourly shifts. Particular attention should be paid to those departments that regularly book shifts using the 'establishment vacancies' code to determine what work has been taken to tackle vacancy issues.	Medium

Agreed Management Actions		Target Date	Responsible Officer
5.1	The mandated fixed codes will be reviewed and streamlined.	Feb 2025	Asst. Director of SWP
5.2	The SOP will include the reason codes and when they should be used. The reason codes used and volumes will be reported to MWPP: PEG.	Feb 2025	Asst. Director of SWP
		Mar 2025	Asst. Director of SWP
5.3	Quarterly audits will be undertaken by CGs to review reason codes and the volumes of each.	Apr 2025	Deputy Chief Operating Officers

Matter Arising 6: Retrospective shifts (Operation)	Potential Impact
Our analysis of the August 2024 data identified 712/2,903 (25%) of the shifts had been created retrospectively. Of these, 426 were classified as 'hourly' shifts. Retrospective shift data is reported in two categories: shifts that are input within two days of being worked; and shifts that were input more than two days. 289 (68%) of the hourly shifts were created more than two days after the shift was worked, within which, we found instances where shifts had been entered up to a month after being worked. We also reviewed the reasons for these retrospective shifts: 265 were due to establishment vacancies, 31 to short-term sickness, and 22 to annual leave. 'Establishment vacancies' should not be used for retrospective shifts as vacancy gaps in a rota would be known in advance. Similarly, if hourly shifts are used to cover annual leave, these should also be known and booked in advance. Additionally, 7/426 shifts were paid above the approved rate card. Whilst we saw appropriate approval within Patchwork, this was after the shift had been worked, leaving no opportunity for the rate to be challenged or not agreed. Our testing also identified 209/591 WLI shifts that were created retrospectively As WLI clinics are planned in advance, these shifts should have not required retrospective creation. The correct management of retrospective shift entries is also key to avoiding an inaccurate financial position, as if a shift is not captured in Patchwork, it is not accrued. We acknowledge that there will be instances where hourly shifts are worked at short notice or outside of normal working hours. Retinue has developed a process map for out-of-hours bookings to aid the creation of shifts in Patchwork ahead of them being worked. As part of this process, Retinue has an out-of-hours (OOH) team that managers or the on-call executive can contact if a shift needs to be created on the system, but they do not have the access to create the shift themselves. Where there are escalated shift rates, the team requires approval via email. However, we understand that the Retinue OOH team is seldom contacted, and urgent or OOH shifts are regularly added retrospectively by the departments, making it difficult to accurately monitor and track these shifts.	Inability to challenge shift rates with higher rates inappropriately paid. Misreporting of financial position as shifts are not accrued.

Recommendations		Priority	
6.1	Management should analyse and monitor retrospective shifts created by care groups to address the root cause of retrospective shifts in each area, especially those entered more than two days after being worked, or where an inappropriate reason code has been used.	High	
6.2	To reduce the occurrence of retrospective shifts, clearer guidance should be in place for: - When retrospective shifts are acceptable, how higher rates should be authorised, the correct use of reason codes and the maximum timeframes for creating the shift in Patchwork after the shift has been worked. Consideration should be given to requiring additional approval where there are significant delays in creating the shift. - Using the Retinue out of hours service to book urgent or outside of normal working hours shifts that cannot be processed in advance by the manager or on duty executive.	Medium	
Agreed Management Action		Target Date	Responsible Officer
6.1	The SOP will confirm the approval control process and appropriate use of retrospective shifts within the Retinue and Patchwork systems.	Feb 2025	Asst. Director of SWP
	Monitoring and analysis of the use of retrospective shifts to be discussed with CGs.	Feb 2025	Deputy Medical Directors
6.2	This is covered in 6.1 above.	Jan 2025	Deputy Chief Operating Officers
	Controls for retrospective approvals will be confirmed. To be analysed and trends will be shared at MWPP: PEG	Mar 2025	Deputy Medical Directors

Matter Arising 7: Removing mandatory breaks within the system before shift is worked (Operation)		Potential Impact	
We were informed that the automatic break function had been applied within the Patchwork app on 31/07/2024. However, our testing of hourly shifts created and worked in August 2024 identified 86/1,043 shifts which were in excess of six hours and had no break included when the shift was set up. As such, it appears that the break had been 'removed' when the shift was created on the system.		Additional costs incurred by the Health Board. Patient safety compromised if staff are unable to take breaks.	
Recommendations		Priority	
7.1	Management should ensure that breaks are not removed when the shift is created. Consideration should be given to implementing a validation step within Patchwork that requires reason codes to be captured if breaks are removed, in the same way they are required if a worker removes a break from a worked shift if they were unable to take the break.	Medium	
7.2	Management should circulate clear and updated guidelines regarding the automatic break function and break policy, especially emphasising the correct process for shifts longer than 6 hours.	Medium	
7.3	Implement a monthly review of shifts where breaks were removed, focusing on shifts longer than six hours. This will help identify patterns of non-compliance and address issues proactively.	Medium	
Agreed Management Actions		Target Date	Responsible Officer
7.1	The automatic break function was turned on 31 st July 2024. Further work to be undertaken with Retinue / Patchwork to ensure that breaks are not removed when shifts are created. Ongoing monitoring will take place to ensure compliance with the SOP.	Jan 2025	Asst. Director of SWP

7.2	The updated guidelines for the automatic break function and break policy to be circulated.	Feb 2025	Asst. Director of SWP
7.3	To work with Retinue to develop reporting for monitoring at MWPP: PEG.	Mar 2025	Asst. Director of SWP

Matter Arising 8: Shifts approved or paid without a timesheet input by the employee (Operational)		Potential Impact	
Our testing identified that 2,700/2,903 shifts worked in August were paid or had payments approved. 159/2,700 were processed without an electronic timesheet being submitted by the employee. The majority of these payments related to sessional work, and we understand that the rota co-ordinator will have input the hours on behalf of the employee. The input of timesheets by the employee is a critical part of the payment process, as they provide an official declaration of the hours worked, ensuring that payments are made accurately and in line with the hours completed.		Financial loss to the Health Board if payments are made against shifts that were never worked or not worked in full.	
Recommendations		Priority	
8.1	Clear guidance should be available to staff emphasising the importance of timely and accurate timesheet submissions by the employee (and not the rota co-ordinator) and the consequences of non-compliance. Guidance should include instructions on how to submit electronic timesheets and the timeframe they should be submitted in. Where necessary, training on the use of the Patchwork app should be provided to shift workers.	Medium	
Agreed Management Action		Target Date	Responsible Officer
8.1	A review of the timesheet process will be undertaken with Retinue and Patchwork to ensure the correct authorisation process is followed in accordance with the SOP.	Jan 2025	Asst. Director of SWP

Matter Arising 9: The use of sessional shifts (Operation)	Potential Impact
August 2024 data showed 591 shifts coded as WLI. Our review identified: - Only 160 shifts gave 'waiting list' as the reason code for creating the shift in the Patchwork app. 292 sessional shifts were to cover establishment vacancies and a further 65 to cover annual leave. WLI sessions should not be used for these reasons. - WLI sessions are only to be allocated to consultants, yet 144 sessional shifts were assigned to more junior medical staff. - We were unable to obtain a comprehensive list of agreed WLI sessions, so we were unable to confirm that shifts coded as WLI were relating to pre-agreed WLI work. - The rate field is a free text box for sessional work, which means any rate can be entered when creating these shifts, and there is no authorisation of higher rates in the same way there is for hourly sessions. Our testing identified sessional shifts created to cover hourly sessions where rates of pay were above the rate card value. As these higher rates had historically been agreed, the department appeared to use the sessional code to avoid the need for getting re-approval. - We were unable to confirm the agreed WLI session rate was being appropriately applied due to the inconsistent ways these shifts are being created in Patchwork. We saw the duration of the sessional shifts varied significantly, ranging from 2 hours to 24 hours. Additionally, because sessional shifts allow free-text entry, it was unclear whether the costs were being recorded as a total cost for the shift, or on an hourly basis.	Additional costs incurred by the Health Board. Inability to properly monitor and report on WLI work.
Recommendations	Priority
9.1 Clear procedures should be in place in relation to WLIs and made available to staff that includes information on a standardised process for creating sessional shifts within the system i.e. consistency between either hourly rates or total costs and ensuring shift duration is accurately recorded. Consideration should be given to providing training for rota coordinators, managers, and relevant staff to ensure they are fully aware of the guidelines and understand the correct usage of sessional shifts.	High

9.2	To aid consistency and monitoring of costs, management should determine if the free-text box for recording sessional shift costs is appropriate, or if a fix rate should be captured in the system. This will also allow appropriate escalation within the system, should anyone request rates above those agreed.	High	
9.3	Management should liaise with Retinue to identify if a control can be built into the process that only allows the 'waiting list' reason code to be selected for WLI sessions. Where this is not possible, management should remind staff of the need for accurate coding and ongoing monitoring should take place to identify non-compliance.		Medium
9.4	Management should remind staff that WLI sessions should only be used for consultants in line with the Welsh contract. Ongoing monitoring should take place to identify non-compliance.		Medium
9.5	Monitoring of shifts coded as sessional should take place to ensure they reconcile back to COO agreed WLI activity.		Medium
Agreed Management Action		Target Date	Responsible Officer
9.1	The SOP will set out the approach for WLIs. Reporting and monitoring will be shared at MWPP: PEG.	Feb 2025 Mar 2025	Asst. Director of SWP Deputy Medical Directors
9.2	Free text option will be reviewed with Retinue and Patchwork systems in line with the FCP and SOP to ensure application of WLIs are applied correctly.	Jan 2025	Asst. Director of SWP
9.3	To discuss with Retinue what controls can be built into the (Retinue and Patchwork) systems	Mar 2025	Asst. Director of SWP
9.4	Management will be reminded of the use of WLIs	Feb 2025	Medical Director

9.5	Monitoring of shifts coded to ensure they reconcile back to COO agreed WLI activity.	Feb 2025	Deputy Chief Operating Officers

Matter Arising 10: Monitoring (Operational)		Potential Impact	
Monitoring of ADH and WLI data should take place at the Performance Escalation Group (PEG), who report into the Medical Workforce Productivity Programme. Our review of papers from May to July 2024 confirmed that there was broad monitoring on areas such as medical and dental variable pay, job planning and high earners. Monitoring in relation to ADH and WLI appears to be restricted to authorisations above the rate card limit. We did not see evidence of monitoring on areas such as retrospective shifts, longer length shifts, correct use of reason codes, and the link with establishment vacancies. Furthermore, we did not see detailed monitoring of WLI / sessional shifts.		Non-compliance with the FCP goes undetected and action is not taken to correct inappropriate approaches to booking and managing shifts. Additional financial costs to the Health Board.	
Recommendations		Priority	
10 Given the wealth of data that is available in the Patchwork app, the Health Board should liaise with Retinue to determine a suite of reports that can be routinely received and analysed to identify non-compliance with the FCP. The reports should be used to enhance the current monitoring at the PEG meeting, and to allow scrutiny in a wider range of matters.		High	
Agreed Management Action		Target Date	Responsible Officer
10	A review of CG access to Retinue and Patchwork will be undertaken	Feb 2025	Asst. Director of SWP
	A review of Retinue (Patchwork) reporting will be undertaken to support the FCP and SOP	Mar 2025	Asst. Director of SWP
	MWPP: PEG reporting will be updated to reflect the recommendations in the audit.	Mar 2025	Asst. Director of SWP

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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



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Charitable Funds

Final Internal Audit Report

2024/25

Cwm Taf Morgannwg University Health Board



Reasonable Assurance

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Review Reference

CTM-2425-20

Fieldwork

September to October 2024

Executive Sign Off

9 December 2024

Audit Committee

17 December 2024

Executive Lead

Sally May, Director of Finance

Audit Team

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

Executive Summary

Purpose

The objective of the audit was to review the processes in place within the Health Board to ensure that charitable funds are appropriately managed and administered in accordance with relevant legislation and Health Board guidance.

Overview

Charitable funds is the term given to money that is donated to the Health Board and is administered through a registered charity: Cwm Taf Morgannwg NHS General Charitable Fund (the 'Charity'). The Health Board is the corporate trustee of the Charity and has appointed the Charitable Funds Committee (CFC) to oversee the management of the funds. There are over 150 individual funds making up the charity, with the day-to-day administration of the funds delegated to fund managers.

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

- The need to revisit the recently approved Financial Control Procedure (FCP) for Charitable Funds to ensure it fully reflects the process and governance arrangements that should be place, including greater clarity on the use of retrospective orders, and the role of the Audit and Risk Committee.
- Ensuring all supplementary guidance is reviewed and aligns to the FCP, and that the most up to date documents are available to staff.
- Providing greater clarity on the monitoring and subsequent management of low value and dormant funds, and to consider the need to monitor higher value funds.
- Ensuring there is a clear policy / strategy in relation to investments and ensure there is monitoring to confirm investments are made in line with the Health Board's agreed approach.

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

- The process for requisitioning goods and services should be reviewed with a view to streamlining it, especially with regards to the level of involvement required by the finance team.
- Consideration should be given to raising awareness of the gift aid process amongst those staff responsible for receiving donations from the public.

Scope & Assurance Summary

Objectives		Related Findings	Assurance
1	Policies and Procedures are in place for the appropriate management of the charitable funds, including training, guidance and management for fundholders.	1	Reasonable
2	Suitable processes are in place to ensure charitable funds income received is accounted for in line with donor wishes and gift aid declarations. Setting up new funds is avoided where possible.	1	Substantial
3	Charitable funds expenditure is appropriate, authorised in line with delegated limits, and is within the terms of the relevant fund.	2	Reasonable
4	Effective governance arrangements are in place for the charitable funds.	1, 3	Reasonable
5	Charitable funds are appropriately monitored, managed and invested.	4	Reasonable

Summary of Management Actions

The table below summaries the findings made, their priority rating, theme and details on whether the finding relates to a control design issue or control operation issue. We group our findings into themes, which allows us to identify common themes and trends across NHS Wales organisations.

0	4		
High Priority	Medium Priority		
	Policies & Procedures	[Control Design]	
	Financial Management & Control	[Control Design]	Control Design Issues: Inadequate or poorly designed controls that do not address risks
	Governance	[Control Operation]	
	Financial Management & Control	[Control Design]	Control Operation Issues: Controls that are not executed correctly or consistently
			3
			1

Findings & Agreed Action Plan

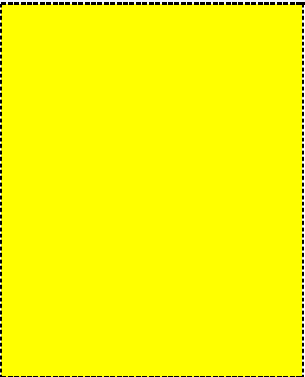
Objective 1: Policies & Procedures	Reasonable

Overview / Summary of Observations

The Health Board has a Financial Control Procedure (FCP 16) for Charitable Funds. The version available for staff on the intranet is dated 2016. In August 2023 the Audit & Risk Committee approved a revised FCP in relation to Charitable Funds, but a finalised version has not been saved to the intranet. A further revised FCP was submitted to the October 2024 meeting of the Charitable Funds Committee (CFC) for endorsement prior to submission to the Audit & Risk Committee (ARC) for approval.

In addition to the FCP, supplementary guidance is available in the form of a 'Charitable Funds Requisition Process' which is a step-by-step guide to the Oracle finance system and a 'Finance Guide to Charitable Funds'.

Key Findings		Risk & Impact	Agreed Management Action
1	Procedures and guidance Whilst the FCP has recently been updated some minor errors and discrepancies remain between the procedure and its appendices and the supplementary requisitioning and finance guidance documents. We note: - Section 2 - Creation of Charitable Funds - there is inconsistency regarding the approver details and the form Appendix A. - Section 9 - Investments & Administration Costs - sets out responsibilities regarding charitable funds investments, which refers to providing updates to the ARC regarding the investment portfolio including, consideration of ethical issues arising from the investments and the approval of changes to the investment policy. We believe this may be a legacy requirement prior to the establishment of the CFC. - Appendix B and C – Donation receipt form and Gift Aid form – both use the previous name of the Health Board. However, we note a revised form is used that is a combination of receipt acknowledgement and gift aid declaration, which negates the need for Appendix B and C. - There is ambiguity around the need for a Statement of Need (SON) for purchasing medical equipment. The FCP states a SON may need to be considered, whereas the Oracle requisition process document requires a SON.	Lack of clear guidance to staff leading to non-compliance with operational policies and legislative requirements.	Agreed Action: The FCP and supplementary guidance will be reviewed to ensure accuracy and consistency. All guidance will be available to staff via a single section of the intranet.
			Expected Evidence of Implementation: Revised FCP and supplementary guidance. Updated versions save to internet and single source of intranet information pages for Charitable Funds.

• The requisition process document has links to training information and forms, but the links no longer work. The document refers to the CEO authorising orders above £50k, whereas this is the responsibility of the CFC. • The Finance Guide contains an out of date (2018) list of funds. We also note that the supplementary guidance documents are held in different parts of the intranet, as opposed to having all guidance in one place. In addition, at the time of our fieldwork the FCP from 2016 was the version available on the intranet.		Officer: Owen James – Head of Corporate Finance Proposed Date: 28 February 2025
Theme: Policies & Procedures		Control Design

Overview / Summary of Observations

The FCP provides suitable guidance for processing charitable donations received by the Health Board. As we note in finding one, the FCP needs to be updated to reflect the latest forms in use for recording receipts and gift aid donations.

We tested a sample of donations to ensure they were processed in line with the FCP in place at that time of our fieldwork. We found that income had been accounted for in accordance with donor wishes, and where relevant, the gift aid declarations had been appropriately made and claimed. We note that a relatively low proportion of the donations that we sampled had a completed gift aid form. While we are not clear why this was, there may be a lack of awareness of the gift aid process by staff receiving donations and completing receipts, resulting in a potential loss of income into the charitable funds.

Our sample included a donation of £50,000, and we confirmed that the Head of Corporate Finance had appropriately given prior approval to the donation being accepted.

Since January 2024 two new funds have been set up. We confirmed that they had been set up appropriately in line with the process set out in the FCP.

Overview / Summary of Observations

The purchasing of goods and services from charitable fund accounts is through the Oracle finance system. This process is accompanied by a paper form that must be completed by the requisitioner, approved by the fund holder to confirm they agree to the spend, and checked by finance to confirm the fund balance is sufficient to cover the costs. A scanned copy of the paper form is attached to the order in Oracle. While our testing did not identify issues in relation to the process, moving to electronic approval forms and fund holders using budget reports to confirm fund balances ahead of approval in Oracle, instead of finance staff doing this check, could improve efficiency.

Our testing of a sample of expenditure transactions found that all expenditure was in line with the purpose of the fund and was appropriately approved. We identified a small number of the orders that were raised and approved retrospectively.

Key Findings		Risk & Impact	Agreed Management Action
2	Retrospective approval of expenditure We reviewed a sample of 20 orders from various funds and in two cases found that the expenditure had been retrospectively approved. It is unclear why approval of this expenditure and the checking of fund balances had not taken place in advance. The FCP has a form specifically for retrospective reimbursements and it had been used on both occasions. However, the FCP is not explicit in stating the circumstances when retrospective approval is acceptable.	Lack of prior authorisation to spend funds, spending not in line with fund purpose and insufficient funds to cover expenditure incurred.	Agreed Action: The FCP and supplementary guidance will be reviewed and updated to explain that retrospective (reimbursement) orders should be an exception and provide greater clarity on when they may be acceptable.
		Medium Priority	Expected Evidence of Implementation: Updated FCP and minimal use of retrospective (reimbursement) orders.
	Theme: Financial Management & Control	Control Design	Officer: Owen James – Head of Corporate Finance Proposed Date: February 2025

Overview / Summary of Observations

The Charitable Fund Committee (CFC) has responsibility for oversight of the charitable funds. There are terms of reference in place for the committee and these were recently reviewed and approved at the October 2024 meeting of the Health Board. The Standing Financial Instructions of the Board also set out the delegated officers and financial limits in relation to charitable funds.

During our review of the FCP we saw a reference to the investment responsibilities of the Audit & Risk Committee (ARC) in relation to charitable funds, which appears to duplicate some responsibilities of the CFC. It appears that the ARC responsibilities were a requirement before the CFC was established and the FCP has not been updated to reflect this change.

The terms of reference of the CFC refer to an investment strategy, and the FCP sets out the Health Board's investment policy requirements in relation to charitable funds. We have not seen an investment policy or strategy in place; however, we saw some strategic investment information in the charitable funds update reports taken to meetings of the CFC.

Key Findings		Risk & Impact	Agreed Management Action
3	Investment Policy / Strategy In accordance with the FCP, the Health Board should have an agreed investment policy to act as a guide for making investments, considering the level of returns expected, and the level of risk to be tolerated. The terms of reference of the CFC refer to the committee having oversight of investments in accordance with the investment strategy. We saw limited investment strategy information included in the charitable funds update reports presented at the CFC meetings. It is unclear if this information is considered to be the Health Board's policy / strategy, or if a more comprehensive document exists. Whilst there is some information included, for example the approach should reserves exceed the investment by a certain amount, key information about the type of funds to be used (e.g. ethical), the level of expected returns and the risk to be tolerated is not included. The paragraphs also state the strategy will be reviewed annually, with particular regard to risk and return, but we can not see where this has taken place. The information contained in these paragraphs again refers to the ARC's role in approving suitable investments, which we cannot evidence and believe is no longer not part of their remit.	Funds are not used to maximise gain. Investments are made that that are not in line with the Health Board's ethos.	Agreed Action: A clearly defined investment policy / strategy will be developed and approved at the relevant committee. The policy / strategy will be reviewed and approved on an annual basis, with particular regard to risk and return. Monitoring of investment activity, to ensure it is in line with the agreed investment policy / strategy, will take place at the relevant committee.
		Medium Priority	Expected Evidence of Implementation: Copy of an investment policy or strategy. Approval at relevant committee. Papers / minutes from relevant committee to evidence monitoring against the policy / strategy.
			Officer: Owen James – Head of Corporate Finance Proposed Date: July 2025
Theme: Governance		Control Operation	

Overview / Summary of Observations

Fundholders receive monthly statements detailing the transactions that have taken place in the year to date for their fund. While there are no regular meetings between fundholders and finance to review the financial position of the funds, fundholders can discuss queries with finance.

The CFC meets twice a year. Prior to these meetings the fund balances are reviewed by the finance team to identify low value funds, or where there has been low or no use of the fund in the financial year. This information is included in the charitable funds update report submitted to the CFC by the Head of Corporate Finance. No information is presented in relation to high value funds. We also note that the FCP does not define what is a low or high value fund, when a fund is considered to be dormant, and what action will be taken with these funds.

Each quarter the finance team receive reports from the investment management company in relation the performance of the charitable fund investment portfolio. These include the current value of the portfolio and any significant changes since the previous report. These performance reports are taken to meetings of the CFC meetings. We note that at the most recent CFC meeting in October, a copy of the investment report was not included on the agenda, as the investment management company attended the meeting to present an update on the portfolio.

While the charitable fund update reports include a brief summary of the investment portfolio performance, in the absence of a clear investment policy or and strategy, it is unclear if investments are being made in accordance with the Health Board's principles. We acknowledge that all of the Health Board's charitable funds are invested in the investment company's ethical investment fund.

Key Findings	Risk & Impact	Agreed Management Action
4 Monitoring of Funds The CFC receive reports at each meeting that include information on low value funds (below £1,000) and funds with low, or no activity in the financial year (dormant). There are approximately 150 funds and the September 2024 CFC update report lists 100 funds with no expenditure in the year and 36 funds with balances below £1,000. The charitable fund update reports to CFC do not include information about high value funds where there is little or no activity and what is being done to encourage spend in line with the purpose of the funds. We note that the FCP does not include guidance on what constitutes a low or high value fund, or when a fund may be classified as dormant, and the subsequent actions required. We did not see monitoring of low value or low use funds outside of the six-monthly analysis that takes place to prepare reports to CFC. However, we understand that a review of low value and low usage funds has started but has been paused while work	Funds are not properly monitored leading to their ineffective use.	Agreed Action: We will define the criteria of 'low value' and of 'dormant' in order for there to be a consistent approach to monitoring. We will set out the actions to be taken if funds are classed as low value or dormant including the process for merging funds where needed. Once our review of fund management responsibilities has taken place, our comprehensive review of all funds will take place and going forward, we will consider if more frequent monitoring is required, for example quarterly instead of six-monthly. We will incorporate a review of high value funds especially those with low activity as part of our update reports to the CFC. As per the FCP, we will require fund managers to prepare spending plans for monitoring by the finance team and CFC. Expected Evidence of Implementation: Agreed process for the management of low value and dormant funds.

	focuses on the structure of funds in relation to the revised operating model and changes in management responsibilities.	Medium Priority	Officer: Abe Sampson – Head of Charity & Income Generation Proposed Date: 28 February 2025
	Theme: Financial Management & Control		
		Control Design	

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

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

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

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

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.



Prince Charles Hospital Redevelopment - Validation of Management Actions Final Internal Audit Report 2024/25

Cwm Taf Morgannwg University Health Board



Substantial Assurance

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Status of Previously Agreed Recommendation 2

Appendix A 5

Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

CTM-SSU-2425-37

November 2024

December 2024

December 2024

Sally May, Executive Director of Finance

Huw Richards, Head of Internal Audit

Eifion Jones, Deputy Head of Internal Audit



Executive Summary

Purpose

This audit originates from the 2024/25 integrated audit plan agreed with management and approved by the Audit & Risk Committee. The overall objective of this audit is to deliver assurance to the Audit Committee that timely and appropriate management action has been applied to address risks identified and reported at the PCH Redevelopment Audit Reports from 2023/24, particularly:

- Validation of Management Action – December 2023 – Substantial Assurance
- Supervisor Role – December 2023 – Substantial Assurance
- Financial Assurance – April 2024 – Reasonable Assurance
- Key Project Objectives – July 2024 – Reasonable Assurance

Overview

All 14 of the agreed actions from the prior reviews have been closed as per table below:

	High	Medium	Low	Total
Closed	-	13	1	14
Partially Implemented	-	-	-	-
Outstanding	-	-	-	-
Total	-	13	1	14

Further audits will be progressed in these areas as a part of the 2024/25 agreed Integrated Audit Plan. This will enable us to further consider and appraise the ongoing effectiveness of the actions taken by management. As a result, we have concluded **substantial assurance** on this area.

Further details on each recommendation are provided below.

Status of Previously Agreed Recommendation

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
Validation of Management Action – December 2023 – Substantial Assurance				
No outstanding recommendations.				
Supervisor Role – December 2023 – Substantial Assurance				
1	The management of observations / defects (and specifically the rate of closure) should be highlighted at progress meetings to gain increased traction.	Responsible Officer, PCH Construction Programme December 2023	Medium Priority	Closed - Supervisor's report re-formatted to draw attention to outstanding defects.
2	The monthly Supervisor Reports could be improved in terms of the clarity of key information provided. The following is suggested: Assurance dials could be used for each key area (progress against programme, quality of works, progress in closing defects/observations etc.), with an indication of movement from the prior month.	Responsible Officer, PCH Construction Programme January 2024	Medium Priority	Closed - Supervisor's report re-formatted to draw attention to priority of outstanding defects.
	The data provided in respect of defects/observations closed/outstanding, could be enhanced to provide information regarding the priority nature of the defects which have not been actioned (e.g. high priority/low priority).	Responsible Officer, PCH Construction Programme January 2024	Medium Priority	Closed- Supervisor's report re-formatted to include visual representation of assurance status.
Financial Assurance – April 2024 – Reasonable Assurance				
1	Improved monitoring protocols should be embedded within the valuation scrutiny process for individual hours worked on-site.	Responsible Officer, PCH Construction Programme July 2024	Medium Priority	Closed – Additional controls had been established to monitor time charged on site. Effectiveness of these controls will be reviewed as part of future reviews.
2	On a periodic basis, management should review the administration of compensation events against contractual requirements.	Responsible Officer, PCH Construction Programme July 2024	Medium Priority	Closed - Change control mechanisms had been adapted to incorporate additional administration dates. Effectiveness of these controls will be reviewed as part of future reviews.

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
3	Management should ensure compliance with payment timescales e.g. communicate with NWSSP Accounts Payable to confirm contractual obligations and ensure compliance.	Responsible Officer, PCH Construction Programme July 2024	Medium Priority	Closed- Correspondence exchanged with NWSSP stressing the need to comply with contracted payment timescales.
4	Management should engage with the Supply Chain Partner to ensure that subcontractors are promptly paid for certified work.	Responsible Officer, PCH Construction Programme July 2024	Medium Priority	Closed - Discussions held with Supply Chain Partner and with NWSSP SES. There is recognition of the differing contractual payment stipulations between existing sub-contractor contract terms prior to the PBA being introduced.
Key Project Objectives – July 2024 – Reasonable Assurance				
1.1	The Health Board should evaluate and source possible funding options (if full, partial, or no additional funding is realised) as a matter of priority. This may also include an evaluation of wider options e.g. continuation, reduced scope etc.	Responsible Officer, PCH Construction Programme September 2024	Medium Priority	Closed – Various sources of funding had been evaluated including gain share on previous sections. Also, discussion fronted by UHB VAT advisers, on behalf of the Health Board, is ongoing with HMRC about VAT recovery.
1.2	The current programme funding risks should be noted at the programme risk register.	Responsible Officer, Prince Charles Hospital Construction Programme September 2024	Medium Priority	Closed - Risk register updated.
2.1	The dispute on design fees for Section 7 should be agreed as a matter of priority.	Responsible Officer, Prince Charles Hospital Construction Programme October 2024	Medium Priority	Closed– design fees have been agreed with certain elements disallowed by the Project Manager. However, design services had been fully reinstated.
2.2	The performance indicator for the 'programme' should be updated to reflect potential delays that may arise from the issues relating to Section 7.	Responsible Officer, Prince Charles Hospital Construction Programme September 2024	Medium Priority	Closed – Performance indicator updated.

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
2.3	The programme risk register should include risks pertaining to the Section 7 design fee, disputed/ withheld fees and the increased cost/ programme associated with the works.	Responsible Officer, Prince Charles Hospital Construction Programme September 2024	Medium Priority	Closed – Risk register updated.
3.1	The risk register should be reviewed for accuracy and updated to reflect the status of the programme.	Closed	Medium Priority	Closed - Risk register updated.
4.1	The externally appointed PM will verify that contractor's insurances remain current and update the progress report accordingly.	Responsible Officer, Prince Charles Hospital Construction Programme September 2024	Low Priority	Closed – Updated insurance documents provided.

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

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



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

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.



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

Date issued: December 2024

Document reference: 3313A2023

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

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting on the economy, efficiency, and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

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About this document

- 1 This document provides the Audit and Risk Committee with an update on our current and planned accounts and performance audit work at Cwm Taf Morgannwg University Health Board.
- 2 We also provide additional information on:
 - Other relevant examinations and studies published by the Audit General.
 - Relevant corporate documents published by Audit Wales (e.g. fee schemes, annual plans, annual reports), as well as details of any consultations underway.
- 3 Details of future and past Good Practice Exchange (GPX) events are available on our [website](#).

Accounts audit update

4 **Exhibit 1** summarises the status of our current and planned accounts audit work.

Exhibit 1 – Accounts audit work

Area of work and	Executive Lead	Focus of the work	Current status	Planned date for consideration
Audit of the 2023-24 Charitable Funds Annual Report and Accounts	Executive Director of Finance	To provide an audit opinion on the 2023-24 Annual Report and Accounts.	We are currently auditing the Annual Report and Accounts, which is mostly done.	Trustee Members are meeting on 30 January 2025 to consider the audited Annual Report and Accounts; and the Auditor General is scheduled to certify them on 31 January. This date meets the

				Charity Commission's deadline.
Audit of the 2024-25 Annual Report and Accounts	Executive Director of Finance	To provide an audit opinion on the 2024-25 Annual Report and Accounts.	We expect to commence audit planning in January 2025; and present the 2025 Audit Plan to the Audit and Risk Committee in the first few months of next year.	Early 2025, regarding the Audit Plan. The Welsh Government's deadline for audit certification is 30 June 2025, being two weeks earlier than the equivalent deadline in 2024.

Performance audit update

5 **Exhibit 2** summarises the status of our current and planned performance audit work.

Exhibit 2 – Performance audit work

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
Primary Care Services - Follow-up Review (Local Work 2023)	Chief Operating Officer	In 2018, we conducted a review of primary care services, specifically considering whether the Health Board was well placed to deliver the national vision for primary care as set out in the national plan. We made several recommendations to the Health Board. This work follows-up progress against these recommendations.	Report finalised and included in today's meeting papers.	December 2024
Structured Assessment 2023 – Deep Dive – Cost Savings	Executive Director of Finance	This work examines the approach the Health Board is taking in respect of achieving cost improvements, efficiencies, and financial sustainability.	Draft report issued to the Health Board for comment and review.	February 2025

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
Structured Assessment – core	Director of Corporate Services / Board Secretary	This work will review the following core areas: • Board and committee effectiveness, cohesion, and transparency. • Corporate systems of assurance. • Corporate planning arrangements. • Corporate financial planning arrangements.	Draft report issued to the Health Board for comment and review.	February 2025
Review of Unscheduled Care	Chief Operating Officer	This work examines different aspects of the unscheduled care system and includes analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. The work includes an examination of the actions being taken by NHS bodies, local government, and Regional Partnership Boards to secure timely and safe discharge of patients from hospital to help improve patient flow (Part 1). We are also reviewing progress being made in managing unscheduled care	Part 1 – Regional report drafting Part 2 – Fieldwork Underway	February 2025 February 2025

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
		demand by helping patients access services which are most appropriate for their unscheduled care needs (Part 2).		
Structured Assessment 2024 – Deep Dive – Digital	Director of Digital	This work will examine digital arrangements, with a particular focus on how the Health Board is investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.	Scoping	To be confirmed
All-Wales thematic review of planned care	Chief Operating Officer	This work follows on from the national report on <u>tackling the planned care backlog</u> and considers: • The extent that health boards have achieved Welsh Government targets for recovering planned care services; • The efficacy of local plans and activity to recover waiting lists; and • Use of the additional Welsh Government financial allocations to improve waiting lists.	Fieldwork underway	To be confirmed

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
Review of Eye Care Services	Chief Operating Officer	This work will assess the Health Board's eye care services to ensure they are delivered efficiently, effectively, and economically, and there are clear plans to meet current and future population needs. The work will also seek an update from the Health Board on its progress in addressing previous audit recommendations arising from the review of follow up outpatient appointments, particularly in the context of ophthalmology patients.	Fieldwork underway	To be confirmed

Other relevant publications

- 6 **Exhibit 3** provides information on other relevant examinations and studies published by the Auditor General in the last six months. The links to the reports on our website are provided. The reports highlighted in **bold** have been published since the last committee update.

Exhibit 3 – Relevant examinations and studies published by the Auditor General

Title	Publication Date
<u>The National Fraud Initiative in Wales 2022-23</u>	October 2024

Additional information

- 7 **Exhibit 4** provides information on corporate documents published by Audit Wales since the last committee update. Links to the documents on our website are provided.
- 8 The Auditor General is currently consulting on revisions to the Code of Audit Practice. The [consultation document](#) sets out a proposed new Code of Audit Practice that includes changes in response to significant factors in the context in which audit and related functions are undertaken. Following the consultation, the Auditor General intends to publish a revised Code of Audit Practice early in 2025. Responses can be submitted using the [online form](#) by 27 January 2025.

Exhibit 4 – Audit Wales corporate documents

Title	Publication Date
Audit Wales Equality Report 2023-24	November 2024
Estimate of Income and Expenses for Audit Wales for the year ended 31 March 2026	November 2024
Audit Wales Interim Report 2024-25	October 2024



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

Primary Care Follow-up Review – Cwm Taf Morgannwg University Health Board

Audit year: 2023

Date issued: November 2024

Document reference: 4606A2024

This document has been prepared as part of work performed in accordance with statutory functions.

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

Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

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Summary report

Introduction

- 1 Primary care is the first point of contact for the majority of people who use health services in Wales. It encompasses a wide range of services, delivered in the community by a range of providers, including General Practitioners (GPs), Pharmacists, Dentists, Optometrists, as well as other professionals from the health, social care, and voluntary sectors.
- 2 In 2018-19, the Auditor General reviewed primary care across all Health Boards in Wales, with a particular focus on general practice. That work focussed on strategic planning, investment, workforce, oversight and leadership, and performance.
- 3 Our [2018 Review of Primary Care at Cwm Taf University Health Board](#)¹ found that the Health Board had a sound plan for primary care and was making reasonable progress towards implementing key elements of the national vision. The Health Board had strong oversight arrangements and its performance against some primary care indicators was above average. However, there was further scope to raise the profile of primary care, shift more resources towards primary care, and to address workforce challenges.
- 4 The landscape for primary care in Wales has changed since our original review in 2018. Welsh Government has published its long-term plan for health and social care - [A Healthier Wales](#). The plan highlights primary care's crucial role in helping to realise the ambition of creating a seamless whole system approach with services designed around people, based on their needs, supporting them to stay well and not just providing treatment when they become ill. This means that more services traditionally provided in a hospital setting are shifted into the community to provide care at home or closer to home to take pressure off hospitals and reduce the time people wait to be treated.
- 5 The [Strategic Programme for Primary Care](#)² sets out its programme aims which are designed to support the delivery of the primary care contribution to 'A Healthier Wales'. These are being taken through six workstreams of work which health boards are expected to then implement at a local level:
 - focussing on 'ill-health' prevention and wellbeing;
 - developing 24/7 access to services;
 - exploiting data and digital technologies;
 - strengthening workforce and organisational development;
 - improving communications and engagement; and

¹ Our 2018 review was undertaken before the transfer of Bridgend to the Health Board from the former Abertawe Bro Morgannwg University Health Board (now Swansea Bay University Health Board) in April 2019.

² The Strategic Programme for Primary Care is the all-Wales primary care response and contribution to 'A Healthier Wales'.

- developing 'cluster-level' vision and enabling service transformation.
- 6 In February 2023, the National Primary Care Board, which oversees the Strategic Programme for Primary Care, identified that work is progressing at a varying pace within each Health Board area. Alongside this, there are wider concerns around Board-level visibility and focus on primary care, as well as the capacity of central Primary Care Services Teams within health boards to deliver organisational priorities.
- 7 Welsh Government has also embarked on an ambitious programme of contract reform across General Medical Services, Dentistry, Community Pharmacy, and Optometry to:
- ensure primary care services are sustainable;
 - improve patient access to primary care services;
 - reinforce the focus on quality and prevention;
 - enable cluster working as a means to plan and deliver services; and
 - strengthening the workforce.
- 8 Primary care services were severely impacted by the COVID-19 pandemic. Whilst the immediate public health emergency has subsided, primary care providers continue to face challenges as they seek to restore, recover, and reconfigure their services to meet the needs and expectations of the public in a post-pandemic world.
- 9 Our review has focussed primarily on assessing the extent to which the Health Board has implemented our 2018 recommendations. However, we have also undertaken some additional work to assess the extent to which:
- the Board and / or its committees regularly consider matters relating to the planning, performance, risks, and opportunities associated with the Health Board's primary care services; and
 - the Health Board's central Primary Care Services Team has the appropriate capacity and capability (in terms of knowledge, skills, and experience) to deliver local and national priorities, as well as to manage day-to-day operational and business needs.
- 10 The methods we used to deliver our work are summarised in **Appendix 1**.

Key findings

- 11 Overall, we found that **the Health Board has made reasonable progress in addressing our previous recommendations, particularly in relation to cluster membership and leadership, workforce planning, and new ways of working. However, it has struggled to establish a financial baseline and demonstrate a shift in resources from secondary to primary care. Whilst the Health Board has an appropriately structured and resourced Primary and Community Care Group, it is experiencing capacity challenges in some areas. Primary care is**

appropriately reflected in Health Board strategies and plans, but coverage of primary care matters at Board requires improvement.

Implementation of previous audit recommendations

- 12 We found that **the Health Board has addressed recommendations relating to cluster membership and leadership and is progressing work on workforce planning and new ways of working. It has also developed its own approach to assessing demand and capacity within GP practices. However, it has struggled to establish a financial baseline and demonstrate a shift in resources from secondary to primary care.**
- 13 The Health Board has taken positive steps to review cluster maturity, widen cluster membership, and support cluster leadership. It also has good arrangements in place for systematically capturing information on the number and skills of staff within general practice, but not for other parts of the primary care sector.
- 14 Evaluations and sharing learning from new ways of working are undertaken on a cluster basis, but not to a standard approach agreed with the Health Board. There are good arrangements in place to promote new ways of working and alternative points of contact with the public, including various social media platforms, but it is unclear whether this activity is reducing demand for GP appointments.
- 15 The Health Board did not collate or share the learning from the Primary Care Foundation's work undertaken in 2018 and has since developed its own approach to demand and capacity assessments in GP practices. The Health Board has not yet established a baseline position for its current investment in primary and community care against which it can assess its progress in shifting resources from secondary care. Whilst it has moved some services from secondary to primary care, this has been facilitated largely by additional Welsh Government funding in support of specific initiatives.

Capacity and capability to deliver local and national priorities

- 16 We found that **the Health Board's new Primary Care and Community Care Group is appropriately structured, resourced, and underpinned by clear leadership, governance, and reporting arrangements. Whilst the Care Group is experiencing capacity challenges in some areas, it was taking appropriate action to mitigate and minimise the associated risks.**
- 17 The Health Board established a new Primary Care and Community Care Group in 2022 with clear leadership, governance, and reporting arrangements. The new Care Group is designed to deliver a range of benefits including enhancing management capacity and oversight; addressing gaps in clinical leadership; strengthening collaboration and resilience between different services; providing greater development opportunities for staff; and supporting effective succession planning. The Health Board has provided additional investment to support these changes. The Care Group is experiencing capacity challenges in some areas as it

tries to fill vacancies and manage sickness absences. These capacity challenges are preventing it from progressing work in some areas, particularly dental services. However, the Care Group is managing the risks associated with these challenges appropriately. The Care Group has appropriate arrangements in place to support staff learning and development.

Board-level visibility and focus on primary care

- 18 We found that **primary care is appropriately reflected in Health Board strategies and plans. However, opportunities remain to provide greater coverage of primary care matters at Board meetings and clarity on which committee will be responsible for providing assurance to the Board on primary care services under the new committee structure being introduced in 2025.**
- 19 Primary care is adequately reflected in the Health Board's long-term strategy – CTM 2030 – with detailed priorities for 2024-25 set out in the organisation's Integrated Medium-Term Plan for 2024-27. The Health Board is also progressing work on its long-term Acute Clinical Services Plan and Integrated Community Services Plan to support the shift of resources and services to primary and community care.
- 20 Primary care is reflected in the Board's terms of reference. However, primary care did not feature in the Board's 2023-24 Cycle of Business, and it did not receive any specific reports on primary care during this period. Instead, matters relating to primary care were largely covered in other routine reports on performance, quality, and finance. Furthermore, the Health Board no longer publishes a dedicated annual report on primary care and there is limited coverage of primary care matters in its overall Annual Report. As a result, Board members are unable to form a strategic view on the overall effectiveness and efficiency of primary care services and whether the Health Board's actions are improving the sustainability of services in the longer-term.
- 21 The Population Health and Partnerships Committee provides good oversight of the Health Board's overall arrangements for primary and community care services, with other committees providing oversight of specific matters relating to quality, performance, and finance. However, the Population Health and Partnerships Committee is being disbanded at the end of December 2024, and its functions will be transferred to two new committees when the Board's new committee structure is introduced in January 2025. However, it is unclear which new committee will be responsible for providing assurance to the Board on the Health Board's arrangements for primary and community care services.

Recommendations

22 The status of our 2018 audit recommendations is summarised in **Exhibit 1**.

Exhibit 1: status of our 2018 recommendations

Implemented	Ongoing	No action	Superseded	Total
2	6	2	1	11

23 **Exhibit 2** details the new recommendations arising from this audit. The Health Board's response to the new recommendations as well as the open recommendations from our 2018 audit is presented in **Appendix 3**.

Exhibit 2: recommendations

Recommendations	
R1	The Health Board should support Board members to form a strategic view on the overall effectiveness and efficiency of primary care services and whether the organisation's actions in this area are improving the sustainability of services in the longer-term by improving the coverage of primary care matters in its routine Annual Report. (Paragraph 59)
R2	The Health Board should clarify which committee within the new committee structure being introduced in January 2025 will be responsible for providing assurance to the Board on the organisation's arrangements for primary and community care services after the Population Health and Partnerships Committee is disbanded at the end of December 2024. (Paragraph 62)

Detailed report

Implementation of previous audit recommendations

- 24 We considered the Health Board's progress in implementing our 2018 audit recommendations. These focus on:
- strategic planning (2018 Recommendation 1);
 - investment in primary care (2018 Recommendations 2a and 2b);
 - primary care workforce (2018 Recommendation 3);
 - new ways of working (2018 Recommendations 4a, 4b, 4c, and 4d); and
 - primary care clusters (2018 Recommendations 5a, 5b, and 5c).
- 25 Overall, we found that **the Health Board has addressed recommendations relating to cluster membership and leadership and is progressing work on workforce planning and new ways of working. It has also developed its own approach to assessing demand and capacity within GP practices. However, it has struggled to establish a financial baseline and demonstrate a shift in resources from secondary to primary care.**

Strategic planning

- 26 We considered whether the Health Board has centrally analysed and collated the messages from the Primary Care Foundation's demand and capacity assessments in GP (General Practitioner) practices and shared the learning across all practices (2018 Recommendation 1).
- 27 We found that **the Health Board did not collate or share the learning from the Primary Care Foundation's work and has since developed its own approach to demand and capacity assessments in GP practices.**
- 28 In 2018, we reported that the Health Board had commissioned the Primary Care Foundation to carry out GP practice demand and capacity assessments. Participation was variable as assessments were offered to GP practices on a voluntary basis. As a result, the Health Board did not collate or share the learning across all practices and decided not to make further use of the Primary Care Foundation. Since then, the Health Board has developed its own approach to assessing demand and capacity, which is aligned to the national access service standards³ and captures wider general practice sustainability considerations. The approach is used by the Health Board to identify general practices requiring specific support to improve their sustainability and resilience, secure operational

³ The Access to In-Hours GMS (General Medical Services) Services Standards were introduced by Welsh Government in March 2019. The standards set clear requirements on practices in terms of minimum expectations relating to access, including an increased digital offering.

stability, and develop more effective ways of working. Specific actions are developed and agreed to address the demand, capacity, and sustainability needs of general practices requiring the most support, with updates on key issues and risks provided to the Population Health and Partnerships Committee. **We therefore consider 2018 Recommendation 1 as superseded.**

Investment in primary care

29 We considered whether the Health Board has:

- calculated a baseline position for its current investment and resource use in primary and community care (2018 Recommendation 2a); and
- reviewed and reported, at least annually, its investment in primary and community care, to assess progress since the baseline position and to monitor the extent to which it is succeeding in shifting resources towards primary and community care (2018 Recommendation 2b).

30 We found that **the Health Board has not yet established a baseline position for its current investment in primary and community care against which it can assess its progress in shifting resources from secondary care.**

31 The Health Board sought to calculate and establish a baseline position for its investment and resource use in primary and community care by March 2019 as part of the primary and community element of the Cwm Taf Partnership Transformation Plan⁴. However, it did not achieve this. In April 2019, the Health Board assumed responsibility for providing services to the population of Bridgend, thus becoming Cwm Taf Morgannwg University Health Board. This presented a further opportunity for the Health Board to calculate and establish a baseline position. However, it did not capitalise on this opportunity. The Health Board has a further opportunity to calculate and establish a clear baseline as part of the development of its long-term Acute Clinical Services Plan and Integrated Community Services Plan (see **paragraph 57**). **We therefore consider that there has been no action on 2018 Recommendation 2a.**

32 As we discuss in **paragraph 57**, the Health Board recognises that its current clinical model places too much emphasis on acute services and does not adequately support the shift of resources and services to primary and community care. It has successfully shifted some activity from secondary to primary care by investing in community-based schemes, such as the initiative designed to assess and monitor lower-risk glaucoma patients by optometrists in the community. However, this shift has been facilitated by additional Welsh Government funding for specific initiatives, rather than decisions taken by the Health Board to redirect core funding from acute care to primary care. Furthermore, without a baseline position in place, the Health Board has been unable to monitor, assess, review, and report

⁴ The plan set out Cwm Taf Social Services and Wellbeing Partnership Board's response to the findings of the Cwm Taf Population Assessment published in April 2017.

annually its progress in shifting resources towards primary and community care. Addressing this recommendation in full will become increasingly important as the Health Board seeks to implement and measure, in due course, the impact of its long-term Acute Clinical Services Plan and Integrated Community Services Plan.

We therefore consider that there has been no action on 2018

Recommendation 2b.

Primary care workforce

33 We considered whether the Health Board has developed and implemented an action plan for ensuring it has regular, comprehensive, standardised information on the number and skills of staff, from all professions working in all primary care settings (2018 Recommendation 3).

34 We found **that the Health Board has good arrangements in place for systematically capturing information on the number and skills of staff within general practice, but not for other parts of the primary care sector.**

35 The Health Board has good arrangements in place for capturing information on the number and skills of staff within general practice. As discussed in **paragraph 28**, the Health Board captures this information as part of its approach to assess, understand, and respond to the demand, capacity, and sustainability needs of general practices. It also makes use of annual workforce census data captured via the Welsh National Workforce Reporting System (WNWRS)⁵ to inform its organisational and cluster-level planning arrangements. There are national plans in place to roll out the WNWRS to the other primary care services; however, this has not happened yet. Furthermore, the Health Board does not have alternative arrangements in place to capture this information locally in a systematic manner.

We therefore consider 2018 Recommendation 3 to be ongoing.

New ways of working

36 We considered whether the Health Board has:

- worked with clusters to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models (2018 Recommendation 4a);
- centrally collated evaluations of new ways of working and shared the key messages across all clusters (2018 Recommendation 4b);
- worked with the public to promote successful new ways of working, particularly new alternative first points of contact in primary care that have the potential to reduce demand for GP appointments (2018 Recommendation 4c); and

⁵ The Welsh National Workforce Reporting System is a digital solution providing workforce intelligence for all Primary and Community Care in Wales.

- evaluated the effectiveness of the new primary care communications officer role and shared the learning with all health boards in Wales (2018 Recommendation 4d).
- 37 We found that **evaluations and sharing learning from new ways of working are undertaken on a cluster basis, but not to a standard approach agreed with the Health Board. There are good arrangements in place to promote new ways of working and alternative points of contact with the public, but it is unclear whether this activity is reducing demand for GP appointments.**
- 38 The Health Board has not worked with clusters to develop and adopt a standard approach to evaluation and sharing learning. Instead, it has sought to empower clusters to develop and adopt their own approaches to evaluation based on their individual needs and circumstances with input from the local Public Health Team as required. It also encourages Cluster Leads and Cluster Development Managers to share learning from evaluations with other clusters. Whilst there is merit in allowing clusters to agree their own approaches to evaluation and sharing learning, a standard approach would ensure that evidence of outcomes and impact is collected, analysed, used, and disseminated in a consistent manner. **We therefore consider 2018 Recommendations 4a and 4b to be ongoing.**
- 39 The Health Board, clusters, and individual general practices use a range of traditional and modern methods to promote new ways of working and alternative points of contact with the public, including publishing social media posts and distributing posters and leaflets to ensure those without internet can access information. The Health Board has a comprehensive programme in place to promote and raise awareness of different matters relating to primary care via its various social media channels and platforms. Whilst this is positive, the Health Board is yet to put arrangements in place to assess whether this promotional activity is reducing demand for GP appointments. **We therefore consider 2018 Recommendation 4c to be ongoing.**
- 40 The Health Board has not formally evaluated the effectiveness of its Primary Care Communications Officer role. However, it has shared information about the role with other health boards in Wales via national groups and fora. The post remains a part-time one, but it is now funded via core funding, rather than cluster funding. Talks are underway about securing additional resource from the Health Board's Corporate Communications Team to strengthen the role further by making it a full-time post. **We therefore consider 2018 Recommendation 4d to be ongoing.**

Primary care clusters

- 41 We considered whether the Health Board has:
 - reviewed the relative maturity of clusters, and targeted and strengthened its support for clusters where necessary (2018 Recommendation 5a);
 - reviewed the membership of clusters and attendance at cluster meetings to assess whether there is appropriate representation from all stakeholder

groups such as local authorities, third sector, lay representatives (2018 Recommendation 5b); and

- developed an action plan to strengthen cluster leadership (2018 Recommendation 5b).

- 42 We found that **positive steps have been taken to review cluster maturity, widen cluster membership, and support cluster leadership.**
- 43 The Health Board is in the process of transforming its clusters through the ACD (Accelerated Cluster Development) programme⁶. The Health Board has put a roadmap in place, with clear milestones and outcomes, to support implementation. Progress is currently overseen by the Partnerships and Population Health Committee. However, it is unclear which committee will oversee progress when the Health Board introduces a new committee structure in January 2025 (see **paragraph 62**). The Health Board uses a range of approaches to assess the maturity of clusters, such as checklists and peer reviews. However, it recognises there is still considerable variation in maturity between clusters that needs to be addressed with the support of the Cluster Development Managers and central Primary Care Team. **We therefore consider 2018 Recommendation 5a to be ongoing.**
- 44 All clusters have adopted the Model Terms of Reference issued by the Strategic Programme for Primary Care in April 2022, with membership extended to include representation from all relevant local services contributing to health and social care within their respective areas. The Health Board has also reviewed and updated the membership of its Pan-cluster Planning Groups⁷, of which there are three in the Health Board area – one for Bridgend, one for Merthyr Tydfil, and one for Rhondda Cynon Taf. **We therefore consider 2018 Recommendation 5b as implemented.**
- 45 The Health Board has taken several positive steps to strengthen cluster leadership. For example, it encourages and supports cluster leads to attend the Expert Leadership Programme run by Health Education and Improvement Wales. The Health Board also continues to invest locally in cluster leadership by supporting the Lead Clinicians and Practice Managers in each cluster, as well as employing full-time Cluster Development Managers. **We therefore consider 2018 Recommendation 5b as implemented.**

⁶ The ACD programme is a strategic initiative to enhance primary care services. It operates through Professional Collaboratives and Clusters, aiming to improve health and well-being for local populations by co-ordinating health services within the community.

⁷ Pan-Cluster Planning Groups lead the development of integrated plans, with the aim of making prudent use of all relevant funding, workforce, and other resources to address the health, care and well-being needs of their local populations.

Capacity for delivering primary care plans

- 46 We considered the extent to which the Health Board's central Primary Care Services Team has the appropriate capacity and capability (in terms of knowledge, skills, and experience) to deliver local and national priorities, as well as to manage day-to-day operational and business needs. In doing so, we considered whether the central Primary Care Services Team has:
- an appropriately resourced structure, which is kept under review, with clear lines of accountability; and
 - arrangements for identifying and supporting learning and development needs, and succession planning on an ongoing basis.
- 47 We found that **the Health Board's new Primary Care and Community Care Group is appropriately structured, resourced, and underpinned by clear leadership, governance, and reporting arrangements. Whilst the Care Group is experiencing capacity challenges in some areas, it was taking appropriate action to mitigate and minimise the associated risks.**
- 48 The Health Board, as part of a wider organisational change process, established a new Primary Care and Community Care Group in 2022⁸ with clear leadership, governance, and reporting arrangements. Senior leadership is provided by a Service Director (1 Whole Time Equivalent), Nurse Director (0.5 Whole Time Equivalent), Medical Director (4 Sessions), Dental Director (4 Sessions), and Unscheduled Care Director (1 Session). The Service Director reports to the Chief Operating Officer.
- 49 The Care Group has well-established boards and groups in place that oversee various matters including health and safety; quality, patient safety, and patient experience; finance; and performance. These boards and groups report to various pan-Health Board boards (such as the Operational Management Board, Integrated Performance Board, and Improving Care Board) who, in turn, provide assurance to various committees of the Board. As we discuss in **paragraphs 61 and 62**, the Care Group also provides Strategic Updates to the Population Health and Partnerships Committee and Highlight Reports to the Quality and Safety Committee.
- 50 The new Care Group structure, which consists of the Primary Care Directorate and Community Directorate, has been designed to:
- retain specialist skills and knowledge in key areas;
 - enhance management capacity and oversight;

⁸ In March 2022, the Board approved the creation of a new operating model with the aim of supporting post-pandemic recovery; improving service quality; streamlining management arrangements; and facilitating joint working across the Health Board. Phase 1 of implementing the new operating model involved replacing the Integrated Locality Group structure with new Health Board wide Care Groups. The Primary and Community Care Group is one of six care groups in total.

- address gaps in clinical leadership;
- strengthen collaboration, alignment, and resilience between the respective services within each directorate; and
- provide greater development opportunities for staff within and across each directorate, and support succession planning.

The overall pay costs of the new structure are slightly higher than the overall pay costs of the previous structure. However, the Health Board agreed to cover the additional pay costs to ensure the changes outlined above could be delivered and embedded in full.

- 51 At the time of our review, the Care Group was experiencing some capacity challenges within the Primary Care Directorate as it was in the process of filling vacant roles and managing sickness absences across some teams. As a result, the Care Group was unable to progress work in some areas, particularly in dental services. However, the risks associated with these challenges were appropriately captured in the Care Group's Risk Register and several mitigating actions had been put in place, including providing greater clarity on operational delivery priorities and enhancing short-term managerial support.
- 52 The Care Group has appropriate arrangements in place to support learning and development. Each new member of staff receives an induction and Performance Development Reviews are used to identify individual learning and development needs. The new Care Group structure has provided promotional opportunities and a full day 'Leading Through Change' was arranged to equip senior leaders and managers with the relevant knowledge and skills to support staff through the organisational change process in a compassionate and inclusive manner.

Board-level visibility and focus on primary care

- 53 We considered the extent to which the Boars and / or its committees regularly consider matters relating to the planning, performance, risks, and opportunities associated with the Health Board's primary care services.
- 54 We expected to see the following:
- Primary care is reflected in Health Board strategies and plans and reflect the ambitions of 'A Healthier Wales.'
 - Primary care features in the terms of reference and workplans of the Board and relevant Committee
 - The Health Board ensures primary care is regularly considered at Board and committee meetings and features within papers and reports from wider elements of the Health Boards business, e.g. finance, risk, and relevant service reports.
 - The contents of Board and committee performance reports adequately cover primary care.

- The Health Board considers publishing a dedicated annual report on primary care.
- 55 We found that **primary care is appropriately reflected in Health Board strategies and plans. However, opportunities remain to provide greater coverage of primary care matters at Board, as well as to clarify which committee will be responsible for providing assurance to the Board on primary care services under the new committee structure being introduced in 2025.**
- 56 Primary care is adequately reflected in the Health Board's key strategies and plans. The Health Board's long-term strategy – CTM 2030 – is aligned to 'A Healthier Wales' and emphasises a whole system approach to health and well-being. As a result, delivering high quality, sustainable, and integrated primary and community care services is at the core of the five life stages (Starting Well, Growing Well, Living Well, Ageing Well, and Dying Well) that frame the Health Board's four strategic goals of Creating Health, Improving Care, Sustaining Our Future, and Inspiring People.
- 57 To support implementation, the Health Board's Integrated Medium-Term Plan for 2024-27 sets out the details of its transformation programme for primary and community services and the specific priorities for 2024-25. The Health Board is currently developing its long-term Acute Clinical Services Plan and Integrated Community Services Plan under the banner of CTM 2030. As part of this work, the Health Board has recognised that its current clinical model places too much emphasis on acute services and does not adequately support the shift of resources and services to primary and community care. However, the Health Board is currently experiencing delays in progressing this work to its original timescales.
- 58 Primary care features in the Board's terms of reference as set out in the Health Board's Standing Orders. However, primary care did not feature in the Board's 2023-24 Cycle of Business, and it did not receive any specific reports on primary care during this period. Instead, matters relating to primary care were largely covered in other routine reports:
- **Integrated Performance Dashboard:** The dashboard appropriately reflected the relevant primary care measures contained in the 2023-24 NHS Wales Performance Framework. However, the Board's ability to oversee and scrutinise the Health Board's performance in this area was hampered by a lack of data for several of the measures. It is unclear why the data was unavailable or when it would be reported to the Board. Furthermore, the primary care measures reported via the dashboard focussed on access to services, rather than quality, effectiveness, and impact of services.
 - **Financial Performance Update:** The updates provided some information on primary care income and expenditure; however, it did not give a sense of whether primary care services are financially efficient or sustainable.
 - **Board Assurance Framework (BAF):** The BAF does not identify any strategic or organisational risks relating to primary care, despite the

significant risks associated with the fragility and sustainability of services. However, some primary care services and initiatives have been listed as mitigating controls for the principal risk relating to healthy life expectancy.

- **2023-24 Annual Plan Quarterly Updates:** The updates provided a good overview of the Health Board's progress in delivering its primary care priorities for 2023-24, with more detail provided in the accompanying appendices. However, it is unclear what impact, if any, the actions were having on the Health Board's primary care measures.

59 Furthermore, the Health Board no longer publishes a dedicated annual report on primary care. Whilst there is some reference in the 2023-24 Annual Report to the Health Board's performance against primary care access targets, the report does not provide an overview or summary of the Health Board's wider activity in relation to primary care during the year. Board members, therefore, are unable to form a strategic view on the overall effectiveness and efficiency of primary care services and whether the Health Board's various actions are improving the sustainability of services in the longer-term. The Health Board should address this by improving the coverage of primary care matters in its routine Annual Report. **(Recommendation 1)**

60 Primary care is reflected in the terms of reference of the Population Health and Partnerships Committee, which is responsible for providing assurance to the Board on the Health Board's arrangements for primary and community care services until it is disbanded at the end of 2024 (see **paragraph 62**). During 2023-24, the committee received two strategic primary care updates, one in February and one in November. Both reports provided comprehensive updates on a range of matters relating to primary care, including:

- progress in addressing national priorities as set out in the Strategic Programme for Primary Care;
- developments relating to the reform of dental and optometry contracts;
- GMS sustainability;
- Accelerated Cluster Development; and
- key risks and matters requiring escalation.

61 Although primary care is not referenced in the terms of reference of other Board committees, items relating to primary care were considered by other committees during 2023-24, specifically the Quality and Safety Committee, the Audit and Risk Committee, and the Planning, Performance, and Finance Committee:

- **Quality and Safety Committee** – the committee received regular Highlight Reports from the Primary Care and Community Care Group. It also received a 'Spotlight Presentation' from the Primary Care and Community Group that appropriately focussed on matters that fall under the committee's remit.

- **Audit and Risk Committee** – the committee received a report on Post Payment Verification⁹ undertaken by the NHS Wales Shared Services Partnership during the period 1st April 2023 to 30th September 2023.
- **Planning, Performance, and Finance Committee** – the committee received regular performance and finance reports, which refer to primary care. However, these reports were largely the same as the ones received by Board.

62 The Health Board has agreed to introduce a new committee structure in January 2025. The Population Health and Partnerships Committee, therefore, is being disbanded at the end of December 2024, and its functions will be transferred to two new committees – the Operational Delivery Committee and Strategic Development Committee. However, it is unclear which of these committees will be responsible for providing assurance to the Board on the Health Board's arrangements for primary and community care services. **(Recommendation 2)**

⁹ Post Payment Verification is the process undertaken to provide assurance to Health Boards that the claims for payment made by Primary Care contractors are appropriate and that the delivery of the service is as defined by NHS specification and relevant legislation.

Appendix 1

Audit methods

Exhibit 3 below sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

Exhibit 3: audit methods

Element of audit methods	Description
Documents	We reviewed a range of documents, including: • Board and committee papers. • Primary Care & Public Health Oversight Group papers. • Quality, Safety, Risk & Governance Meeting papers. • Accelerated Cluster Development papers. • Health Board Self-Assessment. • Cluster Minutes. • Primary care priorities. • Integrated Medium-Term Plan 2024-27.
Interviews	We interviewed the following: • Health Board Vice Chair. • Chief Operating Officer. • Deputy Chief Operating Officer – Primary Care and Mental Health. • Service Director Lead Primary Care. • Head of Nursing Primary Care and Communities. • Nurse Director for Primary, Community, and Mental Health Care Groups. • Clinical Director of Primary Care. • Medical Lead Primary Care. • Head of Primary Care (GMS) • Head of Primary Care (Optometry)

Appendix 2

Summary of progress against our 2018 audit recommendations

Exhibit 4 below sets out the recommendations we made in 2018 and our summary of progress.

Exhibit 4: summary progress against 2018 recommendations

Recommendations	Progress
Strategic planning R1 The Health Board commissioned the Primary Care Foundation to carry out demand and capacity assessments in GP practices but the take-up from practices has been variable. To maximise value from the commissioned work, the Health Board should centrally analyse and collate the messages from the demand and capacity assessments and share the learning across all practices.	Superseded – See paragraph 28.
Investment in primary care R2 While the Health Board recognises that it needs to shift resources from secondary to primary and community settings, it cannot demonstrate that this shift is happening. The Health Board should: a) calculate a baseline position for its current investment and resource use in primary and community care; and b) review and report, at least annually, its investment in primary and community care, to assess progress since the baseline position and to monitor the extent to which it is succeeding in shifting resources towards primary and community care.	No action – See paragraph 31. No action – See paragraph 32.

Recommendations	Progress
The primary care workforce R3 The Health Board's workforce planning is inhibited by having limited data about the number and skills of staff working in primary care, particularly community dentistry, optometry, and pharmacy. The Health Board should develop and implement an action plan for ensuring it has regular, comprehensive, standardised information on the number and skills of staff, from all professions working in all primary care settings.	Ongoing – See paragraph 35.
New ways of working R4 Whilst the Health Board is taking steps towards implementing some new ways of working, more progress is required to evaluate the effectiveness of these new models and to mainstream their funding. The Health Board should: a) work with the clusters to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models; b) centrally collate evaluations of new ways of working and share the learning by publicising the key messages across all clusters; c) work with the public to promote successful new ways of working, particularly new alternative first points of contact in primary care that have the potential to reduce demand for GP appointments; and d) evaluate the effectiveness of the Health Board's new primary care communications officer role and share the learning with all health boards in Wales.	Ongoing – See paragraph 38. Ongoing – See paragraph 38. Ongoing – See paragraph 39. Ongoing – See paragraph 40.

Recommendations	Progress
Primary care clusters R5 We found variation in the maturity of primary care clusters, and scope to improve cluster membership and leadership. The Health Board should: a) review the relative maturity of clusters, to develop and implement a plan to strengthen its support for clusters where necessary; b) review the membership of clusters and attendance at cluster meetings to assess whether there is a need to increase representation from local authorities, third sector, lay representatives, and other stakeholder groups; and c) develop an action plan for strengthening cluster leadership.	Ongoing – See paragraph 43. Implemented – See paragraph 44. Implemented – See paragraph 45.

Appendix 3

Management response to audit recommendations

Exhibit 5 sets out the Health Board’s response to our audit recommendations.

Ref	Recommendation	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R1				
R2				



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galwadau ffôn yn Gymraeg a Saesneg.

Management response form



Report title: Primary Care Follow-up Review - CTMUHB

Completion date: November 2024

Document reference: 4606A2024

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
2024 Recommendations (New)				
R1	The Health Board should support Board members to form a strategic view on the overall effectiveness and efficiency of primary care services and whether the organisation's actions in this area are improving the sustainability of services in the longer-term by improving the coverage of primary care matters in its routine Annual Report.	A Primary Care Dashboard will be finalised by end of January 2025. The requirement to expand the coverage of primary care matters in CTMUHB Annual Report for 2024-2025 and beyond has been captured in the forward planning for the Annual Report development.	31 January 2025 30 September 2025 Welsh Government Timescales for the Annual Report 2024-2025 have yet to be received, however, it is anticipated that the CTMUHB Annual Report 2024-2025 will be	Service Director PCC Care Group Annual Report Content Planning – Director of Corporate Governance / Board Secretary Annual Report Content –

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
2024 Recommendations (New)				
			published no later than the 30 th September 2025.	Service Director PCC Care Group
R2	The Health Board should clarify which committee within the new committee structure being introduced in January 2025 will be responsible for providing assurance to the Board on the organisation's arrangements for primary and community care services after the Population Health and Partnerships Committee is disbanded at the end of December 2024.	If the primary care matter relates to informing the Board in terms of strategic decision making with a focus of 18 months and beyond then it will be considered at the Strategic Development Committee. If the primary care matter relates to in year performance and delivery activity then it will be considered at the Operational Delivery Committee. The Primary Care & Community Service Director in conjunction with the Deputy Chief Operating Officer for Primary Care, Community	Complete - as clarity provided in management response and will form business as usual in terms of the management of business through Board Committees.	Board and Committee Business Management process - Director of Corporate Governance / Board Secretary The Primary Care & Community Service Director / Deputy Chief Operating Officer for Primary Care,

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
2024 Recommendations (New)				
		and MHL D and Chief Operating Officer will notify the Corporate Governance Team of any items for agenda planning for these Committees. Corporate Governance Team to reference the requirement to consider in agenda planning meetings. Board Development programmes will also be utilised to share progress and improve visibility.		Community and MHL D and Chief Operating Officer

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
2018 Recommendations (Open)				
R2	While the Health Board recognises that it needs to shift resources from secondary to primary and community settings, it cannot demonstrate that this shift is happening. The Health Board should: a) calculate a baseline position for its current investment and resource use in primary and community care; and b) review and report, at least annually, its investment in primary and community care, to assess progress since the baseline position and to monitor the extent to which it is succeeding in shifting resources towards primary and community care.	a) A baseline position can be obtained based on the current budget and resource allocation for the Primary Care and Community Care Group. b) This review and report will form part of the Primary Care and Community Transformation Plan and will be aligned to the Acute Clinical Services Plan (ACSP). The aim is to facilitate both the shift in services but also the resource from secondary care into Primary Care and Community Services.	31 January 2025 31 March 2026	Service Director – Primary Care and Community Service Director – Primary Care and Community

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
2018 Recommendations (Open)				
R3	The Health Board's workforce planning is inhibited by having limited data about the number and skills of staff working in primary care, particularly community dentistry, optometry, and pharmacy. The Health Board should develop and implement an action plan for ensuring it has regular, comprehensive, standardised information on the number and skills of staff, from all professions working in all primary care settings.	The Health Board has a Primary Care Academy in place and workforce planning will be an essential remit for this. This will be an objective for 2025/26 onwards.	31 July 2025	Service Director – Primary Care and Community

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
2018 Recommendations (Open)				
R4	Whilst the Health Board is taking steps towards implementing some new ways of working, more progress is required to evaluate the effectiveness of these new models and to mainstream their funding. The Health Board should: a) work with the clusters to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models; b) centrally collate evaluations of new ways of working and share the learning by publicising the key messages across all clusters; c) work with the public to promote successful new ways of working,	a) An evaluation template has been introduced for clusters to use to demonstrate outcomes and support continued investment. Implemented. b) The clusters structure now sit under the GMS Directorate and all evaluations will report into one management and governance structure. Quarterly, these will be reported into the Primary Care and Transformation Board to inform wider strategic developments. The collaborative	March 2025 March 2026	Service Director – Primary Care and Community Service Director – Primary Care and Community

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
2018 Recommendations (Open)				
	particularly new alternative first points of contact in primary care that have the potential to reduce demand for GP appointments; and d) evaluate the effectiveness of the Health Board's new primary care communications officer role and share the learning with all health boards in Wales.	and cluster meetings are all in place and taken the opportunity to share learning of schemes. c) There is an active plan with the Health Board's Communications Team to promote the new ways of working and roles within the primary care model for Wales. Practices also work with the public to promote and discuss their cluster initiatives with their patient participation groups (PPG) as well as advertise services and offer feedback through their websites. d) The Primary Care Communications Officer role is no longer in place and a decision has been taken to take a more holistic approach across the Primary Care to take	December 2024 March 2024	Service Director – Primary Care and Community Service Director – Primary Care and Community / Director of

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
2018 Recommendations (Open)				
		opportunities of differing priorities during the year.		Communications, Engagement & Fundraising
R5	We found variation in the maturity of primary care clusters, and scope to improve cluster membership and leadership. The Health Board should: a) review the relative maturity of clusters, to develop and implement a plan to strengthen its support for clusters where necessary.	a) Each JPB will have a role to review and develop the clusters maturity and to report into Primary Care and Community Transformation Board.	31 March 2025	Service Director – Primary Care and Community

Review of Cost Savings Arrangements – Cwm Taf Morgannwg University Health Board

Audit year: 2023

Date issued: October 2024

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Purpose of this document

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Introduction

- 1 NHS Wales is facing unprecedented financial challenges. The continuing impact of the COVID-19 pandemic on service demand and provision; the rising costs associated with staffing, energy, medicines, and maintaining an ageing estate; and tackling the complex health conditions associated with an ageing population all contribute to the worsening financial situation across the NHS.
- 2 Despite the Welsh Government making an additional £425 million available to the NHS in October 2023, the 2023-24 year-end position for NHS Wales was a collective deficit of £183 million. Whilst some NHS bodies were able to achieve year-end financial balance, the position for others - particularly some Health Boards - was challenging with several not being able to deliver the control total¹ deficit expected by Welsh Government.
- 3 The position for 2024-25 is equally, if not more challenging. Health bodies will need to ensure that they have robust approaches in place to identify and deliver in year cost improvement opportunities and to also take a longer-term approach to achieving financial sustainability that moves away from short-term approaches to ones where savings are achieved by transforming service models and ways of working.

Objectives and scope our work

- 4 Given the challenges outlined above, the objective of our review has been to examine whether the Health Board has an effective approach to identifying, delivering, and monitoring sustainable cost savings opportunities. The detailed audit criteria are set out in **Appendix 1**.
- 5 The work has been undertaken to discharge the Auditor General's statutory duty under Section 61 of the Public Audit (Wales) Act 2004 to be satisfied that the Health Board has proper arrangements in place to secure economy, efficiency, and effectiveness in its use of resources.
- 6 We undertook our work between December 2023 and March 2024. The methods we used to deliver our work are summarised in **Appendix 2**. Our work comments on the approach within the Health Board to identifying, delivering, and overseeing cost saving opportunities. It considers the impact these arrangements had on the 2023-24 year-end position and highlights where arrangements may need to be strengthened for 2024-25 and beyond.

¹ Revised deficit positions for 2023-24, known as 'control totals', were allocated to Health Boards by Welsh Government in November 2023 following the provision of additional funding to support their financial positions.

Key findings

- 7 Overall, we found that **whilst the Health Board has delivered its savings target and a break-even financial position for 2023-24, it now needs to initiate a more future orientated approach focussing on service transformation to maintain its long-term financial sustainability.**
- 8 The findings that support our overall conclusions are summarised below under the following headings:
- Identifying cost savings opportunities;
 - Delivering cost savings plans; and
 - Monitoring and oversight of savings plans.

Identifying cost savings opportunities

- 9 We considered whether the Health Board:
- has a clear understanding of the factors that are driving its costs;
 - routinely uses a range of data and intelligence to help identify cost savings opportunities; and
 - has an effective approach to selecting cost savings opportunities.
- 10 We found that the **Health Board's mechanisms for identifying short-term cost savings are evident, but it needs to maintain current financial performance whilst managing quality and performance risks and transforming services for longer term value and financial stability.**

Understanding the drivers of costs

- 11 The Health Board has a good understanding of the factors driving its costs, which are clearly set out in its 2024-27 Integrated Medium-Term Plan (2024-27 IMTP). These include operating pressures, NICE and high-cost drugs, increasing commissioned activity, local investments, continuing healthcare, prescribing and non-pay inflation pressures, overtime and Allied Health Professional costs, and the Welsh Risk Pool. In addition, it acknowledges the wider contextual challenges facing the organisation including supply chain delays, inflationary pressures, and the ongoing residual post-pandemic service adjustments that apply to most organisations. While there is a good understanding of cost drivers at an organisational level, variation in financial performance at an operational level suggests differing potential for savings delivery within Care Groups and Clinical Service Groups. **(Recommendation 1)**
- 12 During 2023-24, the Board provided a clear steer and focus on achieving a balanced financial position, culminating in a break-even control total and an underlying financial deficit of £19.4 million. In March 2024, the Health Board submitted a financially balanced 2024-27 IMTP to Welsh Government with a recurrent savings target of £26.3 million. The plan sets out the Health Board's ambition to continue to 'live within its means', but this has led to a number of

difficult investment decisions impacting on some services. For example, it has been unable to invest in Stroke Services, which at present is encountering significant performance challenges resulting in the Health Board ranking among the worst in Wales across several of its urgent assessment and discharge measures². While the Health Board has signalled potential opportunities for lower savings targets and higher levels of discretionary investment in years 2 and 3 of its IMTP delivery, it will need to closely monitor and manage any immediate quality and performance risks that may arise.

- 13 Welsh Government has subsequently approved the Health Board's 2024-27 IMTP. However, the Health Board did not meet its financial duty to break even against its Revenue Resource Limit over the 3 year-period 2021-22 to 2023-24 and remains in 'Enhanced Monitoring' for finance, strategy and planning under Welsh Government's NHS Intervention and Escalation Framework³.
- 14 Key to controlling cost drivers and achieving financial sustainability, is delivering the Health Board's long-term strategy - CTM 2030 - which sets four high-level strategic aims⁴, underpinned by three key strategy themes⁵, to transform its acute and community services. During 2023-24, the Health Board has progressed work on many key areas of the strategy including the development of the Llantrisant Health Park⁶ and Maesteg Community Hospital⁷. However, the Health Board's efforts in achieving financial break-even during 2023-24 and the continuing financial challenges it is experiencing during 2024-25 is impacting on the pace of delivering other key strategic objectives, such as development of the Acute Clinical Services Plan which is key to creating more sustainable models of secondary care. The Health Board, therefore, needs to clearly prioritise and set out a roadmap for the potential costs and savings associated with transforming its services and ensure that the timescales for service transformation supports its plans to place its finances on a more sustainable footing. **(Recommendation 2)**

² Stroke Urgent Assessment and Discharge measures: % compliance with direct admission to an acute stroke unit within 4 hours, % of patients assessed by a stroke consultant within 24 hours, % of patients assessed by one of OT, PT SALT within 24 hours, and % of patients discharged with ESD / Community Therapy MDT.

³ Information on NHS Wales oversight and escalation arrangements can be found [here](#). In addition to being in Enhanced Monitoring for finance, strategy and planning, the Health Board is in Targeted Intervention for performance and outcomes

⁴ CTM 2030s four high level strategic aims are 'creating health', 'improving care', 'inspiring people' and 'sustaining our future'.

⁵ CTM 2030s three key strategy themes are 'supporting resilient communities', integrated community services' and the 'clinical services strategy'.

⁶ The Llantrisant Health Park Programme aims to deliver a cutting-edge diagnostics and treatment centre.

⁷ Maesteg Community Hospital is being re-developed into a health, care and wellbeing hub.

Using data and intelligence to identify and select cost savings opportunities

- 15 The Health Board's arrangements for using data and intelligence to inform cost savings identification and selection requires further strengthening. It uses some data and intelligence from sources such as CHKS⁸, VAULT⁹, GIRFT¹⁰ reviews, and local Value-Based Healthcare reviews. However, there is scope for the Health Board to increase its use of data and intelligence across a wider range of service areas to maximise the identification and selection of cost savings opportunities. **(Recommendation 3.1)** Furthermore, while the Health Board is developing a local repository to help capture this information more systematically, it is not fully realising the benefits available from benchmarking its data sources at present which inhibits its ability to identify and select cost savings opportunities. **(Recommendation 3.2)**
- 16 The Health Board has processes to canvas, capture, and assess ideas and suggestions on cost savings opportunities internally and from some external stakeholders based on best practice, including examples from outside Wales. However, the Health Board may also wish to consider identifying cost savings ideas from service users, potentially as part of its proposed engagement on the emerging Acute Clinical Services Plan.
- 17 In addition, the Health Board's Value and Efficiency Programme includes several central 'enabling groups' to help drive pan-Health Board efficiency savings. The groups for 2024-25 have been changed to align with the national Value and Sustainability Board workstreams¹¹ encompassing workforce, continuing healthcare, non-pay / procurement, medicines management, service redesign, and clinical variation. In a cost constrained environment, a particular challenge for the programme will be taking forward savings schemes that require an upfront investment in order to achieve longer term savings, and for such schemes to ensure that they deliver the intended savings as a return on that investment. **(Recommendation 4)**

Selecting Cost Saving Opportunities

⁸ Caspe Knowledge HealthCare Systems (CHKS) is a provider of healthcare intelligence, benchmarking, and quality improvement services.

⁹ The Value, Allocation, Utilisation and Learning Toolkit (VAULT) is managed by the NHS Executive to support and improve resource utilisation across the Welsh NHS.

¹⁰ Getting it Right First Time (GIRFT) is a programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change.

¹¹ The national Value and Sustainability Board (VSB) was set up by Welsh Government and is chaired by NHS Executive to focus on specific themes to deliver possible pan Wales efficiencies. The workstreams include Continuing Health Care, Medicines Management, Workforce, Non-Pay, and Clinical Variation.

- 18 The Health Board has a reasonably effective approach for selecting cost savings opportunities. The Health Board follows both a top-down and bottom-up approach to capturing and appraising potential cost savings opportunities. The 2023-24 Financial Plan was based on a 'control total' approach requiring Care Groups and Corporate Directorates to collectively operate within a maximum allowable overspend of £23.8 million. To meet this control total, they were required to deliver a £28.3 million savings target.
- 19 The Executive Leadership Group has taken a central role in determining individual savings targets for Care Groups and Corporate Directorates. These are predominantly calculated as a percentage of their recurrent budget allocation for the year. Targets were approved by Board and savings plans developed with the Care Groups to achieve the overall savings target. However, our work identified some concerns around the equity and fairness of 'stretch' targets that had been allocated to some areas such as Unscheduled Care, Primary Care and Medicines Management.
- 20 Financial Planning templates are used to assess Care Group and Corporate Directorate savings plans and pipeline ideas. Executive Directors provide scrutiny and challenge over the deliverability of the plans. Each savings scheme is also required to be assessed via a Quality Impact Assessment where necessary and tested to ensure they do not adversely impact on the strategic aims. An Internal Audit report on savings arrangements in December 2023 stressed the need for guidance around Quality Impact Assessments for identified savings schemes. A new revised approach was being implemented at the time of our review; however, it was too early to assess the impact of the change.
- 21 Due to the limited progress on service transformation, savings schemes remain predominantly short-term and transactional in nature to meet in year savings requirements. As Care Groups continue to mature, the wider approach to securing greater financial sustainability needs to include areas such as public health, prevention, community-based care, and regional working that can elicit longer term savings opportunities. **(Recommendation 5).**

Delivery of cost savings opportunities

- 22 We considered whether the Health Board has:
- a good track record of delivering savings plans and cost improvements.
 - clear plans in place to deliver the cost savings opportunities it identifies; and
 - the necessary skills and capacity to deliver its agreed cost savings opportunities.
- 23 We found that **the Health Board's track record for savings delivery is improving, resulting in achievement of its overall savings target for 2023-24. It is also progressively increasing its recurrent savings. However, the financial situation during 2024-25 is looking increasingly challenging due to**

the impact of both predicted and some unforeseen risks necessitating greater financial resilience and consistency in savings plans and delivery.

Track record of delivery savings plans and cost improvements

24 As shown in **Exhibit 1**, with the exception of 2020-21, the Health Board has been able to demonstrate a track record of progressive improvement for both its overall savings and recurrent savings delivery. Notably, 94% of savings delivered in 2023-24 were recurrent. However, the Health Board did also rely on £5.8 million accountancy gains savings in 2023-24, which are non-recurrent in nature and reported separately to Welsh Government¹².

Exhibit 1 In-year Savings Track-record 2019 to 2024

Year	Overall Savings Target £(M)	Actual overall savings delivered (£M)	Recurrent savings as a % of overall savings target	Delivered non-recurrent savings (£M)	Delivered recurrent savings (£M)
2019-20	10.0	9.9	69%	3.0	6.9
2020-21	20.6	5.9	16%	2.6	3.3
2021-22	14.5	12.3	30%	8.0	4.3
2022-23	17.3	17.2	52%	8.2	9.0
2023-24	27.3	27.4	94%	1.7	25.7

Source: Welsh Government Monthly Monitoring Returns and Health Board Finance Reports.

¹² Figure obtained from table C4 in the month 12 Welsh Government Monthly Monitoring Return.

- 25 The Health Board has a recurrent savings target of £26.3 million for 2024-25 but is experiencing challenges in delivering this target. The Month 5 2024-25 Finance Update to Board in September 2024 noted a £3.9 million year-to-date deficit, with the main driver being a £6.8 million shortfall in savings delivery. The Health Board was still reporting a break-even position at year-end, which slightly improved by Month 6. However, a significant incident relating to the Health Board's Princess of Wales Hospital has recently occurred¹³. This is disrupting services as the Health Board enters the critical winter period and potentially puts both their revenue and capital performance at risk and may impact on savings delivery for 2024-25.

Approach to delivery of savings plans

- 26 The Health Board has sufficient processes in place for turning its high-level savings requirements into deployable savings plans. Corporately, there are clear lines of accountability for savings delivery with Executive Directors issued an accountability letter which sets out several financial requirements including a savings target. Responsibility for individual budgets can be sub-delegated to accountable officers within the Health Board's operating structure. Monthly finance meetings with Care Groups and Directorates are used to monitor progress of savings schemes delivery.
- 27 The performance of individual savings schemes during 2023-24 suggests there is scope for the Health Board to ensure stronger accountability for operational savings delivery going forward. For example, it experienced some significant savings shortfalls in service areas such as Clinical Support Services, Primary Care and Community, and Women and Children's services and achieved a greater proportion of savings in areas such as Diagnostics, Therapies and Specialities, Corporate Executives, and Contracting and Commissioning. However, whilst this did not materially impact delivery of the overall savings target as it was offset by favourable variances on non-delegated savings¹⁴, it does indicate a need for greater operational grip and control on savings delivery to manage the risks to its underlying financial position. **(Recommendation 6)**

Skills and capacity to deliver savings opportunities

- 28 The Health Board is developing its skills and capacity in respect of the operational aspects of savings delivery. There is evidence of more collaborative working between the Finance Team and Chief Operating Officer's team in providing oversight of financial performance and there are plans to roll-out financial training

¹³ During October 2024, the Health Board declared a critical incident at its Princess of Wales Hospital site revealing serious deterioration to the building's roof that will require a substantial programme of replacement.

¹⁴ Non-delegated savings are centrally held funds used by the Health Board to support Care Group (delegated) savings delivery.

now the Care Groups are fully established. Finance Business Partners¹⁵ also provide support within Care Groups and Clinical Services Groups for planning and delivery of operational cost savings. In addition, the Project Management Office (PMO) and Change Hub have recently transferred to the Chief Operating Officer's team, which provides an opportunity to ensure capacity is in the right place to achieve operational savings objectives.

- 29 However, there remains a skills and capacity gap in respect of the longer-term service transformation required to deliver financial sustainability. While there are some examples of the Health Board's strategic intent for new service model approaches through its Care Group model, this work remains in its formative stages. The Health Board acknowledges the need to align resources across corporate and operational teams to support transformational change.
- (Recommendation 7)** Furthermore, an Internal Audit report in December 2023 highlighted gaps in the provision of Project Initiation Documents¹⁶ (PIDs) which will need to be addressed before it starts to develop plans for larger scale changes.

Monitoring and oversight of cost savings delivery

- 30 We considered whether the Health Board:
- Has an effective approach to reporting and monitoring the delivery of its cost savings plans;
 - Identifies risks to the delivery of savings plans and actions to mitigate those risks; and
 - Applies learning where cost savings plans have not been achieved.
- 31 We found that **the organisation has clear processes for monitoring, tracking, and reporting delivery of its agreed transactional cost savings plans. However, there are opportunities to improve the management of in-year savings risks and introduce a systematic approach for learning lessons from savings planning and delivery.**

Reporting and monitoring the delivery of savings plans

- 32 The Health Board has reasonably effective arrangements for monitoring and reporting delivery of savings. At a corporate level, financial performance, including savings its reported to the Board, Planning, Performance and Finance Committee (PPFC) and Executive Leadership Group. Financial performance updates are

¹⁵ The finance business partner model ensures engagement on financial management and provides a good link between services and corporate finance. The financial business partners are financial accountants who have responsibility for supporting services, financial reporting and providing an advisory role.

¹⁶ The Project Initiation Document (PID) defines a project, outlines its management approach, the risks and assesses overall success, ensuring a solid foundation before committing to major expenditures.

tailored to each forum with a high-level overview of savings performance reported to Board and a more detailed report to PPFC which includes an analysis of savings by RAG rating and trends in delivery across Care Groups and Corporate Directorates. This information is sufficient to oversee the Health Board savings delivery progress and enables the Board to scrutinise or recommend action where savings schemes are off-track.

Identification of risks to savings plans delivery

- 33 The Health Board has adequately documented the risks around its wider financial position with appropriate financial management structures in place including the Board Assurance Framework (BAF) and Corporate Risk Register outlining key risks including the risk of failure to plan and manage revenue resources within the limits set by Welsh Government. Finance risks are also set out in the routine finance reports to the PPFC and Board with the controls and remedial action the Health Board is taking to address the risks.
- 34 Like all NHS Bodies in Wales, the Health Board applies a RAG rating to its savings schemes to determine the risk of non-delivery. During 2023-24, the Health Board was able to address savings risks quickly, albeit using non-delegated savings to offset forecast savings shortfalls. However, the picture during 2024-25 is more challenging. At Month 1, the Health Board identified that 42% of its savings schemes were 'amber' and 38% 'green'. Welsh Government requires 'amber' schemes to turn to 'green' schemes (i.e. a strong likelihood of delivery) within 3 months. However, at Month 4, while the Health Board reported that 13% remained 'amber' there was also a reduction in its 'green' savings schemes to 17% indicating a deterioration in forecast savings from £19.1 million to £7.2 million. The Health Board does not identify 'red' savings schemes in its finance reports to the PPFC in line with Welsh Governance guidance. Instead, assurance is provided on the actions being undertaken to recover schemes which are under-delivering.

Applying learning

- 35 The Health Board has indicated that its Project Management Office (PMO) and Change Hub (**see paragraph 28**) will provide increased opportunities for learning at an operational level. However, at the time of our review, the structural changes to the Chief Operating Officer's team were relatively new and it was too early to evaluate the impact of the revised arrangements. We noted some innovative service changes in progress, to improve savings delivery, for example, the use of facilities workforce to support patients meal times, thereby reducing the numbers of Nursing and Healthcare Support Workers required on the roster. The Health Board are also looking to manage longer term costs through reducing their use of waiting list initiatives and arrangements for on-call staff as the current three site approach is costly. The Health Board, therefore, should seek to identify the key lessons from these experiences and apply the learning to build savings delivery capability within the Care Groups and Clinical Support Groups. (**Recommendation 9**)

Recommendations

Exhibit 2 details the recommendations arising from this audit. The Health Board’s response to our recommendations is summarised in **Appendix 3**

Exhibit 2: Recommendations

Recommendations	
R1	The Health Board should assess operational savings delivery potential and risks within each Care Group and Clinical Service Group on an ongoing basis. (Paragraph 11)
R2	The Health Board should ensure that its service transformation plans more explicitly set out how they will help the organisation achieve financial sustainability in terms of the savings that will be generated and the timescale for achieving them. (Paragraph 14)
R3	The Health Board should make improvements to how it uses data and intelligence to inform its savings identifications and selections arrangements by: R3.1 Extending its use of data and intelligence across a wider range of services. (Paragraphs 15) R3.2 Rapidly progressing work on its local data repository to facilitate the systematic capture of benchmarking data. (Paragraph 15)
R4	Where “invest to save” opportunities are identified and taken forward through the Value and Sustainability Programme the Health Board should confirm that it is able to provide sufficient upfront funding to support them and able to demonstrate a clear return on investment (Paragraph 17)
R5	Plans for service transformation (5 years plus) need to be developed as the Care Groups continue to mature and increasingly focus on public health, prevention, community-based care and regional working. (Paragraph 21)
R6	The Health Board should ensure stronger operational accountability for savings delivery and manage risks to its underlying position more effectively. (Paragraph 27)

Recommendations

R7 The Health Board should ensure that there is sufficient skills, capacity and capability across its corporate and operational teams to effectively deliver its longer-term service transformation. **(Paragraph 29)**

R8 The Health Board should identify the key lessons from its approach to identifying and delivering savings during 2023-24 and apply the learning to its future approach. **(Paragraph 35)**

Appendix 1

Audit criteria

Exhibit 3 below sets out the detailed audit criteria for this review.

Identifying cost savings opportunities

Area	Audit Criteria
Understanding the drivers of cost	• The organisation's opening balance sheet is true and fair. • The organisation has effective arrangements in place for identifying and analysing the full range of pay and non-pay factors driving its costs in the short, medium, and long-term. • The organisation has a good understanding of the scale of cost savings required to achieve financial sustainability in the short, medium, and long-term and has set realistic and achievable targets accordingly. • The Board is appropriately involved in overseeing, scrutinising, and challenging the organisation's financial analysis and cost savings targets.
Using data and intelligence to identify cost savings opportunities	• The organisation routinely accesses and uses benchmarking information from a range of sources (e.g. NHS Benchmarking, CHKS, Medicines Management KPIs) • The organisation routinely accesses and uses efficiencies data and information from a range of sources (e.g. NHS Wales Efficiency Framework / VAULT, GIRFT reviews, local Value-based Healthcare reviews / opportunities)

- The organisation has clear processes in place to canvas, capture, and assess ideas and suggestions on cost savings opportunities from staff, service-users, and other stakeholders on a regular basis.
- The organisation has clear processes in place for responding to centrally identified cost savings opportunities from the NHS Wales Value and Sustainability Board.

Selecting cost savings opportunities

- The organisation has a clear and iterative process in place to appraise all potential cost savings opportunities for achievability and for impact on delivering the organisation's strategic aims, well-being objectives, population health, the quality and safety of services, and ability to meet performance targets / service specifications in the short, medium, and long-term.
- The organisation has a clear and iterative process in place for scrutinising, agreeing, and approving cost savings opportunities, which also involves the Board and its relevant committee(s).
 - The organisation's agreed cost savings opportunities:
 - are realistic, achievable, and focus on maximising value to the health of the population being served;
 - cover the breadth of the organisation's clinical, administrative, and technical functions;
 - balance one-off non recurrent savings with more sustainable saving opportunities;
 - incorporate productivity savings, but recognise these will not lead to a reduction in monetary terms;
 - focus on medium- to longer-term transformation, as well as short-term and incremental opportunities; and
 - have been scaled and targeted appropriately across all parts of the organisation (rather than a standard percentage applied across all parts.)

Delivery of cost savings opportunities

Area	Audit Criteria
Approach to delivery of savings plans	• The organisation has plans in place for delivering cost savings opportunities which clearly set out: – the financial savings that will be delivered and how they will be measured; – the anticipated impact on strategy, quality, and / or performance; – the key risks, controls, and mitigating actions; – any interdependency with other cost savings plans; – any dependency on other organisational work streams and strategies; – key delivery milestones; and – which senior officer is responsible and accountable for delivery. • The organisation has effective arrangements in place for managing cross-cutting cost savings plans. • The organisation has appropriate arrangements in place to communicate its cost savings plans to staff, service-users, and other stakeholders.
Skills and capacity to deliver savings opportunities	• Roles and responsibilities in relation to delivering cost savings plans at all levels of the organisation are clearly documented and understood.

- The organisation has assessed the skills / capability and capacity required to deliver its cost savings plans at both a corporate and operational level and has put appropriate arrangements in place to address any shortfalls and gaps (including the appropriate use of external capacity / expertise.)
- The organisation has appropriate corporate structures and resources in place (such as a Programme Management Office) to:
 - keep delivery on track,
 - provide challenge when needed,
 - support corporate and operational staff to manage delivery risks, and
 - provide an agile and timely response to under-performance / under-delivery.

Track record of delivery savings plans and cost improvements

- Cost savings plans in recent years have been largely achieved.
- There is evidence of learning being applied where cost savings plans previously haven't been achieved.

Monitoring and oversight of cost savings delivery

Area	Audit Criteria
Monitoring the delivery of savings plans	• The organisation has clear arrangements in place for monitoring delivery which reflect the timescales and risks associated with delivering individual plans and the overall cost savings target. • The organisation has selected appropriate key KPIs and has put effective controls in place to ensure the quality of underlying data are reliable for effective monitoring and reporting.

	• The organisation's approach to monitoring and tracking delivery of its cost savings plan is appropriately aligned to its broader financial management arrangements (e.g., Standing Financial Instructions, Schemes of Reservation and Delegation, budget allocations.) • The organisation produces tailored reports that meet the differing needs of users in the governance chain. • The organisation ensures that delivery of cost savings is accurately reflected in finance reports presented to the Board and / or its relevant committee(s).
Identification of risks to savings plans delivery	• The organisation has identified and documented the key risks to delivery in the appropriate risk registers (operational, corporate, and Board Assurance Framework.) • The organisation is actively managing / mitigating the risks at the appropriate level. • The organisation has appropriate arrangements in place to identify and escalate cost savings plans that are off-track and / or having an adverse / unanticipated impact on strategy, quality, and / or performance. • The organisation takes appropriate action in a timely manner where cost savings plans are off-track and / or having an adverse / unanticipated impact on strategy, quality, and / or performance.
Applying learning	• The organisation seeks assurance on its arrangements by using internal audit, or a similar independent and objective reviewer. • The organisation appropriately evaluates its approach to achieving cost savings. • The organisation actively uses its own evaluation(s) and assurances provided by internal audit to identify lessons learned and to change / improve its arrangements. • Lessons learned and changes / improvements are reported to the Board and / or its relevant committee(s) to enable an agile response in-year. • The organisation has appropriate arrangements in place to fully transfer and / or integrate changes arising from its cost savings plans to its business-as-usual operations and activities.

Appendix 2

Audit methods

Exhibit 4 below sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

Element of audit approach	Description
Self-assessment	Completed self-assessment questionnaire and supporting documents were reviewed
Documents	We reviewed a range of documents, including: • Board and Committees agenda's, papers, and minutes; • Key organisational strategies and plans; • Key risk management documents, including the Board Assurance Framework and Corporate Risk Register; • Key reports in relation to organisational finances; • Reports prepared by the Internal Audit service.
Interviews	We interviewed the following: • Service Director, MH & LD • Chief Operating Officer • Divisional Director of Facilities • Deputy COO for Acute Services • Assistant Finance Director & Director of Ops Unscheduled Care

Element of audit approach	Description
	• Service Director Primary Care and Community • Deputy Director of Finance • Executive Director of Finance Estates and Procurement • Director of Operations for Planned Care
Observations	We observed Board meetings as well as meetings of the following committees: • Public Board • Planning, Performance and Finance Committee

Appendix 3

Management response to audit recommendations

Exhibit 5: Cwm Taf Morgannwg University Health Board response to our audit recommendations.

Ref	Recommendation	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R1				
R2				



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We welcome correspondence and
telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a
galwadau ffôn yn Gymraeg a Saesneg.

Management response form



Report title: Review of Cost Savings Arrangements

Completion date: 6th December 2024

Document reference: 4542A2024

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R1	The Health Board should assess operational savings delivery potential and risks within each Care Group and Clinical Service Group on an ongoing basis.	The IMTP process for 2025/28 will utilise an assessment of operational savings delivery potential to inform savings targets for each Care Group	March 2025	Director Of Finance
R2	The Health Board should ensure that its service transformation plans more explicitly set out how they will help the organisation achieve financial sustainability in terms of the savings that will be generated and the timescale for achieving them	The IMTP process for 2025/28 includes an intention to ensure that at least the first stage of the ACSP public engagement is undertaken, in order to arrive at a set of options for further public consideration. In parallel, there are a range of emergency services changes that are being evaluated for performance, quality and financial sustainability opportunities. This will	March 2025	Director of Strategy and Transformation

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		contribute to the development of a three-year plan, including a realistic assessment of impact on cost savings.		
R3	The Health Board should make improvements to how it uses data and intelligence to inform its savings identifications and selections arrangements by: R3.1 Extending its use of data and intelligence across a wider range of services. R3.2 Rapidly progressing work on its local data repository to facilitate the systematic capture of benchmarking data.	Plan to make improvements in how we use data and intelligence to underpin savings identification and selection to be incorporated into our IMTP planning process	March 2025	Director of Digital/Director of Strategy and Transformation

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R4	Where “invest to save” opportunities are identified and taken forward through the Value and Sustainability Programme the Health Board should confirm that it is able to provide sufficient upfront funding to support them and able to demonstrate a clear return on investment.	Invest to Save opportunities will continue to be supported by clear cases setting out the proposed return on investment in year and recurrently. Any proposals where there is insufficient return in year to maintain cost neutrality will be managed as an investment proposal through our established IMTP processes	March 2025	Director of Finance
R5	Plans for service transformation (5 years plus) need to be developed as the Care Groups continue to mature and increasingly focus on public health, prevention, community-based care and regional working.	Plans for service transformation will continue to underpin our IMTP and strategy development. This will be reflected in our 2025-28 IMTP	March 2025	Director of Strategy and Transformation/Chief Operating Officer
R6	The Health Board should ensure stronger operational accountability for savings	Revised monthly finance reviews are now in place and these are undertaken and led by the COO and DOF. The review focus on both in	Complete	Director of Finance/Chief Operating Officer

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	delivery and manage risks to its underlying position more effectively.	year and recurrent plans and are underpinned with accountability agreements. Issues are escalated to the Chief Executive and to Board through Finance reporting		
R7	The Health Board should ensure that there is sufficient skills, capacity and capability across its corporate and operational teams to effectively deliver its longer-term service transformation.	We will consider the sufficiency of skills, capacity and capability in developing our IMTP and future strategy. Plan to be reflected in our 2025-28 IMTP	March 2025	Director of Strategy and Transformation/Chief Operating Officer/Director for People
R8	The Health Board should identify the key lessons from its approach to identifying and delivering savings during 2023-24 and apply the learning to its future approach.	We will consider the key lessons in developing our IMTP and future strategy. Lessons learned to be reflected in our 2025-28 IMTP	March 2025	Director of Strategy and Transformation/Chief Operating Officer/Director of Finance