

Audit & Risk Committee

Thu 18 April 2024, 14:30 - 16:30

Virtual Via Teams



Agenda

14:30 - 14:35 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

14:35 - 14:45 2. CONSENT AGENDA
10 min

2.1. Items for Approval

2.1.1. Unconfirmed Minutes of the Meeting held on 22 February 2024

Decision Patsy Roseblade, Chair

2.1.1 Unconfirmed Minutes ARC 22 February 2024 v1 KD-GW.pdf (12 pages)

2.1.2. Unconfirmed In Committee Minutes of the Meeting held on 22 February 2024

Decision Patsy Roseblade, Chair

2.1.2 Unconfirmed IC Minutes 122.2.23 ARC 18th February 2024 (GW).pdf (3 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 18 April 2024.pdf (4 pages)

2.2.1a Appendix 1 - Annual Cycle of Business ARC 18 April 2024.pdf (4 pages)

2.2.2. Annual Report Timetable 2023 - 2024

Information Cally Hamblyn, Assistant Director of Corporate Governance & Risk

2.2.2 Annual Report Timetable 2023 2024 ARC 18 April 2024.pdf (4 pages)

2.2.2a Appendix 1 Annual Report Timetable - V3 26.2.2024.pdf (3 pages)

2.2.3. Declarations of Interest and Gifts and Hospitality Report

Information Gareth Watts, Director of Corporate Governance/Board Secretary

2.2.3a DOI and GHS Cover Report ARC 18 April 2024.pdf (4 pages)

- 2.2.3b -Appendix 1 - Declarations of Interest Register 2023-2024 - Board and Non Board.pdf (23 pages)
- 2.2.3c Appendix 2 - GHS Register.pdf (1 pages)

2.2.4. Breaches to the Standing Orders

Information Gareth Watts, Director of Corporate Governance/Board Secretary

- 2.2.4 Breaches to Standing Orders ARC 18 April 2024.pdf (4 pages)

2.2.5. Committee Forward Work Plan

Information Gareth Watts, Director of Corporate Governance/Board Secretary

- 2.2.5 Audit & Risk Committee Forward Work Plan ARC 18 April 2024.pdf (2 pages)

14:45 - 14:55 3. MAIN AGENDA 10 min

3.1. Action Log

Discussion Gareth Watts, Director of Corporate Governance/Board Secretary

- 3.1 Audit & Risk Committee Action Log ARC 18 April 2024.pdf (3 pages)

3.1.1. Matters Arising Not Contained Within the Action Log

Discussion Patsy Roseblade, Chair

3.2. Committee Annual Self Effectiveness Survey Outcome & Improvement Plan

Discussion Gareth Watts, Director of Corporate Governance/Board Secretary

- 3.2 Outcome of Committee Self Effectiveness Survey & Improvement Plan ARC 18th April 2024.pdf (4 pages)

14:55 - 15:25 4. SUSTAINING OUR FUTURE 30 min

4.1. Local Counter Fraud Annual Report

Discussion Matthew Evans, Local Counter Fraud Specialist

To include the following:

- 4.1 Local Counter Fraud Update Cover Report ARC 18 April 2024.pdf (4 pages)
- 4.1a Appendix 1 Counter Fraud Annual Report 2023-24 ARC 18 April 2024.pdf (20 pages)
- 4.1b Counter Fraud Work Plan 2023-24 ARC 18 April 2024.pdf (14 pages)

4.2. Local Counter Fraud Report

Discussion Matthew Evans, Local Counter Fraud Officer

- 4.2 Local Counter Fraud Update Cover Report ARC 18 April 2024.pdf (4 pages)
- 4.2a Appendix 1 -Counter Fraud Investigations Update.pdf (11 pages)
- 4.2b Appendix 1 Local Counter Fraud Update Report ARC 18 April 2024.pdf (3 pages)

4.3. Procurement & Scheme of Delegation Report

Discussion Sally May, Executive Director of Finance & Procurement

- 4.3 Procurement SoD ARC report_April24 ARC 18 April 2024.pdf (12 pages)

4.4. Post Payment Verification Annual Report

Discussion Post Payment Verification Manager

This will now be received at the June meeting

4.5. Progress update on Grant Thornton Recommendations

Discussion

Executive Director of Strategy & Transformation

 4.5a Grant Thornton Update ARC 18 April 2024.pdf (4 pages)

 4.5b appendix 1 Progress update on Grant Thornton recommendations - Completed Form LP.pdf (33 pages)

15:25 - 16:25

60 min

5. IMPROVING CARE

5.1. Annual Review: Risk Management Framework

Discussion

Gareth Watts, Director of Corporate Governance/Board Secretary

 5.1a Annual Review of Risk Management Framework ARC 18 April 2024.pdf (5 pages)

 5.1b Appendix 1 - Risk Management Strategy - Draft v8 ARC 18 April 2024.pdf (27 pages)

5.2. Organisational Risk Register

Discussion

Cally Hamblyn, Assistant Director of Governance & Risk

 5.2a Org Risk Register - Cover Paper - ARC Apr 24.pdf (8 pages)

 5.2b Appendix 1 - Org RR Marc 24 - ARC April 24.pdf (8 pages)

5.3. Audit Recommendations Tracker

Discussion

Cally Hamblyn, Assistant Director of Governance & Risk

 5.3a Audit Recommendations Tracker - ARC 18 April 2024.pdf (7 pages)

 5.3b Appendix 1 AMaT Audit Recommendations Tracker_Audit Risk Committee 18.04.2024- CH.pdf (16 pages)

 5.3c - Appendix 2 Audit Tracker Development Work Programme.pdf (2 pages)

5.4. Medical Rostering - Progress Report

Discussion

Dom Hurford, Medical Director

 5.4 Medical Rostering Progress Report ARC 18 April 2024.pdf (5 pages)

5.5. INTERNAL AUDIT

5.5.1. Internal Audit Progress Report

Discussion

Paul Dalton, Head of Internal Audit

 5.5.1 CTM -Progress report ARC 18 April 2024.pdf (9 pages)

5.5.2. Internal Audit Review – PCH Financial Management and Change Control Progress Report

Discussion

Internal Audit

 5.5.2 IA Report PCH Financial Assurance Final ARC 18th April 2024.pdf (17 pages)

5.5.3. Internal Audit Review - Management of Controlled Drugs

Discussion

Internal Audit

 5.5.3 IA Report Management of Controlled Drugs Final ARC 18 April 2024.pdf (24 pages)

5.5.4. Internal Audit Review - GI Pathways

Discussion

Internal Audit

 5.5.4 GI Pathways Demand Management Final Internal Audit Report (revised) ARC 18 April 2024.pdf (19 pages)

 5.5.4a GI Pathways Demand Management Audit - Action Plan ARC 18 April 2024.pdf (9 pages)

5.5.5. Internal Audit Review - Decarbonisation

Discussion *Internal Audit*

 5.5.5 Decarbonisation Final Internal Audit Report ARC 18 April 2024.pdf (23 pages)

5.5.6. Internal Audit Report - Digital Operating Model Follow up

Discussion *Internal Audit*

 5.5.6 Digital Model Follow Up final IA Report ARC 18 April 2024.pdf (10 pages)

5.5.7. Internal Audit Annual Audit Plan 2024-2025

Discussion *Paul Dalton, Head of Internal Audit*

 5.5.7 2024-25 Internal Audit Plan ARC 18 April 2024.pdf (32 pages)

 5.5.7a CTM -2024.25 - Internal Audit - Indicative days.pdf (5 pages)

5.6. AUDIT WALES

5.6.1. Audit Wales Audit & Risk Committee Update

Discussion *Audit Wales*

 5.6.1 AW Audit Update ARC 18 April 2024.pdf (12 pages)

5.6.2. Workforce Planning Audit - Audit Wales

Discussion *Audit Wales*

 5.6.2 AW Workforce Planning Report ARC 18th April 2024.pdf (32 pages)

16:25 - 16:30

5 min

6. CLOSE OF BUSINESS

6.1. Any Other Urgent Business

Discussion *Patsy Roseblade, Chair*

6.2. How Did we do in this Meeting

Discussion *Patsy Roseblade, Chair*

6.3. Highlight Report to Board

Discussion *Patsy Roseblade, Chair*

16:30 - 16:30

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7. PRIVATE/IN COMMITTEE SESSION

Information *Patsy Roseblade, Chair*

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 Reports*
- *Audit Recommendations Tracker*

16:30 - 16:30

0 min

8. DATE AND TIME OF NEXT MEETING

Information *Patsy Roseblade, Chair*

20th June 2024 - 10.15 - 1215 pm

Agenda Item Number:

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) AUDIT AND RISK Committee Meeting Held via Microsoft Teams

22 FEBRUARY 2024

Members Present:	
Patsy Roseblade	Independent Member (Chair)
Ian Wells	Independent Member (Vice Chair)
Kath Palmer	Independent Member
Jonathan Morgan	Health Board Chair
In Attendance:	
Sally May	Executive Director of Finance & Procurement
Gethin Hughes	Chief Operating Officer
Paul Dalton	NWSSP- Internal Audit & Assurance
Emma Samways	NWSSP- Internal Audit & Assurance
Martyn Lewis	NWSSP- Internal Audit & Assurance
Matthew Evans	Head of Local Counter Fraud Services
Mark Jones	Audit Wales
Sara Utleby	Audit Wales
Nathan Crouch	Audit Wales
Owen James	Head of Corporate Finance
Gareth Watts	Director of Corporate Governance/Board Secretary
Cally Hamblyn	Assistant Director of Governance & Risk
Samia Edmonds	NHS Wales Programme Planning Director (in part - for Agenda item 4.4)
Claire Brown	Head of Quality Assurance and Compliance
Kelly Eddington	Quality Assurance & Compliance Officer
Emma Walters	Head of Corporate Governance & Board Business
Kathrine Davies	Corporate Governance Manager (Secretariat)
1.	PRELIMINARY MATTERS
1.1	Welcome & Introduction 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 have been received from: • Geraint Hopkins, Independent Member
1.3	Declarations of Interest There were no interests to declare.
2.	CONSENT AGENDA
2.1	FOR APPROVAL
2.1.1 Resolution	Unconfirmed Minutes of the Meeting held on 19 December 2023 The Minutes were APPROVED
2.1.2 Resolution	Unconfirmed Minutes of the In Committee Meeting held on 19 December 2023 The Minutes were APPROVED.
2.1.3 Resolution	Audit & Risk Committee Annual Cycle of Business 2024-25 The Annual Cycle of Business was APPROVED
2.2	FOR NOTING
2.2.1 Resolution	Annual Committee Self Effectiveness Survey Outcome & Improvement Plan The Chair advised that this would now be received at the April 2024 meeting and encouraged Members to complete the survey.
2.2.2 Resolution:	Audit & Risk Committee Forward Work Programme G. Watts reminded Members that they were in the process of finalising the recent consultation of the review of the Board Effectiveness which could possibly have implications for this Committee and would keep members appraised. The Forward Work Programme was NOTED.
3.	MAIN AGENDA

3.1	Audit & Risk Committee Action Log The Committee reviewed the Action Log and noted the following updates: G. Watts advised that there were three amber items on the Action Log, two of which would be covered off during the agenda items at the meeting. He confirmed that the third one in respect of the audit tracker that there would be a substantive discussion on that later on in the agenda. Resolution: The Action Log was NOTED.
3.2	Matters Arising not Contained within the Action Log There were no matters arising.
4.	SUSTAINING OUR FUTURE (NB Agenda Item 4.4 was taken first)
4.4	National Commissioning Review And The Establishment Of The New NHS Wales Joint Commissioning Committee (JCC) – Progress Report S. Edmonds presented the report on the progress to establishing the NHS Wales Joint Commissioning Committee (JCC), as hosted by Cwm Taf Morgannwg University Health Board. K. Palmer advised that the Hosted Bodies meeting held earlier had contemplated accountabilities and how that Committee was going to work moving forward with the new arrangement of having two Accountable Officer and the audit of the accounts. S. Edmonds advised that the discussions they were currently having at the moment was in regard to ensuring that the joint standing orders, standing financial instructions and the memorandum of understanding (MOU) were really clear and there would need to be a cross reference in terms of the accountable officer status between the Chief Commissioner and Accountable Officer of Cwm Taf Morgannwg (CTM). She added that they were taking advice on this from a legal perspective and that Chief Executives were also sighted on this. S. Edmonds stated that the suggested arrangement is that they recognised that the Chief Executives of the Health Boards retain overall accountability for the commissioning of services, however, the Chief Commissioner of the JCC in line with managing public money would hold accountable officer status for the management of the funds so not to undermine the Health Board Chief Executive Officers. She added that this was an additional safeguard and that the Accountable Officer would sign off the statement of accounts before submitting them to CTM. She confirmed that this was not a new arrangement and there was a similar arrangement in place for Velindre NHS Trust.

In response to the above, S. May commented that she did not understand how that arrangement would work and that by putting in extra layers was complicating lines of accountability and this needed to be really clear.

S. Edmonds in response advised that it was not their intention to add layers of confusion, but trying to build on the current arrangements and improve upon that. She added that they were mindful that CTM wears 'three hats' in this and they wanted to add levels of protection to those roles.

S. May commented that there was an implied conflict, as they did not have a separate level of commissioning that they had in England, the host one was unique but the others were an inherent conflict. S. Edmonds advised that they had taken legal advice on this and the advice they had received had been unanimous and significant in terms of terms of the budget, looking at explicit scenarios such as cancer and instances of fraud and who would be the Accountable Officer in these instances. The advice was that it should be the Chief Commissioner. She added that she would be very happy to pick this up with S. May outside of the meeting and would share the scenarios.

G. Watts thanked S. Edmonds for the update and advised the Committee of his role sitting on the Governance Work Stream. He advised that they were developing new Standing Orders, Standing Financial Instructions and the Hosting Agreement between CTM and the JCC and confirmed that the JCC team would be employed by CTM. He added that whilst they had received assurance from the Chief Executive of NHS Wales he was still unclear as to how this would pan out in practice, however, hopefully once the Accountable Officer Memorandum and Interface Agreement were issued by Welsh Government that this would become clearer.

G. Watts advised that CTM had also sought the view of Audit Wales in order to get some clarity and understanding of work in practice. He added that the Welsh Government had met with the CEOs last week and provided them with the rationale as to how they had reached this position and this had also been shared with Health Board Chairs.

M. Jones confirmed that CTM had referred some important points into Audit Wales and they were going through internal considerations to provide feedback from an audit perspective.

K. Palmer queried what conflict arrangements would be put in place if there was disagreement between the two accountable officers in regard to use of the funds. S. Edmonds confirmed that they had looked at this scenario and if there was disagreement there would be mechanisms put into place to set out the handling of any conflict.

S. May advised that the current WHSSC Committee worked on the basis of having a unanimous vote and the decision to move to a majority could mean that the Chair and Independent Members plus 4 CEOs could make a

	majority decision with the other CEOs not agreeing and that could be quite interesting in terms of accountabilities. She added that the scenarios need to be tested in full. S. Edmonds, in response, advised that there were inherent risks in the system currently but they were trying to mitigate them as much as possible and they had taken legal advice on whether the Chief Commissioner should have voting rights. G. Watts commented that it was his understanding that the Chief Commissioner irrespective of the Accountable Officer status, would remain an employee of CTM. S. Edmonds confirmed that CTM would be the employing organisation for all members of the JCC team. She added that Welsh Government had shared all the information with Audit Wales in terms of the rationale and that they would be happy to share with the Committee. P. Roseblade queried what would be the role of the CTM Hosted Bodies on behalf of the Health Boards. S. Edmonds confirmed that the Chair and lay members would be independent of the Health Boards and appointed by, and accountable to the Minister. She added that the role of the Hosted Bodies would be similar to what it currently was now and that they did not perceive a huge change with respect to that. P. Roseblade, in response, queried whether the lay members of the JCC would sit on the Audit Committee. S. Edmonds confirmed that she would need to check on this and would respond back outside of the meeting. P. Roseblade sought clarity on the accountability framework and who would be ultimately accountable, for example, the CEO of CTM as the host organisation and accountable officer or the Chief Commissioner. S. Edmonds advised that it would depend on who was accountable for what and this was the suite of accountability and governance documents including the Accountable Office Memorandum, Accountability Map and Interface Agreement would set this out for each different scenario
Resolution	The Committee NOTED the progress on establishing the NHS Wales Joint Commissioning Committee
4.1	Local Counter Fraud Report
	M. Evans presented Members the report provides detail on tasks and actions undertaken with the four strategic counter fraud work areas.
Resolution:	The report was NOTED .
4.1.1	National Fraud Initiatives Progress and Outcomes
	M. Evans presented the report that outlined progress and outcomes.
	I Wells thanked M. Evans for bringing the report to the Committee and queried whether they could improve upon more vigorous ID checks. M.

	Evans advised that he had expected the numbers to be smaller than they were and confirmed that they were reviewing closely for example, overlaps of shifts. The Chair suggested that the report should be referred to the People & Culture Committee as the report raised a fraud risk in relation to fitness to practice due to an agency worker had been booked, worked and paid, in respect of 4 back to back shifts over two consecutive days, across two different hospital sites and had registered with two separate agencies to enable the placements. And to provide assurance about the checks that are undertaken by staff bank and the electronic booking process to ensure that the right robust processes are in place to prevent people being able to work a day and night shift. G Watts advised that in order to refer a matter to a different committee, that three questions needed to be addressed and the Chair took this into account in order that the referral could take place. S. May advised that this was a risk on the organisational risk register that was an issue and would need tracking. The Chair referred to paragraph 5 and the successful prosecution of a locum and recovery of funds and advised that as a deterrent to staff it might be worth working with the Communications Team. M. Evans advised that there was media interest reflected at the time of the prosecution and would be ensuring that there would be full engagement with Communications and Welsh Government for the upcoming trial.
Resolution	The report, progress and outcomes were NOTED .
Action:	Committee Referral to People & Culture Committee to be actioned by Governance Team.
4.2	Procurement & Scheme of Delegation Report S. May presented Members with the report and highlighted the position on procurement matters for the period 1st December 2023 to 31st January 2024. S. May referred to the level of Purchase Order (PO) no Pay summary which was still high. She advised that it was important that Care Groups and Directorates raise POs correctly and that the procurement team were working with the Care Groups in respect of this. The Chair referred to the retrospective orders and the main non receipting areas where it had stated that for agency, £73k of invoices had not been receipted and an order raised and suggested that when dealing with agency staff that this was part of the process. S. May confirmed that they would need to have a discussion with the People Directorate and also on additional

Resolution	charges raised which could be impacting on the figures and advised that she would follow this through as an action.
Action	The Committee NOTED the position on procurement matters for the period 01.12.23 to 31.01.24; and NOTED the update regarding Purchase to Pay and achievement of PSPP target to period of 2023/24; To discuss the agency non receipting with the People Directorate
4.3	Losses and Special Payments Report S. May presented Members with the report that advised the Audit & Risk Committee on the losses and special payments made by the University Health Board (UHB) for the two month period from 1 November 2023 to 31 December 2023, as required by in Standing Financial Instruction. S. May advised that there had been an increase in the net plan expenditure and they were continuing to work around with the Patient Care and Safety Team. The Committee: NOTED the losses and special payments made for the period 1 November 2023 to 31 December 2023; NOTED the WRP forecast overspend and the CTM share of overspend; which has been incorporated into the LHB's annual forecast. NOTED the overspend on net claim expenditure and the impact of this on the in-year revenue position highlighted in Table 2. This expenditure is charged to the Patient Care & Safety revenue position.
WHSS	IMPROVING CARE
5.1	Organisational Risk Register G. Watts presented Members with the report and highlighted key updates to members. K. Palmer referred to 'Right Care, Right Person' and queried whether there was going to be a separate session held on this. She advised that it had also been discussed at the Mental Health Act Monitoring Committee and it was important that this was held. G. Hughes advised that they had a further briefing on this at the Operational Management Board and he would be happy to arrange for a briefing to the Board on how they were managing the risk. I Wells referred to risk 4103 in relation to Ophthalmology and asked for an update. G. Hughes advised that do report the actions against this via the Quality and Safety Committee with detailed updates and advised that he would be happy to share this information. He added that the position

Resolution Action:	continued to improve and there were some exciting development with Glaucoma and Retinal. I Wells requested an update on risk 4632 in relation to Stroke where it stated that an action plan was being development and whether there were plans to bring Bridgend into align with the rest of CTM. G. Hughes advised that in terms of Stroke, again, there were detailed updates provided to the Quality and Safety Committee and these could also be shared. With regard to Bridgend, G. Hughes advised that they had gone live with the supported discharge model at Bridgend and have a single model for the whole of CTM, he added that the other part of the model they would be looking this year to see how they could increase the coverage of stroke practitioners. G. Watts advised that C. Hamblyn would review the risk with the Unscheduled Care Group outside of the meeting. The Chair referred to the emerging risk of the fire door in the staff residential accommodation and queried whether this was being progressed. She also referred to the patient record risks that required to be updated but did recognise that a huge amount of risks had been updated and thanked the team. G. Watts confirmed that those risks had been escalated. In response, G. Hughes advised that the facilities and estates teams had undertaken a whole range of reviews with the level of risk and mitigations had been put in place also looking at the capital investment plan on the management of doors. The Committee REVIEWED the risks escalated to the Organisational Risk Register at Appendix 1 AND CONSIDERED whether the Committee can seek assurance from the report that all that can be done is being done to mitigate the risks. To share the updates to Quality and Safety on Ophthalmology and Stroke.
5.2	Audit Recommendations Tracker G. Watts presented Members report that provided 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 AMaT inspection module. The Chair extended her thanks on behalf of the Committee to C. Brown and K. Eddington for the huge amount of progress they had undertaken on this work and stated that it was now moving in the right direction. K. Palmer referred to the amount of actions and tables, where there were a number of overdue actions and suggested that an analysis could be undertaken to look at these so that the Committee could understand what

they needed to be focussing on and also what the Board should be considering.

G. Watts advised that he recognised the point made with regard to an analysis, they were on a journey and the presentation and analysis within the reports, would be enhanced over the coming months adding additional fields. He added that on the wider point with regard to the recommendations, there was a huge amount to track and many were overdue. He had held discussions with the Assistant Director for Governance and Risk about this issue with regard to how they accept recommendations and whether they should be implemented in the first place, also being clear about sensible timescales.

I Wells advised that it was a positive step in the right direction and particularly the traffic light dashboard on the front page was helpful and showing that it was maturing.

G. Hughes in response to K. Palmer's point advised that they need to mature the organisations' response to audit recommendations and also embedding the Care Groups, for example, managing the patient pathway process.

S. May commented that it was also about ensuring that Officers accept audit actions and recommendations and she referred to Sunnyside as an example where there were 15 recommendations and the Princess of Wales fire enforcement notice which was not currently a capital project.

G. Watts stated that the feedback and comments were appreciated, there was a cultural piece of work that was required within the organisation on how to deal with audit inspections and recommendations and the timeliness of meeting deadlines and something that the team would be taking forward. He added that as the software developed and was embedded there would be an opportunity for the Care Groups to input their information, directly into the database.

P. Dalton advised that from an internal audit perspective they do work with the relevant officers to ensure that that the wording and timings as correct on the tracker to get a balance of what was realistically achievable and what is appropriate for the organization.

S. Utey confirmed that when Audit Wales make recommendations and receive the organization response back they hold meetings to review the recommendations and try to reframe them. She advised that they work with the Health Board on an ongoing dialogue basis and that when you look at the structured assessment things have moved on from that and they were happy to work with the Governance Team.

The Chair referred to the tracker specifically and advised that she agreed with the comments that have been made around combined reporting. She

Resolution	added that they need to see what is limited and what is reasonable which outlines the status of the report, what recommendations are high priority and low priority. She suggested that it could be split in a similar way as the risk register in that the Committee would only see the risks that were above a certain level. S. May suggested that there might need to be a confidential discussion at Audit Committee in a closed session with regard to fundamental disagreement of opinion. The Chair in response added that a discussion in a closed session would ensure that everyone could discharge their responsibilities. G. Watts advised that a process was required for dealing with those situations and he would look at this and have an offline discussion with S. May in relation to this. G. Watts thanked everyone for their feedback in terms of the proposed format. The Committee NOTED the report
5.3	INTERNAL AUDIT
5.3.1	Internal Audit Progress Report P. Dalton presented the progress report that provided the Audit & Risk Committee (the 'Committee') with the current position of the work undertaken by Internal Audit as at 12 February 2024. P. Dalton acknowledged that the Governance Team had a robust plan in place with regard to progressing the reviews and thanked the team. The report was NOTED.
5.3.2	IA report – 4 Hour Emergency Department Performance Reporting (Limited) E. Samways presented the report that updated the Committee of the assurance on the accuracy of the Health Boards 4-hour Emergency Department performance target. G. Hughes advised the Committee to note that the rules for reporting 4 hour targets was different in Wales to England and that there were challenges levelled with Welsh Government. He added that they were not overly reporting but under reporting on 4 hour performance. The Chair referred to the amount of recommendations with a completion date of June 2024 and queried whether they could meet those targets. G. Hughes advised that the completion dates had previously been more ambitious than that and had now been pushed back. He added that work was ongoing and they were required to be reporting by quarter 1.

Resolution	The report was NOTED .
5.3.3	IA Report – IT Service Management M. Lewis Presented the report that Updates the Committee on the evaluation on the adequacy of the systems and controls in place for IT service management. The report has a reasonable assurance. The Chair commented that the report provided a sense of assurance that despite the lack of funding the team were doing everything that they could.
Resolution	The reported was NOTED .
5.3.4	IA Report – Facilities Governance Follow Up – Progress Update On Action Plan G. Hughes presented the report that updated the Committee on the progress with the Action Plan that had been developed in response to a previous Facilities Internal Audit Review. The Committee were advised that they had appointed an Interim Director of Facilities, who was addressing the issued that had been raised. The Chair commented that it was pleasing to see the progress that had now been made and provided assurance that their previous concerns were being addressed.
Resolution	The Committee NOTED the report.
5.4	AUDIT WALES
5.4.1	Audit Wales Audit & Risk Committee Update S. Utley and M. Jones provided the Committee with an update on the current and planned accounts and performance audit work at Cwm Taf Morgannwg University Health Board.
Resolution	The report was NOTED .
5.4.2	Annual Audit Report 2023 S. Utley presented the report that summarised the findings from the 2023 audit work at Cwm Taf Morgannwg University Health Board(the Health Board) undertaken under the Public Audit (Wales) Act 2004.
Resolution	The report was NOTED .
5.4.3	Audit Wales Letter – NHS – Audit Accounts 2023-24 And Fees M. Jones Presented the letter that informed Committee Members of the proposed audit timetable for the 2023-24 audit of accounts, an update on audit fees and the proposed plan for undertaking the audit.

Resolution	M. Jones advised that he had met with the Governance Team and agreed a date of the 10th July 2024 for this Committee to meet and that the Annual Report and Accounts would be certified by the 31st July 2024. The Chair thanked M. Jones for the report and advised that Members of the Committee would be asked for their availability for the additional meetings. The Committee NOTED the update.
6.	CLOSE OUT BUSINESS
6.1	Any Other Business There was no other business to report.
6.2	How Did We Do 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	Highlight Report To Board The Committee Chair advised that this would be drafted outside the meeting by the Governance Team.
7.	PRIVATE/IN COMMITTEE SESSION Members noted the following item would be discussed at the In Committee session: • Organisational Risk Register – Business Sensitive Risks • Financial Control Procedure – Medical Variable Pay Reports – Summary of Authorised Breaches • Audit Recommendations Tracker
8.	DATE AND TIME OF NEXT MEETING 18 APRIL 2024 2.30pm

Agenda Item Number: 2.1.2

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB)

Audit and Risk In Committee held on the 22 February 2024 as a Virtual Meeting via Microsoft Teams

Members Present:

Patsy Roseblade	Independent Member (Chair)
Kath Palmer	Independent Member (Vice Chair)
Ian Wells	Independent Member

In Attendance:

Sally May	Executive Director of Finance & Procurement
Dom Hurford	Medical Director
Paul Dalton	NWSSP- Internal Audit and Assurance
Emma Samways	NWSSP- Internal Audit and Assurance
Sara Utley	Audit Wales
Mark Jones	Audit Wales
Nathan Couch	Audit Wales
Owen James	Head of Corporate Finance
Gareth Watts	Director of Corporate Governance/Board Secretary
Kathrine Davies	Corporate Governance Manager (Secretariat)

1. PRELIMINARY MATTERS

1.1 Welcome & Introduction

P Roseblade, Committee Chair welcomed everyone to the meeting. The format of the proceedings in its virtual form were also noted.

1.2 Apologies for Absence

Apologies had been received from:

- Geraint Hopkins – Independent Member
- Lynda Thomas – Independent Member

1.3 Declarations of Interest

There were no interests declared.

2. MAIN AGENDA

2.1 Organisational Risk Register – Cyber Security Risks

C Hamblyn presented the report for the Audit & Risk Committee to review and discuss the organisational risk register and consider whether the risks escalated to the Organisational Risk Register are in accordance with the Risk Management Strategy.

K. Palmer advised that there had been a robust discussion on the risks at the Digital and Data Committee at their last meeting.

The Chair, in response, advised that it highlighted that the risks were being aligned to the appropriate Committee.

Resolution: The Committee **REVIEWED** the risks escalated to the Organisational Risk Register at Appendix 1 and **CONSIDERED** assurance from the report that all that can be done is being done to mitigate the risks

2.2 Financial control procedure – medical variable pay – summary of authorized breaches

D Hurford presented the Financial Control Procedure (FCP) Medical Variable Pay that was approved at the Management Board meeting in December 2020. The FCP details a consistent process for the monitoring, verification and payment of Additional Duty Hours and agency locum spend, setting out clear roles and responsibilities for approving, engaging, paying and monitoring.

K. Palmer referred to agency staff and queried if there was a breakdown of whether they were covering established posts or covering for a vacancy or sickness. D. Hurford advised that it varied across the Health Board, the long term posts were dominantly where they could not recruit into. He provided assurance that the Care Groups were starting to take control of this now and suggested that they bring a paper to a future meeting from the Care Groups to see the trajectory of change.

Resolution: The Committee **NOTED** the report.

2.3 Audit recommendations tracker

G. Watts presented the report that updated the Audit & Risk Committee on reported progress of Audit report recommendations in the revised format following transition to an automated system using the AMaT inspection module.

M. Jones advised that Audit Wales provided a follow up on all the reports in the Audit Wales Annual Report.

S. Uteley advised that a risk assessment was carried out on an annual basis and also on some of the more bespoke pieces. She provided assurance

that they were starting to prioritise some of the recommendations and have continued dialogue with the Corporate Governance team at CTM on the recommendations.

Resolution: The Committee **NOTED** the report and **AGREED** the assurances provided particularly in relation to closed recommendations

3. ANY OTHER BUSINESS

There were no urgent matters raised.

4. DATE AND TIME OF NEXT MEETING THURSDAY 17 FEBRUARY 2024



Agenda Item

2.1.2

Audit & Risk Committee

Audit & Risk Committee Annual Cycle of Business

Dyddiad y Cyfarfod / Date of Meeting	15/04/2024
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 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 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 Welsh Health Specialised Services Committee, the Emergency Ambulance Services Committee and the National Imaging Academy. The meeting will be split into two parts with Cwm Taf Morgannwg University Health Board business and hosted organisations business discussed and recorded separately.

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

Audit & Risk Committee Cycle of Business (1st January 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				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														
WHSSC Internal Audit Recommendations Tracker	WHSSC Director of Finance	All regular meetings		✍		✍		✍		✍		✍		✍
WHSSC Corporate Risk Assurance Framework including the risk register.	WHSSC Committee Secretary/Head of Corporate Services	All regular meetings		✍		✍		✍		✍		✍		✍
WHSSC Governance Statement	WHSSC Committee Secretary/Head of Corporate Services	Annually						✍						
EASC Risk Register	Chief Ambulance Services Commissioner	All regular meetings		✍		✍		✍		✍		✍		✍
EASC Governance Statement	Chief Ambulance Services Commissioner	Annually						✍						
WHSSC & EASC Annual Accounts	WHSSC/EASC	Annually						✍						
National Imaging Academy for Wales Hosted Compliance Statement.	Director of the National Imaging Academy	Annually						✍						
National Imaging Academy for Wales Risk Register	Director of the National Imaging Academy	Bi-Annually		✍						✍				



Agenda Item

2.2.2

Audit & Risk Committee

ANNUAL REPORT TIMETABLE 2023-2024

Dyddiad y Cyfarfod / Date of Meeting	18/04/2024
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	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 In recent weeks the final iteration of the Manual for Accounts has been received confirming the deadlines for submission of documents to Welsh Government and Audit Wales. The Annual Report encompassing the required reporting elements set out in the Manual for Accounts will be presented at the Health Board's Annual General Meeting on 25 July 2024. As in previous years, the suite of Annual Report documents will be presented electronically at the Annual General Meeting.

2. Specific Matters for Consideration

- 2.1 There is a timetable enclosed at **Appendix 1**, supporting the development of the Annual Report led by the Assistant Director of Governance & Risk and Head of Corporate Governance & Board Business. The timetable highlights the final deadline dates to deliver the Annual Report and Financial Statements for the year 2023/24.
- 2.2 The majority of submissions have now been received from Executive Directors during March 2024 and the content is being worked through. Those which are outstanding are being followed up in order that we are able to complete the complex task of drafting the Annual Report element and these are being processed for the initial review by ELG.
- 2.3 Audit Wales and Internal Audit colleagues have received a copy of the timetable and concur that they will be able to meet the scheduled dates.

3. Key Risks / Matters for Escalation

- 3.1 As is the case each year, the production of these annual reporting documents takes place alongside the delivery of normal business. This task is therefore a significant challenge for all those involved.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:



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

Impact Assessment		
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality</i> <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? / Equality and Welsh Language</i> <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: Not applicable for this report
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	



Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.
Effaith Adnoddau (Pobl /Ariannol) / 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 is asked to **NOTE** the final timescales in place in respect of the delivery of the Annual Report process for 2023-2024.

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

Main Tasks	Executive Lead	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024
Performance Report (within Annual Report) - Performance Overview - Delivery and Performance Analysis - Wellbeing of Future Generations (Wales) Act 2015 - Welsh Language - Sustainability Report Please refer to Content Requirements spreadsheet for further detail on what is required.	- Linda Prosser, Executive Director of Strategy & Transformation - Gethin Hughes, Chief Operating Officer - Stuart Morris, Director of Digital - Philip Daniels, Executive Director of Public Health - Sally May, Executive Director of Finance - Hywel Daniel, Executive Director for People - Lauren Edwards, Executive Director of Therapies & Health Science - Greg Dix, Executive Nurse Director / Deputy CEO - Gareth Watts, Director of Corporate Governance / Board Secretary	Drafting	Submissions to Corporate Governance by 8th March 2024 .	Draft to Executive Leadership Group for comment 15th April 2024 at the latest. Submit to Planning, Performance & Finance Committee on the 30th April 2024, to gain endorsement for submission of draft to WG	By the 3rd May 2024 Internal Audit provide their draft opinion (but not full draft annual report) to allow inclusion in version being prepared for WG submission Draft to Welsh Government/ Audit Wales by Friday 10th May 2024 (<i>request comments before 30th May 2023</i>).	Following any necessary amendments draft prepared (with inclusion of complete internal audit draft annual report submission) for consideration at existing meeting of Audit & Risk Committee on 20th June 2024. <i>Window for final amendments 21st June to 28th June.</i> <i>Initiate welsh translation from 21st June to the 19th July 2024</i>	Final Draft to Extra-ordinary Meeting of Audit & Risk Committee 10th July 2024 – TBA Final Draft received at Extra-ordinary Public Board meeting held in public 11th July 2024 – TBA for approval. Final version to Welsh Government via Auditor General by 12th July 2024. Annual General Meeting 25th July 2024.

Main Tasks	Executive Lead	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024
Accountability Report - Corporate Governance Report - Statement of Accountable Officer and Directors Responsibilities - Governance Statement - Remuneration and Staff Report - Modern Slavery Act 2015	- Gareth Watts, Director of Corporate Governance / Board Secretary - Hywel Daniel, Executive Director for People - Sally May, Executive Director of Finance - Stuart Morris, Director of Digital - Linda Prosser, Executive Director of Strategy and Transformation	Drafting	Submissions to Corporate Governance by 8th March 2024.	Draft to Executive Leadership Group for comment 15th April 2024 at the latest. Submit to Planning, Performance & Finance Committee on the 30th April 2024, to gain endorsement for submission of draft to WG	By the 3rd May 2024 Internal Audit provide their draft opinion (but not full draft annual report) to allow inclusion in version being prepared for WG submission Draft to Welsh Government/ Audit Wales by Friday 10th May 2024 (<i>request comments before 30th May 2023</i>).	Following any necessary amendments draft prepared (with inclusion of complete internal audit draft annual report submission) for consideration at existing meeting of Audit & Risk Committee on 20th June 2024. <i>Window for final amendments 21st June to 28th June.</i> <i>Initiate welsh translation from 21st June to the 19th July 2024</i>	Final Draft to Extra-ordinary Meeting of Audit & Risk Committee 10th July 2024 – TBA Final Draft received at Extra-ordinary Public Board meeting held in public 11th July 2024 – TBA for approval. Final version to Welsh Government via Auditor General by 12th July 2024. Annual General Meeting 25th July 2024.

Main Tasks	Executive Lead	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024
Audited Financial Accounts and Statements	Sally May, Executive Director of Finance	Drafting	Drafting	Drafting	Draft Financial Statements submitted to Welsh Government / Audit Wales by Friday 3rd May 2024	Draft for consideration at existing meeting of Audit & Risk Committee on 20th June 2024.	Audit Certification confirmed as 15th July 2024 Final Draft to Extra-ordinary Meeting of Audit & Risk Committee 10th July 2024 – TBA Final Draft received at Extra-ordinary Public Board meeting held in public 11th July 2024 – TBA for approval. Final version to Welsh Government via Auditor General by 12th July 2024. Annual General Meeting 25th July 2024.



Agenda Item

2.2.3

Audit & Risk Committee

Declarations of Interest & Gifts, Hospitality and Sponsorship Register

Dyddiad y Cyfarfod / Date of Meeting	18/04/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Cally Hamblyn, Assistant Director of Governance & Risks
Cyflwynydd yr Adroddiad / Report Presenter	Cally Hamblyn, Assistant Director of Governance & Risks
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	08/04/2024	Reviewed

Acronyms / Glossary of Terms	
Nil identified.	

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 March 2024, all Board Members were asked to revisit their Declarations of Interest Form and identify any changes ahead of the end of year audit of accounts. Any changes made as part of this process or any other in year change is identified in red in Appendix 1.
- 2.3 A targeted email was issued by the Corporate Governance Team in May 2023 to 746 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 are from individuals that did not receive the targeted email as there is an onus on all employees to declare interests. This exercise will be repeated in May 2024 for the 2024-2025 reporting period.
- 2.4 As at 31st March 2024:
- 27 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".
 - 498 declarations of interest received from staff (excluding Board Members / Executive Team colleagues). Please see Appendix 1 – Sheet 2 – "Non Board Members".
 - 5 declarations received in relation to Gifts, Hospitality and Sponsorship (Appendix 2).
- 2.5 Previous advice 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 and the Gifts, Hospitality and Sponsorship register 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? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required for this report.



Cydraddoldeb <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: 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 **REVIEW** and to examine any entries on the register in full.

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
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.
				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.
				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.

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
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 Director, Keyford Properties Ltd	1994 2023	Ongoing	50 %		
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 Nursing, 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.
				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.
				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 Salaried position	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.
				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 Merthyr Tydfil	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.

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
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. Mel Jehu's term comes to an end with CTMUHB on the 31st March so confirmed as accurate at point of leaving.	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		
				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 interest returned for the period 2023-2024 remains up to date and there are no changes required.	Confirmed continued eligibility via O365 Forms 24.2.2024. No issues identified.
				Partner is Director - The Performance Centres	2011	Ongoing	Owner / Chief Executive		
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	Confirmed continued eligibility via O365 Forms 13.3.2024. No issues

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
				Trustee of Age UK	jan-23	jan-26	None	2023-2024 remains up to date and there are no changes required.	identified. Although identified that she has been Chair of Norfolk Community Health and Care NHS since 01/02/2023
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

Date Approved	Name (Redacted)	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
04.04.2023		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		Department Professional Lead	Adult Weight Management Service	Nil Interests Declared	Not applicable	Not applicable	No	
11.04.2023		Senior Applied Psychologist	Psychology	Nil Interests Declared	Not applicable	Not applicable	No	
11.04.2023		Chief of Staff	Executive Office	Nil Interests Declared	Not applicable	Not applicable	No	
12.04.2023		Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
12.04.2023		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023		Consultant Surgeon	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023		Consultant Radiologist	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023		Consultant Community Paediatrician	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023		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		Consultant Gastroenterologist	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023		Consultant Radiologist	Medical	Part-time employment from May 2023: Deputy Clinical Lead, Musculoskeletal Radiology, Telemedicine Clinic Private Practice: Cobalt Health Care & Nuffield-Vale Healthcare.	Telemedicine Clinic since July 2023 Nuffield Private Practice since 2015 Cobalt Private Practice since 2009.	TMC - salaried position Private Practice, paid on a patient case basis.	No	
		Director of NIAW		Wardle Consulting Partnership Spouse/Partner/Close Family or Friend: Board Member, Techniquet Board Member, Theatr Iolo	2011 2017 & 2020 respectively	See Personal Entries Nil		
17.04.2023		Locum Consultant Psychiatrist	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023		Assistant Director Informatics	Digital	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023		Nurse Director	Mental Health & Learning Disabilities Primary Care and Community Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023		Consultant Radiologist	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023		Consultant Paediatrician	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023		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		Consultant Histopathologist	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023		Assistant Director Governance & Risk	Corporate Governance	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023		Deputy Medical Director	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023		Consultant	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023		Consultant Gynaecologist	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023		Head of Capital	Capital Planning	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023		Deputy Director of Planning	Primary Care	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023		Consultant Surgeon	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023		Consultant (CAMHS)	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023		ICU Consultant - Long Term Locum	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023		Director of Operations	Children & Families Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023		Consultant Anaesthetist	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023		Medical Consultant	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023		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		Head of Health Psychology Service	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023		Medical Secretary	Health Psychology Office	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023		Principal Clinical Psychologist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023		Consultant Surgeon	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023		Assistant Director of Communications & Engagement	Executive Office	Nil Interests Declared	Not applicable	Not applicable	No	

Date Approved	Name (Redacted)	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
17.04.2023		Haematology Consultant	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023		Consultant Hepatologist	Medical	Non Executive trustee of Brynawel Rehabilitation Centre	March 2023 - Present	None	No	
17.04.2023		Assistant Director - Capital and Estates	Capital & Estates	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023		Deputy Director of Strategy & Partnerships	Strategy & Partnerships	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023		Assistant Psychologist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023		Director of Nursing - Planned Care	Planned Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023		Consultant Paediatrician	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023		Assistant Finance Director	USC and Children and Families Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023		Consultant Community Paediatrician	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023		Assistant Director of Finance	Planned Care and DT&S Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023		Locum T&O Consultant	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
17.04.2023		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		Consultant Psychiatrist: Clinical Service Group Director	Mental Health	Nil Interests Declared	Not applicable	Not applicable	No	
18.04.2023		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		Assistant Director of OD & Wellbeing	People Services Team	Nil Interests Declared	Not applicable	Not applicable	No	
18.04.2023		ENT Consultant	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
18.04.2023		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		Critical Care Psychology Team	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
18.04.2023		Paediatric Clinical Psychologist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
18.04.2023		Consultant Physician	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
18.04.2023		Clinical Director of Pharmacy & Medicines Management	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
18.04.2023		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 at New Surgery, Pencoed				

Date Approved	Name (Redacted)	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
18.04.2023		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		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		Consultant Radiologist	Medical	Nil Interests Declared	Not applicable	Not applicable at this time.	No	
18.04.2023		Consultant Orthogeriatrics	Medical	Nil Interests Declared	Not applicable	Not applicable at this time.	No	
18.04.2023		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		Consultant	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
18.04.2023		Strategic Lead for Employee Experience & Wellbeing	People Services Team	Nil Interests Declared	Not applicable	Not applicable	No	
18.04.2023		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		Consultant Oral and Maxillofacial Surgeon	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
18.04.2023		Consultant Psychiatrist	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
18.04.2023		Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
18/04/2023 Hard Copy Form		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		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		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		Consultant T & O	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
19.04.2023		Interim Deputy Medical Director for acute services	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
19.04.2023		Consultant in Palliative Medicine	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
19.04.2023		Consultant EM	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
19/04/2023 & 26/06/2023 (See in year amendment)		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		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		Physiotherapist Rotational	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
19.04.2023		Consultant Physician	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
19.04.2023		Consultant	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
20.04.2023		Assistant Psychologist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
20.04.2023		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		Consultant	Medical	Director of SAARK	From 2018	Annual Dividend	No	
21.04.2023		Consultant Old Age Psychiatrist	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
21.04.2023		Consultant	Medical	Nil Interests Declared	Not applicable	Not applicable	No	

Date Approved	Name (Redacted)	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
21.04.2023		Consultant Radiologist	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
21.04.2023		Medicines Management Support Officer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
22.04.2023		Clinical Lead GPOOH	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
24.04.2023		Care Group Service Director	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
24.04.2023		Consultant O&G	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
24.04.2023		Consultant Acute Medicine	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
24.04.2023		Nurse Director USC	Unscheduled Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
24.04.2023		Consultant Pathologist	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
24.04.2023		Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
24/04/2023 Hard Copy Form		Consultant General Surgeon	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
25.04.2023		Consultant Anaesthetist	Medical	Husband is Director of Cowbridge Specsavers Franchise	2018-Present	None stated	No	
25.04.2023		Consultant Anaesthetist	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
25.04.2023		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		Consultant Radiologist	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
26/04/2023 Hard Copy Form		Consultant Surgeon	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
26.04.2023		Consultant Community Child Health	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
26.04.2023		Acute General Services Manager	Chief Operating Officer Function	Nil Interests Declared	Not applicable	Not applicable	No	
26.04.2023		Clinical Psychologist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
27.04.2023		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 Aberdeen New India	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		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 SPOUSE is also a director in companies 1 &2 listed above.	3 Years 2 Years 6 Months Similar as above	None stated	No	
02.05.2023		Specialist Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Private work at; Neuro Physio Wales, 60 Commercial Street, Kenfig Hill, Bridgend CF33 6DL	mai-23	Paid by the hour	No	

Date Approved	Name (Redacted)	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
02.05.2023		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		Clinical Director for Growing Well Strategy Group	Strategy & Partnerships	Nil Interests Declared	Not applicable	Not applicable	No	
02.05.2023		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		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
03.05.2023		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		Consultant in Public Health	Public Health	Nil Interests Declared	Not applicable	Not applicable	No	
04.05.2023		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 ongoing	payment for private sessions payment as a private contractor	No	
05.05.2023		Pharmacy Technician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
05.05.2023		Registered Nurse	Nursing Bridgend	Declaring secondary employment/private aesthetics practice.	January 2023 ongoing	Private Ltd Company. (HanAesthetics Ltd)	No	
05.05.2023		Pharmacy Technician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
06.05.2023		Consultant	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
09.05.2023		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		ENT Consultant	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
09.05.2023		Accuracy Checking Pharmacy Technician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
09/05/2023 & 12/06/2023		Physiotherapy Health Care Support Worker	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
10.05.2023		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		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		Pharmacy Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
11.05.2023		Pharmacy Technician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
11.05.2023		Pharmacy Technician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
11.05.2023		Medicines Management - Pharmacy Technician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
16.05.2023		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.	

Date Approved	Name (Redacted)	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
16.05.2023		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		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		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		Project Manager	Mental Health - YCC	Nil Interests Declared	Not applicable	Not applicable	No	
22.05.2023		Advance Pharmacist NICE and HCD Medicines	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
24.05.2023		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		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		Academy Administrator	National Imaging Academy Wales (Hosted Organisation)	Nil Interests Declared	Not applicable	Not applicable	No	
30.05.2023		NICE Co-ordinator	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
01.06.2023		District Nurse	Nursing	Nil Interests Declared	Not applicable	Not applicable	No	
01.06.2023		Head of Speech & Language Therapy	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
01.06.2023		Consultant Neonatologist	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
01.06.2023		Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
01.06.2023		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
02.06.2023		Deputy Ward Manager	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
02.06.2023		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
05.06.2023		Therapies Clinical Quality Manager	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
06.06.2023		Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
06.06.2023		Clinical Specialist Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
06.06.2023		Clinical Specialist Physiotherapist - Palliative Care	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
07.06.2023		Therapies Administration Manager	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
07.06.2023		Clinical Lead Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	

Date Approved	Name (Redacted)	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
07.06.2023		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		Physiotherapist Team Lead	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
07.06.2023		Head of Podiatry and Orthotics	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
07.06.2023		Administration	National Imaging Academy Wales (Hosted Organisation)	Nil Interests Declared	Not applicable	Not applicable	No	
07.06.2023		Deputy Head of Podiatry and Orthotics	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
07.06.2023		MSK Podiatrist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
08/06/2023 Hard Copy Form		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		Physio Tech	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
08/06/2023 Hard Copy Form		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
08/06/2023 Hard Copy Form		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
08/06/2023 Hard Copy Form		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		Physiotherapy Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Head Sports Therapist at Rugby Club	3 Years	Voluntary	No	
08/06/2023 Hard Copy Form		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
08.06.2023		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		Physiotherapy Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
08.06.2023		Rotational Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
08.06.2023		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
08.06.2023		Band 7 Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
08.06.2023		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
09.06.2023		Head of Occupational Therapy Services	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
09.06.2023		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		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		Principal Occupational Therapist - Adult Mental Health	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
09.06.2023		Clinical Lead Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
09.06.2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
09.06.2023		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	

Date Approved	Name (Redacted)	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
09.06.2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
09.06.2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
09.06.2023		Rotational Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
12.06.2023		Team Lead Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
12.06.2023		Neuro Rehab Rotational Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
12.06.2023		Assistant Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
12.06.2023		Rotational Inpatient Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
12.06.2023		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		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	
12.06.2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
12.06.2023		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		Therapy Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13.06.2023		Senior Public Health Practitioner	Public Health	Nil Interests Declared	Not applicable	Not applicable	No	
13.06.2023		Deputy Head of Service - Nutrition and Dietetics	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13.06.2023		Public Health Dietetic Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13.06.2023		Public Health Dietetic Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13.06.2023		Specialist Public Health Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13.06.2023		Professional Manager - Acute Speech & Language Therapy	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13.06.2023		Head of Adults Speech and Language Therapy	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13.06.2023		Department Professional Manager	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13.06.2023		Specialist Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13.06.2023		Project Support Officer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13.06.2023		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		Public Health Dietetic Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	

Date Approved	Name (Redacted)	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
13.06.2023		Head of Nutrition and Dietetics	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13.06.2023		Specialist Adult Weight Management Dietitian	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13.06.2023		Public Health Dietetic Support Worker	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13.06.2023		Clerical Support Officer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13.06.2023		Departmental Administrative Officer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13/06/2023 Hard Copy Form		Physiotherapy Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
14/06/2023 Hard Copy Form		Band 6 neuro rotational physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
14.06.2023		Macmillan AHP Lead for Cancer.	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Volunteer committee member (secretary) on the British Dietetic Association Oncology group Volunteer committee member on a social running group	2018-Present 2019-Present	Nil	No	
14.06.2023		Public Health Dietetic Administrator	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
14.06.2023		Public Health Dietetic Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
14.06.2023		Neuro Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
14.06.2023		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		Physiotherapy Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
14.06.2023		Public Health Administration and Clerical Officer	Public Health	Nil Interests Declared	Not applicable	Not applicable	No	
14.06.2023		Highly Specialist Public Health Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
14.06.2023		Public Health Dietetic Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
15.06.2023		Clinical Lead Orthotist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
15.06.2023		Lead Podiatrist In Acute Foot	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
15.06.2023		Public Health Dietetic Support Worker	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
15.06.2023		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		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
16.06.2023		Physiotherapy Clinical Lead	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
18.06.2023		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
19.06.2023		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		Specialist Oncology Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	

Date Approved	Name (Redacted)	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
19/06/2023 & 13/09/2023		Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
19.06.2023		Orthotic Services Administrator	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
19.06.2023		Physio Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
19.06.2023		Dietetic Professional Manager - Acute Services	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
19.06.2023		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		Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
19.06.2023		Dietetic Administration Clerical Officer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
19.06.2023		Diabetes Specialist Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
19.06.2023		Physiotherapy Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
19.06.2023		Professional Lead Speech and Language Therapy	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
20.06.2023		Clerical Officer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
20.06.2023		Generic Therapy Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
20.06.2023		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		General Therapy Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
21/06/2023 Hard Copy Form		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		Rotational Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
21.06.2023		Lead Specialist Pharmacist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
21.06.2023		Team Lead Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
21.06.2023		Clinical Specialist Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
21.06.2023		Podiatrist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Owner of Podiatry Practice	2022 - to date	No financial payments received	No	
21.06.2023		Static MSK Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
21.06.2023		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		Static Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	

Date Approved	Name (Redacted)	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
21.06.2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
21.06.2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
21.06.2023		Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
21.06.2023		Major Trauma Rehab Co-ordinator	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
21.06.2023		Major Trauma Rehab Co-ordinator	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
21.06.2023		Clinical Lead MSK Outpatient Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
21.06.2023		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
22.06.2023		Physiotherapy Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
22.06.2023		Team Lead Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Sole trader for own business - SoPhysio. Veterinary Physiotherapy	Since September 2021	Nil	No	
22.06.2023				Husband part director of Specsavers Bridgend, Porthcawl and Bridgend Derwen	Since 2003			
22.06.2023		Rotational Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
22.06.2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
22.06.2023		Physio	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
22.06.2023		Clinical Specialist Physio	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
22.06.2023		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
22.06.2023		Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
22.06.2023		RGN	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
23.06.2023		PH Physio	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
23.06.2023		Pelvic Health Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
23.06.2023		Pelvic Health Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
23.06.2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
23.06.2023		PH Physio	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
23.06.2023		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		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
26.06.2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	My sister works in IT in Velindre Trust	Not applicable	Not applicable	No	
26.06.2023		Specialist Paediatric Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
26.06.2023		Physiotherapist Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
26.06.2023		Paediatric Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
26.06.2023		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	

Date Approved	Name (Redacted)	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
26.06.2023		Principal Occupational Therapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
26.06.2023		Clinical Specialist Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
26.06.2023		Admin and Clerical	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
26.06.2023		Clerical Officer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
26.06.2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
26.06.2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
26.06.2023		Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
26.06.2023		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		Clinical Lead ED Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
27.06.2023		Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
27.06.2023		Highly Specialist Podiatrist acute foot	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
28.06.2023		Speech and Language Therapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
28.06.2023		Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
28.06.2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
28.06.2023		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	
28.06.2023		Physiotherapist (Junior)	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
29.06.2023		Rotational Inpatient Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
29.06.2023		Integrated Community Network and CRT Lead Dietitian	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
29.06.2023		Community Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Sophie Lewis Physiotherapist	3 Years	None	No	
29.06.2023		Clinical Specialist Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
29.06.2023		Macmillan UGI Lead Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
29.06.2023		Admin Roster Support	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
29.06.2023		Physiotherapy Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
29.06.2023		Advanced Pharmacist in Surgery	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
29.06.2023		Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	

Date Approved	Name (Redacted)	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
29.06.2023		Specialist Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
29.06.2023		Physiotherapy Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
29.06.2023		Specialist Paediatric Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
29.06.2023		Paediatric Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
29.06.2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
30/06/2023 Hard Copy Form		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
30.06.2023		Physiotherapy Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
01.06.2023		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
03.07.2023		Team Lead Paediatric Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
03.07.2023		Physiotherapy Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
03.07.2023		Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
03.07.2023		Deputy Head Occupational Therapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
04.07.2023		Bank Physiotherapy Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
04.07.2023		Clinical Specialist Physiotherapist T&O	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
04.07.2023		Physiotherapy Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
04.07.2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
05.07.2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
05.07.2023		Professional Manager Paediatric Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
06.07.2023		Medical Team Assistant Surgical & Orthopaedics	Clinical Support Services	Nil Interests Declared	Not applicable	Not applicable	No	
06.07.2023		District Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
06.07.2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
07.07.2023		Clinical Specialist Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
07.07.2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
10.07.2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
10.07.2023		Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
10.07.2023		District Nurse - Deputy Team Leader	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
10.07.2023		Static Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
10.07.2023		Physiotherapist Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	

Date Approved	Name (Redacted)	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
11.07.2023		Clerical Officer - Physiotherapy	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
11.07.2023		Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
11.07.2023		Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
12.07.2023		Ward Manager	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
12.07.2023		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
13.07.2023		Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
14.07.2023		Health Care Support Worker - Community	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
17.07.2023		Band 4 Primary Care	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
18.07.2023		Physiotherapy Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
18.07.2023		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		Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
20.07.2023		Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
20.07.2023		Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
21.07.2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
21.07.2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
24.07.2023		Paediatric Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
25.07.2023		Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
25.07.2023		Speech and Language Therapy Professional Manager	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
25.07.2023		Team Leader	Primary Care	Nil Interests Declared	Not applicable	Not applicable	No	
26.07.2023		Clinical Lead Pharmacist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
26.07.2023		Project Manager / TSW Manager	Corporate	Nil Interests Declared	Not applicable	Not applicable	No	
26.07.2023		Physiotherapy Technician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
26.07.2023		Service Director	Mental Health and Learning Disabilities Care Group	Voluntary Chair - West Wales Care & Repair	Since 2019	£0	No	
26.07.2023		Physiotherapy Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
26.07.2023		Physiotherapy Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
26.07.2023		Specialist Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
26.07.2023		Public Health Dietetic Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
26.07.2023		Public Health Dietetic Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
26.07.2023		Advanced Pharmacist Formulary and Interface	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
26.07.2023		Administration and Clerical - Weight Management	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
27.07.2023		Dietetic Professional Manager - Paediatrics	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
27.07.2023		Paediatric Dietitian	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
27.07.2023		Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	

Date Approved	Name (Redacted)	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
27.07.2023		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		Specialist Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
28.07.2023		Team Lead Paediatric Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
31.07.2023		Administrative Support MMPU	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
01.08.2023		Paeds Physio Admin	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
01.08.2023		Highly Specialist Clinical Psychologist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
01.08.2023		Clinical Specialist Paediatric Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	James Smith	jun-22	None	No	
02.08.2023		Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
02.08.2023		Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
03.08.2023		Senior Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
03.08.2023		Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
03.08.2023		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
03.08.2023		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		Dietetic Support Worker	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
04.08.2023		Senior Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
07.08.2023		Care Home Lead Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
07.08.2023		Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
07.08.2023		Dietetic Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
07.08.2023		Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
08.08.2023		Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
10.08.2023		Dietetic PA and Administration Manager	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
11.08.2023		Macmillan Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
11.08.2023		Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
11.08.2023		Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
13.08.2023		District Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
16.08.2023		DHoP - Clinical Lead Pharmacist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	

Date Approved	Name (Redacted)	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
22.08.2023		Sonographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Locum Sonographer in ABUHB	October 2021 - Present	Financial Transaction	No	
22.08.2023		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
24.08.2023		Business Support Manager	People Services Team	Nil Interests Declared	Not applicable	Not applicable	No	
24.08.2023		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		Physiotherapy Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
30.08.2023		Employee Experience Lead	People Services Team	Nil Interests Declared	Not applicable	Not applicable	No	
31.08.2023		Community Stroke Nurse	PCH	Nil Interests Declared	Not applicable	Not applicable	No	
31.08.2023		Consultant Cardiologist	Medical	Nil Interests Declared	Not applicable	Not applicable	No	
05.09.2023		Manager Looked After Children Health Team	Community	Nil Interests Declared	Not applicable	Not applicable	No	
05.09.2023		Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
07.09.2023		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		Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
12.09.2023		Advance Pharmacist Primary Care	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
12.09.2023		Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13.09.2023		Acute Team Lead Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
14.09.2023		Acute Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
14.09.2023		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		Rotational Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
20.09.2023		Specialist Head and Neck Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
20.09.2023		Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
21.09.2023		Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
22.09.2023		Rotational Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
26.09.2023		Strategic Planning & Commissioning Manager	Strategy & Partnerships	Nil Interests Declared	Not applicable	Not applicable	No	
26.09.2023		Acute Lead and ICU Specialist Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
26.09.2023		Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
02.10.2023		Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Podcasting (personal project)	As of October 2023	Nil to declare currently.	No	
02.10.2023		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
04.10.2023		Nurse Practitioner	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
05.10.2023		Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
10.10.2023		CAMHS Therapist	CAMHS	clinical supervisor-own private practice guest lecturer at University of South Wales for MSc Play Therapy course	Current November 2023 - ongoing	Hourly rate paid.	No	
10.10.2023		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	

Date Approved	Name (Redacted)	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
11.10.2023		Senior Pharmacy Technician - Medicines Information & Governance	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
11.10.2023		Superintendent Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
11.10.2023		Advance Nurse Practitioner	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
19.10.2023		Principal Pharmacist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
24.10.2023		Advance Nurse Practitioner	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
24.10.2023		Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
24.10.2023		Senior Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
25.10.2023		Community Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
25.10.2023		Community Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
25.10.2023		Community Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
25.10.2023		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
25.10.2023		Community Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
25.10.2023		Clinical Specialist Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
31.10.2023		Physio Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
3.11.2023		Assistant Head of Physiotherapy	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
14.11.2023		Sonographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
15.11.2023		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		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
16.11.2023		Radiology Nurse Manager	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
23.11.2023		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		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		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		Experienced Rotational Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
15.2.2024		Pharmacist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
28.11.2023		Pharmacist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
29.11.2023		Senior Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
04.12.2023		Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
05.12.2023		Senior Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	

Date Approved	Name (Redacted)	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
06.12.2023		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		Community Nurse	Ysbyty George Thomas	Nil Interests Declared	Not applicable	Not applicable	No	
11.12.2023		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
13.12.2023		Band 5 - Child Health	Bridgend - Children and Family Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13.12.2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
14.12.2023		Band 5 Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
15.12.2023		Clinical Specialist Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
18.12.2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
19.12.2023		Senior Nurse	Primary Care	Nil Interests Declared	Not applicable	Not applicable	No	
20.12.2023		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
20.12.2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
22.12.2023		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		Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
5.1.2024		Prescribing Advisor Pharmacist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
12.1.2024		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		Community Nurse	Primary Care	Nil Interests Declared	Not applicable	Not applicable	No	
17.1.2024		Dietetic Support Worker	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
22.1.2024		Physiotherapy Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
22.1.2024		Physiotherapy Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
23.1.2024		Head of Corporate Governance & Board Business	Corporate Governance	Nil Interests Declared	Not applicable	Not applicable	No	
23.1.2024		Community Staff Nurse	Children & Families Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
31.1.2024		Bank Physiotherapy Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
5.2.2024		Trauma Rehab Co-ordinator	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
8.2.2024		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		SCPHN for Youth Justice Service	People Services Team	Nil Interests Declared	Not applicable	Not applicable	No	
12.2.2024		Band 5 Community Nurse	Children & Families Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
13.2.2024		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	
15.2.2024		Physiotherapy Team Lead	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	

Date Approved	Name (Redacted)	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
14.2.2024		Healthcare Support Worker	Ward B2 Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
15.2.2024		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		Generic Therapy Assistant - Pulmonary Rehabilitation	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
21.2.2024		Clincial Lead ACP Frailty	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
21.2.2024		Registered General Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
23.2.2024		Decontamination Officer	Patient, Care and Safety	Sole trader status as Mark Fumage AE Services	August 2023- current	Paid via consultancy basis.	No	
26.2.2024		Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
27.2.2024		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
1.3.2024		Senior Nurse	Ysbyty Cwm Cynon	Husband owns own business not related to NHS	4 years	None	No	
6.3.2024		Cluster Pharmacist North Bridgend	Primary Care	Nil Interests Declared	Not applicable	Not applicable	No	
13.3.2024		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		Principal Pharmacist - Primary Care Governance	Primary Care	Nil Interests Declared	Not applicable	Not applicable	No	
14.3.2024		Pharmacist	Diagnostics, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
14.3.2024		Advanced Clinical Pharmacist	Diagnostics, Therapies, Specialties & Pharmacy Care Group	Content delivery to foundation year pharmacists for HIEW. Secured funding for a three year research role with Cardiff and Vale Health board research and development department.	Undertaken in March 2023.	Financial Transaction Research Funding	No No	
15.3.2024		Pharmacist	Diagnostics, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
15.3.2024		Pharmacist	Diagnostics, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
15.3.2024		Pharmacist	Diagnostics, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
19.3.2024		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		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No	
27.3.2024		Advance Pharmacist - Anticoagulation	Diagnostics, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	
27.3.2024		Dietetic Support Worker	Diagnostics, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No	

Date Declaration Made	Date Received by Corporate Governance	Name (redacted)	Designation / Department	Provided by / From	Date Received	Details	Gift/Hospitality and or Sponsorship	Accepted or Declined
18.04.2023	19.04.2023		Director of Midwifery	Welsh Government, Office of the Chief Nurse	12th June to 16th June 2023.	Conference attendance at International Confederation of Midwives – Bali, Indonesia Sponsored by Welsh Government, Office of the Chief Nurse - Annual leave is required £800 (fees were paid in 2019, conference postponed due to COVID-19)	Sponsorship	Accepted and supported by Executive Director of Nursing / Deputy Chief Executive
17.08.2023	17.08.2023		Head of VBHC	Novartis Pharmaceuticals UK Ltd	September 2023 - Annual Leave will be taken for the date required.	1hr VBHC expert interview Meeting organised and funded by Novartis Pharmaceuticals UK Ltd Novartis Pharmaceuticals UK Ltd, London 2nd Floor, The WestWorks Building White City Place 195 Wood Lane London, W12 7FQ MLR ID: 292006 £250 Honorarium - Annual leave required	Honorarium	Accepted and supported by Director of Improvement & Innovation
26.09.2023	26.09.2023		Head of VBHC	Kings Fund	11-12th October 2023	Part of panel at the Kings Fund Digital Congress in London Webinar organised Kings Fund Partnerships Manager The King's Fund Telephone 020 7307 2490 Email r.gorringe@kingsfund.org.uk Website www.kingsfund.org.uk The King's Fund, 11-13 Cavendish Square, London W1G 0AN Registered Charity 1126980 £184.20 - £310 – estimated on Internet search, as cost not provided	Honorarium	Accepted and supported by Assistant Director of improvement culture capability and delivery, Patient Care & Safety
28.09.2023	28.09.2023		Director of Digital	Patient	28th September 2023	Location: Llantrisant – Snowdrop Centre / Hyb Event: Two CTM Patients were left without transport home. Both patients were very emotional. On leaving work at approximately 18:00 I offered to take them home to Mountain Ash. One of the patients wanted to offer me money which I repeatedly declined. On arrival home I found £20 hidden on my backseat under my running clothes which were also on the backseat. No idea of the patients full names. I have donated the money to charity.	Gift	Declined. Supported by Chief Executive.
19.10.2023	23.10.2023		Specialist CAMHS Nurse	Patient	13th October 2023	During a final home visit with a family the member of staff had worked with for 2 years they received a thank you card with a £50 gift card inside. Upon seeking advice from the Health Board and adherence to the Standards of Behaviour Framework Policy the member of staff returned the gift card explaining that they were unable to accept gifts of that value.	Gift	Declined. Supported by Line Manager (Clinical Nurse Specialist)

Agenda Item
2.2.4

Audit & Risk Committee

Standing Order Breaches

Dyddiad y Cyfarfod / Date of Meeting	18/04/2024
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	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
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	

1. Situation / Background

- 1.1 Under section 7.1 Preparing for Meetings as stated in the Standing Orders, it is noted that under section of "Notifying and Equipping Board Members":

"Board members shall be sent an Agenda and a complete set of supporting papers at least 10 calendar days before a formal Board meeting. This information may be provided to Board members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided, after this time provided that the Chair is satisfied that the Board's ability to consider the issues contained within the paper would not be impaired."

- 1.2 In practice most Health Boards publish papers electronically 7 days prior to the meeting. The 10 day notice was drafted when papers were sent out in hard copy, however, given that the Standing Orders have not changed and are unlikely to do so in the near future the Audit & Risk Committee should note that all Board Meeting publications are in breach of the 10 day publication period.

2. Specific Matters for Consideration

- 2.1 In the report presented to the August Audit & Risk Committee, it was advised that any other breaches would be reported in future updates to the Committee.
- 2.2 The following breaches are therefore reported:
- The agenda and papers for the Board and Board Committees are published 7 calendar days in advance of meetings which is a breach of the Health Board's Standing Orders which state publication should be 10 calendar days.
 - The papers for the Extra-Ordinary Board meeting that took place on 9 April 2024 to discuss the Emergency Medical Retrieval and Transfer Service, were not received until the 4th April and therefore papers were only five days in advance of the meeting.

3. Key Risks / Matters for Escalation

- 3.1 Later circulation of papers will leave Board Members with less time to review and scrutinise the position.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /	Improving Care
	If more than one applies please list below:



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



	Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau (Pobl / Ariannol) / Resource Impact (People / Financial)	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

- 5.1 The Committee are being asked to **APPROVE** the Breach to Standing Orders being reported



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Agenda Item 2.2.5

AUDIT & RISK COMMITTEE – FORWARD WORK PLAN				
Origin of Request	Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)	Item Title	Lead Officer	Intended Meeting Date
Email from Director of Strategy & Transformation	Additional Item	Progress update on Grant Thornton Recommendations	Executive Director of Strategy & Transformation	18 April 2024
Email from Director of People	Additional Item	Workforce Management – Audit Wales Report	Audit Wales	18 April 2024
Deferred from February 24 Meeting	Deferred Item	Internal Audit Report – PCH Financial	Internal Audit	18 April 2024
Deferred from February 24 Meeting	Deferred Item	Internal Audit Report – Controlled Drugs	Internal Audit	18 April 2024
Deferred from February 24 Meeting	Deferred Item	Internal Audit Report – Patient Pathway Follow Up	Internal Audit	18 April 2024
Proposed approach suggested by the Director of Corporate Governance	Additional Item	Endoscopy JAG Accreditation Closure report - Progress and Associated Risk Mitigation	Chief Operating Officer	13 February 2023 – Deferred to 19 April 2023 as per action log update. Deferred to August 2023 as per action log update. Verbal Update received at the August 2023 meeting. Written progress report to



Agenda Item 2.2.5

				be presented to the meeting being held on 24 October 2023. Agreement given by the Chair outside the meeting for a report to be presented to the Committee in June 2024.
Deferred from April 2024 Meeting	Deferred item	Financial Control Procedure – Medical Variable Pay (In Committee)	Medical Director	20 June 2024
Annual Cycle of Business – Deferred from April 24 Meeting	Annual Item (deferred)	National Clinical Audit Programme Update 2023 – 2024	Medical Director	20 June 2024
Deferred from April 2024 Meeting	Deferred item	Internal Audit Review - Mental Health Clinical Service Groups Review	Internal Audit	20 June 2024

COMPLETED ITEMS

Action from December 2023 Meeting	Additional Item	National Fraud Initiative Progress and Outcomes Bi-Annual Update.	Head of Local Counter Fraud Investigations	22 February 2024 – Completed



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Agenda Item 3.1

ACTION LOG – AUDIT & RISK COMMITTEE					
Minute Reference	Date of Meeting Action Originated	Issue	Lead Officer	Timescale for Action to be completed	Status of Action (as at date papers where circulated)
5.1	22/02/2024	Organisational Risk Register – Agreed to share the detailed update on Ophthalmology & Stroke received by Quality & Safety Committee outside the meeting	Chief Operating Officer	18 th April 2024	In progress Update awaited from Chief Operating Officer as to whether these items have been circulated

Completed Actions



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University Health Board

Agenda Item 3.1

Minute Reference	Date of Meeting Action Originated	Issue	Lead Officer	Timescale for Action to be completed	Status of Action (as at date papers where circulated)
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



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					capture this data, however 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



Agenda Item

3.2

Audit & Risk Committee

**Committee Annual Self Effectiveness Survey Outcome
2023-24 & Improvement Plan**

Dyddiad y Cyfarfod / Date of Meeting	18/04/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Kathrine Davies, Corporate Governance Manager
Cyflwynydd yr Adroddiad / Report Presenter	Patsy Roseblade, Independent Member/Committee Chair
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
Committee members / attendees	20/12/2023	Responses returned as outlined in section 1 of the report

Acronyms / Glossary of Terms	
Nil	

1. PURPOSE

- 1.1 The Chair of the Audit & Risk Committee is required to present an annual report to the Board outlining the Committee's business through the financial year to provide an assurance. As part of this process, The Committee are required to undertake an annual self-assessment questionnaire.
- 1.2 Members of the Committee are asked to discuss and review the feedback set out in this report which relate to its activities and performance during 2023-24.
- 1.3 Members should note that 5 responses were received out of a total of 13 which equated to 38%.

2. SUMMARY REPORT

Positive Assurance	• Committee Effectiveness: There was a clear consensus that Members/Attendees were aware that: • There were approved Terms of Reference in place defining the role of the Committee. • 100% of respondents were aware that the Terms of Reference were reviewed annually. • 100% of respondents were aware that a Committee Highlight Report is produced following each meeting that is submitted to the next Health Board meeting. This is the mechanism that the Committee Chair uses to provide information on activity, areas or assurance and/or areas of escalation • A Committee Annual Report was produced and reported to the Board to provide assurance that the Committee considers activity consistent with its remit. • 100% of respondents were aware that the Committee's self-evaluation process is in place and effective. • A Committee Annual Cycle of Business was presented at each meeting. • Committee Business • Members of the Committee felt that they met with sufficient frequency to deal with planned matters in an effective manner. • Members of the Committee felt that where possible, Committee meetings were scheduled prior to important decisions. • Members felt that Committee had formally considered how it integrated with other Committees reviewing risk, recognizing that the Audit & Risk Committee received the risk register in its entirety, whilst other Committees received their assigned risks only • There was clear consensus that the Committee's meeting papers were complete and received with enough lead time for members to give them due consideration and that minutes were received as soon as possible



following meetings, although on one occasion they were delayed due to clarification requirement.

- 100% of respondents felt that the Committee's role in the approval of the Annual Accounts was clearly defined.
- 100% of respondents felt that the appropriate internal or external support and resources were available to the Committee and it had sufficient membership and authority to perform its role effectively.

Performance

- In terms of the overall assessment of the performance of the Audit & Risk Committee, feedback reflected that performance was good and that the Committee was effective and discharged its responsibility well.
- 75% of respondents agreed that the Committee was briefed on its assurance responsibilities with regard to internal control and risk management, particularly with regard to the Statement of Internal Control, the Assurance Framework, Standards for better Health and the Head of Internal Audit's opinion.

Internal Audit

- 100% of respondents felt that there was appropriate consideration of Internal Audit's plan, resources and ability and that the Internal Audit Plan was reviewed at the beginning of each financial year.
- 100% of respondents thought that there was appropriate consideration of Internal Audit Reports, Management Responses and improvement actions.
- With regard to any scope restrictions placed on internal audit feedback reflected that there could be dependent on the nature of the individual review.
- In terms of the Committee reviewing the effectiveness of Internal Audit and the adequacy of staffing and resources, feedback reflected that effectiveness was considered but not adequacy of staffing.

External Audit

- 100% of respondents agreed that the Committee received and monitored actions taken in respect of prior year External Audit plans.
- 100% of respondents agreed that the Committee reviewed the External Auditor's Annual audit letter and assessed the performance of External Audit.

Areas of Note

1. Committee Effectiveness

- The Terms of Reference were reviewed and approved at its May 2023 meeting as part of the annual review basis prior to subsequent approval by the Health Board in May 2023.

	- The Committee received and approved its Annual Report for 2022-23 at its August 2023 meeting and was submitted to the Board in September 2023. - The Committee Cycle of Business has been implemented to further complement the Forward Work Programme and was approved by the Committee at their February 2024 meeting. 2. Committee Business - The Audit & Risk Committee utilises a Consent Agenda system for routine business consideration. Members are aware that should they consider that any item on consent requires further assurance and scrutiny then it will be moved to the main agenda for discussion. - As with all Board Committees, the Committee, where sufficiently urgent can consider any item 'Out of Committee' via 'Chairs Urgent Action'. - Highlight reports are produced following each meeting so that the Board is kept informed of the nature of the issues considered and any decisions reached. These reports are available as part of the 'public' Board papers to demonstrate the Health Board's commitment to openness and transparency. Feedback reflected that the Highlight reports were succinct and to the point.
Areas Requiring Further Consideration	Not applicable.
Action Plan	
Appendices	Independent Member Scrutiny Toolkit.

3. RECOMMENDATION

3.1 The Committee is asked to **NOTE** the report.



Agenda Item

4.1

Audit & Risk Committee

Local Counter Fraud Annual Report

Dyddiad y Cyfarfod / Date of Meeting	18/04/2024
Statws Cyhoeddi / Publication Status	Open/ Public Choose an item.
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: Not applicable for this report
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: 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 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.



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**Cwm Taf Morgannwg
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**Counter Fraud Annual Report
2023/24**

Matthew Evans

18 April 2024

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1. Introduction

This report has been written in accordance with the provisions of the Fraud, Bribery and Corruption Standards for NHS Wales Bodies (the Functional Standards) which require Local Counter Fraud Specialists (LCFS) to provide a written annual report reflecting the counter fraud, bribery and corruption (economic crime) work undertaken during the financial year.

The Counter Fraud Work Plan for 2023/24 was approved by the Audit Committee in April 2022 and identified a total resource of 616 days for the year. The Counter Fraud Team delivered 604 days of counter fraud activity. The total cost for the provision of local counter fraud services for the year was £157,841.

For ease of reference and in line with the Work Plan, this report is structured under in line with Functional Standards Requirements of Counter Fraud activity. The annual report should be completed in enough detail to enable the responsible officers within the organisation to gain sufficient assurance that the counter fraud, bribery and corruption work undertaken is compliant with the Functional Standard Requirements and has been completed in line with organisations counter fraud workplan.

When the required work has not been completed against the counter fraud work plan or is not fully compliant with the Functional Standard Requirements details of the corrective actions to be undertaken should be reported.

2. Executive summary of organisational compliance

The Functional Standards require each health body to produce a written work plan outlining the LCFS' projected duties for the year. The 2023/24 work plan, agreed by both the Director of Finance and Audit Committee, took due account of the work required to ensure consistent and effective implementation and delivery of the newly introduced Functional Standards. It was designed to ensure a holistic risk-based approach to counter fraud work within the Health Board with work split between proactive and reactive counter fraud activity. Flexibility contained in the work plan allowed high risk work to be undertaken urgently and dynamically.

Progress against the plan has been monitored during meetings with the Director of Finance, with update reports produced and presented to the Audit Committee in line with its agreed work programme.

The Counter Fraud Team continue to attend meetings and forums organised by the NHS Counter Fraud Service (CFS) Wales. These meetings provide an invaluable opportunity to share information and identify emerging risks, themes and areas of best practice with NHS Counter Fraud colleagues across Wales. They have also been utilised by the NHS Counter Fraud Authority Training Delivery Leads to deliver key skills development sessions, refreshing fundamental operational skills and providing information and training on any relevant new economic crime matters or legislation.

As part of the quality assurance process, NHS organisations in Wales are required to complete a self-review of their progress in implementing the Standards. From 2021/22 NHS Wales adopted the Government Functional Standards on Counter Fraud (NHS Requirements) to replace NHS Counter Fraud Authority's (NHS CFA) 'NHS Counter Fraud Standards (Wales)'. Counter Fraud work since that introduction has been focussed on building or maintaining compliance with the new standards. Since 2021/22 the Health Board has shown continual annual improvement in ratings against the Standards or maintained ratings. At the conclusion of 2023/24 the Health Board is assessed as Green overall with each of the 12 Components being Green rated for the first time.

3. Declaration of compliance against the Functional Standard Requirements at the end of March 2022

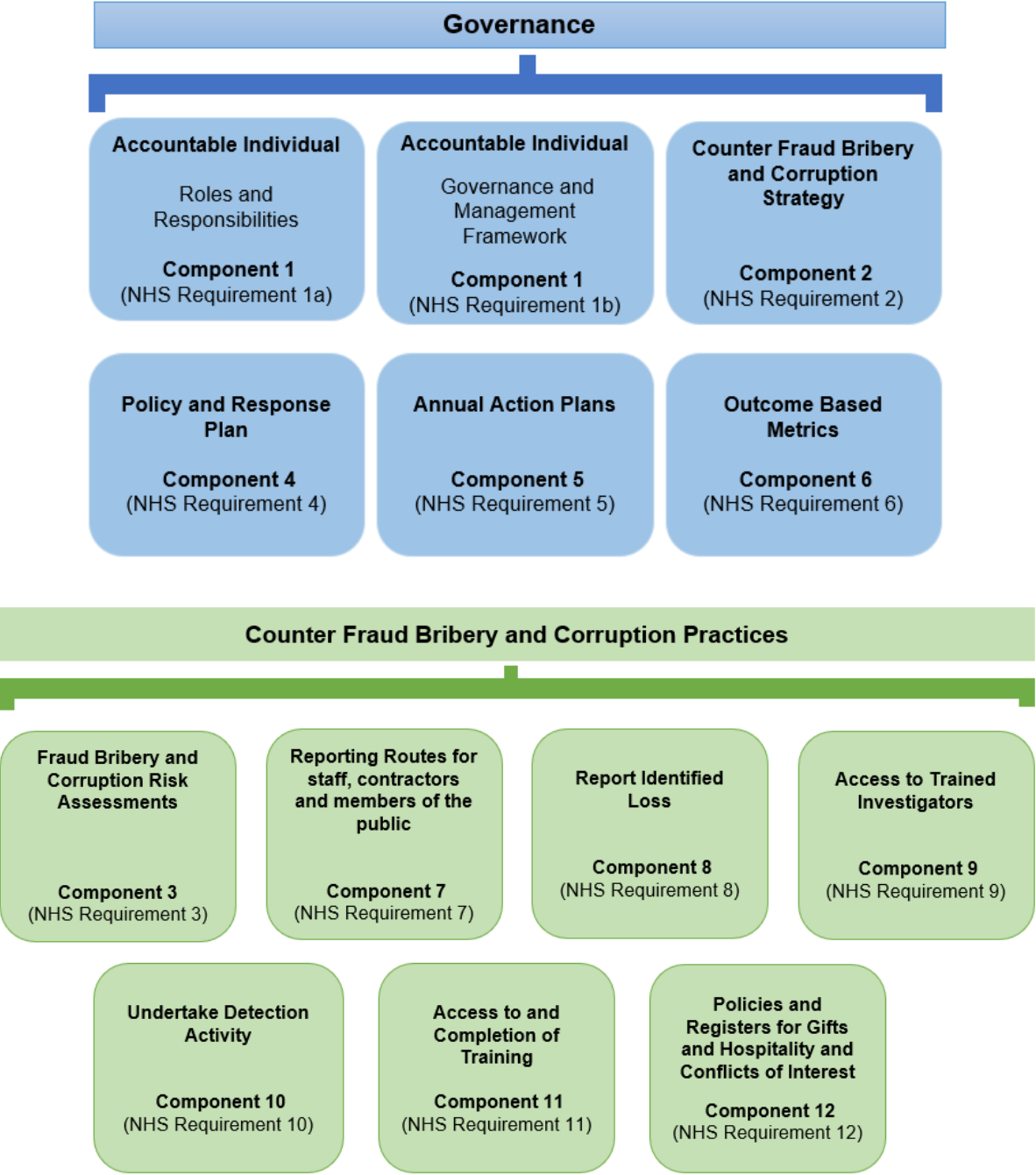
The annual report must contain one of the declarations listed below. This declaration must reflect the organisation type and be signed by the Accountable Board Member in order for the organisation to be compliant with the Functional Standard Requirements.

Organisation Declaration

I declare that the counter fraud, bribery and corruption work carried out during 2023/24 has been self-reviewed against the Functional Standard Requirements relating to fraud, bribery and corruption, and that the above rating has been achieved.

Organisation	Cwm Taf Morgannwg University Health Board
Accountable Board Member Signature	
Date	

4. Work carried out against the Functional Standard Requirements



Governance

This section of the annual report outlines how the organisation supports and directs counter fraud, bribery and corruption work undertaken to create a strategic organisation wide response when combatting fraud bribery and corruption.

Work relating to each Governance Component of the Functional Standard is summarised and current and previous rating for each Requirement is set out below.

Function Standard Component	NHS Requirement		2023 Rating	2024 Rating	Current Position
Component 1 Accountable individual	NHS Requirement 1A	This relates to the role of the accountable board member and their responsibility for the strategic management of, and support for, counter fraud, bribery and corruption work, including timely reporting and accurate notification of nominations to the NHSCFA.	GREEN	GREEN	The Director of Finance is responsible for the strategic management and support of counter fraud work. A good level of support and assistance is given to the Counter Fraud Team in the discharge of responsibilities by the Director of Finance and the wider Finance Directorate. The Health Board's Audit Committee receive regular reports of Counter Fraud activity throughout the year which includes quarterly benchmarking reports. The Audit Committee receive and approve the Health Board's Counter Fraud Annual Report and Workplan. All Counter Fraud submissions to the Audit Committee are sponsored and supported by the Director of Finance.
	NHS Requirement 1B	This relates to the work of the organisations board / governing body in	GREEN	GREEN	NHSCFA proactive exercise reports have been presented to the Health Board's Audit

Function Standard Component	NHS Requirement		2023 Rating	2024 Rating	Current Position
		gaining assurance and evaluating the counter fraud work undertaken during the year. This requirement also covers the role of the Counter Fraud Champion.			Committee. A concluding report Quality & Assurance evaluation has also been presented to Audit Committee which highlighted work undertaken in response to findings. The Audit Committee receives an Annual Report written in line with NHSCFA guidance using the template. This includes details of the Functional Standard Return for review. The Director of Corporate Governance has been nominated as the Fraud Champion supported by the Assistant Director of Governance and Risk. Support around the implementation of fraud risk recording via DATIX, furthering counter fraud awareness at induction under Corporate Governance input, and supporting work around Standards of Behaviour Policy fraud proofing.
Component 2 Counter fraud bribery and corruption strategy	NHS Requirement 2	This Component relates to the organisations over-arching counter fraud, bribery and corruption strategy, and how the counter fraud work plan and resource allocation is	GREEN	GREEN	The Health Board's Counter Fraud Policy & Response Plan includes the overall strategic aims of counter fraud work and operational response aligned to the NHSCFA counter

Function Standard Component	NHS Requirement		2023 Rating	2024 Rating	Current Position
		aligned to the objectives of the strategy and locally identified risks.			fraud, bribery and corruption strategy. A counter fraud work plan is developed in line with key objectives of the strategy, alignment to national standards and includes response to nationally and locally identified risks. The CFP&RP and work plan are agreed by Director of Finance and Audit Committee and progress is tracked via regular reporting and attendance at Audit Committee.
Component 4 Policy and response plan	NHS Requirement 4	This Component relates to the organisations counter fraud, bribery and corruption policy and response plan and its alignment to the NHSCFA strategic guidance.	GREEN	GREEN	The Health Board has a Counter Fraud Policy & Response Plan in place. The Policy is reviewed to ensure that it remains current. Issues relating to bribery and fraud are also referenced within the Standards of Behaviour Policy. Staff awareness of these key policy documents is measured using questionnaires and a survey issued in March 2024.
Component 5 Annual Action Plan	NHS Requirement 5	This Component relates to the development and management of the organisation's annual counter fraud work	GREEN	GREEN	A counter fraud work plan is developed in line with key objectives of the strategy and alignment to national standards. Resource is

Function Standard Component	NHS Requirement		2023 Rating	2024 Rating	Current Position
		plan. This plan should be informed by national and local fraud, bribery and corruption risk assessments.			allocated in line with this within the context of 4 strategic areas of counter fraud activity; Inform and involve, prevent and deter, hold to account and strategic governance. Progress against this work plan is monitored and evaluated through out the year with regular meetings with Director of Finance and regular reporting to Audit Committee. Allocated resource is included as part of this regular reporting along with benchmarking of overall resource availability.
Component 6 Outcome based metrics	NHS Requirement 6	This Component relates to how the organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance	GREEN	GREEN	All Wales Performance statistics are collated on a quarterly basis and shared between Health Boards and Welsh Government. Statistics are utilised to examine performance between NHS Wales organisations. Benchmarking undertaken on an organisational level against previous years and against other NHS Wales Organisations. Reports on performance and benchmarking are shared with the Audit Committee to scrutinise. Clue3 includes recording and reporting mechanisms

Function Standard Component	NHS Requirement		2023 Rating	2024 Rating	Current Position
					for proactive and reactive outcomes of counter fraud work which is utilised as a recording mechanism.

Counter Fraud Bribery and Corruption Practices

This section of the annual report outlines the organisations operational counter fraud activities undertaken during the year when detecting and combatting fraud.

The organisation should report against each Counter Fraud Practice Component, under the Functional Standard and summarise the work completed to meet each Requirement. A high-level summary of each of the Counter Fraud Practice Components is set out below.

Function Standard Component	NHS Requirement		2023 Rating	2024 Rating	Current Position
Component 3 Fraud bribery and corruption risk assessment	NHS Requirement 3	This Component relates to the local risk assessments undertaken in line with Government Counter Fraud Profession methodology to identify fraud, bribery and corruption risks, and how the organisations counter fraud, bribery and corruption provision is proportionate to the level of risk identified.	GREEN	GREEN	Comprehensive risk assessments are carried out in line with the GCFP methodology and recording aligns to the Health Board's Risk Management Policy. The annual counter fraud work is informed by these risk assessments. NHS CFA issued national fraud risks guidance containing 129 fraud risk descriptors across the entirety of business areas the NHS engages in. These risks have been concatenated into core risk areas for review locally. Work since introduction of this Component has been to map fraud risk descriptors to core risk assessments,

Function Standard Component	NHS Requirement		2023 Rating	2024 Rating	Current Position
					development of a fraud risk profile around core risk areas, implementation of managing fraud risk via DATIX, implement sufficient scanning techniques and processes to ensure all emerging fraud risk is captured and reviewed against existing fraud risk assessments.
Component 7 Reporting routes for staff, contractors and members of the public	NHS Requirement 7	This Component relates to the reporting routes in place at the organisations to report suspicions of fraud, bribery and corruption and a mechanism for recording these referrals and allegations on the approved NHS fraud case management system.	GREEN	GREEN	The Health Board has well documented reporting routes for any party to report incidents of fraud, bribery and corruption. Reporting routes are formalised in the Counter Fraud Policy & Response Plan and Bribery Policy. Reporting routes are also highlighted within counter fraud awareness training, newsletters and communications, included on the Counter Fraud Intranet pages and highlighted in the Counter Fraud Information Booklet available for staff. Reporting routes include a central Counter Fraud email inbox, email and phone directly to LCFSS, a Microsoft Forms Fraud Reporting form, the National Fraud and Corruption Reporting Line as well as alternative reporting

Function Standard Component	NHS Requirement		2023 Rating	2024 Rating	Current Position
					routes to Director of Finance and whistleblowing charity Protect-Public Concern at Work. The Counter Fraud Team have regularly received contact from individuals raising concerns resulting in the commencement of new investigations in 2023/24. Surveys have been undertaken in March 2024 to measure effectiveness.
Component 8 Report identified loss	NHS Requirement 8	This Component relates to the organisations use of the approved NHS fraud case management system to record all allegation and investigative activity. Including all outcomes, recoveries and system weaknesses identified during the course of investigations and/or proactive prevention and detection exercise.	GREEN	GREEN	The Health Board fully utilises the Clue case management system to record and report identified loss. The system includes opportunity to record all investigaiton materials, local proactive exercises and operational statistical information. Statistics are collated and submitted on a quarterly basis to Counter Fraud Service Wales and an All Wales Operational Performance report produced. A benchmarking report utilising this information is presented to Audit Committee on a quarterly basis.

Function Standard Component	NHS Requirement		2023 Rating	2024 Rating	Current Position
Component 9 Access to trained investigators	NHS Requirement 9	This Component relates to the accredited Local Counter Fraud Specialist (LCFS) at the organisation, and details of the continuous professional development undertaken. All LCFS undertaking counter fraud activity at the organisation must be nominated with the NHSCFA.	GREEN	GREEN	Local Counter Fraud Services for the Health Board are provided by Swansea Bay UHB under a Service Level Agreement. The service is delivered by qualified, nominated and accredited LCFS, who conduct the full range of anti-fraud, bribery and corruption work on behalf of the organisation. The LCFS attend all necessary training and continuous professional development events as required to appropriately fulfil their role on an ongoing basis. The counter fraud accredited resource for 2023/24 was 2.6 FTE.
Component 10 Undertake detection activity	NHS Requirement 10	This Component relates to the proactive work completed to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and the work undertaken in response.	GREEN	GREEN	LCFS review Final Internal and External Audit reports and meet with the Head of Internal Audit to share details on identified risk. This would include instances where data mining or sampling has highlighted outliers or concerns. A PPV programme is undertaken in respect of GPs, Opticians and Pharmacies, with final reports received by the LCFS. Meetings are held with the PPV Manager. The HB also participates in the NFI process. Risk

Function Standard Component	NHS Requirement		2023 Rating	2024 Rating	Current Position
					assessments are considered as part of this work and completed where necessary. As a result of this information and intelligence review process the Counter Fraud Team have registered local proactive exercises on the case management system in 2023/24.
Component 11 Access to and completion of training	NHS Requirement 11	This Component relates to the programme of work undertaken at the organisation to raise awareness of fraud, bribery and corruption and to create a counter fraud, bribery and corruption culture among all staff. The effectiveness of the awareness programme is measured.	GREEN	GREEN	The Health Board has an ongoing programme of work to raise awareness of economic crime issues amongst all staff, using a range of methods including virtually delivered presentations and e-learning package availability. This is supported by newsletters and intranet pages alongside the regular release of counter fraud information via articles and alerts. The awareness programme is sufficient to achieve a Green rating but is an area that is continually improvement. Work has been undertaken including risk based training resulting from proactive work, embedding of short from blog style communications which are driving

Function Standard Component	NHS Requirement		2023 Rating	2024 Rating	Current Position
					connections with staff with a more informal style. Contact with the Counter Fraud Team has increased and the Team have logged more referrals on the case management system than ever before as a result.
Component 12 Policies and registers for gifts and hospitality and Conflicts of Interest	NHS Requirement 12	This Component requires the organisation to have in place policies and registers for gifts and hospitality and conflicts of interest that reference the requirements of the Bribery Act 2010 that are communicated to all staff. The effectiveness of which is regularly tested.	GREEN	GREEN	The HB has a Standards of Behaviour Policy in place, which has incorporated declarations of interest, gifts, hospitality and sponsorship. The Policy also includes reference to fraud, bribery and corruption and the requirements of the Bribery Act 2010, and is available to all staff via the intranet. It is also promoted during fraud awareness presentations. Testing of staff awareness of the Policy has been included in surveys issued in March 2024.

5. Appendices

Appendix 1 – Counter Fraud Activity

This section of the annual report should detail the total counter fraud resources used by the organisation. The following information must be included in the counter fraud annual report in order for the organisation to be compliant with the Functional Standard NHS Requirement 1B.

Area of activity	Days used
Proactive work	312
Reactive work	292
Total days used	604

Appendix 2 – Counter Fraud Costs

This section of the annual report should detail the total costs of the counter fraud resources used by the organisation. The following information must be included in the counter fraud annual report in order for the organisation to be compliant with the Functional Standard NHS Requirement 1B.

Cost of Counter Fraud, Bribery and Corruption Work	Total Costs £
Proactive costs	£81,534
Reactive costs	£76,307
Total costs	£157,841

Appendix 3 – Nominations Overview

This section of the annual report should detail the nominated officers at the organisation during the reporting period, including all supporting LCFS. If any of the nominations have changed during the year, the date of the change should be included.

The following information must be included in the counter fraud annual report in order for the organisation to be compliant with the Functional Standard NHS Requirement 1B and 9.

Role	Name of Nominated Person
Accountable Board Member	Sally May
Audit Committee Chair	Patsy Roseblade
Fraud Champion	Gareth Watts
Lead LCFS	Matthew Evans
Supporting LCFS	Beverley Jones
Supporting LCFS	Alison Williams

Appendix 4 – Investigation Information

This section of the annual report should detail all the activity recorded on the CLUE Case Management System. The following information must be included in the counter fraud annual report in order for the organisation to be compliant with the Functional Standard NHS Requirement 1B, 6, 7 and 8.

Investigation Information	Number
Investigations carried forward from 2022/23	13
Investigations Opened during the period	50
Investigations Closed during period	44
Investigations Transferred	4
Investigations Ongoing	15

Appendix 5 – Risk Based Exercises

This section of the annual report should detail all the Fraud Risk Assessments (FRAs), Local Proactive Exercises (LPEs) and System Weakness Reports (SWRs) undertaken. The following information must be included in the counter fraud annual report in order for the organisation to be compliant with the NHS Counter Functional Standard NHS Requirement 1B, 3, 5, 6, 8 and 10.

Fraud Risk Assessments	Number
Number of FRAs reviewed in line with the organisations risk management policy	6

Local Proactive Exercises	Number
Number of LPEs conducted during the year	25
Number of LPEs recorded on the NHS CFA Case management system as per component 8	25
Number of LPEs concluded during the year	21

System Weakness Reports	Number
Number of SWRs identified during the year	0
Number of SWRs concluded during the year on the NHS CFA Case management system as per component 8	0
Number of new processes adapted or introduced as a result of SWRs	0

Appendix 6 - Sanction & Redress Overview

This section of the annual report should detail of any sanctions and redress activity undertaken. The following information must be included in the counter fraud annual report in order for the organisation to be compliant with the Functional Standard NHS Requirement 1B, 6 and 8.

Sanction Imposed	Number
Disciplinary	2
Civil	3
Criminal	0
Total Sanctions	5

Redress Imposed	Total Amount £
Fraud identified	£46,446
Fraud Prevented	£11,930
Fraud Recovered	£33,438



Counter Fraud Work Plan 2024/25

Matthew Evans
Head of Counter Fraud Services

18 April 2024

Introduction

The Health Board is assessed as now being in full compliance with Government Functional Standard 013 Counter Fraud: NHS Requirements. All 12 Components are rated Green. This work plan has been devised to embed and consolidate the achievement of Green ratings as all address local and national fraud risk.

The Health Board contracts Swansea Bay UHB via Service Level Agreement for the provision of Counter Fraud Resource. This results in 2.6 FTE of accredited counter fraud specialist resource supplemented by 0.4 FTE admin support which translates to 616 days deliverable for counter fraud activity. There is a current team vacancy within the admin support role, recruitment is in progress with pre-employment checks pending. It is anticipated that the deliverable days of counter fraud activity will be reduced by 10 days for 2024/25. This work plan is therefore based on 606 days of day's deliverable for counter fraud activity but may be subject to further reduction dependant on completion of recruitment processes.

The Work Plan is set around proactive activity covering Inform & Involve, Prevent & Deter and Strategic Governance as well as reactive activity covered by Hold to Account. The planned days are split as proactive days – 296 and reactive days - 310 days. This is in line with delivery of previous years and takes in to account the commitments made within this Work Plan.



INFORM AND INVOLVE

The Organisation is required to maintain an ongoing programme of work to raise awareness of fraud, bribery and corruption and to create a counter fraud, bribery and corruption culture among all staff, across all sites, using all available media.

TASK/OBJECTIVE		RISK/FPN/STANDARD	PROPOSED DELIVERY
I&I.1	Design and deliver a programme of counter fraud awareness presentations to staff at all levels within the Health Board, including participation in the Health Board induction programme, with the aim of ensuring that the organisation is proactive in raising fraud awareness and building an anti-fraud Review and maintain materials and media used. Evaluate presentations, collate results, and amend presentations as a result of the feedback received. Report outcomes to the Director of Finance.	GovS 013 component 11	Throughout the Year
I&I.2	Undertake awareness work to highlight the availability of counter fraud awareness training aiming to increase attendance numbers.	GovS 013 component 11	Throughout the Year
I&I.3	To develop and maintain the counter fraud information contained on the Health Board intranet site, to include details of successfully prosecuted cases – both local and national	GovS 013 component 11	Q2 and Q4
I&I.4	Ensure that Fraud and Corruption Reporting Line advertising posters are displayed throughout the organisation, publicising the free-phone reporting line number.	GovS 013 component 11	Throughout the Year
I&I.5	Actively promote and encourage staff awareness and completion of the Counter Fraud E-learning package.	GovS 013 component 11	Throughout the Year

INFORM AND INVOLVE

The Organisation is required to maintain an ongoing programme of work to raise awareness of fraud, bribery and corruption and to create a counter fraud, bribery and corruption culture among all staff, across all sites, using all available media.

TASK/OBJECTIVE		RISK/FPN/STANDARD	PROPOSED DELIVERY
I&I.7	Design, produce and distribute two counter fraud newsletters annually, containing articles on proven fraud cases (both local and national) and other “beware” notices and relevant messages.	GovS 013 component 11	Q2 and Q4
I&I.8	In conjunction with the Health Board Communications Team, review the strategy in place for raising awareness of economic crime risks and publicise the work of the LCFS, to ensure that it remains fit for purpose and that all appropriate awareness-raising mechanisms are being fully exploited.	GovS 013 component 11	Q2
I&I.9	Undertake targeted surveys of staff to measure awareness of: Counter Fraud, Bribery and Corruption Policy and Response Plan; Fraud, Bribery and Corruption incident reporting routes; and Policy and procedures relating to Conflicts of Interests, Gifts and Hospitality and Bribery Act.	GovS 013 Components 4, 7 and 12	Throughout the Year
I&I.10	Utilise the finding and results of the fraud risk assessment programme to inform delivery of counter fraud training to business areas of higher risk of exposure to fraud.	GovS 013 Components 7 and 12	Throughout the Year
TOTAL DAYS ALLOCATED		100	

PREVENT AND DETER

The organisation must carry out comprehensive local risk assessments to identify fraud, bribery and corruption risks, and has counter fraud, bribery and corruption provision that is proportionate to the level of risk identified.

The organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance.

The organisation undertakes proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and takes the appropriate action, including local exercises and participation or response to national exercises.

TASK/OBJECTIVE		RISK/FPN/STANDARD	PROPOSED DELIVERY
P&D.1	Review key organisational policies, procedures and documents, to ensure that they are adequately robust to counter fraud. The communication of revised policies, procedures and documents as appropriate, emphasising the organisational commitment to countering fraud.	GovS 013 component 3 GovS 013 component 10	As Appropriate
P&D.2	Carry out risk analysis in line with Government Counter Fraud Profession (GCFP) fraud risk assessment methodology. Record and manage assessed risk in line with the Health Board's Risk Management policy and include on the risk registers where appropriate.	GovS 013 component 3	Throughout the Year
P&D.3	Utilise DATIX for recording of risk assessment work to effectively manage, evaluate, evidence and measure the effectiveness of counter fraud work in mitigating and reducing fraud risk or expenditure and influencing of policy and procedure aimed at reducing fraud.	GovS 013 component 2 GovS 013 component 3 GovS 013 component 5	Throughout the Year

PREVENT AND DETER

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The organisation undertakes proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and takes the appropriate action, including local exercises and participation or response to national exercises.

TASK/OBJECTIVE		RISK/FPN/STANDARD	PROPOSED DELIVERY
P&D.4	Review existing fraud risk assessments with Risk Owners before recording on DATIX for ongoing management.	GovS 013 component 2 GovS 013 component 3 GovS 013 component 5 FR01, FR02, FR03, FR04, FR06, FR07, FR21, FR26, FR60, FR61	Q2
P&D.5	Liaise with Corporate Governance colleagues around measuring effectiveness and staff awareness of conflicts of interest policy and registers that include gifts and hospitality with reference to fraud, bribery and corruption, and the requirements of the Bribery Act 2010.	GovS 013 component 12	Q1
P&D.6	Utilise National Fraud Initiative data, which matches payroll records to creditors and suppliers, to undertake a proactive exercise to measure compliance with the conflicts of interest policy.	GovS 013 component 10	Q2
P&D.7	Follow up to Proactive Exercise undertaken around Impersonating a Medical Professional and finalise a fraud risk assessment.	FPN H-003-23	Q2

PREVENT AND DETER

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The organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance.

The organisation undertakes proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and takes the appropriate action, including local exercises and participation or response to national exercises.

TASK/OBJECTIVE		RISK/FPN/STANDARD	PROPOSED DELIVERY
P&D.8	Finalise fraud risk assessment around identified issue of False International English Language Testing System Certificates (IELTS)	FPN H-005-23	Q1
P&D.9	Finalise fraud risk assessment around identified issue of Salary Sacrifice	FPN – L004-23	Q1
P&D.10	Finalise fraud risk assessment around identified issue of Working Elsewhere	FPN – L001-23	Q2
P&D.11	Review both FR08 & FR09 around updated issue of Mandate Fraud. Seek to amalgamate both risks into one comprehensive risk assessment to streamline future review of this ever evolving fraud risk	FPN – L002-23	Q1
P&D.12	Review FR22 in response to the identified issue of CEO/Unsolicited Payment Requests	FPN-M001-24	Q1
P&D.13	Participate in NHS Counter Fraud Authority national proactive procurement risk exercise entered around specific risks of due diligence and contract management.	FR02 FR03 FR04 FR05	Q2

PREVENT AND DETER

The organisation must carry out comprehensive local risk assessments to identify fraud, bribery and corruption risks, and has counter fraud, bribery and corruption provision that is proportionate to the level of risk identified.

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The organisation undertakes proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and takes the appropriate action, including local exercises and participation or response to national exercises.

TASK/OBJECTIVE		RISK/FPN/STANDARD	PROPOSED DELIVERY
P&D.14	Review and update information sharing protocols currently in place. Review and refresh protocols with People Services.	Service level	Q1
P&D.15	Regular meetings with the Head of Internal Audit (NWSSP Audit & Assurance)	Service level	Throughout the Year
P&D.16	Record and respond to ad-hoc requests for assistance received.	Service level	Throughout the Year
P&D.17	Action Fraud Prevention Notices issued by NHS Counter Fraud Authority and/or Counter Fraud Services Wales as and where appropriate.	GovS 013 component 3	As Appropriate
P&D.18	Issue of fraud alerts to all appropriate staff.	GovS 013 component 11	As Appropriate
P&D.19	Regular liaison with the Post Payment Verification Location Manager (NWSSP Primary Care) and Primary Care leads to ensure that any contractor visits which result in the identification of anomalies are reported to the LCFS.	Service level	Throughout the Year

PREVENT AND DETER

The organisation must carry out comprehensive local risk assessments to identify fraud, bribery and corruption risks, and has counter fraud, bribery and corruption provision that is proportionate to the level of risk identified.

The organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance.

The organisation undertakes proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and takes the appropriate action, including local exercises and participation or response to national exercises.

TASK/OBJECTIVE		RISK/FPN/STANDARD	PROPOSED DELIVERY
P&D.20	Participate in mandatory national proactive exercises, as instructed by NHS Counter Fraud Authority, Auditor General for Wales and/or the Cabinet Office (e.g. NFI).	GovS 013 component 10	Throughout the Year
P&D.21	Participate in thematic fraud risk evaluation exercises as instructed by the NHS Counter Fraud Authority.	GovS 013 component 10	As Required
P&D.22	Conduct proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption. Results of this work are evaluated and where appropriate feed into improvements to prevent and deter fraud, bribery and corruption in line.	GovS 013 component 10	Throughout the Year
P&D.23	Membership of Local Intelligence Network and attendance at meetings.	Service level	As Required
TOTAL DAYS ALLOCATED		148	



HOLD TO ACCOUNT

The organisation employs or contracts in an accredited, person (or persons) nominated to the NHSCFA to undertake the full range of counter fraud, bribery and corruption work, including proactive work to prevent and deter fraud, bribery and corruption and reactive work to hold those who commit fraud, bribery or corruption to account.

The organisation must have well established and documented reporting routes for staff, contractors and members of the public to report incidents of fraud, bribery and corruption.

The organisation uses the approved NHS fraud case management system to record all incidents of reported suspect fraud, bribery and corruption, to inform national intelligence and NHS counter fraud functional standard return submission by the NHSCFA.

TASK/OBJECTIVE		RISK/FPN/STANDARD	PROPOSED DELIVERY
HTA.1	Conduct investigations into all allegations of economic crime as required, in line with the requirements of the NHS Counter Fraud Authority Counter Fraud Manual, and all relevant guidance and legislation.	GovS 013 component 9	As Required
HTA.2	Appropriate use of the prescribed case management system, in line with NHS Counter Fraud Authority and NHS CFS Wales requirements.	GovS 013 component 6 GovS 013 component 8	As Required
HTA.3	Assist NHS Counter Fraud Authority and/or NHS CFS Wales as required in respect of any regional or national investigations.	GovS 013 component 9	As Required
HTA.4	Ensure the application of sanctions in line with legislation and the policy document 'Applying Appropriate Sanctions Consistently'.	GovS 013 component 6 GovS 013 component 9	As Required
HTA.5	Identify and maintain appropriate records and, wherever possible, seek financial redress/recovery in respect of any proven loss to the Health Board, having due regard to the particular circumstances of each case.	GovS 013 component 6 GovS 013 component 8	As Required

COUNTER FRAUD WORK PLAN 2024/25



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HTA.6	Review professional competencies and capabilities of accredited staff nominated to undertake the full range of counter fraud work to assess requirements for professional development opportunities.	GovS 013 component 9	Q1
HTA.7	Explore Memorandum of Understanding between South Wales Police and the Health Board to cover matters of joint interest when undertaking investigation.	Service level	Throughout the Year
TOTAL DAYS ALLOCATED		310	

STRATEGIC GOVERNANCE			
A member of the executive board or equivalent body is accountable for provision of strategic management of all counter fraud, bribery and corruption work within the organisation. The organisation's non-executive directors, counter fraud champion or lay members and board/governing body level senior management are accountable for gaining assurance that sufficient control and management mechanisms in relation to counter fraud, bribery and corruption are present within the organisation. The organisation maintains an annual work plan that is informed by national and local fraud, bribery and corruption risk assessment identifying activities to improve capability and resilience.			
TASK/OBJECTIVE			PROPOSED DELIVERY
SG.1	Attendance at all Fraud Forum meetings held by CFS Wales.	Service Level	As Required
SG.2	Completion and agreement of the annual work plan with Director of Finance.	GovS 013 component 2	Q4
SG.3	Completion and agreement of the annual report with Director of Finance.	GovS 013 component 5	Q1
SG.4	Regular meetings/liaison with Director of Finance.	GovS 013 component 1	Throughout the Year
SG.5	Preparation for and attendance at Audit Committee meetings.	GovS 013 component 1	As Required
SG.6	Full participation in the quality assurance process as directed by NHS Counter Fraud Authority	Service Level	Q4 and As Required
SG.7	Undertake additional training as required by the Health Board or NHS Counter Fraud Authority.	Service Level	As Required



STRATEGIC GOVERNANCE

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The organisation's non-executive directors, counter fraud champion or lay members and board/governing body level senior management are accountable for gaining assurance that sufficient control and management mechanisms in relation to counter fraud, bribery and corruption are present within the organisation.

The organisation maintains an annual work plan that is informed by national and local fraud, bribery and corruption risk assessment identifying activities to improve capability and resilience.

TASK/OBJECTIVE			PROPOSED DELIVERY
SG.8	Continuing use of CLUE3 case management system, as mandated by the NHS Counter Fraud Authority. Utilise system to record all fraud, bribery and corruption investigative activity, including all outcomes, recoveries and system weaknesses identified during the course of investigations and/or proactive prevention and detection exercises.	GovS 013 component 8	Throughout the Year
SG.9	Provide regular reports and <i>ad hoc</i> information to NHS Counter Fraud Authority and Welsh Government as required	GovS 013 component 6	Throughout the Year
SG.10	Review the Health Board's Counter Fraud Policy and Response Plan to ensure up to date and relevant contents as well as alignment to Government Functional Standards.	GovS 013 component 4 GovS 013 component 7	Q2
TOTAL DAYS ALLOCATED		48	

SUMMARY TOTALS

	STRATEGIC AREA OF ACTIVITY	RESOURCE ALLOCATED (in days)
A	INFORM AND INVOLVE	100
B	PREVENT AND DETER	148
C	HOLD TO ACCOUNT	310
D	STRATEGIC GOVERNANCE	48
	TOTAL	606



Agenda Item

4.2

Audit & Risk Committee

Local Counter Fraud Update Report

Dyddiad y Cyfarfod / Date of Meeting	18/04/2024
Statws Cyhoeddi / Publication Status	Open/ Public Choose an item.
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: Not applicable for this report
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: 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 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.



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Item 4.2 – Appendix

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 2023/24
15	1	44
Case Rates		
Referrals Received 2023/24	Cases Under Investigation for Over 12 Months	
50	1	
Sanctions/Outcomes		
Criminal Sanctions	Civil Sanctions (Inc. Financial Recovery)	Disciplinary Sanctions
0	3	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 in this case has entered a not guilty plea to 9 counts of dishonesty offences relating to deceit around gaining employment in the NHS. Trial preparation hearings have been completed and trial is planned to commence in June 2024. There has been press interest in this case with TV and print media coverage. Further interest anticipated at trial. A communication plan was in place and continues to be maintained with support from the Health Board's Communications Dept and NHS CFA Communications Team. The subject resigned their Health Board position whilst disciplinary proceedings were underway. NMC are awaiting outcome of criminal case.
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 investigaiton forms part of a wider investigative strategy with Home Office immigration and Police involvement. Case review underway to align and assess potential for CPS consideration.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/23/01588	01/08/2023	Timesheet Fraud	Information received following concerns established during disciplinary process. Allegation that staff member has not been completing contracted hours and is in deficit. Enquiries have sought data of Outlook account, IT logins, system logins, and ESR. This has been measured against fob data to established working hours. Enquiries have established a small deficit which would not be proportionate to seek prosecution. Findings have been shared with disciplinary process which is proceeding with investigation phase concluded. Disciplinary process is ongoing and case will remain open to capture resolution given advanced stage of that process.
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. A further meeting will be held with Primary Care colleagues to decide on way forward.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/23/2885	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 will be approached to discuss upon receipt of secondary employer information
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/24/00067	09/01/2024	Prescription Fraud	Allegation that Pharmacy contractor has been receiving fake prescriptions, not dispensing any items and then claiming reimbursement. Primary Care Prescribing Services colleagues have been contacted for advice and input. Claims data for the contractor has been gathered and is being analysed.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/24/00157	23/01/2024	False NHS compensation Claim	Information received from the Fraud and Corruption Reporting line that a member of the public claims that they are unable to work and is in process of claiming against the NHS for issues linked to surgery but in fact does work regularly. Enquiries have established that compensation has been paid previously for the member of public linked to NHS treatment. Enquiries are being undertaken to ascertain the exact nature of that compensation and whether any dishonesty is present in the context of the allegation.
INV/24/00220	29/01/2024	Fraudulently Obtaining Controlled Drugs	The partner of a patient currently serving a custodial sentence in prison, has been obtaining repeat prescriptions from the GP in the name of the patient, for controlled drugs (gabapentin), for a 6 month period, when the patient has been prescribed this medication through the prison. GP has been engaged as initial enquiries seek to corroborate allegation.
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.

Open Cases			
Reference Number	Date Opened	Allegation	Status
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.
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. Further enquiries undertaken assess how firm existing job plan arrangements are for this consultant and to attempt to clarify what actual sessions have been completed during the period of concern.
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 ben 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.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/24/00708	19/03/2024	Patient Prescription Fraud	A patient has been alleged to have registered at multiple GP Practices in the area and is seeking prescriptions for immediate need relating to pain. GP Practices have been approached to gather information around the registration of the patient and what information was provided by them to the Practices. Further checks undertaken to ascertain whether any other GP practices have registered this patient. Controlled Drugs Accountable Officer has been made aware and an alert has been requested for dissemination to GP Practices to highlight the concerns.
INV/24/00789	25/03/2024	Pharmacy Contract Fraud	Allegation that a Community Pharmacy has provided false information on an application to be included on the Health Board's Pharmaceutical List. The potential false information relates to premises address and appears to be linked to a dispute around freehold/leasehold of the property. General Pharmaceutical Council have previously visited the contractor on two occasions and are satisfied with the operation of the pharmacy. The Pharmacy Team have sought legal advice on the matter from Legal and Risk. Opinion is awaited to inform potential investigation.

Closed Cases			
Reference Number	Date Opened	Allegation	Outcome
INV/23/01232	27/06/2023	False Overtime	Allegation received that staff are not completing overtime hours or not attending at all and claiming full day overtime payments. Allegation states that supervisors are aware of this. Enquiries are ongoing but made more difficult by allegation that managers are aware of and allow conduct limiting investigative approaches. A senior manager contact has been identified and approached in efforts to progress investigation. Following discussions no evidence was able to be established to indicate suspects and there was found to be a poor record keeping in relation to overtime. Continuation of criminal investigation was not possible in these circumstances. A wider review is underway in this area by senior managers and these concerns will feed into that.
INV/24/00267	02/02/2024	NHS Patient Selling Prescribed Medication	A Patient is alleged to be selling medication prescribed to her by the GP. Medication is food supplements with relatively high resale value. The patient has appeared to text the GP practice by mistake offering her products for sale. Text message records to the GP Practice have been gathered. LCFS to engage GP Practice for further background information around the prescribing.

Closed Cases			
Reference Number	Date Opened	Allegation	Outcome
			Enquiries have established that the prescribed items were nutritional drinks and that available evidence was lacking with regard to evidencing actual sales. The subject of this investigation was arrested by the Police in relation to a separate serious crime and is now residing out of the area in a resettlement home. She has changed her GP to the Bristol area. Information has been shared to new GP around the concerns raised.
INV/24/00290	06/02/2024	Theft	Information received from the Fraud and Corruption Reporting line that a steals items from the stock cupboard including antibiotics, pain killers and adhesive remover. Referral states that subject submits stock orders for items. Information was shared with subject's managers and an initial assessment of facts was undertaken. This concluded that the process for ordering and stocking pain killers was reviewed and revised. Antibiotics are ordered for the ward, pharmacy colleagues reviewed and established no concerns. Adhesive remover was not a usual stocked item on the ward and would be ordered by the ward manager as and when required. Following these conclusions there is no evidence to proceed with criminal investigation into this matter.
INV/24/0578	07/03/2024	Working elsewhere whilst in receipt of occupational sick pay	Allegation that a staff member has worked for a secondary employer whilst on sick leave from substantive Health Board position.

Closed Cases			
Reference Number	Date Opened	Allegation	Outcome
			Enquiries were undertaken with the alleged secondary employer who advised that they held no record of the individual on HR or payroll systems. No fraud established in this instance.



Cwm Taf Morgannwg University Health Board

Audit & Risk Committee – 18 April 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	49
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.	118	91
Prevent and Deter		
Discouraging those who may want to commit crimes against the NHS and ensure that such opportunities are minimised.	130	172
Hold to Account		
Detecting and investigating crime, prosecuting those who have committed crimes and seeking redress as a result.	320	292
TOTAL	616	604*

*The under delivery of days is due to loss of resource due to staff leaving the Team in March 2024.

4. STRATEGIC GOVERNANCE

The Counter Fraud Team attended a NHS Finance Academy led workshop to discuss Counter Fraud strategy and approach. Despite not arriving at a definitive conclusion this was a very useful exercise with Counter Fraud colleagues engaging in dialogue around ideas in a round table style approach. A further workshop is planned to devise and arrive at Counter Fraud recommendations around potential options for future approach.

5. INFORM AND INVOLVE

A staff survey on counter fraud arrangements within the Health Board has concluded. The surveys covered all staff for response but also targeted Finance Department, Workforce & OD and Primary Care with surveys aligned to specific counter fraud risks they face. This information will be utilised to inform engagement approaches to those departments and wider Health Board.

6. PREVENT AND DETER

Following previous NHS Counter Fraud Authority exercises centred on procurement spend during the Covid-19 pandemic in April 2022 and procurement fraud risk areas including contract management and purchase order (PO) vs non-PO spend in June 2022 a new proactive exercise has been launched focussed on procurement contract management and due diligence. This exercise has been included in the Counter Fraud Work Plan 2024/25 and is scheduled for completion in Quarter 2.

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.



Agenda Item

4.3

Audit & Risk Committee

Procurement & Scheme of Delegation Update

Dyddiad y Cyfarfod / Date of Meeting	18/04/2024
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 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	
OJEU	Official Journal of the European Union
FCPs	Financial Control Procedures
SoD	Scheme of Delegation
PSPP	Public Sector Payment Policy

1. Situation / Background

1.1 Procurement Matters

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

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

This report provides details of any such transactions within the period 01.02.24 to 31.03.24

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 2023-24.

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 01.02.24 to 31.03.24.

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 01.02.24 to 31.03.24

Table A – Single Tender Actions 01.02.24 to 31.03.24

STA	Revenue / Capital	Division	Contract description	Supplier	Contract Value Exc. VAT	Reason for approval	Date Returned
1716	Rev	ICT	Maintenance & support of Lillie Sexual Health Management System.	Idox Software Ltd	£46,757	(c)	07/02/24



1717	Cap	National Imaging Academy	CLIN006 Needle Trainer Plus (US Only+ ROW only) Plus 2x Scanner and support	Intelligent Ultrasound	£50,840	(c)	08/02/24
1718	Cap	Theatres	Piezo Power Drill	General Medical	£37,950	(b)	22/02/24
1720	Cap	Estates	Replace existing flues to two CHP's (Combined Heat and Power) generators at Royal Glamorgan Hospital	Rung Heating Supplies Ltd	£24,609	(b)	22/02/24
1721	Cap	Radiology	MRI Upgrade	Siemens Healthiness	£179,880	(b)	22/02/24
1723	Cap	OPD	1 x N- LINE PRO Cabin/UVB	MGC Lamps Ltd	£26,800	(C)	08/03/24
1724	Cap	Estates	Remediatin g works identified by LCM Environme ntal Ltd	LCM Environmen tal Services Ltd	£59,914	(a)	07/03/24



1726	Rev	Estates	Workforce and Productivity Management Software System	MRI Software Ltd	£185,638	(d)	26/03/24
1727	Rev	Pathology	AI software histology	IBEX	£15,000	(d)	28/03/24
1728	Rev	Clinical Audit & Quality Informatics	AMaT Clinical Audit & NICE Clinical Effectiveness Management System	Meantime Information Technologies Ltd	£20,500	(c)	21/03/24
1729	Maintenance	Maintenance	Maintenance for washer-disinfectors	Dekomed Ltd	£28,124	(c)	27/03/24
1706	Maintenance	Orthoptic	3 years comprehensive, maintenance and service contract for Zeiss equipment used in Ophthalmology and Glaucoma services in POW &	CARL ZEISS LTD	£46.264	(c)	07/02/24



			MCH including: Clarus 700, Clarus 500, Cirrus 6000, Cirrus 500 and FORUM software.				
1711	Cap	Estates	Upgrades to life critical fire alarm system at RGH, PCH, YCR, YGT Hospital, Cefn Yr Aton & Pinewood House.	Morris Churchfield - Morris Line Engineering Limited	£154,258	(c)	07/02/24

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

STA 1726- MRI SOFTWARE

MRI Software are the sole supplier of the Planet-FM maintenance database. The database was initially installed in ABMU at the time of the boundary change in 2019. Following the boundary change the system was rolled out

across the former Cwm Taf Estates Departments to synchronise Planet across the UHB. Transferring to a new system will reset the current progress made with the implementation of Planet-FM and the current roll-out of mobile devices. Transferring to an alternative supplier will incur significant costs and staff time related to data transfer, training, and setup costs, together with the associated disruption and down time for each user when migrating to an alternative system.

STA 1727 - AI Galen Prostate software to support diagnostics within cellular pathology

Three HB's (BCU, Swansea Bay and Aneurin Bevin Health Boards have received funding via the Small Business Research Initiative to develop and trial the software under pre-commercial procurement terms. The trial was successful, and funding has been approved by WG to 'scale and spread' the use of the software at the remaining HB's ahead of any national procurement of an AI solution, to inform scoping and specifications of any all Wales solution.

Table B - Single Tender Actions- Retrospective

There are no retrospective Single Tender Actions in this period

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

There are no contracts requiring Ministerial approval for this period.

e) Summary of contracts awarded over £500,000

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

f) 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 01.02.24 to 31.03.24:

There is currently a review being undertaken for People and OD for Retinue and KPMG-this is still ongoing.

g) 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:

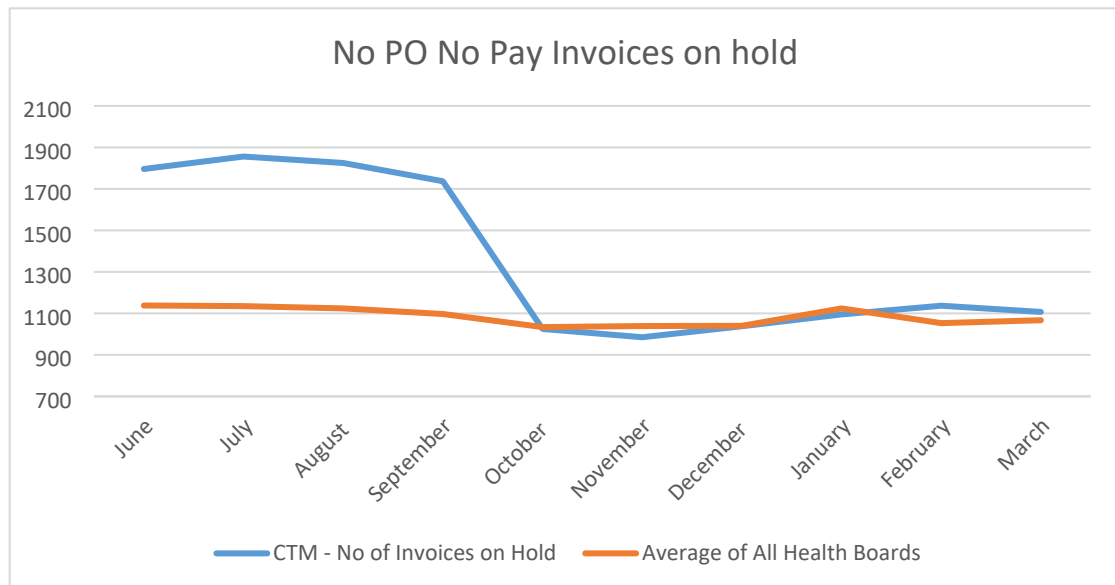
	Areas	Value of retro orders	Comments
CLEAR VIEW SURGICAL LTD	532994_CANCER BUSINESS UNIT (This was the only Location)	£184,992	AGENCY STAFFING.MEDICAL LOCUMS
CARDIFF & VALE UNIVERSITY LOCAL HEALTH BOARD	533890_RGH PATHOLOGY 555173_PCH BIOCHEM 533102_DOLS	£184,222	ADMIN FEES
BLUE ARROW LTD	559148_Houskeeping YCC 544053_MAIN CPU TREORCHY 533928_RGH CAT STORE	£142,781	AGENCY STAFFING

h) Consultancy Contracts

No consultancy contracts have been awarded between 01.02.24 to 31.03.24.

i) No PO No Pay Summary

Below shows the trend of number of No PO No Pay holds over the past 10 months.



2.2 Purchase to Pay (P2P)

The PSPP figures are reported for the second quarter to 31 March 2024.

The Health Board has met its annual 95% target of paying non-NHS invoices within 30 days achieving 96.9% (value 95.4%).

	0 - 30 Days		Total		%	
	Number	Value	Number	Value	Number	Value
Apr-23	15,571	38,586,322	16,298	43,991,964	95.5	96.0
May-23	23,465	69,816,166	23,924	76,960,512	98.1	97.9
Jun-23	22,974	35,244,677	23,533	39,126,216	97.6	95.2
Jul-23	31,044	54,058,760	31,830	56,526,210	97.5	95.6
Aug-23	18,381	34,149,207	18,973	36,983,288	96.9	92.3
Sep-23	19,722	46,960,932	20,740	51,217,771	95.1	91.7
Oct-23	22,915	39,801,116	23,334	41,882,427	98.2	95.0
Nov-23	23,410	47,800,063	23,727	49,377,365	98.7	96.8
Dec-23	15,337	38,211,080	15,501	38,750,462	98.9	98.6
Jan-24	21,818	43,895,380	22,760	45,859,741	95.9	95.7
Feb-24	19,810	39,379,798	20,799	42,534,765	95.2	92.6



Mar-24	23,417	67,720,710	24,751	70,521,136	94.6	96.0
YTD	257,915	555,676,452	266,221	582,322,464	96.9	95.4

The NHS invoice position continues to be challenging and shows that 79.1% (number) and 95.0% (value) of invoices were paid within 30 days to year end.

2.3 Scheme of Delegation and Financial Control Procedures (FCPs)

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

There are a number of other FCPs that are currently under review and have been shared with Senior Managers for comment, these will come to the next Audit & Risk Committee for approval.

3. Key Risks / Matters for Escalation

- 3.1 While there has been an improvement in recent months the level of No PO No Pay Holds remains a concern, this is particularly having an impact on the PSPP percentage for payment of NHS invoices. It is important that directorates raise POs in a timely manner in order for efficient payment of invoices. Finance and Procurement teams continue to engage with appropriate officers to communicate the importance of the No PO No Pay process.

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	Not Applicable
	If more than one applies, please list below:



150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	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 Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality Have you undertaken a Quality Impact Assessment Screening?	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? / Equality and Welsh Language Have you undertaken an Equality and Welsh Language Impact Assessment Screening?	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): 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.	



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

6.

6.1 The Audit & Risk Committee is asked to:

NOTE the position on procurement matters for the period 01.02.24 to 31.03.24;

NOTE the update regarding Purchase to Pay and achievement of PSPP target for period of 2023/24;



Agenda Item

4.5a

Audit & Risk Committee

Progress update on Grant Thornton recommendations

Dyddiad y Cyfarfod / Date of Meeting	Click or tap to enter a date.
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Vicki Wallace Deputy Director of Strategy and Partnerships
Cyflwynydd yr Adroddiad / Report Presenter	Linda Prosser Executive Director of Strategy and Transformation
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Linda Prosser, Executive Director of Strategy & Transformation

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
ILG	Integrated Locality Group
RAG	Red, Amber, Green

1. Situation / Background

- 1.1 In August 2021, the Health Board commissioned Grant Thornton to provide research, data and challenge to support the development of CTM2030. A number of clinical service planning workshops were held over a number of stages, to develop overall health board actions and pathway specific actions For implementation.
- 1.2 The Grant Thornton Report set out a number of overall health board actions and others specific to strategy groups/patient pathways. Appendix 1 sets out each of these actions.
- 1.3 It should be noted that since the production of the report, the organisational structure of CTMUHB has changed – many of the recommendations relate to the ILGs and their ways of working, which has now been superseded by the care group structure.

2. Specific Matters for Consideration

- 2.1 This paper attached as Appendix 1 aims to give an overview of progress to date in delivery of these recommendations. It gives the detail of the original action, progress to date, the organisational lead for the work, the work programme it falls within and a RAG rating.
- 2.2 As can be seen in Appendix 1, many of the recommendations are RAG rated “Amber” – to show they are in progress. As can be seen from the narrative, for the majority of actions, a great amount of progress has been made but the work is either not yet complete, or is tied into wider work programmes.
- 2.3 There are only two recommendations that are RAG rated “Red”, both of which relate to an absence of Level 2/3 obesity services for children and young people. As the report sets out, a business case is being developed to support this development, but there is no guarantee of funding.

3. Key Risks / Matters for Escalation

- 3.1 As stated above, good progress is being made against all recommendations excepting the two related to obesity services for children and young people.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Creating Health
	If more than one applies please list below:
	Inspiring People
	Improving Care
	Sustaining our Future
	Starting Well



Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	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 (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	Leadership If more than one applies please list below: Learning, Improvement and Research
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))	Effective If more than one applies please list below: Efficient Equitable Person Centred Timely Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	Yes - Refine 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: If appropriate this is taken forward through the individual areas of work
Cydraddoldeb a'r Gymraeg Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? / Equality and Welsh Language Have you undertaken an Equality and Welsh Language Impact Assessment Screening?	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: If appropriate this is taken forward through the individual areas of work



	Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	Yes (Include further detail below) There could be a negative reputational impact if the health board were not able to deliver on the recommendations set out within the original Grant Thornton report.	
Effaith Adnoddau (Pobl / Ariannol) / Resource Impact (People / Financial)	Yes (Include further detail below) Each recommendation relates to an area of work which has a resource impact.	

5. Recommendation

- 5.1 The Committee are asked to **NOTE** the overview set out within this cover paper.
- 5.2 The Committee are asked to **NOTE** the progress made against each of the recommendations from the Grant Thornton review which are set out within Appendix 1.

6. Next Steps

- 6.1 The work programmes aligned to each of the recommendations set out in Appendix 1 will continue to deliver the necessary actions to meet the recommendations within resourcing constraints.

Progress update on Grant Thornton recommendations

In August 2021, the Health Board commissioned Grant Thornton to provide research, data and challenge to support the development of CTM2030. A number of clinical service planning workshops were held over a number of stages, to develop overall health board actions and pathway specific actions for implementation. This paper aims to give an overview of progress to date in delivery of these recommendations.

Since the production of the report, the organisational structure of CTMUHB has changed – these recommendations do reference ILGs so this needs to now be replaced by the appropriate care group.

The Grant Thornton report set out a number of overall health board actions and others specific to strategy groups/patient pathways and this update report is structured in the same fashion.

Health Board Actions

	Recommendation	Progress to date	Lead & RAG Red – outstanding Amber – in progress Green - complete
1.1	A crucial role will be to facilitate better risk stratification of patients to aid the right channelling and most appropriate use of hospital and community resources consistent with national and local policy. Technologies to support stratification and decision making will become increasingly important.	Workshop planned for March 2024 to review and identify the appropriate tools to support our forward direction. A Population Health Management (PHM) approach has been implemented in CTM, supported by the Population Segmentation and Risk Stratification programme (PSRS). This aims to help Primary Care Clusters, Joint Partnership Boards, GPs, Care Groups, Strategy Groups and other partners to decide how best to use limited time and resources to deliver anticipatory and pre-emptive care for patients. This approach uses data from all bar one GP practice in CTM linked with secondary care data via the SAIL Databank. Two PHM projects in primary care have been successfully completed and evaluated, with further implementation projects initiated to test delivery models for the PHM approach in primary care. The priorities are now to: • Develop and implement new applications of PSRS data, including application in the community commissioning and redesign programme in CTM • Review current value and utility of PSRS data and explore wider PHM approaches including use in secondary care systems • Develop a sustainable and stable local approach and models of delivery • Use experience and learning to support the national PHM agenda including the creation of a national PHM framework for Wales	Phillip Daniels: Ongoing PHM Population segmentation and Risk stratification programme
1.2	Join up and map the NHS services delivering the solution including public health. Each pathway identified opportunities to communicate better	Health pathways programme initiated and service models in key specialties being changed to support eg ENT, Ophthalmology	Gethin Hughes: Clinical Pathways programme

	with other NHS led services often where duplication could be found. Working across acute, primary and community care services supporting each other and leveraging specialist expertise and technologies when needed would benefit both the workforce and the population served		
1.3	Join up and map the services with the local authority and the third sector. Each of the pathways fully recognise that its services are not delivered in isolation. If it is to realise the full benefit of services it needs to work with its partners to plan, develop and deliver health and care services. The Health Board must leverage the strong networks it has developed and identify third sector partners with whom to collaborate.	This has been partly completed. Mapping of services with local authorities underway as part of integrated care work being developed across the region. Exploration of solutions for third sector mapping and service delivery has commenced (e.g. Unite Us) and questions being asked to WG about a Wales wide position on this work as also integral and referenced as part of the newly published national social prescribing framework. Work closely with partners through the PSB, RPB and subgroups, the integration agenda, ILB, PLT and Leaders Group. Working with our community and third sector groups has hugely advanced through CTM Leaders Network	Linda Prosser: Ongoing RPB and Integrated Community services programmes
1.4	Standardise referrals and ways of working across the ILGs to ensure equity of treatment. Examples were presented throughout the workshop process of different patient experience and outcomes. To reduce unwarranted variation and to address inequalities a standardised referral process across the ILGs would prevent different experiences of care	Post OPC 2 moved to once for CTM care groups and standardising services across the HB. Clinical Pathways programme covers this too	Linda Prosser / Gethin Hughes: ACSP programme

1.5	Define a digital strategy across ILGs addressing community, primary and secondary care. With the improvement of data and the development of one strategy across all three ILGs there would be the ability to link various data sources and analyse them to derive insights to drive process efficiency, better integration, continuous quality improvement and adaptability. This is at the heart of an adaptive Learning Health System, which will enable the Health Board to future proof its contribution to the health and wellbeing of the population it serves.	A digital & data strategic delivery plan is currently being developed. This is dependent on some critical Health Board decision points in the first half of 2024 to determine the approach for delivery of an Integrated Care System for the region of CTM. The digital & data tools will be underpinned by a Local and National Data Repository that will support the development and delivery of our population health strategy. Capability and Capacity of analytical and data science resource is a constraint to the pace at which the Health Board can move.	Stuart Morris – Digital Workplan
1.6	Forming a comprehensive workforce strategy to impact the robustness of the workforce	Developed a workforce strategy in 2023 to fully address the issues raised in the report.	Hywel Daniel - closed
1.7	Making the best use of the estate, including looking at the services offered on the acute sites (eg. Trauma and orthopaedics) to make best use of the facilities /deployment of services to meet future demand.	Programme underway to reshape services across the HB, initial focus on Orthopaedics, ophthalmology, H&N and Urology	Gethin Hughes / Linda Prosser: ACSP programme
1.8	Developing a digital strategy and sufficient digital maturity to support a modern, forward-looking digital infrastructure. including developing a workforce to create strong capability in data management and analysis, and	A digital & data strategic delivery plan is currently being developed. This is dependent on some critical Health Board decision points in the first half of 2024 to determine the approach for delivery of an Integrated Care System for the region of CTM.	Stuart Morris – Digital Workplan

	clinical decision making to the top of its licence across all three ILGs		
1.9	Working with education providers to ensure the education, training and continuing professional development meets the needs of the staff so they are equipped with the skills to contribute fully to a digitally enabled health board	This is ongoing work, the health board has strong links with education providers and development of staff is a key work area of the People team.	Hywel Daniel – People Directorate workplan

1.10	Addressing governance, monitoring, and reporting across the organisation to improve communication and delivery of services	There is greater clarity on roles, responsibilities, accountability, and governance in relation to quality and patient safety and this will be further strengthened with the implementation of new cross CTMUHB structures resulting from the OCP. Monitoring quality and performance information now occurs at all levels of the organisation to provide 'Community/Ward to Board' reporting. Performance, risk and incident reports are received regularly by the Operational Management Board providing oversight that CTMUHB is meeting both internal and external targets for quality and performance, with relevant information disseminated at team meetings, leadership Team briefings and other digital channels. Consequently, the Health Board has a stronger strategic focus on quality and patient safety, which result in improved outcomes. Underpinning the strength of the enhanced governance arrangements is a well embedded Board Assurance Framework which brings together the organisation's strategic goals and the strategic risks which may prevent them from being achieved.	Gareth Watts - closed

Starting Well – Focus on Attachment and Wellbeing

	Recommendation	Progress to date	Lead & RAG Red – outstanding Amber – in progress Green - complete
2.1	Join up the NHS services across the ILGs that impact perinatal wellbeing and early years parental attachment. Parenting, Health Visitor services, Homestart, Mind, childcare settings and other projects are just as important for early identification. Also include therapies as part of this review of the services as Speech and language therapy must be involved from early months along with early language services to help prevent permanent neurological changes.	Work under the Parent-Infant Relationship service and the Peri-natal service development has supported the regional partners to establish good working relationships. The Early Years Transformation programme has strengthened the collaborative working arrangements with partners and within the Health Board The Public Health Midwife has advised that 48% of pregnant women going through the Bump start programme (weight management in pregnancy) have identified mental health problems. The Consultant Midwife has also confirmed that the only dedicated resource allocated to support women's mental health in the perinatal period is one 0.6WTE Specialist Midwife post for the whole of CTM.	Elle McNeil & Lucy Smothers: Born Well Strategy Group work plan
2.2	Identify and work with Local Authority partners, children's services and other public sector bodies to broaden and focus resources. There are pockets of good practice/training skills across these which	A multi-agency training programme for early years has been developed and delivered. Work is	Elle McNeil & Lucy Smothers: Born Well Strategy Group work plan

	we need to use as a baseline for improvement and progression and ensure that all relevant staff can identify those at risk and signpost to the relevant service	ongoing to maintain this work and revisit the skills baseline.	
2.3	Join up the third sector and LA services to harness the use of the third sector as they can provide many of the non-specialist services. Unless services are coordinated, they can remain fragmented during transition to other levels of services. Partnership working needs to include the third sector and the small community groups as well that provide invaluable, ongoing support and even early identification given the right support and seek to integrate our aims with other agencies/services to fully embed within the community	The Regional Children's Programme Board engages with 3rd sector, LA and health to ensure service provision is joined –up and coordinated. Sub-groups programmes of work include the third sector in order to provide a range of non-specialist services. Work within maternity and health visiting has engaged 3rd sector partners to provide non-specialist and peer support.	Elle McNeil & Lucy Smothers: Born Well Strategy Group work plan. Closed
2.4	Map the Health and Social Care services and handovers in place. Explore information sharing and improved communication during a 'hand over' period between services so that they run parallel to support families better. This way services will gain more knowledge of each other, share expertise and recognise that professionals that the families have built relationships with already are key	The Early Years Transformation Board have completed a comprehensive service mapping exercised covering 0-7 year olds (and parental services). Health visiting are currently reviewing transition points for families in order to improve information sharing between partners. Work within the Parent-Infant Service development includes mapping handover and escalation points and considers the role of the key relationship holder with the families.	Elle McNeil & Lucy Smothers: Born Well Strategy Group work plan
2.5	Link with infant feeding specialists where there are breastfeeding challenges. Successful and supported breastfeeding experiences can protect against subsequent issues such as post-natal depression and the effects of birth trauma.	CTMUHB Infant Feeding Strategy has been developed with regional partners and is currently in the final stages of consultation.	Elle McNeil & Lucy Smothers: Born Well Strategy Group work plan

2.6	Improve service monitoring and develop robust reporting mechanisms. Currently reporting centres around referrals and thresholds however early intervention and prevention benefit from a more liberated way of practising. A redesign of the monitoring and reporting is required to capture earlier interventions.	Work is ongoing across CTMUHB to develop monitoring and reporting that focuses on health outcomes and patient experience through the use of PROMS and PREMS.	Elle McNeil & Lucy Smothers: Born Well Strategy Group work plan
2.7	Review and standardise the rigid and limited referral criteria. The limited timeframe for referral into the appropriate services means many patients don't receive the support they need.	Unclear what referral criteria relates to. All CTMUHB services operate within WG/ national referral guidelines.	Elle McNeil & Lucy Smothers: Born Well Strategy Group work plan. Closed
2.8	Define the Born Well strategy to consider the focus on supporting the parent infant relationship and make this as good as it can be, address the mental health needs of all pregnant women alongside the specialist work to achieve improvements in population mental health and wellbeing. Incorporate a recent CTMUHB regional attachment project which has mapped services, population needs, workforce gaps/training needs and parent views on attachment services that support the parent-infant relationship.	Due to internal restructures and staff changes this recommendation is no longer appropriate. Work is ongoing to develop a 0-25 year old strategy.	Elle McNeil & Lucy Smothers: Born Well Strategy Group work plan

2.9	Define a multi-disciplinary workforce plan and training plan to include therapies, social workers, family support workers, health visitors and third sector staff. A plan must include upskilling of existing staff in post to address mental health identification and prevention to ensure staff are equipped with the skills to work with the most vulnerable adults and children.	A multi-agency training programme for early years has been developed and delivered. Work is ongoing to maintain this work and revisit the skills baseline.	Elle McNeil & Lucy Smothers: Born Well Strategy Group work plan. Closed
2.10	Improve communication and signposting of services to families	Work is ongoing to develop CTMUHB website based information. A 'box-set' has been co-produced with families, 3rd sector and statutory partners to provide signposting, information and advice for families. The Bump, Baby and Beyond resource which was available for pregnant women has now been revised by Public Health Wales. There are two resources now available. Pregnancy –Birth. Every Child Your Pregnancy & Birth (pagesuite-professional.co.uk) Birth – age 2. Every Child – Newborn to Age 2 Resource Links Every Child (everychildwales.co.uk) The key messages for pregnant women and families with early years children will already be within these resources. The action should be for all professionals who interact with these families to be consistently delivering these messages, rather than making up different ones.	Elle McNeil & Lucy Smothers: Born Well Strategy Group work plan

2.11	Work with public health to create a Public Health Messages for Parents to realise that having a baby will have an impact on their mental and emotional health as well as their physical health	PHW 'Bump and Beyond' has been redeveloped inclusive of mental health and emotional wellbeing information. This is a nationally driven and directed as is Nutritional Skills for life. The Bump, Baby and Beyond resource which was available for pregnant women has now been revised by Public Health Wales. There are two resources now available. Pregnancy –Birth. Every Child Your Pregnancy & Birth (pagesuite-professional.co.uk) Birth – age 2. Every Child – Newborn to Age 2 Resource Links Every Child (everychildwales.co.uk) The key messages for pregnant women and families with early years children will already be within these resources. The action should be for all professionals who interact with these families to be consistently delivering these messages, rather than making up different ones.	Elle McNeil & Lucy Smothers: Born Well Strategy Group work plan. Closed

Growing Well – Focus on Healthy Weight in children

	Recommendation	Progress to date	Lead & RAG Red – outstanding Amber – in progress Green - complete				
3.1	Join up existing NHS services by mapping all the existing services across public health, the local authority and all three ILGs. A next step will be to also understand the third sector services, improve links with Sport Wales and Public Health. The workshop surfaced parallel initiatives with different funding streams. On a very practical level stories were exchanged at the workshop on the movement of portable equipment which can be taken to different sites improving access to patients, understanding these services across the ILGs will help community access across all ILGs rather than in pockets.	Mapping has been undertaken by PHW Healthy Weight lead in order to inform the development of a regional approach to healthy weight on a whole systems basis. The Whole Systems Approach feeds into our CTM Healthy Weights Strategy Steering Group along with CTM anchor institution (what’s happening on CTM sites for staff and visitors) and clinical services for Adults and Children.	Elle McNeil & Emily Payne: Growing Well Strategy group work plan. Closed				
3.2	Clarify mechanisms to identify, predict and risk stratify children across Tier 1 services, in primary care, from population health data, the national child measurement programme and direct referral.	The Healthy Weight Healthy Wales Strategy (HWHW) was first published in November 2019, and would have informed Grant Thornton’s work. Level 1 services are defined as follows: Table 1: Children, Young People, and Families Weight Management Pathway 20 <table><tr><th>Level</th><th>Description</th></tr><tr><td>1</td><td>Self-Directed support Self-directed, support for achieving or maintaining a healthy weight. This could support to develop parental confidence and skills improve diet, increase physical activity or play and reduce the amount of time spent being sedentary.</td></tr></table>	Level	Description	1	Self-Directed support Self-directed, support for achieving or maintaining a healthy weight. This could support to develop parental confidence and skills improve diet, increase physical activity or play and reduce the amount of time spent being sedentary.	Elle McNeil & Emily Payne: Growing Well Strategy group work plan. Closed
Level	Description						
1	Self-Directed support Self-directed, support for achieving or maintaining a healthy weight. This could support to develop parental confidence and skills improve diet, increase physical activity or play and reduce the amount of time spent being sedentary.						

		Level 1 services are not about risk stratification and referral. They are about universal opportunities for families to access healthy food options and options to increase physical activity	
3.3	Ensure critical success factors and key performance indicators are identified, standardised and routinely measured for key programmes like HENRY. These standardised programmes should be rolled out across all three ILGs	Current there are two programmes running in CTM at Level 1, these programme are age and locality specific. Therefore, patients over the age of 5 in Bridgend and RCT and over the age of 7 in Merthyr are unable to access Level 1 services. HENRY (0-5 years) – CTM wide – fixed term funded until March 2025  HENRY.docx Merthyr PIPYN (3-7 years) – Merthyr Tydfil only – fixed term funded until March 2025 by Public Health Wales as part of a multi-centre research project.  Merthyr PIPYN.docx These services are overseen by Public health and have each developed their outcome measures. The funding for both programmes is due to end in March 2025.	Elle McNeil & Emily Payne: Growing Well Strategy group work plan
3.4	Identify, map and signpost services including transitions and escalation processes between Tier 1, 2 and 3 services and ensure	Mapping has been undertaken by PHW Healthy Weight lead in order to inform the development of	Elle McNeil & Emily Payne: Growing Well Strategy group work plan. Closed

	there is a clear, standardised referral process across all three ILGs, identifying children of school age.	a regional approach to healthy weight on a whole systems basis. As outlined in recommendation 3 there is inequitable access to Level 1 weight management service across the region and there is no Level 2 or 3 services available in CTM. Work is underway to develop a business case for a comprehensive children and young person's weight management service in line with the All Wales Weight Management pathway. The proposals for a weight management service for children has been presented to the Improving Care Board and the Creating Health Board.	
3.5	Define the size, scope and organisation of Tier 3 services for CTMUHB, clarifying if it is a hospital or a community-based service. Clear roles for clinical staff are needed, such as ACPs, Specialist Nurses and AHPs and the workforce plan must be reviewed to ensure adequate staffing now and in the future.	A healthy weight/ child obesity service specification has been worked-up into a business case. Due to financial constraints the service is not being taken forwards. February 2024 update: There are no Level 2/3 services for CYP and Families in CTM, even though this is a requirement in the HWHW delivery plan 2022-24. A business case is being prepared to go to the Creating Health Board – but there is no guarantee of any funding to support this.	Elle McNeil & Emily Payne: Growing Well Strategy group work plan
3.6	Join up and consolidate work with the Born Well pathway to identify and mitigate risk during pregnancy and support mothers to breastfeed. Low breastfeeding rates have been linked to increased rates of child obesity and there is an opportunity to develop a	CTMUHB Infant Feeding Strategy has been developed with regional partners and is currently in the final stages of consultation.	Elle McNeil & Emily Payne: Growing Well Strategy group work plan

	transformation programme for sustaining out-of-hospital breastfeeding rates.	The breastfeeding strategy will also feed into the CTM Healthy Weight Strategy Steering Group via the clinical services arm.	
3.7	Introduce universal and specialised workforce training programmes that support the effective use of available services, such as school nursing and health visitors. By linking health visiting services such as Bump and post-natal services such as Flying Start, the workforce can be supported to identify overweight children and support parents to manage their children's weight during the first consultation.	MECC training has been undertaken across health visiting services to discuss mental health, obesity and smoking at all contacts. This includes sign-posting to appropriate services/ 3rd sector/ LA partners delivering healthy lifestyle support in their area. Work is ongoing to join-up transition between school nursing and health visiting. A CYP healthy weights steering group has been established, chaired by our lead for school nursing, to develop this area of work. This group feeds into the CTM Strategy Steering group via the "clinical services" arm.	Elle McNeil & Emily Payne: Growing Well Strategy group work plan
3.8	Develop individualised care plans for more severely affected children as a minimum offer across all ILGs.	As outlined in recommendation 3 and 4 there is inequitable access to Level 1 weight management service across the region and there is no Level 2 or 3 services available in CTM. Work is underway to develop a business case for a comprehensive children and young person's weight management service in line with the All Wales Weight Management pathway. It has been recommended to the C&F care group paediatric lead that the medical assessment and management of obesity is looked into to ensure that there is standard good practice across the health board.	Elle McNeil & Emily Payne: Growing Well Strategy group work plan

3.9	Develop a data-led reporting framework and governance structure which brings all parties across health, social care, Public Health and local government to review progress, reflect and refresh.	Public Health Wales has developed a Minimum Data Set by which health boards have to report progress against adult weight management services every 6 months from April 2024. A minimum data set for CYP and Families weight management services is in development.	Elle McNeil & Emily Payne: Growing Well Strategy group work plan
3.10	As part of one governance structure explore and invest in new initiatives, such as: 1. Defining the role of local community hubs to deliver services within a community, thereby fostering peer support, helping to reduce stigma, and facilitating the co-ordination of care 2. Engaging local non-health partners with Local Authority support to discuss food policy, such as fast food outlets and opportunities across education. By working together with Public Health to co-ordinate Welsh government campaigns and engage local businesses such as supermarkets, healthier lifestyles will be promoted 3. Considering the use of technology to support healthier lifestyles in pregnancy, such as online tools to support families with weight issues, and nudge psychology, such as the use of digital coins for families making successful changes	This work is being taken forward via the Healthy Weight Strategy Steering group and whole systems approach being led by PHW and supported by the strategy group.	Elle McNeil & Emily Payne: Growing Well Strategy group work plan
3.11	Review a system wide approach that is community owned to achieve engagement, not proprietary from the outset.	This work is being taken forward via the Healthy Weight Strategy Steering group and whole systems approach being led by PHW and supported by the strategy group.	Elle McNeil & Emily Payne: Growing Well Strategy group work plan

Living Well – Focus on Colorectal Cancer

	Recommendation	Progress to date	Lead Red – outstanding Amber – in progress Green - complete
4.1	At a higher level the overarching governance with three separate ILGs does not lend itself to integrated working. This influences all of the actions below and should be considered as an action to solve in parallel to the practical actions set out.	Plans in place to move to a single MDT, implementation of robotic surgery for CTM at RGH, creation of a Digestive Diseases Directorate to coordinate a single pathway design	Tarek Allouni: Planned Care Group work plan
4.2	Standardise the pathway from GPs in primary care through to surgery and post-surgical care. This could be achieved through a full pathway mapping exercise.	Plans in place to move to a single MDT, implementation of robotic surgery for CTM at RGH, creation of a Digestive Diseases Directorate to coordinate a single pathway design	Tarek Allouni: Planned Care Group work plan
4.3	Provide clarity on referral pathways and vetting to ensure they are followed across the ILGs. According to clinicians, patients are often coming into secondary care having not been guided by NICE threshold guidelines. The Health Board must establish a clear referral process and this needs to be communicated with referrers with clear instructions on when and how patients should be treated within secondary care. Referrers should be further supported with specific training to reduce the pressure on secondary care services. Digital connectivity is critical for this to succeed and must form part of the digital solution.	Plans in place to move to a single MDT, implementation of robotic surgery for CTM at RGH, creation of a Digestive Diseases Directorate to coordinate a single pathway design Development of Health pathways to support key specs underway as part of GI pathways Audit	Tarek Allouni: Planned Care Group work plan
4.4	Define a clear strategy on Diagnostics including looking at site, investment, and workforce development. • Site - Strategic partnerships with other organisations around Diagnostic and Community Hubs; how many and where • Investment - Maximise interoperability including digital radiology and pathology networks which facilitate reporting and automated screening	Service developing clinical strategy with a new model evolving as part of a single service for CTMUHB. Implementation of robotic surgery and single MDT has commenced the hub model.	Tarek Allouni: Planned Care Group work plan

	• Workforce – ensure a systematic approach to workforce development and deployment, by training sufficient nurse endoscopists, CT Colographists, and reporting radiographers. Staffing three sites is unlikely to be sustainable in the longer term.	Endoscopy plan for increased capacity and review of workforce is being progressed.	
4.5	Manage demand by standardising timed pathways to remove current inequity and facilitate effective demand management. • consider patient navigators • create risk stratified non two week wait standardised pathway • systematise one stop clinic approach to two week wait referrals • ensure deprived populations get the same access to care as more affluent populations • uniform follow up protocols and "survivor" support	Plans in place to move to a single MDT, implementation of robotic surgery for CTM at RGH, creation of a Digestive Diseases Directorate to coordinate a single pathway design Development of Health pathways to support key specs underway as part of GI pathways Audit	Tarek Allouni: Planned Care Group work plan
4.6	Review the immediate administrative workforce supporting the clinical workforce. Including a review of booking systems, processes and digital skills.	Workforce review to be undertaken as part of the focus on digital enablers for clinical services. All services and support will require review and workforce plan.	Tarek Allouni: Planned Care Group work plan
4.7	Establish a standardised MDT approach with annual review and comparison across all colorectal MDTs in the Board. The Health Board will need to consider holistic, patient centred care and direct referrals to relevant external agencies for non-clinical support. Currently non-clinical multidisciplinary meetings across colorectal teams are not completed due to a lack of administrative resource. This should be considered as part of step 6 above.	Plans in place to move to a single MDT, implementation of robotic surgery for CTM at RGH, creation of a Digestive Diseases Directorate to coordinate a single pathway design Development of Health pathways to support key specs underway as part of GI pathways Audit	Tarek Allouni: Planned Care Group work plan
4.8	Create and offer a better patient engagement with patients, relatives and carers to support them through treatment and improve patient experience. This includes, but should not be limited to, psychological and body image support, self-management techniques, anxiety, and fatigue management. Investing in the	The service is actively discussing to progress as part of the clinical strategy and new model. Includes WISE, 3Ps and 111	Tarek Allouni: Planned Care Group work plan

	existing workforce through training is required to support patients effectively in all areas		
4.9	Provide a digital strategy for investment in digital infrastructure and an electronic referral system that allows two way sharing of patient information between all points of contact for an integrated service. Two patient administration systems (PAS) systems are currently in operation across Bridgend and Merthyr. Across the two systems, clinicians can't always find patients, or their whole records. Nor are they able to document additional information into both systems after seeing a patient. This can often lead to patients being the conduit having to pass information from one clinician to the next which results in information gaps and clinicians not having access to the full picture of the patient. Information sharing and having a single PAS that works across all points of delivery constitutes the biggest barrier to running a single service at present.	Digital enablers are priority for the organisation. Service will be a priority for roll out: WPRS WPAS Digital dictation	Tarek Allouni: Planned Care Group work plan
4.10	Consider the creation of an elective hub with a single patient tracking list and pooled lists. The implications of this would be to develop an overarching colorectal department across all CTMUHB. One department, and potentially even Copyright Grant Thornton UK LLP 37 Commercial in confidence a single site centre of excellence would allow for the pooling of limited workforce resource, particularly for on call rotas, and improve outcomes for emergency patients. The Health Board should review its current Estates Strategy, prioritise existing space to deliver elective activity, and ensure that current facilities are maximised to their full utilisation.	Plans in place to move to a single MDT, implementation of robotic surgery for CTM at RGH, creation of a Digestive Diseases Directorate to coordinate a single pathway design Development of Health pathways to support key specs underway as part of GI pathways Audit Review of future model of Gen Surge part of ACSP and linked to GIRFT recommendations on Laparotomy model	Tarek Allouni: Planned Care Group work plan
4.11	Introduce a standardised perioperative medicine approach to embrace shared decision making. There is also opportunity for better alignment with other NHS services. There is a need to	Being assessed as part of IMTP planning for service.	Tarek Allouni: Planned Care Group work plan

	establish prehab services for all chronic conditions, supporting patients with wider lifestyle changes beyond physical exercise. This will provide optimisation for the most deprived quintiles, clear rehabilitation plans for complex cases agreed with all partners before surgery and wider lifestyle interventions before and continuing after surgery to impact population health		

Living Well – Focus on Lower Limb Musculoskeletal Disorders

	Recommendation	Progress to date	Lead & RAG Red – outstanding Amber – in progress Green - complete
5.1	Join up NHS services across the Heath Board to simultaneously improve productivity and patient experience through the better integration with other NHS services. Avoidable admissions have been noted as an area to address and increased investment in the Pain Management service would help tackle this, a service which provides real value to patients but does not currently have the resource to meet demand. There is an opportunity for the Heath Board to simultaneously improve productivity and patient experience through the better integration with other NHS services. Avoidable admissions have been noted as an area to address and increased investment in the Pain Management service would help tackle this, a service which provides real value to patients but does not currently have the resource to meet demand.	Use of WISE as alternative pathway for Chronic Pain service Regional pathway in place for lower limb arthroplasty and single mode for patient information Implementation of First Contact Practitioners in Primary Care GIRFT to support development of workplan	Tarek Allouni: Planned Care Group work plan. Closed
5.2	Third sector services are currently disjointed, both in pre and post medical interventions. The Health Board should look to make better use of third-party organisations like Versus Arthritis and NERS/Escape in prehab and pain pathways respectively which has been undertaken in other areas of Wales.	Opportunity with 3 rd sector to be assessed in 24/25 as part of restructure of service. 3 rd sector link to regional programmes.	Tarek Allouni: Planned Care Group work plan
5.3	Standardise referral pathways and implement a single point of access for all referrals to a triage process led by a consultant and AHP putting in place a Global "First Contact" approach. Aim for the majority of patients to be managed locally out of hospital and wrap support services (strength/conditioning, balance, pain management,	Use of WISE as alternative pathway for Chronic Pain service Regional pathway in place for lower limb arthroplasty and single mode for patient information	Tarek Allouni: Planned Care Group work plan. Closed

	joint injections, social prescribers) around this. Consider role of community hubs. It has also been noted there are issues disaggregating the MSK service from Swansea Bay. The Health Board should look to prioritise a standardised MSK pathway to give clarity to both staff and patients and reduce the risk of avoidable admissions. All referrals should go through an initial, single point of contact to ensure patients are directed appropriately and consistently across the three ILGs.	Implementation of First Contact Practitioners in Primary Care Use of Health Pathways to have single process across CTM GIRFT to support development of workplan	
5.4	Create trauma capacity over weekends and develop a staffing model to support this. Virtual fracture clinics run by ACPs may free workforce capacity to deliver this. Co-ordination across the ILGs will help deliver this service.	Additional Trauma lists in place Plans for virtual fracture clinic being developed	Tarek Allouni: Planned Care Group work plan
5.5	Creation of an Elective Hub to allow the consolidation of the workforce, with all three hospital sites currently struggling to manage rotas. This would need to be managed carefully with demand for trauma services but, by pooling resource, the Health Board will improve efficiency in delivery of orthopaedic surgical activity, driving the reduction of the elective backlog. As part of this change and as a next step day case joint surgery could be considered	In place at RGH for primary Arthroplasty and exploring an upper Limb hub at POW and Ankle and Feet at PCH fits with regional work and day case hips and knees being undertaken	Tarek Allouni: Planned Care Group work plan
5.6	Standardise an approach to perioperative medicine as the majority of MSK treatment should be delivered outside of secondary care and there is a significant opportunity for the Health Board to improve preventive care, with a more holistic approach to clinical outcomes required. Prehab services are not currently funded across CTM. These are key to improving prevention, and looking forward, offsetting morbidity over the coming years.	Regional programme in place with focus on prehab programme	Tarek Allouni: Planned Care Group work plan

5.7	MSK conditions are often preventable rather than treatable. Training needs have been identified by the workforce across all services to educate patients on their health and the consequential effects from an MSK perspective, taking advantage of each point of contact. Investment should be made in developing these communications and making every contact count. Demographic analysis shows that there is a higher incidence of MSK conditions in areas of deprivation. Similarly, obesity is a big driver of MSK issues and also linked to areas of higher deprivation. There is an opportunity for the Health Board to increase its preventative work through patient access to nutritional advice and exercise classes. Whilst these do currently exist, they should be targeted in areas of deprivation and refocussed to ensure higher uptake	This will be addressed as part of the PHM model	Tarek Allouni: Planned Care Group work plan
5.8	Establish a bone health pathway that identifies those at risk of bone fragility and proactively manages as well as screens those with first fractures. Fall prevention services, focussing on strength and balance, are a key part to MSK health and further investment upstream is required with current access to services varied across the three ILGs. Osteoporosis services should also be considered for investment to reduce fractures. The workforce implications of this action would require the service to be geriatrician-led but delivered by ACPs and specialist Nurses linking into out of hospital pathways.	Proposal in place	Sarah Follows: USC Care Group work plan
5.9	Review the need for an Orthogeriatrics service with consultant support but delivered by a team of ACPs and AHPs which will encompass key pathways like fractured neck of femur (NoF), upper limb fractures and an inpatient pathway for elderly admitted patients with fractures not requiring intervention. This will reduce patient length of stay because of the interactions with the prehabilitation service, the #NoF pathway and ensuring appropriate plans for elderly trauma patients who do not require surgery. The Bone Health pathway is important in the latter two. It is not solely	Implemented in POW and proposal for PCH and RGH now in place	Sarah Follows: USC Care Group work plan

	appointing Geriatricians. They can supervise but it needs ACPs/Specialist Nurses and linking into out of hospital pathways.		

Ageing Well – Focus on Frailty

	Recommendation	Progress to date	Lead Red – outstanding Amber – in progress Green - complete
6.1	Implement an electronic Frailty Index (eFI) (see figure 15 below detailing a clinical frailty scale) to provide a standardised mechanism to identify and assess the population living with frailty. This will require multi-staff group training across both health and social care supported by a communication plan across the Health Board. Once in place the eFI will provide the ability to map the existing population and will help the ILGs to understand the distribution of fit/mild/severely affected groups in CTMUHB. The implications of implementing the eFI will mean care can be provided proactively rather than reactively and a focus can be placed on providing support to citizens whilst they have low level of needs i.e. before they become a 'patient'.	Work is ongoing between colleagues in the Digital Team, Primary, Community and Mental Health Care Group and Unscheduled Care Group to identify the potential for an electronic patient record that would be accessible to primary, community and ED services. Discussions are currently centred round where the record would be housed (e.g. PAS, Myrddin, Welsh Clinical Portal, Vision and GPOOH systems). The Rockwood Frailty scale is currently used in ED and further work would be needed to identify the potential for assessments using the scale to be accessible across primary and secondary care.	Kevin Duff & Raja Biswas; Aging Well Strategy group
6.2	Join up of existing NHS services. The workshop raised several queries about existing services with different funding streams. There was an immediate set of actions: • map all the existing services including social care across all three ILGs and relate these to the existing population. • add in third sector services and Public Health • review the movement of portable equipment which can be taken to different sites to improve access for patients Understanding these services across the ILGs will help community access across all ILGs rather than in a small number of areas.	Commissioning Group established for Implementation of the Integrated Pathway Model for CTM. Mapping and Gapping document developed (informed by previous extensive mapping of community services by the Ageing Well Strategy Group) to inform implementation of the regional model of integrated health and social care services across CTM.	Kevin Duff & Raja Biswas; Aging Well Strategy group. Clsoed

6.3	Standardise the existing frailty services to reduce unwarranted variation. The At Home Service, Care Home Locally Enhanced Service, Community Health and Well Being Teams including Social Prescribers exist across all three ILGs, but there is no standard way of working and care differs by locality. A standardisation of access statement is required as a first step. In the workshop an example was given about a patient who was seen with cognitive and language issues. They were discharged home without having been referred for full MDT assessment, even though this would have been available in another ILG.	Commissioning Group established for Implementation of the Integrated Pathway Model for CTM (see above). The RPB paper on the optimum CTM model for integrated services describes how “delivering health and social care services for the future will rely heavily on developing strong and sustainable primary and community services that are able to focus on prevention and early intervention, as well as providing rapid and intensive community support when needed”. The model therefore consists of two pathways: Urgent Community Response and Population Health Management. The commissioning group will work through existing structures, specifically the Adults Board and Integrated Leadership Board the onto the RPB, to develop a holistic implementation plan in line with the approach set out above and ensure its delivery. The emphasis is on alignment, delivery and making the whole greater than the sum of the parts.	Kevin Duff & Raja Biswas; Aging Well Strategy group
6.4	Consider equality of treatment and unwarranted variation for strokes. Strokes can have a big impact on a patient's frailty, but the lack of a stroke-focused early supported discharge (ESD) in Bridgend, despite availability in other parts of CTMUHB should be reviewed alongside the Welsh government stroke plan and recommendations.	ESD service has been extended with additional funding to cover the Bridgend area, providing support for stroke patients in the community following discharge from POWH. Service became operational and started to take referrals in January 2024. This now means there is an ESD service covering the whole of CTM UHB area, taking referrals from acute stroke wards at POWH and PCH.	Kevin Duff & Raja Biswas; Aging Well Strategy group. Closed

6.5	Standardise Advanced Care Planning including ceiling of care and last days of life. This should be jointly considered with the end of life workstream. As part of the solution, you should consider implementing a signed off care plan for all moderate or above frailty as a minimum.	ACP currently being implemented in community by primary care and care homes. Implemented ACP and ceiling of care in community hospitals. Frailty workshops established with input from specialist palliative care team to input to the work around acute and community services.	Kevin Duff & Raja Biswas; Aging Well Strategy group
6.6	Establish a shared digital vision across primary, secondary and community care services establishing a single patient record accessible across all ILGs with a mechanism for joint data sharing.	Part of wider development around digital vision for CTM UHB. Infrastructure issues to be addressed, feeding into work around acute and community frailty.	Kevin Duff & Raja Biswas; Aging Well Strategy group
6.7	Risk stratify the ageing population and consider what the standardised offer will be across all ILGs . It is important to remember that it will not be necessary to offer everything to everyone. Risk stratification can be in terms of: • most complex • moderate complexity • those who are simple/fit in terms of contact for case management • MDT discussion • care co-ordination • individualised plan review • regular touch points • scheduled follow ups • medication review • falls assessment • cold weather checks	Extensive work undertaken by public health team on the development of a risk stratification and population health management tool. The commissioning programme for the CTM model of integrated community services (see 2 & 3) will consist of two pathways: urgent community response and population health management. The population health management pathway will improve population wellbeing by seizing the opportunity of data-informed planning and delivery of proactive care to achieve maximum impact for the health and wellbeing of the population. Linked datasets used to segment, stratify, and model the local “at risk” and “rising risk” cohorts that in turn are used to design, target and personalise interventions to deliver proactive care.	Kevin Duff & Raja Biswas; Aging Well Strategy group

6.8	Establish a single point of entry via community hubs based in each ILG. It is necessary to review and consider where services are best delivered, such as addressing frailty at the Front Door in acute setting, at home services in the community and one stop frailty assessments in the community. Care co-ordination and navigation can be used to standardise access, transitions and minimise hand offs or multiple attendances for the individual across time and location. Additionally, access to memory, strength and conditioning, balance and befriending services should be co-located where possible with other services and included within the care pathway, as community staff often see people who have repeated appointments with different departments without any link between them	Clinical Navigation Hub established providing a range of services: • DN call taking • Recognition of life extinct • Care homes pathway • GPOOH • Urgent and Emergency Dental Service • Professional Advice Line • 11 Press 2 • COVID Anti-viral Assessment Service • ED Redirection • PTAS Paramedic on Scene • PTAS C3 Remote Triage • Emergency Supply of Palliative Care Medicines. Some of the next steps planned for the CNH include: • Integration with other community resources, includes collaborative working with LA partners • Will become single point of access for all community resources • Further develop digital and remote services support patients remaining safe at home. The above work and wider commissioning programme for the CTM model of integrated community services will also be informed by work to develop the acute frailty model (including front door in acute settings).	Kevin Duff & Raja Biswas; Aging Well Strategy group

6.9	Workforce training is required to ensure all staff, from community coordinators and GP receptionists to consultants, can identify frailty needs, signpost individuals to relevant services, be familiar with escalation triggers and understand the importance of health checks.	Workforce communication, training and awareness of the new pathway will be developed as part of the commissioning programme for the integrated service model.	Kevin Duff & Raja Biswas; Aging Well Strategy group
6.10	A review of the workforce plan is needed alongside a standardised frailty service across healthcare optimising the use of non-medical workforce with Advanced Clinical Practitioners, Specialist Nurses, non-clinical practitioners and volunteers supported by medical teams.	Workforce plan to be developed as part of commissioning programme for model of integrated community services. Use of non-medical workforce (e.g. ANPs) to be considered as part of the development of frailty services in acute settings.	Kevin Duff & Raja Biswas; Aging Well Strategy group
6.11	An implementation strategy for technology to support frail individuals is needed to aid patients, relatives and carers to improve their own digital health awareness and increase the partnership of care. This should include assistive technology, and patient facing digital services for access and education	Development of assistive technology and mobile response service will form part of the commissioning programme for the urgent response pathway in the integrated community services model. This will include installation of lifeline monitoring and a mobile response to provide assistance for people in their homes (e.g. falls, welfare check etc.).	Kevin Duff & Raja Biswas; Aging Well Strategy group

Dying Well – Focus on Last 12 Months of Life

	Recommendation	Progress to date	Lead Red – outstanding Amber – in progress Green - complete
7.1	Map and join up the existing NHS services across health and social care within each ILG including integration with the local authority and better coordinated support to the Care Home sector. The hospice at home service is not available across all ILGs, but the use of third sector for palliative care is good across the Health Board. There is a general feeling among respondents that the workforce is well engaged and highly skilled but lacks the resource and integrated operations to provide the service that patients need.	Service Mapping and development undertaken through the CTM UHB Palliative and EOL Care Delivery Group. Detailed mapping of Specialist Palliative Care Service undertaken to inform re-modelling of service in north of CTM. Commissioning review of third sector SLAs underway to enable an informed approach to the commissioning of third sector services across the Health Board, ensuring QSRE.	Kevin Duff & Raja Biswas; Aging Well Strategy group
7.2	Educate and train health care, social care and care home staff on core principles of the last year of life, last months of life and last days of life to enable all staff to deliver basic care, record interventions and escalate as appropriate. This is for all individuals and not disease specific, and this approach must be systematised. There is currently a lack of consistency in identifying end of life patients across the Health Board and it should become 'everyone's' role. Acute staff must become more aware of patients' end of life needs so they can be referred or discharged appropriately.	Widespread work undertaken across the Health Board to deliver education and training for staff in acute, community and primary care services on the delivery of EOL care. The training programme included face to face group and online training and promotion of the use of the care decisions tool. Senior clinical time is being identified to scope and identify the range of educational needs and develop a package to put in place. Extensive additional training and support has also been provided across the Health Board on the issue of bereavement.	Kevin Duff & Raja Biswas; Aging Well Strategy group

7.3	Wider communication is needed with the public but also with staff to understand the services available and the roles of key staff. Communication can be difficult from multiple services to the patient, relatives, carers, community services, GPs and care homes. An example given in the workshop was when a patient is under the care of palliative and oncology services, they can be confused in the care and advice offered. There is often confusion around when patients should be referred to specialist palliative care nurses.	Detailed work is currently underway to scope and clarify the patient pathway for specialist palliative care in CTM UHB. The resultant plan for the service will enable clear communication with patients and other services on referral to the SPC team around the 4 key pillars of provision: • SPC In-Patient Beds • Acute In-reach • Education and Awareness • Community Services (inc. day provision). Education and training across the Health Board has also enabled communication with staff. Promotion of public awareness surrounding death including Dying Matters Week. Patient and family feedback via Civica.	Kevin Duff & Raja Biswas; Aging Well Strategy group
7.4	Build on the work already started on the six steps of life and introduce standardised Advanced Care Planning (this will overlap with Frailty).	ACP currently being implemented in community by primary care and care homes. Implemented ACP and ceiling of care in community hospitals. Frailty workshops established with input from specialist palliative care team to input to the work around acute and community services. The CTM UHB Palliative and End of Life Care action plan reflects the six steps of life: Step 1 Discussions as the end of life approaches Step 2 Assessment, care planning and review Step 3 Co-ordination of care Step 4 Delivery of high quality care in care homes Step 5 Care in the last days of life	Kevin Duff & Raja Biswas; Aging Well Strategy group

		Step 6 Care after death. The action plan is overseen and coordinated through the CTM UHB Palliative and End of Life Care Delivery Group which has identified 4 key areas: • Care Decisions Guidance • Bereavement Services • Education, Training and Information • Patient Feedback and Communication.	
7.5	Improve data capture across all the ILGs and identify data sets which reflect required outcomes, collect and evaluate progress. There is no robust coordination between hospital and GP databases. Whilst GPs can upload notes to the Welsh Clinical Portal, this is a manual task and requires duplication of efforts and therefore is not always followed through.	Last Year of Life Dashboard - Value in Health (nhs.wales) Last Year of Life Dashboard now in place providing a range of information on patient activity in last year of life (mostly secondary care with exception of 111 Calls and GP OOH data).	Kevin Duff & Raja Biswas; Aging Well Strategy group. Closed
7.6	Implement a standardised end of life care offer ensuring equity of access for all. This should address the Hospice at Home out of hours service (not available in all ILGs) with a single point of contact for advice and signposting to support. A review of the front door presence for those patients admitted to hospital and a review fast track services which are not currently providing access to services quickly enough is also needed	Development of a CTM UHB Palliative and EOL Plan will include options for implementing a revised model for specialist palliative care services. Linking into the development of acute frailty services in secondary care to enable review of patients at front door of hospital.	Kevin Duff & Raja Biswas; Aging Well Strategy group
7.7	Undertake a review of access to end of life services for to ensure diversity and inclusion of all patients. There is a social and cultural reluctance to discuss planning for ill health and end of life and this should be addressed for all patient groups in order to improve health inequalities across the region.	Review of access to form part of Palliative Care and EOL Plan.	Kevin Duff & Raja Biswas; Aging Well Strategy group

7.8	Establish a shared digital vision across primary, secondary and community care across all ILGs and implement digital data collection on a simplified accessible platform.	This is part of the wider digital strategy being developed across the Health Board.	Kevin Duff & Raja Biswas; Aging Well Strategy group
7.9	Reduce unnecessary interventions (diagnostics, procedures, medication and attends) and hospital visits for identified patients. Any changes to operational delivery will be in line with the wider integration with Welsh Government National Programme for end of life care. For many patients, oncology will take the lead on decision making	Implementation of ceiling of care plans in community settings and treatment escalation plans across acute settings to reduce unnecessary interventions and hospital visits. Awaiting establishment of WG National Programme by NHS Executive (national workshop arranged to take place on 1 st March).	Kevin Duff & Raja Biswas; Aging Well Strategy group
7.10	Review workforce plans across health and social care to ensure they are staffed to deliver the service. The current hospice at home service needs additional resource to provide a more robust package of care.	Review of workforce and to form part of Palliative Care and EOL Plan.	Kevin Duff & Raja Biswas; Aging Well Strategy group



Agenda Item

5.1

Audit & Risk Committee

Annual Review: Risk Management Framework

Dyddiad y Cyfarfod / Date of Meeting	18/04/2024
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 / Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	Endorse for Board Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Board Members Via Email	26.3.2024-8.4.2024	Endorsed
Executive Leadership Group	15.4.2024	Reviewed and Management Sign Off received
Audit & Risk Committee	18.4.2024	Pending
Health Board Meeting	30.5.2024	Pending

Acronyms / Glossary of Terms	



1. Situation /Background

- 1.1 As good governance on an annual basis the Health Board reviews its risk management framework which is made up of the following suite of documents:
1. Risk Management Strategy
 2. Board Assurance Framework
 3. Risk Appetite Statement
 4. Risk Domain & Scoring Matrix
 5. Risk Management Policy
 6. Risk Assessment Procedure
- 1.2 This annual review focusses on items one to four and during April 2023, Board Members considered these areas of the risk management framework in terms of its continued adoption for a further 12 months.
- 1.3 The Risk Management Policy and Risk Assessment Procedure were reviewed and approved in 2022 with the next review date set for 2025. They remain extant.

2. Specific Matters for Consideration

- 2.1 This section is broken down into the review of the relevant component parts of the framework.

2.2 ***Risk Management Strategy (Appendix 1)***

The purpose of the strategy is to provide guidance to all staff on the management of strategic and operational risks and the Board Assurance Framework within the organisation.

The Strategy has been subject to amendments to Appendix 2 and 5.

1.3 ***Risk Appetite Statement (Appendix 2 of the Risk Management Strategy)***

An organisation's risk management framework harnesses the activities that identify and manage uncertainty, allows it to take opportunities and to take managed risks not simply to avoid them, and systematically anticipates and prepares successful responses. A key consideration in balancing risks and opportunities, supporting informed decision-making and preparing tailored responses is the conscious and dynamic determination of the organisation's risk appetite.

During the recent review of the Risk Appetite Statement, an additional "Innovation" domain was proposed. Following consultation on the review it has been suggested that in order to avoid potential duplication with the "Technical Advances" domain further work is needed before inclusion, also incorporating research and development definitions. Therefore it is

recommended that for this review the status quo remains and work will be undertaken during the year on these future developments.

1.4 Risk Domain Scoring Matrix (*Appendix 2 of the Risk Management Strategy*)

No changes proposed in this year's review.

1.5 Board Assurance Framework (BAF) (*Appendix 5 of the Risk Management Strategy*)

The BAF is an integral part of the system of internal control and defines the strategic/principal risks, which impact upon the delivery of Strategic Objectives/Goals of the organisation.

There were no changes to the concept of the BAF. There have been changes in year to Strategic risks that have been approved by the Board.

It should be noted that in April 2023 an Internal Audit review of the Board Assurance Framework resulted in an outcome of Substantial Assurance.

The BAF and current ten principal/strategic risks are captured in Appendix 5 of the Risk Management Strategy.

3. Key Risks / Matters for Escalation

- 3.1 The principal risks are outlined in the BAF, which is reviewed at all routine meetings of the Health Board. No new risks have been escalated at this time and no risks have been removed.

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

Impact Assessment		
Ansawdd Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality Have you undertaken a Quality Impact Assessment Screening?	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required.
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): Completed – No potential negative impact identified	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.	
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 endorse the following:

- **APPROVAL** of the Risk Management Strategy.
- **APPROVAL** the Risk Appetite Statement and agree that it is implemented for the next 12 months with assurance that it is set to

ensure that progress is being made to the 'risk appetite' the Health Board wishes to achieve.

- **APPROVAL** of the Risk Domain & Scoring Matrix and its continued application.
- **APPROVAL** that the Board Assurance Framework remains fit for purpose and appropriately reflects the strategic risk profile of the Health Board.

6. Next Steps

- 6.1 If endorsed for approval this will framework will be presented to the Health Board Meeting in May 2024 for approval.

RISK MANAGEMENT STRATEGY & BOARD ASSURANCE FRAMEWORK

Ref:	RM 01
Document Author:	Assistant Director of Governance & Risk
Executive Sponsor:	Director of Corporate Governance / Board Secretary
Approval / Effective Date:	30 th May 2024
Review Date:	30 th May 2024
Version:	Version 8 Draft

Target Audience:

People who need to review this document in detail	All Staff with the responsibility for undertaking risk assessments. All staff who approve risks as a risk owner or manager.
People who need to have a broad understanding of this document	All staff.
People who need to know that this document exists	All staff.

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	Date: 20.11.2020 Outcome: No potential negative impact identified.
Welsh Language Standard	Yes - If Standard 82 applies you must ensure a Welsh version of this policy is maintained.
Date of approval by Equality Team:	23.11.2020
Aligns to the following Wellbeing of Future Generation Act Objective	Provide high quality, evidence based, and accessible care

Approval Route:

Where	When	Why
Audit & Risk Committee	18 th April 2024	Endorse for Board Approval
Health Board	30 th May 2024	Approved

Disclaimer:

If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or CTM_Corporate_Governance@wales.nhs.uk

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1. Introduction and Aims

- 1.1 Cwm Taf Morgannwg University Health Board (CTMUHB) is committed to developing and implementing a Risk Management Strategy (and Board Assurance Framework) that will identify, analyse, evaluate and control the risks that threaten the delivery of its strategic objectives and delivering against its Integrated Medium Term Plan (IMTP). The Board Assurance Framework (BAF) will be used by the Board to identify, monitor and evaluate risks which impact upon strategic objectives. It will be considered alongside other key management tools, such as workforce, performance, quality dashboards and financial reports, to give the Board a comprehensive picture of the organisational risk profile.
- 1.2 The purpose of this document is to provide guidance to all staff on the management of strategic and operational risks and the Board Assurance Framework within the organisation.
- 1.3 It aims to:
- set out respective responsibilities for strategic and operational risk management for the Board and staff throughout the organisation;
 - set out responsibility for Board committees, in particular, the Audit and Risk Committee; and
 - describe the procedures to be used in identifying, analysing, evaluating and controlling risks to the delivery of strategic objectives;
- 1.4 The objectives of CTMUHB's Risk Management Strategy (and Board Assurance Framework) are to:
- minimise impact of risks, adverse incidents, and complaints by effective risk identification, prioritisation, treatment and management;
 - ensure that risk management is an integral part of CTMUHB's culture;
 - maintain a risk management framework, which provides assurance to the Board that strategic and operational risks are being managed effectively;

- maintain a cohesive approach to corporate governance and effectively manage risk management resources;
- minimise avoidable financial loss;
- ensure that CTMUHB meets its obligations in respect of Health and Safety and Quality and Safety;
- Manage all potential risks CTMUHB are exposed to;
- supports the calibration of risk scoring so the Health Board can achieve a consistent and moderated approach to risk assessment;
- supports an informed understanding of risk in order for the Health Board to be able to appropriately scrutinise risk treatment options; and
- compliment the Risk Management Policy and Risk Assessment Procedure.

2. Scope

2.1 The Risk Management Strategy (and Board Assurance Framework) covers the management of Strategic/Principal and Organisational risks and the process for the escalation of risks for inclusion on the Organisational Risk Register and Board Assurance Framework.

2.2 A risk can be defined as: “the chance of suffering harm caused by a hazard, loss or damage or the possibility that the CTMUHB will not achieve an objective”.

Risk is the uncertainty surrounding events and their outcomes that may have a significant effect, either enhancing or inhibiting:

- Achievement of aims and objectives
- Operational performance
- The meeting of stakeholder expectations

Types of Risk

2.3 **Strategic/Principal Risks:** are significant risks that have the potential to impact upon the delivery of Strategic Objectives and are reviewed and monitored by the Strategic Leadership Group (SLG), Board Committees and the Board.

- 2.4 **Organisational Risks:** are risks that are mainly operational in nature and arise from the CTMUHB's day-to-day activities.
- 2.5 The Board Assurance Framework (BAF) is an integral part of the system of internal control and defines the strategic/principal risks, which impact upon the delivery of Strategic Objectives/Goals of the organisation. It also summarises the controls and assurances that are in place or plans to mitigate them. The BAF aligns strategic/principal risks, key controls and assurances on controls alongside each of the Health Boards strategic objectives.
- 2.6 The BAF identifies the assurances reported to Board and Committees in relation to the strategic/principal risk identified. It also highlights the gaps in controls and assurances. This enables the development of an action plan for closing the gaps and mitigating the risks, which is subsequently monitored by the Board for implementation.
- 2.7 This Strategy applies to all Staff directly employed by CTMUHB and/or those that hold any form of contract (including agency, honorary, locum etc). The culture of risk management and discussion of risk with partners and stakeholders, where appropriate should be encouraged.
- 2.8 The Risk Management Strategy is intended to cover all the potential risks that the organisation could be exposed to.

3. Risk Management Organisational Structure

The Board

- 3.1 Executive Directors and Independent Members share responsibility for the effective management of risk and compliance with relevant legislation. In relation to risk management, the Board is responsible for:
- articulating the Strategic Objectives/Goals of CTMUHB;
 - articulating the Strategic/Principal Risks of CTMUHB;
 - protecting the reputation of CTMUHB;

- providing leadership on the management of risk;
- approving the risk appetite for CTMUHB;
- ensuring the approach to risk management is consistently applied;
- ensuring that assurances demonstrate that risk has been identified, assessed and all reasonable steps taken to manage it effectively and appropriately;
- reviewing and approving risks on the Board Assurance Framework;
- endorsing risk related disclosure documents;
- approving the Risk Management Strategy and Board Assurance Framework on an annual basis.

Audit & Risk Committee

- 3.2 The Audit and Risk Committee has a specific role in relation to undertaking an annual review of the effectiveness of the Risk Management Strategy and the Board Assurance Framework.
- 3.3 In relation to risk management, the Audit and Risk Committee shall review the establishment and maintenance of an effective system of internal control and risk management. In particular, the Committee will review the adequacy of:
- all risk and control related disclosure statements (in particular the Governance Statement), together with any accompanying Head of Internal Audit Opinion, External Audit Opinion and/or other appropriate independent assurance, prior to endorsement by the Board.
 - the structures, processes and responsibilities for identifying and managing clinical and non-clinical risks facing the organisation. This will be addressed by ensuring there is a periodical review that risk registers are in place and updated for corporate and clinical areas.
 - the Health Board's organisational risk register and the adequacy of the scrutiny of risks by assigned Committees. This will be addressed by ensuring all significant risks (i.e. those escalated to the organisational risk register scoring 15 or above or those not able to be managed locally) are assigned to a Board Committee for scrutiny, and ensuring that updates on actions to mitigate the risks are provided at each committee meeting.

- the Board Assurance Framework.
- the policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct and accountability requirements. By identifying and assessing regulatory, legal and code of conduct issues that could have been prevented by more effective management of risk and assurance of controls in place.
- the operational effectiveness of policies and procedures, through regular review of policies and procedures.
- the effectiveness of risk identification, management, escalation and monitoring. This will be addressed by reviewing the number of risk registers in place, the frequency of updates to the risk register and the escalation of high risks to the Care Group /Central Function and Organisational Risk Registers.

All Board Committees

3.4 All Board Committees have a role to play in ensuring effective risk management in particular they will:

- Receive and scrutinise risks and provide onwards assurance to the Board in relation to risks assigned to them to provide oversight and scrutiny.
- will receive updates in terms of actions taken to mitigate the risks, and provide feedback and challenge to risk owners on the actions taken and any further action required.

Executive Leadership Group (ELG)

3.5 The ELG undertake the following duties:

- Promote a culture within the Health Board, which encourages open and honest reporting of risk with local responsibility and accountability.
- Provide a forum for the discussion of key risk management issues within the Health Board.
- Ensure appropriate actions are applied to organisational risks.
- Enable risks which cannot be dealt with locally to be escalated, discussed and prioritised.
- Ensure Care Groups and Central Corporate Functions Risk Registers are appropriately rated and action plans agreed to control them.

- Review the risks on the Organisational Risk Register (those escalated to the organisational risk register scoring 15 or above or those not able to be managed locally) to determine whether they will impact on the Health Boards Strategic Objectives/Goals, and if so, the risk will be added to the Board Assurance Framework (BAF) aligned to the appropriate Strategic/Principal Risk.
- Review the Organisational Risk Register and Board Assurance Framework prior to its presentation to the Board and Committees as appropriate.
- Review and monitor the implementation of the Risk Management Strategy and Board Assurance Framework.
- Ensure that all appropriate and relevant requirements are met to enable the Chief Executive to sign the Governance Statement, outlines how risks are identified, evaluated and controlled, together with confirmation that the effectiveness of the system of internal control has been reviewed.
- Approve documentation relevant to the implementation of the Risk Management Strategy and Board Assurance Framework.
- Provide assurance to the Board that there is an effective system of risk management across the Organisation.

Care Groups / Local Services Groups / Corporate Central Functions Leads

- 3.6 Care Groups, Local Service Groups / Corporate Central Functions are responsible for risks within their areas of operation and providing assurance to the SLG on the operational management and any support required in relation to the management of risk.
- 3.7 These functions are responsible for the implementation of the Risk Management Strategy and relevant policies, which support the Health Board's risk management approach.
- 3.8 Specifically they will:
- promote a risk culture which encourages open and honest reporting of risk with local responsibility and accountability;
 - use the Datix Risk Management system for recording and reviewing risk.
 - ensure a forum for discussing risk, risk management and organisational learning is maintained within their system

group area of responsibility;

- co-ordinate the risk management processes which includes risk assessments, incident reporting, the investigation of incidents/near misses and the management of the risk register;
- ensure there is a system for monitoring the application of risk management within their area and that risks are treated in accordance with the risk grading action guidance contained in this document;
- update ELG on the management and mitigation of risk for their area;
- provide reports to the Management Board and appropriate Committee of the Board that will contribute to the organisational monitoring and auditing of risk;
- escalate service risks graded 15 and above all those not able to be managed to the Strategic Risk Owner for consideration and review at the ELG for escalation to the Organisational Risk Register and Board Assurance Framework;
- contribute to the organisational monitoring and auditing of risk;
- ensure staff attend relevant mandatory and local training programmes;
- ensure a system is maintained to facilitate feedback to staff on risk management issues and the outcome of incident reporting;
- ensure the moderation and calibration of risks across the Health Board to avoid duplication, ensure compliance and alignment with the Risk Management Strategy and ensure shared learning across the Health Board;
- review and updating of existing risks, consider new risks for inclusion and escalate/de-escalate risks as appropriate to the Executive Team Member assigned as the Strategic Risk Owner for the risk being escalated.

3.9 CTMUHB's 'Risk Management Process – Service to Board' is included at Appendix 3.

4. Duties

4.1 The following paragraphs set out the respective risk management duties and responsibilities for individual staff members.

All Staff

- 4.2 All members of staff are accountable for maintaining risk awareness, and identifying and reporting risks as appropriate to their line manager.
- 4.3 In addition, they will ensure that they familiarise themselves and comply with all the relevant risk management strategies and procedures for CTMUHB and attend/complete risk management training as appropriate.
- 4.4 They will:
- accept personal responsibility for maintaining a safe environment, which includes being aware of their duty under legislation to take reasonable care of their own safety and all others that may be affected by the Health Board's business;
 - report all incidents/accidents and near misses;
 - comply with the Health Board's incident and 'near miss' reporting procedures;
 - be responsible for attending mandatory and relevant education and training events;
 - participate in the risk management system, including the risk assessments within their area of work and the notification to their line manager of any perceived risk which may not have been assessed; and
 - be aware of the Health Board's Risk Management Strategy and Policy documents, and Board Assurance Framework and processes and the local strategy and procedures and comply with them.

All Managers (Leaders of Teams, Service Managers, Area Leads etc)

- 4.5 The identification and management of risk requires the active engagement and involvement of staff at all levels, as staff are best placed to understand the risks relevant to their areas of responsibility and must be supported and enabled to manage these risks, within a structured risk management framework.

- 4.6 Managers at all levels of the Organisation are therefore expected to take an active lead to ensure that risk management is embedded into the way their service/team/area operates. Managers must ensure that their staff understand and implement this Strategy and supporting processes, ensuring that staff attend relevant mandatory and local training programmes.
- 4.7 Managers must be fully conversant with the Health Board's approach to risk management and governance. They will support the application of this Strategy and its related processes and participate in the monitoring and auditing process.

Director of Corporate Governance

- 4.8 The Director of Corporate Governance will, with the support of the Assistant Director of Corporate Governance & Risk:
- work closely with the Chair, Chief Executive, Chair of the Audit and Risk Committee and Executive Directors to implement and maintain the Risk Management Strategy and Board Assurance Framework and related processes, ensuring that effective governance systems are in place;
 - work with the Board of CTMUHB to develop a shared understanding of the risks to the CTMUHB's strategic objectives/goals;
 - develop and communicate the Board's risk awareness, appetite and tolerance;
 - develop and oversee the effective execution of the BAF and ensure effective processes are embedded to rigorously manage the risks therein;
 - monitor the action plans and reporting to the Health Board and relevant Committees.

Executive Directors

- 4.9 Executive Directors are accountable and responsible for ensuring that their areas of responsibility are implementing this Strategy and related policies. Each Director is accountable for the delivery of their particular area of responsibility and will therefore ensure that the systems, policies and people are in place to manage, eliminate or transfer the key risks related to the Health Board's strategic objectives.

4.10 Specifically they will:

- act as strategic risk owner for risks within their remit escalated to the Organisational Risk Register;
 - use the Datix Risk Management system for recording and reviewing risk;
 - communicate to their staff the Health Board's strategic objectives and ensure that Care Group, Clinical Service Group and Corporate Departments and individual objectives and risk reporting are aligned to these;
 - ensure that a forum for discussing risk and risk management is maintained within their area which will encourage the proactive management of risk;
 - co-ordinate the risk management processes which include: risk assessments, incident reporting, the investigation of incidents/near misses and the management of the risk register;
 - ensure there is a system for monitoring the application of risk management within their area and that risks are treated in accordance with the risk grading action guidance contained in this document;
 - provide reports to the appropriate committee of the Board that will contribute to the monitoring and auditing of risk;
 - ensure staff attend relevant mandatory and local training programmes;
 - ensure a system is maintained to facilitate feedback to staff on risk management issues and the outcome of incident reporting;
 - ensure the specific responsibilities of managers and staff in relation to risk management are identified within the job description for the post and those key objectives are reflected in the individual performance review/staff appraisal process;
- and

- ensure that the BAF and the risk management reporting timetable are delivered to the Health Board.

Chief Executive

4.11 The Chief Executive as Accountable Officer of the Health Board has overall accountability and responsibility for ensuring it meets its statutory and legal requirements and adheres to guidance issued by the Welsh Government in respect of Governance. This responsibility encompasses risk management, health and safety, finance, and organisational control and governance.

4.12 The Chief Executive has overall accountability and responsibility for:

- ensuring the Health Board maintains an up-to-date Risk Management Strategy and Board Assurance Framework endorsed by the Board;
- promoting a risk management culture throughout the Health Board;
- ensuring that there is a framework in place which provides assurance to the Health Board in relation to the management of risk and internal control;
- putting in place and maintaining an effective system of risk management and internal control.

4.13 The Welsh Government requires the Chief Executive to sign a Governance Statement on behalf of the Board. This outlines how risks are identified, evaluated and controlled, together with confirmation that the effectiveness of the system of internal control has been reviewed.

Internal Audit

4.14 Internal Audit Services, provided by NHS Wales Shared Services Partnership will, through a risk based programme of work, provide the Health Board with independent assurance in respect of the adequacy of the systems of internal control across a range of financial and business areas in accordance with the standards

and good practice. They will also review the effectiveness of risk management arrangements as part of their programme of audits and reviews, reporting findings to the Audit and Risk Committee as appropriate.

5. Risk Management Process

- 5.1 CTMUHB is committed to developing a pro-active and systematic approach to risk management.
- 5.2 Appendices 2 and 3 outline the risk management and risk quantification process.

Risk Assessment

- 5.3 Each service within the Health Board needs to identify risks through the completion of risk assessments and ensure that risk assessments are completed and regularly reviewed on an ongoing basis.

Organisational Risk Register (Risks Rated 15 or above and/or those that cannot be managed locally)

- 5.4 The Organisational Risk Register is a record of all the risks identified across the Health Board through the Risk Management process, their controls, score and risk treatment/mitigation.

Management of Local Risks (Risk Rated below 15)

- 5.5 Any risks identified and evaluated as having a low/moderate rating, i.e. a score of between one and eight, can be managed locally within the relevant area. These risks can typically be resolved quickly and relatively easily if the correct actions are identified, completed and become controls under business as usual. These risks are recorded locally in the local risk register within each service area / department.
- 5.6 Any risks identified and evaluated as having a medium rating, i.e. a score between 9 and 12 are managed as follows:
 - If a risk is scored below 12 and can be managed at Service Group Level it will not require escalation, however, it is felt that the risk can no longer be managed at Service Group level and requires more Senior input and support then it will be first escalated through the relevant structure e.g. Care Group.

- If a risk is scored at 12 or above it should be escalated to the Care Group. or relevant escalation point within the function.
- 5.7 All local risks should be reviewed and updated regularly in accordance with the risk grading. This may need to be more frequent if circumstances require. Risks have been reviewed more frequently (i.e. Monthly) as a consequence of alignment to the new operating model and the new revised Organisational Risk Register.
- 5.8 If a risk is scored 15 and above it should be escalated as outlined in Appendix 3.

Board Assurance Framework (BAF)

- 5.9 The Health Board's Board Assurance Framework was last approved by the Board on the 25th May 2023. The BAF is reviewed on annual basis by the Audit & Risk Committee for onward approval by the Board.
- 5.10 The BAF will be articulated via a Board Assurance Report (BAR) presented to Board that brings together the Health Board's strategic goals and the principal/strategic risks, which may prevent them from being achieved.
- 5.11 The BAR identifies the controls in place to manage these risks and the assurances, which show whether they are working.
- 5.12 The BAR will:
- Incorporate action plans for the strategic risks within the "Mitigating Actions" section of the BAR which are closely aligned to the gaps in controls and/or assurances;
 - link to key measures of performance and National Priority Measures;
 - align strategic risks to operational risks on the Organisational Risk Register.
- 5.13 The benefits of the BAF include:
- that it is designed specifically for Board-level oversight
 - it is a structured and evidence-based assessment of the key risks facing the CTMUHB.

- can be used to shape cycles of business and the work of the Board & committees
- enables Independent Members to focus their scrutiny and constructive challenge
- supports strategic decision-making

5.14 The table below articulates how the BAF differs from the Organisational Risk Register:

Board Assurance Framework	Organisational Risk Register
• Strategic/Principal risks aligned to the Health Board's four strategic priorities • Includes only nine principal risks • Risks identified advised by the Executive Team and agreed by Board ('top down') • Decisions to add, remove or re-score risks are taken by the Board • Risks are organisation-wide in scope	• Mostly operational risks arising from the CTMUHB's day-to-day activities • Includes over 50 of the highest level (currently scored over 15) risks • Risks usually identified by individual services or departments ('bottom up') • Agreed by Executive Leadership Group following triage by Care Group / relevant leads • Some are organisation-wide, others are specific to services or directorates, but require involvement by the Executive Team or other services

5.15 The Health Board will monitor and ensure the BAF remains up to date by the following activity:

- Each strategic/principal risk has a Lead Executive(s);
- The Assistant Director of Governance and Risk will review the risk score, action plan and current performance with the Lead Executive(s) in readiness for reporting to the Board;
- Each principal risk has a lead Board Assurance Committee;
- More than one Board Committee will monitor some principal risks. These committees will scrutinise and seek assurances on the principal risks which they own;

- The Board should consider annually whether the principal risks are comprehensive, or if risks need to be added / removed / changed.

5.16 The Audit and Risk Committee, as a Committee of the Board, has oversight of the processes through which the Board gains assurance in relation to the management of the BAF.

Risk Quantification and Escalation & De-escalation

5.17 The approach to quantifying risk is described in Appendix 2. Each risk is assessed and scored on the likelihood of occurrence and the severity/impact in the initial (without controls), current (with controls) and target risk score (after completion of actions). A risk-scoring matrix to describe the quantification of risk is also included in the Procedure.

5.18 The process of risk escalation and de-escalation will be monitored by the Audit and Risk Committee, through monitoring new risks hitting threshold scores and being escalated as appropriate and/or current risks having their risk grading reduced so that the risks are appropriately de-escalated from the Organisational Risk Register.

5.19 The score of a particular risk will determine at what level decisions on acceptability of the risk should be made and where it should be reported. The Board defines as "High" any risk that has the potential to damage the Organisation's objectives. General guidelines are:

High Risk	Score 15 - 25 and above or a risk which can no longer be monitored locally	Report immediately to relevant Executive Director and escalate to the Organisational Risk Register. Where a risk is considered appropriate, the Executive Director will escalate to the SLG. In the event this causes delay, the Care Group Director can report directly to the Chief Executive. Formally record on Datix.
Medium Risk	Score 9-12	9-11 – reports to Clinical Service Group

		12-14 – reports to Care Groups /Corporate Functions Formally record on Datix.
Low Risk	Score 1-8	Report to Service Lead / Team Lead with proposed treatment/action plans, for particular monitoring. Formally record on Datix.

Risk Appetite

5.20 At its simplest, risk appetite can be defined as the amount of risk that an organisation is prepared to accept in the pursuit of its strategic objectives.

5.21 Decisions on accepting risks may be influenced by the following:

- the likely consequences are insignificant;
- a higher risk consequence is outweighed by the chance of a much larger benefit;
- occurrence is rare;
- the potential financial costs of minimising the risk outweighs the cost consequences of the risk itself;
- reducing the risk may lead to further unacceptable risks in other ways.

5.22 Therefore, a risk with a high numerical value may be acceptable to the organisation, but that decision would be taken at an appropriate level.

5.23 The Board will review its risk appetite on an annual basis to ensure that progress is being made to the 'risk appetite' the Health Board wishes to achieve.

5.24 The matrix has the following risk levels:

Risk Appetite	Description
Averse	Avoidance of risk and uncertainty in achievement of key deliverables or initiatives is key objective. Activities undertaken will only be those considered to carry virtually no inherent risk.
Minimalist	Preference for very safe business delivery options that have a low degree of inherent risk with the potential for benefit/return not a key driver. Activities will only be undertaken where they have a low degree of inherent risk.
Cautious	Preference for safe options that have low degree of inherent risk and only limited potential for benefit. Willing to tolerate a degree of risk in selecting which activities to undertake to achieve key

	deliverables or initiatives, where we have identified scope to achieve significant benefit and/or realise an opportunity. Activities undertaken may carry a high degree of inherent risk that is deemed controllable to a large extent.
Open	Willing to consider all options and choose one most likely to result in successful delivery while providing an acceptable level of benefit. Seek to achieve a balance between a high likelihood of successful delivery and a high degree of benefit and value for money. Activities themselves may potentially carry, or contribute to, a high degree of residual risk.
Eager	Eager to be innovative and to choose options based on maximising opportunities and potential higher benefit even if those activities carry a very high residual risk.

5.25 The Health Board's Risk Appetite Statement is included at Appendix 4.

6. Information / Support

- 6.1 Support and guidance is available from the Assistant Director of Governance & Risk via cally.hamblyn2@wales.nhs.uk.
- 6.2 Risk Assessment templates and training information is available via the following site on SharePoint:
<http://ctuwb-intranet/dir/HealthandSafety/default.aspx>

7. Appendix 1 - Definitions

Assurance	Confidence gained, based on sufficient evidence, that internal controls are in place and are operating effectively, and that objectives are being achieved. Sources of assurance include; reviews, audits, inspections both internal & external.
Assurance rating	This is the rating which has been given regarding the level of assurance: (1)= Management Reviewed Assurance (2)= Board Reviewed Assurance (3)= External Reviewed Assurance
Control Measures	A control is any measure or action that modifies risk. Controls include any policy, procedure, practice, process, technology, technique, method, or device that modifies or manages risk. Risk treatments become controls, or modify existing controls, once they have been implemented.
Current Risk Rating	The risk rating whilst risk responses are in the process of being implemented. Some controls are probably in place but others required are still being actioned & will be shown as gaps in control & actions until implemented.
Initial Risk Rating	The risk rating before any controls have been put in place.
Risk Actions	Actions required to mitigate the risk. Actions should be SMART & have clear owners assigned. This will allow action progress to be tracked & monitored & issues with action completion to be visible & dealt with.
Risk Appetite	At its simplest, risk appetite can be defined as the amount of risk that an organisation is prepared to accept in the pursuit of its strategic objectives.
Risk Assessment	Risk assessment is a process that is made up of three separate processes: risk identification, risk analysis, and risk evaluation. Risk identification is a process that is used to find, recognize, and describe the risks that could affect the achievement of objectives. Risk analysis is a process that is used to understand the nature, sources, and causes of the risks that you have identified and to estimate the level of risk. It is also used to study impacts and consequences and to examine the controls that exist. Risk evaluation is a process that is used to compare risk analysis results with risk criteria in order to determine whether or not a specified level of risk is acceptable or tolerable.
Risk Description	A structured statement describing the risk usually containing the following elements: sources, events, causes and consequences / impact. A well-written risk statement captures three main parts; If, Then, Resulting In.

Risk Management	Risk management refers to a coordinated set of activities and methods that is used to direct an organization and to control the many risks that can affect its ability to achieve objectives. The term risk management also refers to the programme that is used to manage risk. This programme includes risk management principles, a risk management framework, and a risk management process.
Risk Owner	Senior person best placed to keep an eye on the risk with decision making authority. This person is accountable for the Risk & should be aware of its current status.
Risk Rating	This is calculated by multiplying consequence x likelihood (impact x probability). Consequence: is the outcome of an event and has an effect on objectives. Likelihood: is the chance that something might happen. Likelihood can be defined, determined, or measured objectively or subjectively.
Risk Treatment	This is a risk modification process. It involves selecting & implementing one or more treatment options. Once a treatment has been implemented, it becomes a control or it modifies existing controls. Treatment options include; Avoidance / Remove the source of the risk Reduction Transference Retain / Accept the risk Also known as the four T's – Treat, Transfer, Tolerate & Terminate
Strategic Risk Owner	Usually the Executive Director in relation to the risk area.
Target Risk Rating	When action is taken to treat risks, it may eradicate the possibility of the risk occurring. However, actions are often more likely to reduce the probability of the risk occurring, leaving the residual risk. The remaining level of risk after all treatment plans have been implemented is the residual risk. Generally the target level is the level at which the organisation is saying it's happy to live with. All agreed controls are in place & assurance is being provided that controls are working as planned. At this point the risk should be closed unless further actions are deemed required.

8. Appendix 2 - Risk Domain and Scoring Matrix

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Safety & Well-being - Patients/ Staff/Public	Minimal injury requiring no/minimal intervention or treatment. No time off work. Physical injury to self/others that requires no treatment or first aid. Minimum psychological impact requiring no support. Low vulnerability to abuse or exploitation - needs no intervention. Category 1 pressure ulcer.	Minor injury or illness, requiring minor intervention. Requires time off work for >3 days Increased hospital stay 1-3 days. Slight physical injury to self/others that may require first aid. Emotional distress requiring minimal intervention. Increased vulnerability to abuse or exploitation, low-level intervention. Category 2 pressure ulcer.	Moderate injury/professional intervention. Requires time off work 4-14 days. Increased hospital stay 4-15 days. RIDDOR/Agency reportable incident. Impacts on a small number of patients. Physical injury to self/others requiring medical treatment. Psychological distress requiring formal intervention by MH professionals. Vulnerability to abuse or exploitation requiring increased intervention. Category 3 pressure ulcer.	Major injury leading to long-term disability. Requires time off work >14 days. Increased hospital stay >15 days. RIDDOR Reportable. Regulation 4 Specified Injuries to Workers. Patient mismanagement, long-term effects. Significant physical harm to self or others. Significant psychological distress needing specialist intervention. Vulnerability to abuse or exploitation requiring high levels of intervention. Category 4 pressure ulcer.	Incident leading to death. RIDDOR Reportable. Multiple permanent injuries or irreversible health effects. An event, which impacts on a large number of patients.
Quality/ Complaints/ Assurance/ Patient Outcomes	Peripheral element of treatment or service suboptimal. Informal complaint/inquiry.	Overall treatment/service suboptimal. Formal complaint (Stage 1). Local resolution. Single failure of internal standards. Minor implications for patient safety. Reduced performance.	Treatment/service has significantly reduced effectiveness. Formal complaint (Stage 2). Escalation. Local resolution (poss. independent review). Repeated failure of internal standards. Major patient safety implications.	Non-compliance with national standards with significant risk to patients. Multiple complaints/independent review. Low achievement of performance/delivery requirements. Critical report.	Totally unacceptable level or quality of treatment/service. Gross failure of patient safety. Inquest/ombudsman/inquiry. Gross failure to meet national standards/requirements.
Workforce/ Organisational Development/ Staffing/ Competence	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/service due to lack of staff. Unsafe staffing level (>1 day)/competence. Low staff morale. Poor staff attendance for mandatory/key professional training.	Uncertain delivery of key objective/ service due to lack/loss of staff. Unsafe staffing level (>5 days)/competence. Very low staff morale. Significant numbers of staff not attending mandatory/key professional training.	Non-delivery of key objective/service due to loss of several key staff. Ongoing unsafe staffing levels or competence/skill mix. No staff attending mandatory/professional training.
Statutory Duty, Regulation, Mandatory Requirements	No or minimal impact or breach of guidance/statutory duty.	Breach of statutory legislation. Reduced performance levels if unresolved.	Single breach in statutory duty. Challenging external recommendations/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low achievement of performance/ delivery requirements. Critical report.	Multiple breaches in statutory duty. Zero performance rating. Prosecution. Severely critical report. Total system change needed.
Adverse Publicity or Reputation	Rumours. Low-level negative social media. Potential for public concern.	Local media coverage - short-term reduction in public confidence/trust. Short-term negative social media. Public expectations not met.	Local media coverage - long-term reduction in public confidence & trust. Prolonged negative social media. Reported in local media.	National media coverage <3 days, service well below reasonable public expectation. Prolonged negative social media, reported in national media, long-term reduction in public confidence & trust. Increased scrutiny: inspectorates, regulatory bodies and WG.	National/social media coverage >3 days, service well below reasonable public expectation. Extensive, prolonged social media. MP/MS questions in House/Senedd. Total loss of public confidence/trust. Escalation of scrutiny status by WG.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national targets.10-25 per cent over project budget. Schedule slippage. Key objectives not met.	>25 per cent over project budget. Schedule slippage. Key objectives not met.
Financial Stability & Impact of Litigation	Small loss. Risk of claim remote.	Loss of 0.1–0.25% of budget Claim less than £10,000.	Loss of 0.25–0.5% of budget. Claim(s) between £10,000 and £100,000.	Uncertain delivery of key objective. Loss of 0.5-1.0% of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time.	Non-delivery of key objective. Loss of >1 per cent of budget. Failure to meet specification. Claim(s) >£1 million. Loss of contract/payment by results.
Service/ Business Interruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours. Some disruption manageable by altered operational routine.	Loss/interruption of >1 day. Disruption to a number of operational areas in a location, possible flow to other locations.	Loss/interruption of >1 week. All operational areas of a location compromised, other locations may be affected.	Permanent loss of service or facility. Total shutdown of operations.
Environment/Estate/ Infrastructure	Minimal or no impact on environment/service/property.	Minor impact on environment/ service/property.	Moderate impact on environment/ service/property.	Major impact on environment/ service/property.	Catastrophic impact on environment/service/property.
Health Inequalities/ Equity	Minimal or no impact on attempts to reduce health inequalities/improve health equity.	Minor impact on attempts to reduce health inequalities or lack of clarity on the impact on health equity.	Lack of sufficient information to demonstrate reducing equity gap, no positive impact on health improvement or health equity.	Validated data suggests no improvement in the health of the most disadvantaged, whilst supporting the least disadvantaged, no impact on health improvement and/or equity.	Validated data demonstrates a disproportionate widening of health inequalities, or negative impact on health improvement and/or equity.
Fraud/Bribery	Unlikely to result in material loss or reputational damage. (Little or no loss to the organisation, material loss less than £500)	Material loss or reputational damage likely to be minimal. (Some risk to the organisation, which may result in minor reduction in service capacity or material loss of up to £5000. Reputational damage likely to be within the organisation which may lead to complaint)	Could result in material loss or reputational damage. (Moderate risk to the organisation, which may result in reduction of service. Material loss of up to £10000. Reputational damage across the NHS with a high potential for complain or a low risk of litigation)	Could result in high material loss or reputational damage (may result in temporary loss of service or material loss of up to £50,000. Reputational damage widespread and outside of NHS with a likelihood of litigation.	Could result in significant material loss or reputational damage. (High risk, which may result in, prolonged loss of service or material loss of over £50,000. Nationwide media coverage causes reputational damage, which is likely to lead to criminal prosecution or external investigation.

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	Frequency:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
1 Highly Unlikely: Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely: Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Likely: It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Highly Likely: Will probably happen/recur, but not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain: Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

RISK REVIEW

It is essential to continue to reduce risks to their lowest level practicable through ongoing monitoring and review. It is best conducted through normal day-to-day management. A review must be undertaken whenever there are any changes to the existing risk assessment. Risk assessments should also be reviewed on a regular basis as determined below:

1-6	Low	This type of risk is considered low and should be reviewed and progress on actions updated at least every six months.
8-12	Moderate	This type of risk is considered moderate and should be reviewed and progress on actions updated at least quarterly
15-25	High	This type of risk is considered high and should be reviewed and progress on actions updated, at least every two months. If scored 20 or above the risk should be reviewed on a monthly basis.

9. Appendix 3 – Risk Management Process – Service to Board Escalation

	TASK / ACTIVITY	RISK RATING	RESPONSIBILITY	RISK REGISTER	ESCALATION
1.	Risk Assessment Identify Operational and Strategic risks through the completion of risk assessment and for ensuring that risk assessments are completed on an ongoing basis. Training is available for Risk Assessments and for the Datix System Please contact: Cally.Hamblyn2@wales.nhs.uk or visit: Risk Assessment - Risk		Each: It is everyone's responsibility to identify risks however, escalation would be through the - Care Group - Central Leads - Corporate Function Lead - Executive Lead	N/A	No
2.	Risk Register Use the Datix Risk Management System to record all risks identified through the Risk Management Process, their Controls, and score and risk treatment/mitigation and generate risk registers.		Each: - Care Group - Central Corporate Function - Executive Lead	N/A	No
3.	Management of Local Risks - Any risks identified and evaluated as having a low/moderate rating, i.e. a score of between one and eight, can be managed locally within the relevant area. - These risks can typically be resolved quickly and relatively easily if the correct actions identified, completed and become controls under business as usual. These risks are recorded locally in the local risk register within each service area/department. - All local risks should be reviewed and updated as per the frequency captured in Section 9 of the Risk Assessment Procedure.	Scored Between 1-8	Each: - Care Group - Central Corporate Function - Executive Lead Held and Managed Locally	Local Risk Register	NO If it can be managed locally. YES If it is felt that the risk can <u>no longer be managed locally</u> and requires more Senior input and support then it will be first escalated by the risk owner up through the using the notification / escalation via the Datix system Care Group Director Triumvirate or Central Corporate Functions as appropriate
4.	Clinical Service Group Risks - Risks Identified at a Service Level should be recorded by a relevant Manager on a Service Group Risk Register. - Reviewed <u>at least</u> bi-monthly at the relevant Service Group / Directors meeting.	Scored Between 8-12	Central / Clinical Service Group Held and Managed at Service Group Level	Central / Clinical Service Group Risk Register	NO If it is scored below 12 and can be managed at Service Group Level YES 1) If it is felt that the risk can <u>no longer be managed at Service Group level</u> and requires more Senior input and support then it will be first escalated up through the Care Group Director Triumvirate as appropriate through the using the notification / escalation via the Datix system And 2) If the risk is scored at <u>12 or above</u> it should be escalated to the Care Group Director Triumvirate
5.	Central and Care Group Risks - The Central Function Director Lead and Care Group Director Triumvirate should have sight of the Service Group Risk Registers and ensure that risks scored at 12 or above are recorded. - Care Group Risk Registers should be monitored at Care Group QSPE Meetings and considered for escalation to the Organisational Risk Register at the Operational Management Service Board. - Central Function Risk Registers should be received at Senior Management Team meetings and considered for escalation to the Organisational Risk Register at the Operational Management Service Board.	All Risks	Central Functions Care Group Director Triumvirate Held and Managed at Care Group Level	Care Group Risk Register Central Corporate Functions Risk Register	NO If scored below 15. YES 1) If it is felt that the risk can <u>no longer be managed at Central and Care Group Level</u> and requires Executive Level input and support then it will be first escalated up through the Operational Management Board (OMB) or the Executive Leadership Group (ELG) as appropriate to consider escalation to the Organisational Risk Register 2) If the risk is scored at <u>15 or above</u> and/or novel or contentious it should be considered for escalation by the Operational Management Board (OMB) or Executive Leadership Group (ELG) as appropriate to the Organisational Risk Register

Appendix 4 – Risk Appetite Statement

Cwm Taf Morgannwg University Health Board

Risk Appetite Statement

1. Introduction:

Public sector organisations cannot be culturally risk averse and be successful. Effective and meaningful risk management in government remains more important than ever in taking a balanced of risk and opportunity in delivering public services. Risk management is an integral part of good governance and corporate management mechanisms. An organisation's risk management framework harnesses the activities that identify and manage uncertainty, allows it to take opportunities and to take managed risks not simply to avoid them, and systematically anticipates and prepares successful responses. A key consideration in balancing risks and opportunities, supporting informed decision-making and preparing tailored responses is the conscious and dynamic determination of the organisation's **risk appetite**.¹

The Health Board should make a strategic choice about the style, shape and quality of risk management and should lead the assessment and management of opportunity and risk. The Board should determine and continuously assess the nature and extent of the principal risks that the organisation is exposed to and is willing to take to achieve its objectives - **its risk appetite** – and ensure that planning and decision-making reflects this assessment. Effective risk management should support informed decision-making in line with this risk appetite, ensure confidence in the response to risks and ensure transparency over the principal risks faced and how these are managed.²

The challenge for the Board in managing risk whilst balancing **quality & safety, people, performance activity** and **financial duties** is not underestimated, and the intention of the Risk Appetite Statement is to support an informed risk based decision.

2. Cwm Taf Morgannwg University Health has adopted the following **Risk Appetite Matrix**:

Risk Appetite	Description
Averse	Avoidance of risk and uncertainty in achievement of key deliverables or initiatives is key objective. Activities undertaken will only be those considered to carry virtually no inherent risk.
Minimalist	Preference for very safe business delivery options that have a low degree of inherent risk with the potential for benefit/return not a key driver. Activities will only be undertaken where they have a low degree of inherent risk.
Cautious	Preference for safe options that have low degree of inherent risk and only limited potential for benefit. Willing to tolerate a degree of risk in selecting which activities to undertake to achieve key deliverables or initiatives, where we have identified scope to achieve significant benefit and/or realise an opportunity. Activities undertaken may carry a high degree of inherent risk that is deemed controllable to a large extent.
Open	Willing to consider all options and choose one most likely to result in successful delivery while providing an acceptable level of benefit. Seek to achieve a balance between a high likelihood of successful delivery and a high degree of benefit and value for money. Activities themselves may potentially carry, or contribute to, a high degree of residual risk.
Eager	Eager to be innovative and to choose options based on maximising opportunities and potential higher benefit even if those activities carry a very high residual risk.

3. Cwm Taf Morgannwg University Health Boards **Risk Appetite Statement**:

The Health Boards risk appetite has been defined following consideration of organisational risks, issues and consequences. Appetite levels will vary, in some areas our risk tolerance may be cautious in others we may be eager for risk and are willing to carry risk in the pursuit of important strategic objectives.

The Health Board will always aim to operate organisational activities at the levels defined below. Where activities are projected to exceed the defined levels, this will be escalated through the appropriate governance mechanisms to the Board for ratification.

- **Quality and Safety risks** - (including physical and/or psychological harm) of its patients, people and the population) – the Health Board has adopted a **Cautious** stance for quality and safety risks, with a preference for safer delivery options, tolerating a cautious degree of residual risk and choosing the option most likely to result in successful delivery, high quality care and value for money services to its population.
- **People risks** - (including physical and/or psychological harm) to people directly engaged by the Health Board as staff or volunteers – the Health Board has adopted a **Cautious** stance for people risks, with a preference for consideration of the impact on the well-being of staff, including insufficient staffing numbers, unmanageable workload, burnout, or any safety risks, tolerating a cautious degree of residual risk and choosing the option most likely to result in a positive, healthy experience of work for our people, while also balancing service provision to our population.

¹ Government Finance Function – Risk Appetite Guidance Note – August 2021 – V2.0

² The Orange Book – Section A

- **Operational Performance risks** – the Health Board has adopted an **Open** stance for Operational Performance risks, with a preference for innovating service delivery, adoption of new technologies and models of service reconfiguration for the benefit of its patients, people and the population.
- **Reputation / Adverse Publicity (Trust in Confidence) risks** - the Health Board has adopted a **Cautious** stance for reputational risks, with a preference for safer delivery options, tolerating a cautious degree of residual risk and choosing the option most likely to result in successful delivery, high quality care and value for money services to its population.
- **Business Continuity risks** - the Health Board has adopted a **Cautious** stance for Business Continuity Risks. The Board will receive ongoing assurance from the testing of business continuity plans.
- **Legal / Regulatory Compliance risks** – the Health Board has adopted a **Cautious** stance for Legal, Regulatory and Compliance risks, seeking a preference for adhering to responsibilities and safe delivery options with little residual risk. The Board will receive assurance that compliance regimes are in place.
- **Data and Information Management risks** – the Health Board has adopted a **Cautious** stance for data and information management risks seeking a preference for adhering to responsibilities and safe delivery options with little residual risk. There is acceptance for the need for operational effectiveness with risk mitigated through careful management of information sharing and limiting distribution.
- **Financial stability risks** – the Health Boards stance for financial risk is varied as follows:
 - **Averse** for financial propriety, statutory and regularity risks with a determined focus to maintain effective financial control framework accountability structures.
 - **Averse** – in terms of risks related to the Health Boards qualification of accounts, associated process and deviation from reporting timescales.
 - **Cautious** - in terms of risks related to the Health Board’s financial breakeven duties set out in the NHS Wales Finance Act (Wales) 2014, recognising the need to ensure appropriate balance with the Duty of Quality.
 - **Cautious** – In relation to the Health Boards budget, spend with the intention that it should maximise the use of resource each year. The Health Board will seek safe delivery options with little residual risk that only yield some upside opportunities. The Board would receive ongoing assurance through reporting structures that policies and procedures are in place to comply with HMT guidance.
- **Assets and Estates risks** – the Health Board has adopted **Cautious** and **Open** stances for assets and estates respectively, seeking value for money but with a preference for proven delivery options have that a cautious residual risk. this means that the Health Board will us solutions for purchase, rental, disposal, construction, and refurbishment that ensures it protects the public purse from as much risk as possible, producing good value for money whilst fully meeting organisational objectives.
- **Technological advances** - the Health Board has adopted an **Open** stance for risks associated with technological advances accepting that system and technology developments can enable improved delivery. Responsibility for non-critical decisions may be devolved in accordance with the Scheme of Delegation. Plans aligned with functional standards and organisational governance.

10. Appendix 5 – Board Assurance Framework (Strategic / Principal Risks)

As at the end of March 2024, the following Strategic Risks are identified for CTMUHB.

Risk no	Strategic / Principal Risk	Strategic Goal	Lead(s) for this risk	Assurance committee
1.	Sufficient capacity to meet emergency and elective demand Click Here for Risk 1	Improving Care 	Chief Operating Officer / Executive Director of Strategy and Transformation	Quality and Safety; Planning, Performance and Finance
2.	Ability to deliver improvements which transform care and enhance outcomes Click Here for Risk 2	Improving Care 	Executive Dir. Of Nursing, Midwifery / Executive Medical Director	Quality and Safety
3.	Finance Revenue Resources Click Here for Risk 3	Sustaining our Future 	Executive Director of Finance.	Planning, Performance and Finance;
4.	Sufficient workforce to deliver the activity and quality ambitions of the organisation Click Here for Risk 4	Sustaining our Future 	Executive Director of People	People & Culture Committee
5.	Community and Partner Engagement Click Here for Risk 5	Creating Health 	Director of Communications, Engagement & Fundraising	Population Health & Partnerships
6.	Delivery of a digital and information infrastructure to support organisational transformation Click Here for Risk 6	Improving Care 	Director of Digital	Digital & Data
7.	Leadership and Management Click Here for Risk 7	Inspiring People 	Executive Director for People	People and Culture
8.	Culture, Values and Behaviours Click Here for Risk 8	Inspiring People 	Executive Director for People	People and Culture
9.	Fulfilling our Environmental and Social Duties and ambitions Click Here for Risk 9	Sustaining our Future 	Executive Director of Strategy and Transformation	Population Health and Partnerships
10.	Healthy Life Expectancy Click Here for Risk 10	Creating Health 	Executive Director of Public Health	Population Health and Partnerships



Agenda Item

5.2

Audit & Risk Committee

Organisational Risk Register

Dyddiad y Cyfarfod / Date of Meeting	18/04/2024
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 / Board Secretary
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	February / March 2024	RISKS REVIEWED
Operational Management Board / Offline via Email	21 st February 2024	ENDORSED NEW RISKS FOR ELG
Executive Leadership Group (ELG)	11 th March 2024	MANAGEMENT SIGN OFF RECEIVED
Quality & Safety Committee	14 th March 2024	ASSIGNED RISKS REVIEWED

Acronyms / Glossary of Terms

1. SITUATION/BACKGROUND

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

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

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 1st March 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

- 2.4 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.
- 2.5 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

2.5 As at the end of March 2024, **601** members of staff trained to date since training commenced in 2021.

2.6 Focussed sessions to discuss risk have also been undertaken with Care Group Leads and other departments/directorates as required.

2.7 Feedback on the training continues to be positive, please see below:

- 31 attendees have provided formal feedback (using the URL Code for the Evaluation Form, which was introduced in November 2023).
 - 77% (24/31) provided a score of 5/5 in terms of content of the session
 - 20% (6/31) provided a score of 4/5 in terms of content of the session
 - 3% (1/31) provided a score of 3/5 in terms of content of the session
- 100% of the 31 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.
- None of the 31 attendees considered that changes or improvements were needed to the training content.
- 97% of the 31 attendees providing formal feedback said they felt more confident to escalate a risk through the organisation.
- Some of the recent comments received through evaluation have been included below:

"Easy to understand and helpful training".

"Content was informative, trainer was knowledgeable and approachable. Practical help was provided with the Datix risk module".

2 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 NEW RISKS

Central Function – Digital & Data

- **Datix Risk ID 5669 – Increased cost of Citrix Subscription.** New risk escalated to the Organisational Risk Register in March 2024. Risk score of 16.

Diagnostics, Therapies, Pharmacy & Specialties Care Group

- **Datix ID 5658 – Lack of Dietetic service provision to Princess of Wales Critical Care.** New risk escalated to the Organisational Risk Register in March 2024. Risk score of 16.

Primary Care and Community

- **Datix Risk ID 5417 – Paediatric Dentistry – General Anaesthetic Theatre Lists.** New risk escalated to the Organisational Risk Register in March 2024. Risk score of 16.

3.2 CHANGES TO RISKS

- a) Risks where the risk rating **INCREASED** during the period
Nil

- b) Risks where the risk rating **DECREASED** during the period

Central Function – Corporate Governance

- **Datix Risk ID 4922 - Covid-19 Inquiry Preparedness - Information Management.** Risk score reduced from a 16 to a 12 in March 2024. The system for the timeline is now in place and population of information linked to the repository has commenced. The resource implications are significant and therefore it will take some time for the Health Board to map and archive all information, however, it is considered appropriate to reduce the likelihood score from a 4 to a 3 at this stage.

Central Function – Information Governance

- **Datix Risk ID 4699 - Failure to deliver a robust and sustainable Information Governance Function.** Risk score reduced from a 15 to a 9 in March 2024. The Health Board has increased the capability and capacity for the Information Governance and cyber security functions which is enabling the Health Board to practice in line with legislation and to make inroads into training and organisational development, required to enhance the culture of the organisation in working in a digital and AI era. The Information Commissioners Office have closed off their audit engagement

with the Health board having been given the necessary evidence to provide the requisite assurances.

Central Function - Finance

- **Datix Risk ID 5427 - Failure to reduce the planned recurrent deficit of £79.6m at the end of 2023/24.** Risk score reduced from a 16 to a 12 in March 2024. As at Month 10 the Health Board is reporting a forecast underlying deficit at the end of 23/24 of £19.4m. This forecast assumes that the Health Board secures the £51m recurrent funding that is conditional on achieving the breakeven Control total for 23/24. This forecast underlying deficit is the starting position for the draft financial plan for 24/25. On this basis the likelihood risk score has been reduced from a 4 to a 3.

Children and Families Care Group

- **Datix Risk ID 3008 - Risk of injury due unavailability of opportunities to train and maintain compliance with Manual handling training.** Risk score reduced from a 16 to an 8 in March 2024. Children and Families Care Group have reviewed this risk in light of the manual handling training now being mandated sessions. Service wide training is also on track to be completed by September 2025. Risk score therefore reduced in terms of likelihood from a 4 to a 2. The risk will now be managed on the Children and Families local risk register. On this basis the likelihood risk score has been reduced from a 4 to a 2. The rationale for the reduction in consequence score is captured in Appendix 1.

3.3 CLOSED RISKS FROM THE ORGANISATIONAL RISK REGISTER

Central Function – Health, Safety & Fire

- **Datix Risk ID 4780 - Patient Handling Training** – This risk has now closed as the Health Board has approved a business case to support additional training staff within the Manual Handling Team. These posts have now all been recruited except the risk Support Officer who is due to start on the 11th March 2024. A new training strategy has been implemented to provide additional training availability throughout the Health Board.
- **Datix Risk ID 4827 - Lack of Lead for Face Fit Training along with Face Fit Trainers**– This risk has now closed as a business case has been approved and a Fit Testing Team have been appointed. The lead is due to start on the 18th March 2024 and the two Fit Testers will commence on the 8th April 2024.



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

Consequence	5			3337 3993 4080	4664 5276	
	4				4337 4906 4809 3131 4671 4908 5404 5579 5658 5417	4152 3133 4417 5374 5254 4907 5602 5646 2713 5669
	3					4491 4071 4103 3826 1133 5590 5640 4632 5462
	2					4732 4650
	1					4672 4691 2808 5040
	CxL	1	2	3	4	5
Likelihood						

3.5 Matters to Note / Notified emerging risks

- The Assistant Director of Transformation previously identified a new risk for escalation relating to the "Community Brain Injury Service in Bridgend", an update has been received noting that whilst a full replacement service is not in place control measures have been implemented providing risk mitigation and therefore is not considered for escalation to the Organisational Risk Register at this time.
- In January 2024, this report noted that the "Primary Care and Community Care Group have identified a new risk for approval relating to the "Palliative Medicine Staffing Merthyr Cynon", this is expected to be captured in the next iteration of the organisational risk register in March 2024, once agreed by the Operational Management Board". As at time of the March 2024 iteration of the Organisational Risk Register being run this risk is still being assessed and has not yet been escalated to the Organisational Risk Register.
- The January 2024 cover report noted that a new risk (Lack of Dietetic service provision to Princess of Wales Critical Care) was being considered for escalation by the Diagnostics, Therapies, Pharmacy and Specialities Care Group. Members will note that this risk has been escalated in March 2024 under Datix Risk ID a 5658. See section 3.1.



- In January 2024, the Facilities Directorate identified a new risk for approval relating to "Fire doors in staff residential accommodation across organisation are non-compliant to the Regulatory Reform Fire Order 2005". This was expected to be escalated to the organisational risk register in March 2024, once agreed by the Operational Management Board. Since this update various control measures and mitigating action was taken by facilities and estates teams and the risk assessment reviewed and the score reduced to a moderate level, negating the need for escalation to the Organisational Risk Register.

4. IMPACT ASSESSMENT

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

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



Have you undertaken a Quality Impact Assessment Screening?		organisational Risk Register. Individual risks may have been subject to QIA.
Cydraddoldeb <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required for the Organisational Risk Register.
Cyfreithiol / Legal	Yes (Include further detail below)	
	See detail for each risk	
Enw da / Reputational	Yes (Include further detail below)	
	See detail for each risk	
Effaith Adnoddau <i>(Pobl / Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	Yes (Include further detail below)	
	See detail 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
	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
1	5640	Executive Medical Director	Central Support Function - Medical Directorate	Medical Directorate Manager	Sustaining Our Future	Patient / Staff /Public Safety	Potential Junior Doctors Industrial Action	If... the NHS Wales Junior Doctors take industrial action related to a dispute over pay erosion between 21st-23rd February 2024 and as expected monthly going forward Then... there will be significant disruption on clinical services and planned and unscheduled care provision will likely be impacted. Resulting in... the quality of the care and services provided to patients and service users being affected in terms of access to services and compliance with performance and delivery objectives. This includes an impact on waiting list times for surgery and outpatients increasing, and patients being unable to access some health care services.	This is a national issue and decisions on any pay increases are out of CTM's control. A decision on strike action has been confirmed for 15th-18th January 2024 and 25th-29th March. There will be no derogation agreed ahead of the proposed strike unless the health board has offered BMA agreed rates to the doctors Consultants/SAS doctors in some cases will be asked and negotiated with to cover gaps in service. National group in place which includes group of senior colleagues who are agreeing process around pay rates for "acting down"	Process to be agreed with BMA for derogation decisions on day of strike with clear info on the information UHB's will have to provide. BMA have stated they will turn these around in 30-60 minutes CTM working group taking place regularly HB can switch pre-existing locum hours around with agreement, however, locums have already cancelled their shifts Planning and preparation with contingency plans for all affected service will be taken. With these measures in place the consequence score will reduce to 3, with a target score of 15. Update March 2024 - Medical Directorate undertaken a review of this risk and no changes made to mitigation or risk score on this review.	Planning, Performance & Finance Committee Quality & Safety Committee People & Culture Committee	20	C4xL5	C3xL5	↔	04.12.2023	20.02.2024	31.03.2024
2	5590	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Radiology Service Manager	Improving Care	Patient / Staff /Public Safety	Radiopharmaceutical Business Interruption	IF: CTMUHB Radiology Department are unable to procure radiopharmaceuticals as per Service Level Agreement with CAV. 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. WG directive is to share capacity regionally. Clinical stratification of patient priority - USC i.e. imaging at Princess Of Wales. Use of Mag Trace or alternative for SNLB - Breast Services	Update January 2024 Risk reviewed at the end of November 2023. Weekly meeting regionally, engaged with pharmacy Royal Glamorgan Hospital (RGC), dispensing training arranged at RGH with support from Cardiff and Vale clinical scientist, ARSAC license in place, reviewing Delegated Authorised Guideline (DAG) (under radiation protection legislation)for authorising and reporting. USC patients currently being seen in POW as most clinically vulnerable. Will continue to review on a weekly basis. Potential backlog for non USC work. Next review scheduled for mid-January 2024. Update 9th January 2024 - Update 9.1.24: New Service Level Agreement (SLA) required with Swansea Bay, currently in progress. All CTM patients being scanned at Princess of Wales Hospital (POW). Update March 2024: Risk reviewed on the 19th February 2024 and remains unchanged in terms of mitigation and score as reflected in January 2024. Next review end of March 2024.	Quality & Safety Committee	20	C4xL5	4 C4xL1	↔	23.10.2023	19.2.2024	31.03.2024
3	5276	Director of Digital	Central Support Function - Digital and Data	Assistant director of therapies and health science	Sustaining Our Future	Business Objectives - Operational Patient safety	Failure to deliver replacement Laboratory Information Management System, LINC Programme, by summer 2025, by summer 2025, Wales interdependencies	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 January 2024 - This risk was discussed at the LIMS Programme Board on the 9th January 2024. The outcome of the discussion was to retain the risk on the Organisational Risk Register as the risk priority remains high due to reporting issues across all Health Boards. Local build is going well although there are risks in terms of resources. Paper submitted to ELG requesting resource within the department to support the implementation for the next two years. Risk score remains unchanged at present. Update March 2024 - risk to be reviewed a the next LIMS Deployment Programme Board meeting on the 21st March 2024. It is anticipated that the risk score will decrease once Pathology fixed term IT posts are in place.	Digital & Data Committee Quality & Safety Committee	20	C5xL4	5 (C5xL1)	↔	26.10.2022	04.03.2024	31.03.2024
4	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	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: - 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 speciality codes can be added to an unreported list, this will be refined over the coming months. - All unreported lists that appear to require reporting have been added to the RTT reported lists - All unreported lists that are to remain unreported (as they do not form part of the RTT criteria) are being reviewed and will be visible and monitored going forward. • Patients prioritised on clinical need using nationally defined categories • Demand and Capacity Planning being refined in the UHB to assist with longer term planning. • Outsourcing is a fundamental part of the Health Board's plan going forward. • The Health Board will continue to work towards improved capacity for Day Surgery and 23:59 case load. • A Harm Review process is being piloted within Ophthalmology - it will be rolled out to other areas. • The Health Board has taken advice from outside agencies especially the DU when the potential for improvement is found. • Appropriate monitoring at ILG and Health Board levels via scheduled and formal performance meetings with additional audits undertaken when areas of concern are identified Planned Care board established. - The Health Board is exploring working with neighbouring HBs in order to utilise their estate for operating.	Update March 2024: Pressure has remained very high across the system over the winter months and the risk scoring remains unaltered. There is daily scrutiny across the organisation and actions being undertaken including the following: • Management focus remains strong within the area of Flow - ensuring that as much as possible, beds are used efficiently; • Within Planned Care, outsourcing has largely stopped, with the UHB now insourcing instead, focusing on increasing theatre capacity and activity and running the system at maximum capacity; • Outpatient activity is now running at pre-Covid rates, ensuring that patients are seen as soon as possible. They are prioritised on the basis of urgency and priority as is appropriate; • Activity within Inpatients and Daycases is increasing month on month; • The Navigation Hub is well embedded now in the screening of nursing homes and hours are increased when the demand is present and resources available. The whole issue of providing timely care to patients remains front and centre of all the work undertaken by the Health Board with resources focused on ensuring that the situation continues to improve, no matter the difficult context. No change to risk score.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4xL5	12 C4 x L3	↔	13.7.2023	4.3.2024	04.04.2024
5	4071	Chief Operating Officer	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety	Failure to sustain services as currently configured to meet cancer targets.	IF: The Health Board fails to sustain services as currently configured to meet cancer targets. Then: The Health Boards ability to provide safe high quality care will be reduced. Resulting in: Compromised safety of patients, potential avoidable harm due to waiting time delays for treatment.	Tight management processes to manage individual cases on the cancer Pathway. Regular reviews of patients who are paused on the pathway as a result of diagnostics or treatment not being available. To ensure patients receive care as soon as it becomes available. Regular Quality Impact assessments with the MDTs, to understand areas of challenge and risk Harm review process to identify patients with waits of over 104 days and potential pathway improvements. Initiatives to protect surgical capacity at the Vale hospital for ASA 1+2 level patients until alternatives become available. All three 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 January 2024 - Further work undertaken in streamlining the Haematuria pathway. Work undertaken with Bowel screening Wales. Next review 5.2.2024. Update March 2024 - no changes to risk update on this occasion and review of risk score has not led to any changes.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4 x L5	12 (C4 x L3)	↔	01.04.2014	27.2.2024	31.03.2024
6	4103	Chief Operating Officer	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety	Sustainability of a safe and effective Ophthalmology service	IF: The Health Board fails to sustain a safe and effective ophthalmology service. Then: The Health Boards ability to provide safe high quality care will be reduced. Resulting in: Sustainability of a safe and effective Ophthalmology service	Measure and ODTC DU reviews nationally. • Clinical staffing structure stabilised and absence reduced (new consultant, nurse injectors, ODTC's, weekend clinics). • On going monitoring in place with regards RTT impact of Ophthalmology. • In line with other services, to meet the RTT requirement services are being outsourced - maintaining this level of performance will be challenging going forward. • Additional funding for follow up appointments provided and significant outsourcing undertaken (6,500 cases) with harm review piloting to assess all potential harms. • Additional services to be provided in Community settings through ODTC (January 2020 start date). • Intravitreal injection room x2 established with nurse injectors trained. • Follow up appointments not booked being closely monitored and outsourcing enactioned. Regular updates re follow up appointments not booked being monitored by Management Board / Q&SR (patient safety issues) and Finance, Performance and Workforce Committee (performance issues). Reviewing UHB Action Plan in light of more recent WAO follow up review of progress. Primary and Secondary Care working Groups in place. Ophthalmology Planned care recovery group established overseeing a number of service developments: WLI clinics, outsourcing of Cataract patients, development of an ODTC in Maesteg Hospital, implementation of Glaucoma shared care pathway, implementation of Diabetic Retinopathy shared care pathway, regional work streams, trial of new Glaucoma procedure (IMS), streamlining pathways. Quality and Performance Improvement Manager post created to provide dedicated focus, detailed demand and capacity analysis being undertaken. All patients graded according to the WG risk stratification R1, R2, R3. Additionally, several specific waiting lists are further risk stratified to ensure that the highest risk patients are prioritised.	Update March 2024 A Harm Review Panel set up to monitor and investigate incidents has identified and mitigated risk areas. Glaucoma: • Substantive glaucoma consultant appointments have commenced work in RGH and POW supported by two locum consultants. • Outsourcing of longest waiting referrals is active with harm review panel oversight. • Business Case completed for expansion of Ophthalmic Diagnostic and Treatment Centre community services in Neusteg and YCC. • WGO54 manual publication promoting discussions on shared care of uncomplicated cases with community optometery. Intravitreal Injection Service: • Prioritised to reduce delays in injections • Harm Review Panel identified administrative changes required to substantially reduce incidents arising Cataract: • Long waiting patients outsourced as part of a South East Wales regional plan to increase cataract surgery capacity. • Additional theatre capacity identified in POW with increased theatre staff and extra surgeon involvement Risk score reviewed and remains unchanged.	Quality & Safety Committee	20	C4 x L5	12 C4 x L3	↔	01.04.2014	27.2.2024	31.03.2024
7																		

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
1	4632	Executive Director of Therapies and Health Sciences.	Unscheduled Care Group	Head of Strategic Planning and Commissioning	Improving Care	Patient / Staff /Public Safety	Impact on the safety - Physical and/or Psychological harm	IF: changes are not made to improve and align stroke prevention initiatives, early intervention campaigns, and acute and rehabilitation stroke care pathways across CTM THEN: avoidable strokes may not be prevented, patients who suffer a stroke may miss the time-window for specialist treatments (thrombolysis, thrombectomy), and patients may not receive timely, high-quality, evidence-based stroke care RESULTING In: higher than necessary demand for stroke services, poorer patient outcomes/increased disability, increased length of stay, and poor patient/carer experience. Impact will extend to the need for increased packages of care, increased demand for community health services, and increased carer burden when discharged to the community.	- Executive-led Stroke Strategy Group in place, with targeted task and finish under development. Membership updated to reflect senior Ops changes. - ToR and membership of Strategy Group updated. - Close working amongst executive team to escalate and address operational and clinical issues in relation to stroke pathway - 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 CTM 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 March 2024 - the Care Group continue with new governance arrangements to give a greater level of focus and assurance in relation to an organisational approach relating to Stroke: - Operational Performance Group and Stroke Programme board now fully established to focus on the performance and actions for improvement. - Consultant recruitment remains challenged. - On the 18th December the Brainomix AI Software (reporting for CTs and CT angiograms to minimise delays in referral for thrombectomy) was implemented and a report on its early stages was presented at February's Programme Board. It reported that whilst the access to view CT scans was much improved that the current stage of development of the AI was not sufficiently reliable for the reporting of scans. - The South Central Regional Stroke Programme continues in developing options towards a regional solution for stroke services. - Consultant vacancy - discussions are underway to explore opportunities for a Regional approach with Cardiff and Vale to support the Service. - In order to improve the performance of our Stroke service across both PCH and POW a proposal has been developed that would increase the CNS cover up to 24/7. Decision awaited on this. If approved and implemented this should contribute to improving the % of patients admitted to a stroke ward within 4 hours and the number of eligible patients thrombolysed door to needle time of >45mins. - A proposal has been made to expand the remit of the Stroke Data co-ordinator role at PCH to incorporate POW to achieve consistency of process and data collection and robustness across both sites. - The Early Support Discharge Service has been extended to Bridgend to improve equity across the Health Board. - There are challenges to meet demand at the front door at both sites and achieve effective discharge pathways, this is impacting flow across the system, which is an issue in relation to the ring-fencing of Stroke beds, CT scans and conveyancing of self-presenting patients at RGH to PCH. This is not however a CTM only issue as reflected in the National Review of the impact of Flow on Stroke services. An improvement plan is in place to address the national recommendations.	Quality & Safety Committee	20	C4 x L5	12 (C4 x L3)	↔	11.05.2021	27.02.2024	31.03.2024
8	5462	Executive Director of Public Health Executive Director of Therapies & Health Science	Diagnostics, Therapies, Pharmacy and Specialities Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety	Impact on the safety - Physical and/or Psychological harm	Adult weight management service - insufficient capacity to meet demand If there is insufficient capacity within the adult weight management service to meet the demand Then patients will not be offered timely intervention in line with the All Wales Weight Management Pathway. The current waiting list is over 6 years. 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 January 2024 Last review 15.12.23 next review 11.03.23 Current actions are the monitoring of capacity and demand alongside pathway redesign. Mitigations via provision of an interim offer of a level 2 service have been fully explored. 1300 people remain on the waiting list. There was a 47% response rate to the partial booking letters sent in November. If this trend continues, estimated waiting time will reduce from 6 years to under 3 years. Initial findings from evaluation of pathway redesign (group interventions) will be completed in Quarter 4, from which further capacity mapping will take place. Update March 2024 - no change. risk scheduled for review in March 2024.	Quality & Safety Committee People & Culture Committee Population Health & Partnership Committee	20	C4xL5	8 - (C4xL2)	↔	07.06.2023	15.12.2023	11.03.2024
9	4664	Director of Digital	Central Support Function - Digital & Data	Chief Information Officer	Creating Health	Legal / Regulatory	Statutory duty, regulatory compliance, accreditation, mandatory requirements	Ransomware Attack resulting in loss of critical services and possible extortion IF: The Health Board suffers a major ransomware attack. Then: there could be potential data loss and subsequent loss of critical services. Resulting in: Catastrophic service loss to all clinical and business services adversely impacting on population health management, patient care, business continuity, health and wellbeing of staff, organisational relationships, substantial financial risk and the UHB's other routine and improvement work - culminating in a culture of mistrust of the Health Board and all things digital leading to the likelihood of the opportunities that present from digital transformation being less likely to be achieved.	Redacted due to business sensitivities. Detail received in closed session of the Committee.									
10	3826 Linked to 4839 and 4841 in Bridgend Linked to 4462	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director - Unscheduled Care.	Improving Care	Patient / Staff /Public Safety	Impact on the safety - Physical and/or Psychological harm	Emergency Department (ED) Overcrowding IF: As a result of exit block due to hospital capacity and process issues patients spend excess amounts of time within the Emergency Department. This is manifested by, but not limited, to significant 12 hour breaches currently in excess of 400 per month. There are also large numbers of patients spending longer than 24hrs and 48hrs within the ED (please see attached information). Then: patients are therefore placed in non-clinical areas. Resulting In: 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. Filling the last resus space compromises the ability to manage an immediate life threatening emergency. Clinicians taking increasing personal risk in management of clinical cases. Environmental issues e.g. limited toilet facilities, limited paediatric space and lack of dedicated space to assess mental health patients. Some of the resulting impact such as limited space has been exacerbated by the impact of the Covid-19 pandemic and the need to ensure appropriate social distancing.	Increased number of nursing staff being rostered over and above establishment. Additional repose mattresses have been purchased with associated equipment. Additional catering and supplies. Incidents generated and attached to this risk. Weekly report highlighting level of above risk being generated. All patients are triaged, assessed and treatment started while waiting to offload. - Escalation of delays to site manager and Director of Operations to support actions to allow ambulance crews to be released. - Rapid test capacity in the POW hot lab has recently increased with a reduction in swab turnaround times. - Expansion of the bed capacity in Y5 to mitigate against the loss of bed capacity in the care home sector and Maesteg community hospital. - Daily site wide safety meeting to ensure flow and site safety is maintained. - There is now a daily WAST led call (including weekends) with a senior identified leader from the Health Board representing CTM and talking daily through the plans to reduce offload delays across the 3 DGH sites. - Twice weekly meetings with BCBC colleagues to ensure that any delays in discharge are escalated at a senior level to maximise the use of limited care packages/ care home capacity. - Appointment of Clinical Lead and Lead Nurse for Flow appointed Feb 21 - Operational Performance is now monitored through the monthly performance review. Performance review process has been restructured to bring more rigour with a focus on specific operational improvements. - Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board.	Update March 2024 - The Unscheduled Care Group Senior Management Team reviewed current ambulatory pathways and the site based clinical teams are in the process of developing an Standard Operating Procedure (SOP) relating to R2sult. The Care Group also continue to explore the potential to expand ambulatory footprint at the Princess of Wales site. Following the successful bid for WG funding for RGH nurse call bell and emergency call system within Ambulatory Emergency Care Unit (AECU), PCH Ambulatory plans are in place to complete this work by April 24. This will improve patient experience within these departments. 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 the recent onsite of winter pressures, risk rating to remain at 20.	Quality & Safety Committee Planning & Performance Committee	20	C4xL5	12 (C4xL3)	↔	24.09.2019	27.2.2024	31.03.2024
11	1133 Linked to risk 3826	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety	Impact on the safety - Physical and/or Psychological harm	Long term sustainability and staffing of the Emergency Department (ED) at the Royal Glamorgan Hospital. (RGH). IF: the Clinical Service Group (CSG) is unable to deliver a sustainable staffing model for the Emergency Department (ED) at the RGH; Then: the Health Board will be unable to deliver safe, high quality services for the local population; Resulting in: compromised safety of the patients and staff and possible harm.	ED sustainable workforce plan developed and being implemented (May 2021). Option 1 funded so risks around sustainability remain particularly in respect of the consultant workforce. Financial position remains a challenge as locum and agency staff still used. No agreed plan to align staffing to benchmarking standards and the staffing levels on other sites within CTM. Boundary change and challenges across CTM continue to have a significant impact on the RGH site.	Update March 2024 - Unscheduled Care Group Senior Management Team risk reviewed, nurse establishment review continues in RGH ED, invest to save paper submitted for RGH ED nursing staff. This forms part of the investment cycle for the financial period 24/25 In the interim the requested staffing level has been achieved via bank and agency and the Care Group hope to reduce and or close this risk in the future months. Risk score remains 20.	Quality & Safety Committee. People & Culture Committee - Workforce aspect	20	C4xL5	12 (C4xL3)	↔	20.02.2014	27.02.2024	31.03.2024
12	5417	Chief Operating Officer	Primary Care and Community Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety	Impact on the safety - Physical and/or Psychological harm	Paediatric Dentistry - General Anaesthetic (GA) theatre list IF: Regular additional GA theatre lists (necessary to meet current and future demand) are not made available to the Community Dental Service team for paediatric GA. Then: the number of children waiting list for assessment and treatment will continue to increase beyond 1000 by March 2024. Resulting in: 1. children waiting increased times for assessment/treatment who have high levels of dental caries and painful teeth requiring extraction, 2. a further increase in the number of children requiring GA, due to long waits for assessment more children need GA when assessed, conversion rate has jumped from 48% to 80%. Children can only wait 8 wks from assessment to treatment therefore there is a large backlog of assessments due to limited GA lists to provide treatment.	Current theatre lists are run on Monday mornings and Friday afternoons and are likely to be cancelled due to bank holidays. This impacts the running of the service, no additional lists are available when lists are missed. There are currently 800+ patients waiting for appointments, with some already waiting for 17 months. Patients are advised to return to their General Dental Practitioner (GDP) if they experience pain, some children are being prescribed multiple courses of antibiotics to ease dental infections that can only be alleviated by tooth extraction. There is a risk these patients will require the removal of more teeth/more require GA when assessed/children will present as an urgent case in Accident and Emergency if left untreated.	The mitigating action for this risks is the allocation of the Adhoc additional lists by secondary care- if the Care Group can secure these regularly it will improve the output on the list resulting in more patients being assessed and being seen for treatment. The lists do not need to be permanent but regular for a period of time to address the backlog, more children are converting for GA due to the long wait, if the Care Group can get through the backlog and see patients more quickly the conversion rate should decrease and the need for additional lists will reduce. This risk was opened in April 2023, the score has recently increased resulting in escalation to the Organisational Risk Register. The rational for the increase is that the existing theatre lists were not sufficient and additional list to support the backlog and additional referrals has still not been identified. The waiting list is continuing to grow and more children are requiring multiple teeth removing that require a double slot on the GA list which reduces capacity even further/more converting to GA due to extensive waits.	Quality & Safety Committee	16	C4xL4	9 C3xL3	New risk escalated to the organisational risk register in March 2024	20.04.2023	05.03.2024	31.03.2024
13	5658	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialities Care Group	Care Group Service Director	Creating Health Improving Care	Patient / Staff /Public Safety	Impact on the safety - Physical and/or Psychological harm	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 rated 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 review.	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.	Establish funding for POW critical care dietitian. Meeting with POW Critical Care to discuss risk and mitigations and explore solutions to funding the position as per Guidelines for the Provision of Intensive Care Services (GPIC) Standards. Timeframe March 2024.	Quality & Safety Committee. People & Culture Committee - Workforce aspect	16	C4xL4	8 (C4xL2)	New risk escalated to the organisational risk register in March 2024	19.12.2023	24.01.2024	8.3.2024
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1	5669	Director of Digital	Central Support Function - Digital and Data	Assistant Director for Digital Delivery	Improving Care	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.	A task and finish group has been started to reduce Citrix use across CTM. Additional WG slippage money has been secured to replace a large percentage of our iGel estate, approx ~2,500 devices, out of an iGel estate of ~3,500 devices. The T&F group are working on a number of strands: Understand and minimising ~1000 Citrix users not using iGels. Understand and start to roll out of iGel replacement - (2,600 PCs) Understand approach to licensing Citrix delivered DHCW Apps (WLIMS, WPAS, etc). Complete Procurement of temp Citrix licenses to take us up to December. Continue conversation with national groups about Citrix. Understand more about National Procurement Exercise for Citrix and key dates. Consideration of alternative technologies to Citrix Even with the current control measures, it is recommended that the risk score stay at 16 until further conversations with Citrix and DHCW in March 2024.	Digital & Data Committee	16	C4xL4	2 (C1xL2)	New risk escalated to the organisational risk register in March 2024	12.01.2024	26.02.2024	08.04.2024
15	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.	IF: South Wales Police (SWP) implement Right Care Right Person Then: In some circumstances the Health Board will not be able to routinely call upon SWP to assist with people in mental health crisis or with social care issues, for example, missing patients, welfare checks and supervising people who are detained on S136 Mental Health Act. 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. 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.	The Health Board will gather and analyse available data to further understand the issues and impact The Health Board will explore options to manage the need in a different way. Risk likelihood assessment: Initial data gathering suggests that the likelihood is more likely to be weekly and not daily. Update March 2024 - Phase 1 of RCPR commenced 26/02/2024. Head of Nursing for MHLd Care Group is tactical lead. Awareness sessions attended by over 250 staff. Health Board wide planning meeting continues to meet. Daily troubleshooting Multi-agency meetings with South Wales Police continue.	Quality & Safety Committee Mental Health Act Monitoring Committee	16	C4xL4	12 (C3XL4)	↔	08.12.2023	29.02.2024	30.04.2024
16	2713	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Radiology Service Manager	Improving Care	Patient / Staff /Public Safety	Backlog of Reporting Radiology Examinations	IF there is consistent backlog of Radiology reports THEN there will a delay in patient diagnosis and treatment, which could lead to poorer patient outcomes RESULTING IN deterioration of health and potential death. All radiological examinations should be reported in a timely manner. There is a risk of delay in diagnosis of patient condition and any additional interventions/treatment that may be required following diagnosis due to an excessive backlog and increasing demand in imaging services. There is also a risk of damage to the reputation of the Organisation due to the failure to meet performance targets. The reporting backlog has been compounded by; Reduced effective Radiologist workforce due to retirements, sickness, secondment, maternity leave and limited available Radiologist workforce. RadIS merger which caused problems for outsourcing as prior imaging has not been available as it previously has been. National Cyber attack, computer & RadIS patches which caused two weeks downtime for reporting. Colon CT - All barium enema examinations are now scanned in CT which has increased the specialist reporting significantly with no increase in Radiologist support. Long term inability to recruit Radiologists as there are insufficient numbers trained in the UK. There is also risk of work related stress due to pressure placed on existing Radiologist workforce to meet the demands of the service.	Radiologists performing extra reporting sessions in addition to their normal working hours. Radiographers trained to report accident & emergency images. Up to date job plans for all Radiologists. Datix incident and concerns procedures in place. Data tracked weekly.	Update January 2024 Risk reviewed in November 2023. Risk reduced from 20 to 16 due to additional funding secured, £300,000 non-recurrent until end of March 2024, to be used for outsourcing reports. 250 CT per week, 200 MRI, monitoring to adjust greatest need. 6.5 consultant vacancies still stand, with active recruitment ongoing. Risk score remains under review as likelihood may increase when funding's ends due to sustainability. Risk to be reviewed mid January 2024. Update March 2024 - risk reviewed and there was no change to mitigation, which remains ongoing, and risk score. Next review 18th March 2024.	Quality & Safety Committee Planning Performance & Finance Committee	16	C4xL4	4 C4xL1	↔	08.02.2017	22.02.2024	18.3.2024
17	5579	Executive Director of Public Health Executive Director of Therapies & Health Science	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Head of Nutrition and Dietetics, Therapies, PCH	Creating Health	Patient / Staff /Public Safety	Lack of Children and Young Persons Weight Management Service	IF there is no children and young person's weight management service Then the Health Board will be unable to support children and young people to manage their overweight and obesity Resulting in non-compliance with national standards and pathways, significant risk to patients with increase in childhood obesity rates, obesity related conditions, healthcare costs and no improvement in the health of the most disadvantaged.	Some Level 1 weight management service exist across the Health Board, namely PIPYN (3-7yrs Merthyr only) and Henry (0-5 CTM wide), these programmes are currently fixed 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 March 2024 - Communication has been sent out to Children and Families and DTPS care groups to clarify the current level 1 service and that there is no current level 2 & 3 offer within CTM. Written information was sent to care groups on 19.2.24 advising that all referrals should be signposted to first line advice. The business case completion is delayed due to operational pressures, a revised target completion date is 1.3.24.	Population Health & Partnerships Committee Quality & Safety Committee	16	C4xL4	8 C4xL2	↔	13.10.2023	19.1.2024	29.3.2024
18	5602	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	Door security in pharmacy Department at Ysbyty Cwm Rhondda (YCR) Hospital.	IF the door security system fails Then security of medicines cannot be guaranteed Resulting in closure of YCR pharmacy dept. and relocation of medicines. Resulting in reduced service delivery as no on site access to medicines.	Redacted due to business sensitivities. Detail received in closed session of the Committee.									
19	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	IF: The Health Board is unable to meet the demand for the predicted influx of Covid19 related, FUNIB Ophthalmology Redress/Claim cases Then: the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. Resulting in: Risk to quality and safety of patient care, resulting from poor management of cases. Financial impact to the Health Board from Redress cases which have been poorly managed and consequently proceed to claim.	Controls are in place and include: * Regular reports run on all Redress cases, with monitoring by the Head of Legal Services & Legal Services Manager The 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 March 2024 - The Legal Services team continue to prioritise other areas of work which have risk of penalties i.e. LFERs and Inquests. An SBAR proposal for a member of the team to undertake some overtime to address extra redress cases has been developed. New invest to save bid has been prepared and is being reviewed. A demand versus capacity versus productivity assessment is being undertaken and will be completed early March. Redistribution of work within the team is being explored.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	02.11.2021	29.2.2024	01.04.2024
20	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	IF: The Health Board was unable to sustain ongoing funding for the two temporary Legal Services Officers Then: the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. Resulting in: Risk to quality and safety of patient care, resulting from lack of capacity to management cases in a efficient and effective manner, which could result in failure to comply with the WRP procedures resulting in financial penalties	The Health Board are developing an action plan in response to the Welsh Risk Pool review, which includes the reviewing structures and workloads 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 March 2024 - The Business Intelligence team has produced a report for the Legal Services team and the Care Group teams which provides statement request and progress details. Inquests are now being graded to identify high risk inquests (Red, Amber and Green). Legal Services staff are in the process of reviewing older inquests. Regular meetings continue with Legal and Risk and HMC to ensure open communication in order to manage any issues more efficiently. New process has been developed in line with the Coroners new directions. This has been circulated across the Health Board. Members of Legal Services team now attend Governance meetings to assist with review of statement progress, to provide assistance, identify issues and escalate where necessary.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	02.11.2021	29.2.2024	01.04.2024
21	5404	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	Post Mortem Backlogs in Mortuary	IF: the Coronal service fails to ensure consultant Pathologist capacity to undertake post mortems to meet the increasing demand across the Health Board region. THEN: There will be delays in performing and reporting autopsies. RESULTING IN: * Mortuary capacity breaches * Inability to store deceased appropriately including long term freezer storage of which the Health Board only has 8 spaces. *deterioration of deceased due to length of stay leading to poor experience for the bereaved and complaints *Failure of the Health Board to provide a quality Bereavement service to the population. * Families not being able to view loved ones due deteriorating condition of the deceased due to prolonged storage *Non-compliance with HTA regulatory requirements and current WG bereavement framework principles *Reputational damage *Reliance on additional contingency storage creating financial risk for the Health Board	Additional contingency storage in place. Weekly situation meetings with Coroner's Office to assess current situation. Short term use of Locum pathologist by service provider commissioned by the Coroner's Office using our current supporting APT resource whilst Pathologist on leave.	Update March 2024 - Maintaining weekly meetings to monitor backlog. Current backlog being maintained at 8 days with the use of additional sessions. Application for Planned Activity Additional Rate (PAAR) to be submitted (funded by the Coroner) to support weekend additional sessions to improve flex to demand increases.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	13.04.2023	05.03.2024	02.04.2024
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	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence x Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
1	3131	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety	Mortuary Capacity	IF: There is insufficient Mortuary capacity across the Health Board, including bariatric capacity THEN: the Health Board will be unable to accommodate any increases in deaths (due to seasonal pressures, pandemics, general increases in service demand), and may exceed capacity in the event of Mortuary closure or refrigeration failure, or funeral directors/undertakers being unable to collect bodies or move bodies between sites due to adverse weather. Resulting In: bodies not being placed in storage that is in compliance with HTA licencing standards. No capacity for bariatric bodies, leading to HTA reportable incidents, complaints and reputational damage.	Mortuary capacity log is in operation and informs the pathology scorecard for monthly reporting (average, max and min). Business continuity plan is in place to move bodies around the sites to ensure capacity is maintained within the HB. This relies on the Health Boards contracted funeral director to move the bodies in an appropriate and dignified manner. Mortuary staff are trained to complete the mortuary capacity log on a daily basis and to ensure the business continuity plan is executed in the event of likely capacity issues. Nuttwell units in use at Royal Glamorgan Hospital (RGH) and Prince Charles Hospital (PCH) "Real time" capacity white board installed in both mortuaries so porters/APTs can visualise quickly capacity issues. Private ambulance with a dedicated driver, now in use between sites. 4x4 vehicle so can be used during inclement weather (within reason). Can transport up to 4 deceased per journey, in a dignified manner.	Update March 2024: Daily monitoring of capacity continues. Occupancy appears to be reducing. Risk of further seasonal spike in deaths is still high. Bank Holiday weekend at month end also likely to place additional demand on Mortuary body storage capacity. Further risk by the MES becoming Statutory, increasing it's remit in April. Planned works at the University Hospital of Wales Mortuary places additional risk around regional Mass Fatalities incident(separate risk to be created). Nuttwell units still being utilised to manage capacity at Royal Glamorgan Hospital (RGH) which provide an undignified solution to body storage capacity management at RGH site. Dignity in Death Workshop engaging stakeholders in process scheduled for 7th March.	Quality & Safety Committee	16	C4xL4	C4xL2	↔	05.03.2018	05.03.2024	02.04.2024
23	5254	Executive Nurse Director / Deputy Chief Executive	Centre Support Function - Quality Governance - Concerns and Claims	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety	Failure to manage Redress cases efficiently and effectively in respect of Duty of Candour	IF: The Health Board is unable to meet the increased work demand in respect of the implementation of Duty of Candour Then: the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. Resulting in: Risk to quality and safety of patient care, resulting from poor management of cases. Financial impact to the Health Board from Redress cases which have been poorly managed and consequently proceed to claim.	Controls are in place and include: • New incident framework developed • Engagement with the All Wales Duty of Candour Network to discuss implementation of the Duty • Reports run on predicted case numbers • Request to the All Wales Duty of Candour Network that an impact assessment is undertaken	Update March 2024 - The Legal Services team continue to prioritise other areas of work which have risk of penalties i.e. LFRs and Inquests. A SBAR proposal for a member of the team to undertake some overtime to address extra redress cases has been developed. New invest to save bid has been prepared and is being reviewed. A demand versus capacity versus productivity assessment is being undertaken and will be completed early March.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	07.10.2022	29.02.2024	01.04.2024
24	5374	Executive Director of Strategy & Transformation	Central Function - Environmental Sustainability	Deputy Director of Strategy and Transformation	Sustaining Our Future	Environment /Estate/ Infrastructure	Fulfilling our environmental and social duties	IF: the health board's decisions fail to reflect our values or consider the long term environmental or social impact Then: we will not fulfil our socio-economic duty, our Wellbeing of Future Generations objectives or our value based healthcare principles Resulting in: negative environmental and social impacts and loss of trust and confidence among stakeholders	• Integrated Medium Term Planning Process aligned to the seven Welsh wellbeing goals and five ways of working. • 'CTM 2030' delivery focusses on community developments, employment and local procurement where possible. • CTM becoming established as an Anchor Organisation. • Decarbonisation Action Plan • Established a CTM Environmental Sustainability Group which will have oversight and delivery of CTM's decarbonisation agenda • 'CTM 2030' seeks to ensure that services take account of the impact on the environment • All-Wales approach to sustainable procurement • Green CTM Staff Forum • Fleet emissions reduction programme and trial of electric vehicles • Tree planting initiatives • Waste management – elimination of landfill for foodstuffs • Use of less environmentally impactful anaesthetic gases • CTM representatives attend the Welsh Government Green meeting • Update of the DAP by March 2024 • Board and Committee cover papers also now include environmental impact against SRs.	Update March 2024. Sustainability Position for the Health Board has been approved and will shortly be advertised. No Change to risk score as at this review.	Population Health & Partnerships Committee	16	C4xL4	8 (C4xL2)	↔	21.2.2023	16.2.2024	31.5.2024
25	3133	Chief-Operating Officer Executive Director of Nursing / Deputy Chief Executive	Central-Support Function-Facilities Patient Care and Safety	Governance-and compliance manager-Facilities Head of Clinical Education	Improving Care	Patient / Staff /Public Safety	Poor compliance with Medical Gas Safety Training . Impact on the safety – Physical and/or Psychological harm	IF: Staff are not able to attend Medical Gas Safety training or courses are being continuously rescheduled. Then: Staff are not being trained in safe storage and flow of cylinders (e.g. oxygen). Resulting In: Failure to adequately and safely obtain and continue flow of cylinders (e.g. oxygen), potentially causing harm to patients.	PSN041 Patient Safety Notice and local safety alert disseminated to all staff. Posters developed and displayed in areas to encourage attendance. New staff trained at induction. TMA has been undertaken. Refresher training is undertaken, however current attendance levels by clinical staff for Medical Gas Safety training is poor, hence the current risk score. Medical Gas Cylinder Policy developed with training section completed by Medical Device Trainer, referencing the mandatory requirement for training by all users. Completed To make it a key requirement that staff can be released to attend training to re-enforce safety and operating guidelines of medical gas cylinders. Completed. Medical Device Trainer has put in place a B4 role who is undertaking a rolling programme for Medical Gas Training, with two sessions, twice a month, at each ILG every month. However, although training has been undertaken for Porters and graduate nurses, nursing staff currently in post are still not attending and attendance continues to be poor due to current circumstances with Covid-19 and due to not being able to be released for the 2 hours of training. Medical Device Trainer and Assistant Director of Facilities to request again for the Executive Director of Nursing Midwifery and Patient Care to review nursing attendance and make the necessary arrangements to allow nursing staff to attend training and also to look at the possibility of introducing a 'training day' that will allow nursing staff to be released to attend those courses that are struggling with attendance levels. Meeting held and COO has requested for Facilities to work on a monthly Medical Device Training Compliance report template that can be presented to both COO and ILG Director leads to inform current compliance position and actions to improve attendance and compliance for all courses including Medical Gas Training. Medical Device Trainer has stated that the current report template needs to be reconfigured to account for the change of wards and Directorates for the new ILG structure and to deal with the pandemic, this will take time to complete, hence the change in action implementation date to account for this.	Update March 2024 - New module of training and education related to medical gases has been introduced in collaboration with Learning & Development and All Wales ESR Team to improve compliance and flexibility for all relevant staff to undertake training. Risk score to remain unchanged until training embedded.	Quality & Safety Committee. People & Culture Committee.	16	C4 x L4	8 (C4xL2)	↔	01.05.2018	04.03.2024	30.04.2024
26	4152	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director.	Improving Care	Patient / Staff /Public Safety	Back log for Imaging in all modalities / areas and reduced capacity Impact on the safety – Physical and/or Psychological harm	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 and 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.	Updated January 2024. Risk reviewed 22.11.2023. Non obstetric Ultrasound 7050 pts - 98 week wait - in-house Waiting List Initiatives (WLI), evenings and weekends MRI 2693 PTS - 50 week wait (main cohort of patients at 20 weeks) ongoing validation and planning for booking more complex cases e.g. arthrograms and General Anaesthetic paediatric lists. CT 2174 pts - 52weeks - active validation and cross site booking in progress Active review of compliance with Referral To Treatment (RTT) booking guidelines and streamlining. Next review scheduled for 15.1.2024. Update March 2024 -MRI van to be sited at CDC from April 2024.	Quality & Safety Committee	16	C4 x L4	4	↔	01.06.2020	19.2.2024	18.03.2024
27	4337	Director of Digital	Central Support Function - Digital & Data	Chief Information Officer	Creating Health	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Integrating Patient Records across the Health Board	IF: The Health board does not have a unified electronic health and care record and systems which are integrated across the organisation and with our primary and social care providers Then: The Health board will be unable to deliver safe, high quality, clinically and cost effective care to patients Resulting In: Compromised safety of patients needing treatment that are reliant on clinical test results and information being available to clinicians to plan and deliver the treatment plan and the requirement for sub-optimal manual processes Gaps in Control The full business case for the Bridgend / old-CT integration remains unfunded. There are currently a number of CTM systems that are not compatible with Bridgend systems. 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 UHB 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 MS365 platform however there are no resources available to support, train or integrate this platform within the EPR architecture	Key Controls 1. SBUHB Service Level Agreement 2. Bridgend disaggregation and the one-CTM aggregation plan 3. NHS Wales Control Agreement and data sharing agreements 4. Numerous national service management boards and Technical oversight groups providing strategic, tactical and operation governance. 5. National ePR programme and systems Additional Funding for ICT Integration of Bridgend - 27/02/2024 - large WG (AWCP/DIPF) capital sums received in Q3 and Q4 for improvements across CTM: £990k in Q3 for replacement of legacy devices (Win 7 and old Win 10 h/w), plus £2.98m received in Q4 for device replacement (i.e. £1.7m against Citrix reduction (igels)), replacement of older wireless access points (L1m linked to HEPPMA), and £200k for server/network security. This is in addition to the discretionary capital investments that have taken place during 2023/24. Good progress made against onboarding the data network and all of the servers. The remaining infrastructure transition task is Cisco telephony disaggregation. Further discretionary and AWCP (HEPPMA wireless funding) investments will take place in 2024/25, with a plan submitted to ECMG for the anticipated £1.888m of discretionary in 2024/25. In the case of revenue, there remain significant concerns that work has been onboarded at CTM resulting in a significant reduction in the SBU SLA, however only a small proportion has been reinvested in the additional staff required to carry out the work recurrently, the rest has been submitted to CRES to meet the Digital savings target. CTM Digital has accepted responsibility for these work areas and retained the SLA funding, but not invested in the required Digital staff to undertake the work, exposing CTM to unnecessary risk.	Update March 2024: Integrate Bridgend ICT Systems - Decision around retaining Cisco telephony has been made and recommended by the Transition Board, subject to recirculation of the SBAR. ISE Project is being setup following procurement of services and licences. Contracts are under review - LAN/WAN/Telephony. Update January 2024 - Meetings with Lead Nurse have taken place proposal training paper discussed at the 12/12/23 Mental Health and LD Health and Safety Committee. Recommendation 5 nurses are contracted to deliver PMVA training to the Care Group 25 days per year on band 4. PSA to provide professional governance. Deputy Head of Nursing, Mental Health is leading, existing trainers have been consulted on the proposal. Review planned for 31.3.2024. Update March 2024 - Funding for addition trainers have been produced in the way of a business case for Executive Leadership Group. This will be presented in February 2024. Risk to be reviewed end of March 2024.	Digital & Data Committee	16	C4 x L4	8 (C4xL2)	↔	14.10.2020	28.2.2024	30.04.2024
28	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 Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	A training review was undertaken to identify HB violence and aggression training requirements. Following review the HB is unable to achieve full compliance on any training module. This is due to a lack of training resource within the Health Safety and Fire Team. If the training is not delivered, then the organisation will not be compliant with mandatory Violence and Aggression Training. Restraint training is mandatory for inpatient acute services for Mental Health and CAMHS. Training is delivered by inpatient staff and the Health Safety and Fire Personal Safety Advisor. If there is insufficient training resource available then the organisation will be unable to maintain compliance on annual refreshers. If the PSA is unable to deliver key aspects of their role due to the high demand for violence and aggression training delivery then advice to clinical areas is greatly reduced. Resulting in non compliance of mandatory training and a risk of injuries to both staff and patients and possible claims.	Personal Safety Advisor delivers training modules with some support from part time trainers within Mental Health and CAMHS. However there is insufficient resource to ensure compliance within the entire organisation. Trained tutors available from clinical areas. The PSA regularly has to support training due to ward based trainers unable to be released to deliver. This role is not currently included in their job description which has resulted in some trainers resigning from delivering, hence compounding the lack of training resource. The availability of the PSA to offer personal advice to clinical areas is greatly reduced due to the excessive training requirement.	Update January 2024 - Meetings with Lead Nurse have taken place proposal training paper discussed at the 12/12/23 Mental Health and LD Health and Safety Committee. Recommendation 5 nurses are contracted to deliver PMVA training to the Care Group 25 days per year on band 4. PSA to provide professional governance. Deputy Head of Nursing, Mental Health is leading, existing trainers have been consulted on the proposal. Review planned for 31.3.2024. Update March 2024 - Funding for addition trainers have been produced in the way of a business case for Executive Leadership Group. This will be presented in February 2024. Risk to be reviewed end of March 2024.	Health Safety & Fire Sub Committee	16	C4 x L4	9 C3xL3	↔	31.08.2021	02.01.2024	31.3.2024
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	4906	Executive Nurse Director / Deputy Chief Executive	Central Support Function - Quality Governance (Concerns & Claims)	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety	Failure to provide evidence of learning from events (Incidents and Complaints)	If: The Health Board is unable to produce evidence of learning from events. Then: the Health Board will be unable to recoup any costs from Welsh Risk Pool for personal injury or clinical negligence claims made against the Health Board. Resulting in: Risk to quality and patient safety with potential for further claims as learning and improvement will not have taken place. Financial impact to the Health Board	Controls are in place and include: • Monitored and reported through the weekly Executive Quality & Safety meeting. • Regular engagement and meetings with the Executive team to assist in gathering of learning. • Improvement plan implemented by WRP with monthly targets to submit the backlog. • Learning From Event Report (LFER) Standard Operating Procedure devised and disseminated • LFER 'How to Guide' devised and disseminated • Ad-hoc training available on request. • Internal targeted monitoring in place.	Update February 2024: LFER status is regularly monitored in: Weekly Patient Safety, Complaints and Legal Services data meeting, Weekly Executive Patient Safety Meeting and Quality & Safety Committee. New systems and processes have been in place for some time in respect of the management of LFERs. However, benefits from improvements are now coming to fruition, with LFERs being managed in a more efficient way. If non-engagement, more timely escalation is proving successful. A deadline for the end of January 2024 has been set by WRP to submit and have approved all LFERs triggered before 1st September 2023. All deferred LFERs were submitted within timeframes, therefore 53 submitted. We have received a penalty on 1 of the cases. WRP have indicated that penalties will be applied to LFERs which are not submitted within timeframes, this remains a risk area for the health board with 16 LFERs overdue. These will be submitted, with a risk of these being Red or Amber deferred. LFER SBAR developed in readiness for Q&S Committee.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	02.11.2021	29.02.2024	01.04.2024
30	4417 (Linked to Risk IDs 4706 and 4703)	Chief Operating Officer	All Care Groups	Deputy COO (Acute Services & Primary, Community & Mental Health)	Improving Care	Patient / Staff /Public Safety	Management of Security Doors in All Hospital Settings	Following several serious incidents following patients absconding from clinical areas, the HSE have issue an Improvement Notice on Bridgend Integrated Locality Group (see Documents) outlining the following actions: In consultation with employees and involving competent persons: 1. Identify the units, wards and premises where in-patients may be at risk from wandering, absconding or escaping. 2. For each of these, undertake a suitable and sufficient risk assessment of physical and procedural measures to prevent in-patients from wandering, absconding or escaping. 3. Identify the measures needed to protect patients at risk 4. Record the significant findings. Any lessons learned from the above should be formally shared with the other 2 Integrated Locality Groups for action. IF: the Health Board do not comply with the notice. THEN: the Health Board may be subject to prosecution by the HSE RESULTING IN: Large Fines and poor publicity.	Clinical areas across the Health Board should have in place local arrangements/procedures to prevent patients from absconding. A document has been circulated from Estates which outlines procedures around how and where staff should be reporting failures in doors.	Update March 2024: Update from Health & Safety Co-ordinator and Head of Business Support. Night shift / Out of Hours observations was completed for Princess of Wales and the report uploaded to document section. Meeting held with Head of Business Support for the Chief Operating Officers team on 4 March 2024 to plan acute site assessments looking at arrangements in all ward areas for access. The first assessment will happen on Monday 11 March at the Royal Glamorgan Hospital, to be followed by the other DOH sites and also Community Hospitals. A template has been developed as a starting point for discussion - and will look at current and preferred arrangements, demographics of ward, CCTV, staffing and any other implications. It is anticipated that after the first day's assessment, the process will develop as the themes come more sharply into focus. No change to risk score.	Health Safety & Fire Sub Committee	16	C4 x L4	8 C4xL2	↔	30.09.2020	04.03.2024	31.03.2024
31	4671	Director of Digital	Central Support Function - Digital & Data	Chief Information Officer	Creating Health	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects	Lack of a resilient and performant Digital Network Infrastructure and Assets	IF: The Health Board suffers regular local and/or national network issues and/or outages to critical clinical and business systems or performance issues in accessing and using systems. 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. 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: Loss of information integrity and accessibility as multiple copies of clinical records. Threat of malware being introduced on to the network from unmanaged data, systems and software. Possible breaches to the GDPR, safeguarding and information governance risks. Mistrust by staff of the ICT systems and services they are using	Redacted due to business sensitivities. Detail received in closed session of the Committee.									
32	4732	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety	Lack of orthogeriatrician as NICE guidance and KP11 NHFD	IF: If we do not have this specialist service THEN: our patients will receive suboptimal care than others in the UK and across Wales with potential for non achievement of KPIs set by the Welsh Government, increased length of stay, increased complications such as delirium and pressure ulcers and increased mortality. RESULTING IN: The inability to achieve good outcomes and care appropriately for our patients has a detrimental effect on staff wellbeing too.	The already stretched on call medical team are contacted for ad hoc advice. There is no Care of The Elderly (CoTE) service and no specialist advice available	Update January 2024: Senior Management Team reviewed, following clarity of ask from Executive Team. Unscheduled Care Group will hold responsibility for Consultant orthogeriatrician to be working with the wider Care of the Elderly Team on each site. Awaiting disestablishment of posts in planned care in order to fund. Risk rating remains at 16. New review date 28/02/24. Update March 2024 - Previous update remains, Orthogeriatrician service model is being reviewed in CTM as part of the trauma and orthopaedic reconfiguration of service. SMT reviewed and has requested that this risk is transferred to planned care Directors for management. SMT again reviewed Awaiting disestablishment of posts in planned care in order to fund. This forms part of the investment cycle for the financial period 24/25.	Quality & Safety Committee	15	C3 x L5	4 (C2 x L2)	↔	31.8.2023	27.02.2024	31.03.2024
33	4080	Executive Medical Director Executive Director of People	Central Support Function - Medical Directorate & People Directorate	Assistant Medical Director	Improving Care	Patient / Staff /Public Safety	Failure to recruit sufficient medical and dental staff	If: the CTMUHB fails to recruit sufficient medical and dental staff. Then: the CTMUHB's ability to provide high quality care may be reduced. Resulting in: a reliance on agency staff, disrupting the continuity of care for patients and potentially affecting team communication. This may 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 CTMUHB being drafted • Establishment of medical workforce productivity programme • Work to understand workforce establishment vs need • Development of 'medical bank' • Developing and supporting other roles including physicians' associates, ANPs • Improving induction and development of new doctors	Update March 2024 - led by the Change Hub Programme Team, in collaboration with the Care Group leads and Chief Operating Officer, the Medical Workforce Productivity Programme (MWPP) has now been referred to focus its efforts on workforce performance across the health board. There are now two accountability groups that meet monthly (Performance and Escalation Group & Workforce Framework Group) - these feed in to the MWPP, Value and Efficiency, and then Transformation Board. No change to risk score.	Quality & Safety Committee People & Culture Committee	15	C5 x L3	10 (C5xL2)	↔	01.08.2013	04.03.2024	31.05.2024
34	2808	Chief Operating Officer	Children and Families Care Group	Clinical Service Group Manager	Improving Care	Patient / Staff /Public Safety	Waiting Times/Performance: ND Team	IF: The Neurodevelopment service does not have capacity to achieve the WG assessment target (80% of assessments to commence within 26 weeks of referral) and to follow up patients in a timely way, due to demand exceeding capacity Then: Patients will wait excessive periods to reach a diagnosis and children on medication that require titration and monitoring may not be able to be seen within the appropriate timeframes Resulting in: Delays in appropriate treatments being commenced, delays in accessing support e.g. in school following a diagnosis, delay in being effectively titrated, risks associated with delays in medication monitoring	The service is operating as efficiently as possible e.g. enhanced roles for SLT/CNS/Pharmacist. Pathways have been reviewed e.g. ADOS's limited to only those cases where clinically necessary. Clinical Lead role created to support this (as below). Recurrent funding agreed at Planned Care Board 25/08/2022 and successfully appointed 1.0 wte Psychiatrist (Clinical lead role, Uplift from 8a to 8b 0.6 wte Pharmacist, 1.0 wte Band 3 admin & 0.6 wte Band 3 HCSW - appointed Nov 22 Meetings with National Lead for Values Based and Prudent Health Care taken place to look at modelling of the service. Bids have been submitted through successive IMTPs and previously against new WG funding sources for the ND service. Internal working group in place to repatriate SLA from Swansea Bay so that a local service can be developed WG funding (£12m) announced for ND services - health, education and third sector. SBARS being developed to bid for funding to enhance provision moving forwards. WLI agreement following Neurodivergence Improvement Programme funding via RPB until end of March 2023 to address longest waiters achieved no patients to be waiting over 104 weeks at end of March 2023. WLI agreed to continue April 2023 onwards to maintain current wait times whilst additional funding is being agreed through regional partnership board to develop a pan CTM model.	Update March 2024 - Realignment of budgets completed - 3.5 wte AHP going currently out to advert. Once successfully recruited into, the capacity available within the team will meet the demand. Further discussion and investment to address backlog of patients will be required.	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	14.07.2017	22.2.2024	28.3.2024
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1	3993	Executive Director of Strategy & Transformation	Central Function - Planning Project Risk	Head of Capital, Strategic and Operational Planning	Improving Care	Patient / Staff /Public Safety	Fire Enforcement Notice - POW Theatres.	IF: The Health Board fails to meet fire standards required in this area. Then: the safety of patients, staff, contractors/visitors etc. and the protection of the buildings could be compromised. Resulting in: potential harm, risk of fire. Possible further enforcement in the form of prosecution.	Storage room obtained on ward 16 to store theatre equipment to ensure evacuation corridor is kept free for evacuation. Staff training on lift evacuation. Closed storage cupboards purchased for safe storage of equipment. "safe" areas identified with Senior Fire officer for storage of equipment in corridors. Weekly meetings to discuss and plan building work necessary to meet requirements of the enforcement notice. Enforcement notice has been extended to December 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 January 2024 – A request was made to South Wales Fire & Rescue Service (SWF&RS) to extend the Fire Enforcement Notice by a period of 2 years to enable the remedial scheme to be implemented. SWF&RS have initially agreed an extension of 12 months, with the agreement the Health Board could apply for a further extension if necessary. The current Notice is now due to expire on 1st January 2025. There is documentation on this available on request from the Assistant Director of Health, Safety & Fire. Update March 2024 - status of the Fire Enforcement Notice remains as outlined in January 2024. Business Case is in development for Welsh Government Funding and is due to be submitted by October 2024.	Quality & Safety Committee Health, Safety & Fire Committee	15	C5xL3	8	↔	31.01.2020	05.3.2024	06.05.2024
36	4672	Director of Digital	Central Support Function - Digital & Data	Chief Information Officer	Creating Health	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Access to a complete, integrated, and coded medical record.	IF: The Health Board is not able to record information accurately and reliably, with complete and up to date information Then: the data informing the clinical, regional and organisational decisions we and our partners (including WG) make, will be inaccurate, out of date or incomplete Resulting in: Degradation in our delivery of the quadruple aim and strategic objectives and damage to our reputational standing with our population and partners. Further we will be prevented from driving forward our ambitions to become a digital organisation, an exemplar for R&D and Value etc. Tactical controls: Digital element of the strategic programme - Culture to digitise the EPR, our communications, how we do business National Architecture Review - encompassing (NDR /CDR & Sharing arrangements) Coding transformation programme . Gaps in controls Scanning time of outpatient activity to digitise the record is at 51 days cf maximum clinically safe time of 24-48 hours Quality of paper record and its filing is very poor with audits identifying over 70% of paper records are not maintained to acceptable standards Digital solutions not yet using snomed-CT/ structurally coded data Information and Technical Standards not being followed with national body favouring document rather than data exchange Vast amounts of clinical information stored in disparate spreadsheets not visible to central medical record or available to patients or system leaders (including value based healthcare) Digital transcription programme unsupported & unsupported from march 23	Operational controls: Coding key performance indicators covering productivity, demand and backlog robustly monitored Digitised Patient Notes programme board monitors scanning times, adherence of contractor to terms and quality of staff in maintaining a record DHCW annual coding quality audit. Coding Improvement and transformation plan established incorporating additional trained coding capacity, coding at source, use of data captured in other systems and e-forms implemented. Natural language programming resource deployed and outputs of programme being validated. Tactical - EPR programme with deployment of snomed-CT ontology server, WCP & E-forms etc. Tactical controls: Digital element of the strategic programme - Culture to digitise the EPR, our communications, how we do business National Architecture Review - encompassing (NDR /CDR & Sharing arrangements) Coding transformation programme . Gaps in controls Scanning time of outpatient activity to digitise the record is at 51 days cf maximum clinically safe time of 24-48 hours Quality of paper record and its filing is very poor with audits identifying over 70% of paper records are not maintained to acceptable standards Digital solutions not yet using snomed-CT/ structurally coded data Information and Technical Standards not being followed with national body favouring document rather than data exchange Vast amounts of clinical information stored in disparate spreadsheets not visible to central medical record or available to patients or system leaders (including value based healthcare) Digital transcription programme unsupported & unsupported from march 23	Update March 2024 - Day forward scanning has been maintained to be within the agreed 48 hour turn around due to a focus by our external provider (GDS) moving from legacy note scanning to day forward. Significant financial and opportunity costs in maintaining scanned record Moratorium on destroying records has been lifted Clinical coding improvement programme delivering 95% of episodes being coded within the month and 98% by 2 months being maintained Clinical resource and Admin support levels to maintain and record the record being cited as challenging Digital dictation programme being refreshed Integration architecture determined and repository developed. Optimise launch using HB developed e-forms well received by clinicians and operational team, with funding committed to supporting digitalisation of E-PR Contract to explore API between HB and GPs signed with 3rd party supplier NDR programme greatly accelerating.	Digital & Data Committee	15	C3 x L5	9 (C3xL3)	↔	05.06.2021	06.03.2024	06.05.2024
37	5040	Director of Digital	Central Support Function - Digital & Data	Chief Information Officer	Creating Health	Operational: • Core Business • Business Objectives • Projects Including systems and processes, Service /business interruption	Digital Healthcare Wales (DHCW interdependencies	IF: The Health Board can not integrate new applications into its digital architecture in a timely fashion Then: there could be a detriment to patient care, inefficiencies in care provision and loss in confidence by Health Board staff in the technology provided to them leading to them using alternative software and bespoke systems (including paper based systems) to carry out their duties which are not integrated and major strategic priorities for the organisation (e.g. Bridgend aggregation and the deployment of the new Emergency Department system) not being delivered Resulting in: delays in clinical decisions and consequently treatment which may affect clinical outcomes, reduced levels of productivity and thus poorer access to services, staff appetite to work digitally and in accordance with the digital standards required to realise the full strategic benefits of an integrated record and repository not being realised. Other consequences include: 1. Loss of information integrity and accessibility as multiple copies of clinical records. 2. Failure and delay of digital system deployments (e.g. WEDS) 3. Possible breaches to the GDPR, safeguarding and information governance risks. 4. Mistrust by staff of the ICT systems and services they are using 5. Money being wasted	A Myrdin strategic programme group has been established, chaired by the CEO of DHCW to map out how the constraints can be overcome SLAs are in place between DHCW and NHS Wales organisations, however their futility has been exposed by demand pushing the waiting times for developments to start (not complete) to over 12 months Gaps in controls: WG have agreed some funding for the PAS element, however the DHCW IMTP continues to be a top down decision process rather than one being based on HB (user / customer) needs - driven in part by demand overwhelming their capacity (much of which is either Covid born or results from the significant overrun in establishing a minimum viable product to replace CanISC) and numerous critical constraints not continuing to be observed in the system whilst the architecture remains closed. HB carrying vacancies in critical areas with no capacity to cover the work from within. As a consequence programme to digitise the Emergency Department processes and records has been suspended. Data acquisition from DHCW products is a curates egg, some new APIs are being made available to standards, however latest PAS offering is via csv download, presenting challenges to adoption of standards within certain areas. UHB still awaiting availability of access to key HB data such as radiology and tests results.	Update March 2024 - Chief Digital Officer for Wales has funded a review of the EPR strategy looking to find strategic solutions to the inability to integrate systems within and across organisations that enables the efficient and effective management of workflow and data. CTM Board Development session scheduled for the 15th March 2024 will consider the requirements of an EPR to support CTM 2030 strategic direction and whether there is a requirement for a revision to the tactical route for delivery, which is presently National System delivery with document exchange in a closed architecture. Funding for digital systems is being reduced in 2024/25 presenting risks to the deliverability of step change improvements.	Digital & Data Committee	15	C3xL5	9 C3xL3	↔	07.02.2022	06.03.2024	06.05.2024
38	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 Mental Health Care Group	Lead Infrastructure Architect Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Creating Health	Patient / Staff /Public Safety	Use of Welsh Community Care Information System (WCCIS) in Mental Health Services	IF: Mental Health Services do not have a single integrated clinical information system that captures all patients details. Then: Clinical staff may make a decision based on limited patient information available that could cause harm. Resulting In: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace.	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 CTMUHB staff who currently use WCCIS via local authority over to CTMUHB WCCIS platform. Requires Programme Board approval. 3. Business case to be progressed following Board approval. 4. A new MHL D 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 March 2024 - There is still no confirmation of national replacement system as yet. The Health Board and Care Group are exploring alternative interim digital systems and there are 2 events in March to look at the suitability of the PARSi and RIO systems. The mitigation and risk score remains unchanged.	Quality & Safety Committee	15	C5xL3	6	↔	07.11.2018	05.03.2024	31.07.2024
39	4691 Linked to RTE Risks 4803, 4799, 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	IF: Mental health inpatient environments fall short of the expected design and standards. Then: Care delivered may be constrained by the environment, which is critical to reducing patient frustration and incidents as well as presenting more direct risk as a result of compromised observations. Resulting in: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace and extended lengths of stay.	Assistant Director of Strategic Transformation – Mental Health has commenced in post. This new role will lead a range of strategic programmes including recommencing a capital business case for a new Mental Health Unit. Annual revisiting of all patient ligature risks and completion of Statement of Needs via capital process for any ligature risks assessed as needing resolution. All anti ligature works planned for 2022 – 2023 have now been completed. A scoping document case to be prepared and submitted to Welsh Government Inpatient Improvement Programme has been 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.	Quality & Safety Committee	15	15 (C3xL5)	6 (C3xL2)	↔	15.06.2021	29.02.2024	01.07.2024
40																		

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
4922	Director of Corporate Governance Interim - Executive Director of Nursing	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	Covid-19 Inquiry Preparedness - Information Management	IF: The Health Board doesn't prepare appropriately for the Covid-19 Inquiry THEN: the organisation will not be able to respond to any requests for info RESULTING IN: poor outcomes in relation to lessons learnt; supporting staff-wellbeing and reputational issues.	The Covid-19 Inquiry Working Group are monitoring a number or preparedness risks such as: - Retention and Storage of information, emails and communication - Capturing reflections of key decision makers prior to any departure from the Health Board - Organisational Member. The Health Board has a Covid-19 Inquiry CTM Preparedness Plan which is monitored via the Covid-19 Inquiry Working Group. The Board and Quality & Safety Committee received a detailed update on the preparedness progress at their respective meetings in March 2022 and September 2022. The Assistant Director of Governance & Risk is the first point of contact for any Inquiry contact and the Executive Director of Nursing is the Interim Senior Responsible Officer (SRO).	Update March 2024 - Covid-19 Inquiry Project manager has been working with the Head of Information in the digital team to explore automation options to support the archiving and cataloguing of information. It is important to note that the archiving will be a hybrid approach. While the automation will undoubtedly save time - it will extract properties data from files within a specified folder, this can then be manipulated to speed up the coding as well as the capture of this data, there is still a need for manual elements such as description and identifying keywords. There is also a need to be able to capture Adhoc files and data. A form/workflow has been designed that will incorporate these elements also to support the archiving process.	Quality & Safety Committee	12 (Risk score reduced from a 16 in March 2024)	8 (C4xL2)	The system for the timeline is now in place and population of information linked to the repository has commenced. The resource implications are significant and therefore it will take some time for the Health Board to map and archive all information, however, it is considered appropriate to reduce the likelihood score from a 4 to a 3 at this stage.
3008	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Risk of injury due unavailability of opportunities to train and maintain compliance with Manual handling training.	If: There is a lack of manual handling training there is the risk of potential injury to a member of staff or injury to the patient. Then: There are a number of clinicians who have not had the opportunity to meet the requirements for manual handling training. Resulting In: Potential harm being caused to both staff and patients.	1. Staff are aware of the risks associated with manual handling. 2. All staff have been informed to consider the ergonomics of the environment that this activity is being undertaken. 3.Appropriate equipment is available in the clinical areas or on request from the MH team e.g. pat slides, slide sheets, hoists. 4. Manual Handling risk assessments are incorporated into the admission bundles 5. The training group are planning training for clinical staff with the manual handling department - current position that this can not be supported 6. Ask other HB`s their MH requirements SBUHB online training package to be shared. 7. Directorate will Seek out any opportunities for online updating to support current practice 8. 2 registered nurses to undertake train the trainer and initially cascade to community midwifery staff, commencing Sept 2022. 9. Staff member identified to action monthly module B training to facilitate improvement in knowledge and skills- agreed 11.10.22 10. In agreement with MH team 2 midwives to undertaken 5 day TTT course for manual handling in July. Meeting arranged with MH team to arrange bespoke 3 hour course for all midwives to be implemented 2023/2024 for 100% compliance in 12 months.	Update January 2024 - Bespoke Manual Handling training was commenced in Sept 2023. The plan is that the agreed sections of the All Wales Manual Handling Passport will be completed by all staff over a 2 year period. Year 1 (Part1) – Mod A, B, part of C Year 2 (Part 2) - Mod C, D and E (with agreed exceptions) With regards to compliance, the majority of staff are already rostered to attend Part 1 between Sept 23 – July 24. A follow up email was sent to line managers and roster managers before Christmas reminding them to book on any staff who had not already been rostered. With regards to Part 2, when the training dates for next academic year are released, the roster managers will roster all of there staff on to training for the entire year so that we can see the compliance trajectory and chase up rebooking staff in an efficient manner should they not attend training for any reason. Update March 2024 - on target to achieve compliance with part one of course, therefore risk score in terms of likelihood reduced.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	6 (Risk score reduced from a 16 in March 2024)	2 (C2xL1)	Children and Families Care Group have reviewed this risk in light of the manual handling training now being mandated sessions. Service wide training is also on track to be completed by September 2025. Risk score therefore reduced in terms of likelihood from a 4 to a 2. The risk will now be managed on the Children and Families local risk register. The rationale for the reduction in consequence as well as likelihood is as follows. It is anticipated that with training and awareness sessions 3-4 hours this year and 4 hours next year, clinicians will minimise their risk of a manual handling injury and where one could not be avoided e.g. back strain leaning over a birthing pool, the impact is minimised through training i.e. changing the position more regularly reduces the potential amount of back strain.
5427 (Replacing 5154)	Executive Director of Finance & Procurement	Sustaining Our Future	financial Stability Risk	Failure to reduce the planned recurrent deficit of £79.6m at the end of 2023/24.	IF: The Health Board is not able to plan and deliver changes which enable current run rates of expenditure to align with the available funding for 2023/24. Then: The Health Board will not be able to deliver a break-even financial position for 2024/25. Resulting in: Potential deficit in 2024/25 leading to potential short term unsustainable cost reductions with associated risks, qualification of the accounts and potential Welsh Government regulatory action. Failure to meet statutory financial duty WG not supporting the Health Board's plan Potential cash shortfalls in the latter months of 24/25	Developing the Health Board's understanding and use of Value Based Healthcare principles to drive service planning and improvement going forward. Developing a more project and programmatic approach to planning and delivery of efficiency savings schemes, with focus on pipeline schemes as well as schemes in delivery. Including the development and implementation of the CTM Improvement Plans. Developing the Value & Efficiency Programme with a focus on 'Enabling schemes' to support savings identification and delivery. Routine monitoring arrangements in place. Regular reporting to the Executive Leadership Group, the Planning, Performance & Finance Committee and the Board.	Update March 2024 - As at M10 the Health Board is reporting a forecast underlying deficit at the end of 23/24 of £19.4m. This forecast assumes that the Health Board secures the £51m recurrent funding that is conditional on achieving the break even Control total for 23/24. This forecast underlying deficit is the starting position for the draft financial plan for 24/25. On this basis the likelihood risk score has been reduced from a 4 to a 3.	Planning, Performance & Finance Committee	12 (Risk score reduced from a 16 in March 2024)	8 (C4xL2)	
4699	Director of Digital	Creating Health	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm & Statutory Duty / Legislation	Failure to deliver a robust and sustainable Information Governance Function	IF: The Health Board is not able to legally share the business and patient sensitive information for which it is a data controller and which it is required to shared for the delivery of care Then: There will be a loss of trust and confidence in the Health Board from its patients, population, staff and 'care providing partners' and thus will not have the information required to provide safe, high quality and effective care and to make informed evidenced based decisions. Resulting in: Poor outcomes for our population, a loss of reputation for our organisation, substantial delays in improving services, inability to collaborate regionally or deliver integrated care services.	Key Controls: - Adoption and implementation of All Wales IG and Data protection policies, - Continual improvement and progress made in mitigating non delivery of legislation (CLDC, DPA etc.) - Mandatory training in Information Governance with auditing functionality (such as NI(AS) built in to monitor compliance, - Accessible but robust data protection process for new and existing data sharing arrangements (DPIA procedures) - Joint data controllership arrangements with DHCW + WASPI -Professional (clinical) training and approach to maintain an accurate and timely medical record Gaps in Controls: 1. Shortfall in trained IG professionals 2. Inability to legally stipulated timescales for Freedom of Information and Subject Access Requests	Update March 2024 - The Health Board has increased the capability and capacity for the Information Governance and cyber security functions which is enabling the Health Board to practice in line with legislation and to make inroads into training and organisational development, required to enhance the culture of the organisation in working in a digital and AI era. The Information Commissioners Office have closed off their audit engagement with the Health board having been given the necessary evidence to provide the requisite assurances.	Digital & Data Committee	9 (Risk score reduced from a 15 in March 2024)	6 (C3xL2)	In response to the mitigation and controls now in place as outlined in column H this risk has score has been reduced and therefore de-escalated from the Organisational Risk Register.

	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	4780	Executive Director for People	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Patient Handling Training	If there are no Trainers available to provide patient handling training Then all new starters need to be on restricted duties. Organisational compliance is affected. Training response to Incidents such as W156305 cannot be achieved. Manual Handling Training staff resource is not sufficient for new HB. Current establishment of two Trainers to approx. 7000 patient handling staff makes compliance with regulatory requirements unachievable. Resulting in breach of Health & Safety Law, particularly MHOR 1992, LOLER 1998, PUWER 1998, H&S at Work Act. Non-compliance with Organisational mandatory training requirements. Enforcement action from the HSE.	Two Band 3 Training Assistants continue to deliver Inanimate Load Handling Training so staff groups such as Admin & Clerical are not at risk. The current Training Post for Bridgend is vacant, new Trainer commencing employment 31st August 2021. Trainer in post at Tonteg is on LTS (Long Covid). Manual Handling Advisor picking up training where possible which is impacting on their ability to function within their role.	Update January 2024 -All funding now approved for these additional posts and all posts are in the various stages of recruitment. Risk score will be reviewed in February.	Health Safety & Fire Sub Committee	mar-24	The Health Board has approved a business case to support additional training staff within the Manual Handling Team. These posts have now all been recruited except the risk Support Officer who is due to start on the 11th march 2024. A new training strategy has been implemented to provide additional training availability throughout the Health Board.
2	4827	Executive Director for People	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Lack of Lead for Face Fit Training along with Face Fit Trainers	If the organisation fails to appoint and provide a fully qualified face fit testing lead and suitable number of Face Fit Testers. Then there is a potential for staff to be exposed to airborne viruses e.g. Covid, flu, etc.; Resulting in lack of assurance that the risk is being adequately managed at a local and Board level further resulting in a high risk of prosecution by the Health and Safety Executive.	Departmental Trainers have been trained but not in the numbers required by the organisation. Many of those trained during the first phase has now returned to substantive posts and are unable to undertake this role. Also may now be out of compliance for annual review of practice. Single H&S Coordinator is taking up this role on a part-time basis but this is inadequate for the requirements due to the commitments of his substantive post and the demands/size of the organisation. Departmental trainers are in post across the organisation but not all are able to fulfil this role either due to returning to busy substantive roles or being out of compliance of their annual review. Despite posts being added to Trac, it has become apparent that there is no funding available in the UHB to support this work. Discussions are underway between the Director for People and the Deputy Director of Nursing. No clear plan available to address this risk currently.	Update January 2024 - Business case approved but not for the full funding. Two fit testers and lead roles have been advertised and due to close middle January 2024. Risk score ill be reviewed in February.	Health Safety & Fire Sub Committee	mar-24	Since the last update provided on this risk, a business case has been approved and a Fit Testing Team have been appointed. The Lead is due to start on the 18th March 2024 and the 2 Fit Testers will commence on the 8th April 2024.
3											



Agenda Item

5.3

Audit & Risk Committee

AUDIT RECOMMENDATIONS TRACKER UPDATE REPORT

Dyddiad y Cyfarfod / Date of Meeting	18/04/2024
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

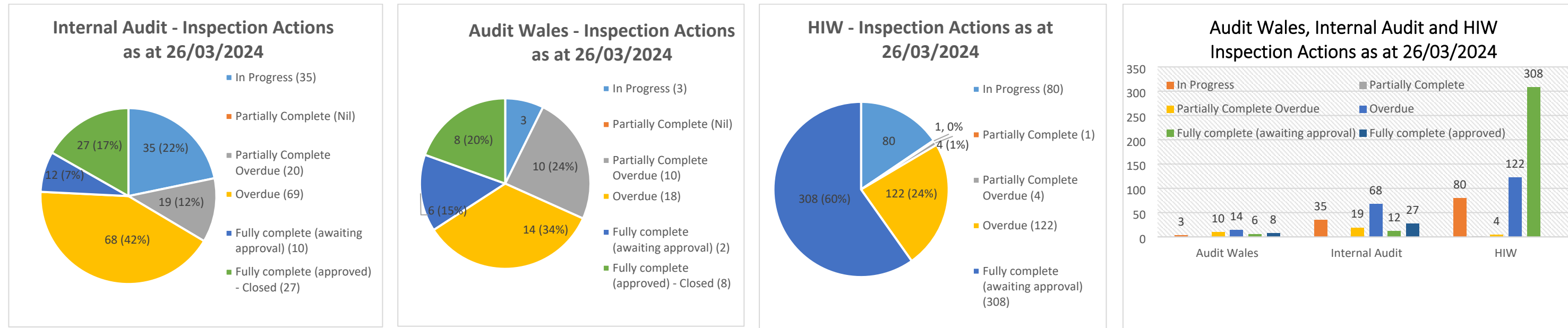
Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Executive Leadership Group	08/04/2024	<i>Pending</i>

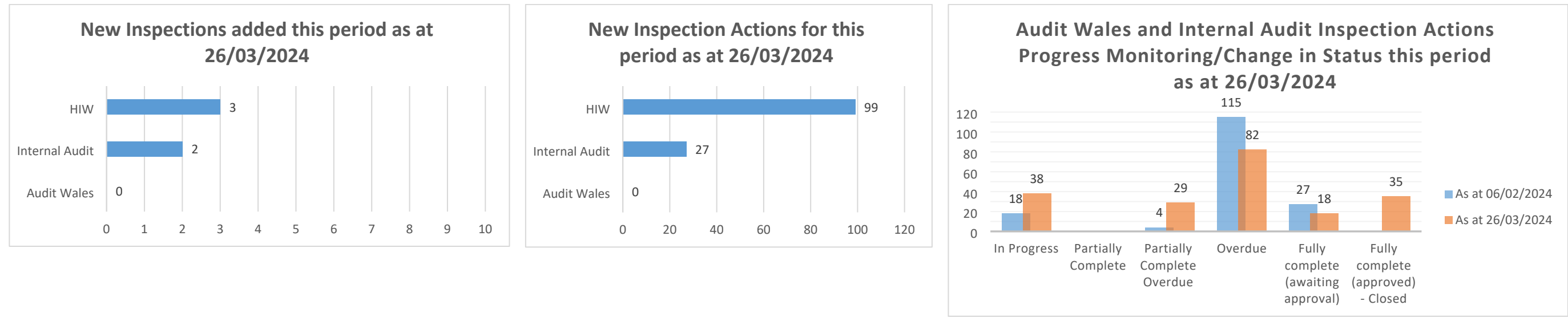
Acronyms / Glossary of Terms	
AMaT	Audit Management and Tracking
HIW	Healthcare Inspectorate Wales

Tracker Dashboard

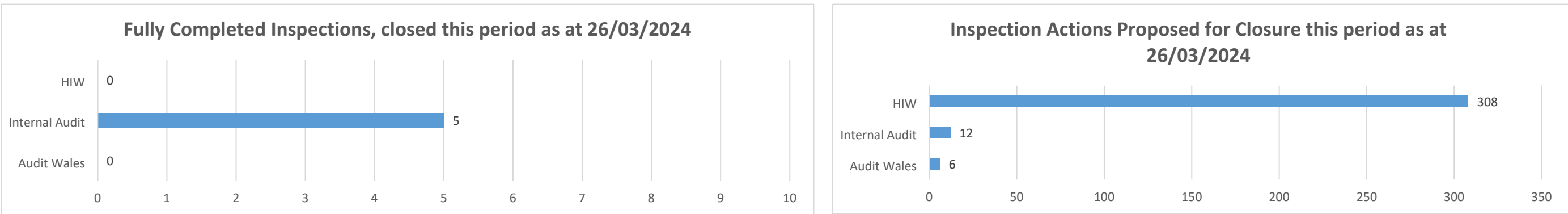
Status: Inspection Actions:



Inspections / Inspection Actions Added:



Closed Inspections:



1. Situation /Background

- 1.1 The main purpose of this report is to present an update to the Audit & Risk Committee on reported progress of audit report recommendations and actions 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.
- 1.3 A dashboard summary of the Health Inspectorate Wales (HIW) Improvement plans and Immediate Assurances from inspections have been included on page 2 of this report, however, the detailed tracker is currently in the process of being updated for the Quality & Safety Committee in May 2024, and will therefore be received at the next meeting of the Audit & Risk Committee in June 2024.

2. Specific Matters for Consideration

- 2.1 Please see the detailed dashboard and tracker with progress updates in **APPENDIX 1**.

2.2 Report format

The Committee are reminded that the report being presented is a transitioning process and will continue to evolve. There have been some changes and advances made in the dashboard capabilities allowing a more in-depth review of the progress.

The report at **APPENDIX 1**, remains a hybrid approach and has still required manual manipulation for some aspects.

The Quality Governance and Compliance Team continue to work with the system provider on further developments needed to fully automate and provide a robust and effective report as evidenced in **APPENDIX 2**.

The table at **APPENDIX 2** also captures the requests that were suggested by Committee members in February 2024, and therefore assurance is provided that the team are fully engaged with the software developers in order to improve the system assurance purposes.

The proposed approach for this report was shared with Committee members and attendees via email on the 19th January 2024 for comment and feedback and discussed again in the February Audit and Risk Committee.

2.3 Tracker Updates

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

2 NEW Internal Audit Reviews have been added to the Audit Recommendations Tracker including **27 NEW** Inspections Actions:

- Internal Audit/2024/162 (COO)- 4-hour Emergency Department Performance Reporting Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)
- Internal Audit/2024/163 (Digital)- IT Service Management Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)

5 Internal Audit recommendations have been completed and are proposed for **CLOSURE**, Please note that the data extracted from AMaT includes actions following a data cleanse conducted on 11th March 2024:

- Internal Audit/2022/123
CSG & ILG Quality Assurance_Final Internal Audit Report August 2022 (Review reference: CTMUHB-2122-05)
- Internal Audit/2023/70
Follow-up: Bridgend Transfer of Informatics Services_Final Internal Audit Report April 2023 (Review reference: CTMU -2223 - 28)
- Internal Audit/2023/54
Medical Variable Pay – Agency Costs_Final Internal Audit Report February 2023 (Review reference: CTMUHB-2223-12)
- Internal Audit/2023/104
PCH Programme Redevelopment_Final Internal Audit Report July 2023 (Review reference: SSU_CTMUHB_2223_06,08 & 09)
- Internal Audit/2022/90
Welsh Risk Pool Claims_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-06)

Currently the AMaT system does not have ability to pause or suspend audits or actions when there is an expected delay in completing audits or actions. As part of system development the Team have discussed this with the AMaT development team with regards to the below audit with a view to pausing whilst also keeping it on the radar of committee members:

- Internal Audit/2021/76
Sunnyside Health & Wellbeing Centre_Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03)

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

0 NEW External Audit Reviews have been added to the Audit Recommendations Tracker.

6 Audit Wales recommendations have been completed and are proposed for **CLOSURE**, these are:

- Audit Wales/2022/11- *Equality Impact Assessments R4*
- Audit Wales/2022/17- *CTMSB SLA Review R3*
- Audit Wales/2023/150- *Audit of Accounts Addendum 2022/2023 R4*
- Audit Wales/2023/150- *Audit of Accounts Addendum 2022/2023 R6*
- Audit Wales/2023/150- *Audit of Accounts Addendum 2022/2023 R7*
- Audit Wales/2023/150- *Audit of Accounts Addendum 2022/2023 R9*

2.3.3 **Health Inspectorate Wales (HIW) - Reports** from Healthcare Inspectorate Wales will be included in brief for noting and observation. The data concerning the HIW tracker is presented to the Quality & Safety Committee in May for monitoring and tracking.

- There have been **3 New** agreed Improvement Plans:
- There was **1 New** Immediate Assurance (*PCH Maternity Unit Ref: 03600*)
- **308** Inspection actions fully **complete** and to be **closed**.

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.
- 3.2 Steps have been taken to seek updates from management leads in relation to outstanding internal and external audit recommendations which are classed as high/medium/low priority. The team has been engaging with Management leads to get registered onto AMaT and engage in training as needed. There has been a slightly improved, temporary process implemented whereby leads were asked to update their progress via AMaT in the first instance or if there were any issues with this a live SharePoint document with limited access was shared which allowed updates to be collected more easily. It is expected that most management leads will be registered and updating AMaT independently by the July Audit and Risk Committee meeting.
- 3.3 Due to the change in the audit management and tracking process which is still a work in progress (please see table of software development requests **(APPENDIX 2)**, there continues to be a requirement for extra manual inputting and management of the data in order to provide committee members with useable data. This continues to necessitate the requirement to adhere to a strict deadline for receipt of updates.
- 3.4 All leads should now have received instructions and assistance in getting set up on the AMaT system. The team will continue to guide and support leads through this new automated process to ensure committee members are receiving robust, meaningful and timely updates.



3.5 Identification of themes and risks will continue to develop over the next 6-12 months.

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 (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	Leadership
	If more than one applies please list below:
Dolen i Feysydd Ansawdd (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))	Not Applicable
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / 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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
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 <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 **NOTE** this report and **CONSIDER** if sufficient assurance has been provided that due process in terms of the updates and closure of recommendations has been followed.

Inspection Code	Inspection Title	Date of Inspection	Executive Lead	Recommendations	Actions	Assurance Rating
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	Greg Dix, Executive Director of Nursing & Deputy Chief Executive Officer	7	7	Not Applicable
Audit Wales/2021/7	Audit of Accounts Report Addendum – CTMUHB 2020-21 (Document reference: 2535A2021-22)	01/08/2021	Hywel Daniel, Executive Director for People	1	1	Not Applicable
Audit Wales/2022/11	Equality Impact Assessments: more than a tick box exercise? Report of the Auditor General for Wales September 2022	01/09/2022	Hywel Daniel, Executive Director for People	1	1	Not Applicable
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	Linda Prosser, Executive Director of Strategy & Transformation	5	5	Not Applicable
Audit Wales/2022/17	Commissioning and contracting arrangements post Bridgend boundary change - SB & CTMUHB 2020-21_October 2022 (Document reference: 2725A2021-22)	01/10/2022	Linda Prosser, Executive Director of Strategy & Transformation	1	1	Not Applicable
Audit Wales/2023/149	Structured Assessment 2023 – CTMUHB 2023_October 2023 (Document reference: 3920A2023)	01/10/2023	Gareth Watts, Director of Corporate Governance & Board Secretary Linda Prosser, Executive Director of Strategy & Transformation Stuart Morris, Director of Digital	6	6	Not Applicable
Audit Wales/2023/150	CONFIDENTIAL Audit of Accounts Report Addendum – CTMUHB 2022-23_November 2023 (Document reference: 3727A2023)	01/11/2023	Sally May, Executive Director of Finance	9	9	Not Applicable
Audit Wales/2023/18	Structured Assessment 2022 – CTMUHB 2022_February 2023 (Document reference: 3313A2023)	01/02/2023	Gareth Watts, Director of Corporate Governance & Board Secretary Sally May, Executive Director of Finance Linda Prosser, Executive Director of Strategy & Transformation Stuart Morris, Director of Digital	8	8	Not Applicable
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	Gethin Hughes, Chief Operating Officer	3	3	Not Applicable
Internal Audit/2020/120	Health & Safety Management_Final Internal Audit Report August 2020 (Review reference: CTMU-1920-16)	03/08/2020	Hywel Daniel, Executive Director for People	1	1	Reasonable
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	Gethin Hughes, Chief Operating Officer	2	2	Reasonable
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	Gethin Hughes, Chief Operating Officer	1	1	Reasonable
Internal Audit/2021/76	Sunnyside Health & Wellbeing Centre_Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03)	06/08/2021	Sally May, Executive Director of Finance	15	15	Reasonable
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	Greg Dix, Executive Director of Nursing & Deputy Chief Executive Officer	1	1	Reasonable
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	Gethin Hughes, Chief Operating Officer	8	8	Limited
Internal Audit/2022/40	Fire Safety Management_Final Internal Audit Report February 2022 (Review reference: CTM 2021_01)	07/02/2022	Hywel Daniel, Executive Director for People	2	2	Limited
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	Linda Prosser, Executive Director of Strategy & Transformation	13	13	Limited
Internal Audit/2022/66	Financial Systems_Final Internal Audit Report June 2022 (Review reference: CTMUHB-2122-04)	15/06/2022	Sally May, Executive Director of Finance	4	4	Reasonable
Internal Audit/2022/67	Radiology Service Review Final Internal Audit Report October 2022 (Review reference: CTMUHB-2223-03)	24/10/2022	Gethin Hughes, Chief Operating Officer	5	5	Reasonable
Internal Audit/2022/89	Follow-up: Consultant Job Planning_Final Internal Audit Report May 2022 (Review reference: CTM 2122.16)	12/05/2022	Dom Hurford, Executive Medical Director Hywel Daniel, Executive Director for People	1	1	Reasonable
Internal Audit/2022/95	Follow-up: Medical & Dental Rostering_Final Internal Audit Report June 2022 (Review reference: CTM 21/22-31)	15/06/2022	Dom Hurford, Executive Medical Director Hywel Daniel, Executive Director for People	1	1	Reasonable
Internal Audit/2022/97	Medical Records Management_Final Internal Audit Report October 2022 (Review reference: CTMU-2223-06)	10/10/2022	Stuart Morris, Director of Digital	1	1	Reasonable
Internal Audit/2023/100	Welsh Risk Pool Claims_Final Internal Audit Report May 2023 (Review reference: CTMUHB-2223-24)	31/05/2023	Greg Dix, Executive Director of Nursing & Deputy Chief Executive Officer	3	3	Reasonable
Internal Audit/2023/107	Decontamination_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-25)	08/08/2023	Greg Dix, Executive Director of Nursing & Deputy Chief Executive Officer	5	5	Reasonable
Internal Audit/2023/113	National Incident Framework_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-05)	08/08/2023	Greg Dix, Executive Director of Nursing & Deputy Chief Executive Officer	8	8	Reasonable
Internal Audit/2023/117	Performance Reporting – Integrated Performance Report_Internal Audit Report July 2023 (Review reference: CTMUHB-2223-15)	28/07/2023	Linda Prosser, Executive Director of Strategy & Transformation Stuart Morris, Director of Digital	2	2	Reasonable
Internal Audit/2023/124	Follow-up: Concerns_Final Internal Audit Report May 2023 (Review reference: CTM 22/23-29)	31/05/2023	Greg Dix, Executive Director of Nursing & Deputy Chief Executive Officer	4	4	Reasonable
Internal Audit/2023/146	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	11/10/2023	Dom Hurford, Executive Medical Director	8	8	Limited
Internal Audit/2023/147	Follow-up: Facilities Systems_Final Internal Audit Report October 2023 (Review reference: CTM-2022.23-42)	16/10/2023	Gethin Hughes, Chief Operating Officer	7	7	Limited
Internal Audit/2023/148	IT Infrastructure_Final Internal Audit Report October 2023 (Review reference: CTM-2324-19)	09/10/2023	Stuart Morris, Director of Digital	5	5	Reasonable
Internal Audit/2023/151	Deprivation of Liberty Safeguards (DoLS)_Final Internal Audit Report November 2023 (Review reference: CTMUHB-2324-07)	28/11/2023	Greg Dix, Executive Director of Nursing & Deputy Chief Executive Officer	8	8	Reasonable
Internal Audit/2023/152	PCH Redevelopment Programme: Supervisor Role_Final Internal Audit Report December 2023 (Review reference: CTM-SSU-2324-07)	07/12/2023	Sally May, Executive Director of Finance	4	4	Substantial
Internal Audit/2023/37	Arrangements for Managing Service Level Agreements_Final Internal Audit Report June 2023 (Review reference: CTMUHB-2223-17)	06/06/2023	Linda Prosser, Executive Director of Strategy & Transformation	5	5	Limited
Internal Audit/2023/57	Reasonable Offer Process_Internal Audit Report April 2023 (Review reference: CTMUHB-2223-04)	03/04/2023	Gethin Hughes, Chief Operating Officer	4	4	Limited
Internal Audit/2023/73	Follow-up: Radiology Workforce_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2324-22)	08/08/2023	Gethin Hughes, Chief Operating Officer	4	4	Reasonable
Internal Audit/2024/162	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	06/02/2024	Gethin Hughes, Chief Operating Officer	15	15	Limited
Internal Audit/2024/163	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	08/02/2024	Stuart Morris, Director of Digital	11	12	Reasonable

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)	The Inspection Actions and recommendations have been fully completed and are waiting to be approved to be closed.
Fully complete	Inspection actions and all recommendations have been fully completed, approved and closed.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Inspection / Executive Lead	Date Due	Revised Due Date	Progress Status	Comments/Updates	Risks	Barriers	Theming
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/HIW 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	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 Officer Executive Director of Therapies & Health Science	01.10.2021	Revised Due Date October 2024	Partially complete (Overdue)	March 2024 Update - An update against this recommendation has not been provided on this occasion. January 2024 Update - Complaints and Concerns compliance is now above 80% therefore real time data and learning from this is now shared with the Care Groups in a timely manner. LFRs compliance continues to improve and a new improved process for the management of Inquests is being developed. Meetings have also taken place in order to a review current methodologies to collate a more robust Patient Experience data. Following the OCP process internal Care Group Quality & Safety Governance frameworks are being developed, this will support and further clarify the roles, responsibilities, accountability, and governance in relation to quality and patient safety within the Care Groups. With the completion of the OCP, the structure clearly outlines the quality and safety responsibilities of both Medical and Nurse Directors. This is furthermore established at directorate and service level leadership, with established governance reporting mechanisms as well as roles and responsibilities. The corporate function has also been designed to ensure quality and safety support to individual care groups whilst ensuring corporate oversight and reporting to triangulate learning and data collection.			
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/HIW Quality Governance Follow Up Review R4.1 The roles and function of the QSRC need to be reviewed to ensure that it is fit for purpose and reflects the Quality Strategy, Quality and Patient Safety governance framework and key corporate [organisational] risks for quality and patient safety. This should include the following: a- Implement the sub-groups to support QSRC must be completed ensuring there is sufficient support (administratively and corporately) to enable these groups to function effectively b- Improvements to the content, analysis, clarity, and transparency of information presented to QSRC c- Focus should be given to ensure the Quality and Patient Safety Governance Framework is used to improve oversight of quality and patient safety across the whole organisation, including Bridgend services. This should be accompanied by the necessary resource for its timely implementation, internal communications, and training.	Meeting structure to sit under Management Board being developed to support the operational oversight and Health Board wide co-ordination and learning.	Patient Care and Safety Executive Director of Nursing/Deputy Chief Executive Officer Executive Director of Therapies & Health Science	01.12.2021		Partially complete (Overdue)	March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - An update has not been provided on this occasion. December 2023 Update - The follow up review undertaken in August 2023 identified that Audit Wales felt that this recommendation had been partially implemented so this has been added back onto the tracker. An update against this recommendation has not been provided on this occasion.			
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/HIW Quality Governance Follow Up Review R6.1 There needs to be sufficient focus and resources given to gathering, analysing, monitoring, and learning from patient experience across the Health Board. This must include use of real-time patient feedback.	Health Board purchased CIVICA (captures population feedback using a patient insight software platform).	Patient Care and Safety Executive Director of Nursing/Deputy Chief Executive Officer Executive Director of Therapies & Health Science	01.07.2021	Revised Due Date: Now December 2024 when Civica contract ends	Partially complete (Overdue)	March 2024 Update - v8 of system has been released. Scoping out SMS across CTM. Still awaiting B2 Apprentice job approval from workforce. Awaiting copy of CTM Civica contract from NWSPP to be reviewed by Finance and procurement internally before agreement can be made on renewal of contract to 2027 or not. Meeting with the NHS Executive Quality & Safety Manager for Performance and Assurance to be organised and discussed on the future of Civica within CTM. January 2024 update - Band 2 recruitment/ onboarding unsuccessful - is now going through the apprenticeship scheme. Currently being banded by workforce and then will be put on Trac. Band 3 started 2nd January. Have your say (paper copies) have now been inputted on the system and caught up. Supporting the input of Paediatrics team to input their data onto the system as a temporary basis (until caught up) Draft people experience report has been developed and will go out for approval mid Feb. Gynaecology is now set up on SMS. RGH roadshow cancelled due to winter pressures, Covid-19 and resource etc. Social media campaign internally and externally being established instead for the Months of Feb and March. Commas & Engagement plan being developed. Rebuilding the Civica hierarchy to reflect the new care groups is currently being done. Looking into an iPad kiosk across acute sites, awaiting feedback from Infection Prevention & Control (IPC). ED SMS feedback mechanism now in operation. PALS team aligned to hospital sites and dashboards being developed to pull together data and qualitative information to inform patient and service user feedback. The first Peoples Experience Steering Group has taken place and the Terms of reference of reference is being reviewed for a substantive plan to strengthen strategic oversight and discussion on experiences of patients and service users.			
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/HIW Quality Governance Follow Up Review R14.5 The Health Board must develop a stronger approach to organisational learning which takes account of all opportunities presented through concerns, clinical audit, patient and staff feedback, external reviews and learning from work undertaken in the Princess of Wales hospital.	Implementation of PREMS and CIVICA system to gather data on patient experience to inform learning and service enhancement and improvement. Project has been initiated and Project Manager appointed.	Patient Care and Safety Executive Director of Nursing/Deputy Chief Executive Officer	01.09.2021	Revised Due Date June 2024	Partially complete (Overdue)	March 2024 Update - An update against this recommendation has not been provided on this occasion. January 2024 Update - The Health Board has a Listening and Learning Framework in place. The Listening and Learning forum is currently under review. The Health Board holds annual Learning and Learning event to share learning across the Health Board. The event for 2024 is due to be held in June 2024. The Health Board are part of the Enhanced Learning Programme coordinated by Welsh Risk Pool and have received the Enhanced Organisational Learning Template to localise for the Health Board. There is a Learning Repository on the SharePoint system which has been shared with colleagues across Wales, with many organisations looking to follow suit.			
Audit Wales/2021/7	01/08/2021	Audit of Accounts Report Addendum – CTMUHB 2020-21 (Document reference: 2535A2021-22)	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.	There is a context to the DoTYS 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 Services Executive Director for People	31.08.2021	Revised Due Date May 2024	Overdue	March 2024 Update - An update against this recommendation has not been provided on this occasion. January 2024 Update - The Health Board was instructed by the NHS Wales Confederation to withdraw our draft Retire and Return Procedure which was being consulted upon internally during December 2023. They advised this matter had been raised with them by a Full-time Trade Union Officer as the new All Wales Pension Policy will set out the process and procedure in respect of this matter. The NHS Wales Confederation were not able to indicated when the All Wales Policy would be ready for Welsh Partnership Forum approval, noting they had previously advised it would be published to the Service by the autumn of 2023. Completion of this action is now dependent on the progress made by Welsh Partnership Forum and at this time no revised timescales have been advised.			
Audit Wales/2022/11	01/09/2022	Equality Impact Assessments: more than a tick box exercise? Report of the Auditor General for Wales September 2022	Equality Impact Assessments R4 Reviewing public bodies' current approach for conducting EIAs: While there are examples of good practice related to distinct stages of the EIA process, all public bodies have lessons to learn about their overall approach. Public bodies should review their overall approach to EIAs considering the findings of this report and the detailed guidance available from the EHRC and the Practice Hub. We recognise that developments in response to our other recommendations and the Welsh Government's review of the PSD Wales specific regulations may have implications for current guidance in due course.	CTM UHB welcomes the report's recommendations for a national approach to clarifying the scope of the duty to impact assess policies and practice and developing guidance for integrated impact assessment. CTM UHB is currently reviewing the EIA process, in line with the findings of this report, and the guidance available from the EHRC and the Practice Hub. As such work has commenced on benchmarking against other NHS organisations. Quality Assurance measures are also being designed to monitor EIAs, as well as monitor the impact of the decisions in the context of the PSD. In addition, further staff guidance and policies will be developed to ensure that the EIA process is both robust and informed. Consideration will be given, as part of the review, to determine whether the EIA forms part of a wider integrated impact assessment.	People Services Executive Director for People	01.03.2023	Revised Due Date January 2024	Fully complete (Awaiting approval)	March 2024 Update - Action closed January 2024. AMA status updated. To be presented to ARC April 2024 for closure. January 2024 Update - Newly revised EIA which also includes the Welsh Language Impact Assessment was approved at the EDI working group 17th Jan 2024 chaired by Linda Prosser. The new EIA process will be circulated via Health Board Communications on 25th January 2024 which will include link to drop in sessions (which will start fortnightly from Feb 2024). Work continues with the Health Boards across Wales to develop an All Wales approach to the EIA process. As part of the EDI working group, the EIA process will be continually evaluated to see what impact is being made and what additional interventions may need to be put in place to support the roll out and embedding of EIA process within CTMUHB. The governance around the completion of the EIAs will be held with policy holders, and number of completion (including quality and impact) will be discussed at the EDI working group which has been established to support the delivery of the Strategic Equality Plan of which EIA activity sits within. This can now be closed.			
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 R1 Strategic planning and applying the sustainable development principle Our work found opportunities for the TLPB to strengthen its planning arrangements and demonstrate how it is acting in accordance with the sustainable development principle (as set out in the Well-being of Future Generations (Wales) Act). The principle should be integral to the TLPB's thinking and genuinely shaping what it does by: a) taking a longer-term approach to its planning beyond five years, b) ensuring greater integration between the long-term plans of the four statutory bodies of the TLPB, and c) improving involvement of all members of the TLPB to ensure an increased voice for non-statutory partners and a better understanding of the purpose of the RPB more generally.	Agreed. Although the sustainable development principle is a fundamental consideration in all decision making, this will be made more explicit in reports to TLPB and RPB going forward. Transition to a new delivery plan has been completed and work will continue to integrate the long term plans of the four statutory bodies improve involvement of non-statutory partners.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	31.03.2023	Revised Due Date 31 March 2024	Overdue	March 2024 Update - Following an initial pilot in 2020/21 the Welsh Government have developed a self assessment exercise for Regional Partnership Boards. The purpose is to give RPBs a chance to reflect on how they operate, how effectively they carry out their statutory duties. The survey was issued to all RPB members for completion by 7th March 2024. A summary of the results will be provided by independent facilitators (CW and HIW). Workshop planned for 18th April to feedback results and provide opportunity for discussion. The online assessment covered the following areas - Governance systems and arrangements, Workforce strategies (development and practice), outcome measurement and frameworks, resources and progress in developing integrated models of care. January 2024 Update - The CTM Model of Integrated Community Services therefore consists of two pathways: - Urgent Community Response - Population Health Management. - Urgent Community Response To coordinate resources around the need for an urgent community response, an integrated central Navigation Hub has been established to triage and stream services appropriately. The Navigation Hub is currently able to provide advice and stream to certain responses (top areas from management information are self-care, advised to contact to GP, refer to 999, refer to GP for handover of care) with the intention to bring other existing clinically led services, social care and other community responses into scope for streaming, along with opening additional points of access into the Navigation Hub. "			
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.	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	Revised Due Date 31 March 2024	Overdue	March 2024 Update - On the 5th February a letter was received from WG that stated that the tapering element of the Regional Integration Fund had been removed. This news was welcomed by partners however the letter reinforced other elements of RIF including - Embedding the 6 models of care consistently and equitably across Wales, focus on benchmarking against other regions, and support 'once for Wales' approach. January 2024 Update - Some challenges remain over appointing to vacant posts. Awaiting clarity from Welsh Government regarding relaxation of RIF tapering for 2024/25.			
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 R5 Regional Commissioning Unit Our work found that the lack of capacity within the RCU was leading to some delays in progressing actions. The work of the RCU is crucial to the continuing success of the TLPB. The TLPB needs to consider how it can build capacity and maximise resources to support the TLPB and minimise overreliance on a small team."	Agreed. Additional infrastructure has been agreed to support dementia work and NEST framework and capital. Additional capacity will also be identified from partner organisations to support the programme delivery.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	31.12.2022	Revised Due Date January 2024	Overdue	March 2024 Update - NEST Co-ordinator now appointed to commence early April. 3 capital programme manager currently out to advert, Additional programme Management to support the Integration Director agreed, to be advertised in April. January 2024 Update - Failed to recruit to NEST co-ordinator first time around. Readvertised and shortlisting taken place, interviews scheduled before the end of January. 3 Capital Programme Managers to be advertised January 2024, on post to focus on tech enabled care. Additional capacity Linked to Integration Director now being progressed.			
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.	Agreed. The development of the RIF delivery plan is only one funding stream and TLPB recognises that we will need to align core budgets, for example around children with complex needs. This will be addressed through the planning cycle in advance of 2023/24.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	31.03.2023	Revised Due Date 31 March 2024	Overdue	March 2024 Update - Through the regional integrated Community Care Services Program the Director for Integration is supporting the region to jointly define and implement a target service and management model for our community services across the region. Regular meetings scheduled with Chief Executives to update on progress. January 2024 Update - Challenges over mainstreaming RIF projects. Awaiting further guidance from Welsh Government over expectations.			
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"	Agreed. Regional workforce development arrangements exist through SCWDP 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	Revised Due Date 31 March 2024	Overdue	March 2024 Update - The priority for the Integrated Community Care Services program is the development of robust pathways. As part of this work exploration of organisational forms will be explored as to how they can best support integration. Section 33 agreements are being reviewed and memorandum of understanding being drafted. January 2024 Update - Market Stability report being updated. Challenges and opportunities to be discussed within RPB sub groups to take forward.			

Audit Wales/2022/17	01/10/2022	Commissioning and contracting arrangements post Bridgend boundary change - SB & CTMUHB 2020-21_October 2022 (Document reference: 2725A2021-22)	CTMSB SLA Review R3 Our work identified that service users and patients' needs are not routinely assessed when variations to agreements are made, and we have seen no evidence of the use of quality impact assessments. The health boards should implement a process for conducting impact assessments when making changes to the way in which services are delivered for the Bridgend population.	Changes in patient flows and impact on patients is addressed in the cessation paperwork and is always discussed as part of the disaggregation discussions. Equality Impact Assessments have started to be completed for the cessation of the Clinical Capacity SLAs in NPH as the changes will impact on patient flow and access to services. However, there is not enough corporate resource to complete a detailed impact assessment for each SLA cessation and in most cases the impact is not necessary as there is no change in patient flow. The Community Health Councils are kept up to date on all cessations and detailed engagement is undertaken where changes will affect patient flow.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	01.11.2022		Fully complete (Awaiting approval)	March 2024 Update - All service cessations are subject to full impact assessment, including EQIA and there is engagement with service users in line with service change guidance. The communication group continues to meet and provides a summary of the work programme's engagement and stakeholder interests. While capacity to facilitate changes remains a risk, a Head of Commissioning post is out to advert, which will have oversight of this programme. This recommendation can now be closed. December 2023 Update - The communication and engagement group continues to meet and there will be joint engagement with Liais on any service changes in the shared work programme. All service changes are subject to benefits appraisal, impact assessment and risk assessment prior to agreement of any changes to commissioned service arrangements. The Joint Executive Group approved an updated process flow chart which strengthens the agreed processes. (4.12.23).			
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).	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	Revised Due Date 31 May 2024	Overdue	March 2024 Update - A revised implementation date is requested as 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. February 2024 Update - In Progress: Head of Corporate Governance and Board Business to consider how this recommendation can be achieved 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).	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 Executive Director of Strategy & Transformation (Performance Framework) Chief Operating Officer (Operational Performance) Director of Digital (Performance Information)	01.02.2024	Revised Due Date - Revised Due Date end of Quarter 3 2024-2025 (31.12.2024)	Overdue	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 R1 The Health Board and WHSSC/EASC must ensure that all elements of their related-party process are properly applied each year, to support the disclosures required by the Manual for Accounts.	Health Board The finance team did utilise the Corporate Governance function's register of the DOIs. • There were omissions at draft stage for two related party disclosures. • Due to the related party not existing at the end of the financial year period (only part of the year) the related party was not identified by finance and therefore was omitted at the draft stage. • These were identified and addressed prior to the audit being finalised. We do not agree with the findings that the summary had not been utilised. The Corporate Governance Team have worked with Finance colleagues to review the presentation of disclosures within the Declarations of Interest Register, and have implemented presentational changes that support will support the Finance Team in extracting disclosures in future. All future disclosures will be made on an accruals basis. WHSSC / EASC For the WHSSC and EASC Committee's, one DOI remained outstanding late into the audit due to a Joint Committee being on long term sickness absence. We acknowledge that the financial ledger checks required three amendments to the accounts to disclose material related parties and will ensure the DOI cross ledger checks are rigorously undertaken as part of the process for the 2023-24 accounts.	Finance Executive Director of Finance	01.04.2024		In progress	March 2024 Update - This will be actioned for the year end accounts, so will be in place for submission at the beginning of May. February 2024 Update - An update has not been provided against this recommendation on this occasion. New recommendation so no previous 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 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.	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		In progress	March 2024 Update - This will be actioned for the year end accounts, so will be in place for submission at the beginning of May. February 2024 Update - An update has not been provided against this recommendation on this occasion. New recommendation so no previous 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 R4 The Health Board should strengthen its Blueteq password control by requiring a minimum of eight characters.	WHSSC have asked Blueteq to implement the requirement of minimum 8 characters for the passwords. A password change is forced every 90 days as is common in NHS. Therefore, once Blueteq imminently implements the recommendation the new requirements will come into place.	Finance Executive Director of Finance	01.11.2023		Fully complete (Awaiting approval)	March 2024 Update - The request to BlueTeq to update password was made when notified through the finding. February 2024 Update - An update has not been provided against this recommendation on this occasion. New recommendation so no previous 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 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.	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		Overdue	March 2024 Update - Awaiting confirmation on whether disaster plan has been updated. February 2024 Update - An update has not been provided against this recommendation on this occasion. New recommendation so no previous 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 R6 The Health Board should strengthen the controls over the Proleaxe IT system by setting a more robust minimum password requirement; requiring formal access management procedures, with an appropriate access request and approval form; and setting up at least one other system administrator.	As stated in the finding the Proleaxe system is not administered within CTMUHB and was brought in on a national basis. The capital team will work with colleagues across NHS Wales to review the process and implement the changes as required.	Finance Executive Director of Finance	01.03.2024		Fully complete (Awaiting approval)	March 2024 Update - As per response, CTM are not responsible for the system and this is administered on an All Wales basis. February 2024 Update - An update has not been provided against this recommendation on this occasion. New recommendation so no previous 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 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 (i.e., where requested by the Health Board). Also, the Health Board should document its review of the Welshy 'Inactive Users' report to determine whether any inactive user accounts need to be closed or suspended.	System managers will ensure regular reviews are undertaken	Finance Executive Director of Finance	01.11.2023		Fully complete (Awaiting approval)	March 2024 Update - This will be an ongoing action which is now in place. February 2024 Update - An update has not been provided against this recommendation on this occasion. New recommendation so no previous 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 R8 The Health Board should amend the RAM IT system so that it requires a user to create a new password when they first login after having their password reset by a system admin officer.	This will be investigated with MRI Software Solutions as the provider of the RAM system and implemented if this option is available.	Finance Executive Director of Finance	01.12.2023		Overdue	March 2024 Update - Awaiting confirmation on whether this could be actioned by the administrator. February 2024 Update - An update has not been provided against this recommendation on this occasion. New recommendation so no previous 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.	The Health Board will now document its review of the Healthroster super-user report	Finance Executive Director of Finance	01.11.2023		Fully complete (Awaiting approval)	March 2024 Update - This is an ongoing action that has been agreed to be undertaken. February 2024 Update - An update has not been provided against this recommendation on this occasion. New recommendation so no previous updates.			
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.	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 WBGF 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	Revised Due Date 31 July 2024	Partially complete (Overdue)	March 2024 Update - Items a, c and d are complete. A revised implementation date is requested as the publication of Advisory and Sub Committee minutes is being captured in the Effective Management of Board Business Proposal which is due to conclude circa July 2024. February 2024 Update - In Progress - Update remains as reported in December 2023. The Director of Corporate Governance & Board Secretary appointed in September 2023 would also need sufficient time to attend to review the position of the Advisory Group meetings. Will be incorporated into the Review of the Effective Management of Board Business Proposal (January 2024). Timeframe currently remains as 31st March 2024.			
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 Recognises. 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.	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	Revised Due Date - Revised Due Date end of Quarter 3 2024-2025 (31.12.2024)	Overdue	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 - An update has not been provided against this recommendation on this occasion. December 2023 Update - An update has not been provided against this recommendation on this occasion.			
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.	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 Executive Director of Strategy & Transformation (Performance Framework)	01.09.2023		Partially complete (Overdue)	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. December 2023 Update - An update has not been provided against this recommendation on this occasion.			

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. 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.	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 CTMO30 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. 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.	Digital Director of Digital (Performance Information)	31.12.2023		Overdue	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 - We have completed the initial recruitment with colleagues starting during September and October. However given the current recruitment constraints we are unable to recruit further at this point in time.			
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 in line with the Health Board's performance.	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.	All Executives	30.06.2023		Partially complete (Overdue)	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	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 cases 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		Partially complete (Overdue)	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 received on this recommendation. August 2023 Update - This recommendation is proposed for closure in light of the update provided in June 2023. June 2023 Update - a) Reviewed So & SFIs and confirmed upper limit for contracts is consistent with model SAs and SFIs. Contract in excess of £1m require WG Ministerial approval CLOSED, b) Quarterly Capital reports included on PPF agenda, c) FCP review ongoing			
Audit Wales/2023/18	01/02/2023	Structured Assessment 2022 – CTMUHB 2022_February 2023 (Document reference: 3313A2023)	Structured Assessment 2022 R8 Enhancing financial reports to the Board Structured Assessment 2022 R8: Whilst the Health Board has effective arrangements for reporting financial performance to the Board, we identified opportunities to enhance these reports further. The Health Board should: a) provide greater assurances that mitigating actions are in place to address key financial risks highlighted in the reports; NOT COMPLETED b) report the financial performance of the new Care Groups at the earliest possibility.	The monthly finance reports to the Board and the Planning, Performance and Finance (PPF) Committee summarise the key risk and opportunities facing the Health Board. These reports will be reviewed to ensure they provide assurance to the Board that mitigating actions and plans are in place and that the PPF Committee has confidence the risks are being appropriately managed. These reports will capture financial performance of the new Care Group Model.	Finance Executive Director of Finance	31.07.2023		Partially complete (Overdue)	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 received on this recommendation. June 2023 Update - 1. Board Report reviewed and updated for 2023-24. 2. Care Group level reporting continues into PPF. Any issues of concern will be escalated to Board through committee reports.			
Audit Wales/2023/18	01/02/2023	Structured Assessment 2022 – CTMUHB 2022_February 2023 (Document reference: 3313A2023)	Structured Assessment 2022 R10 Strengthening Board-level oversight of estates issues and risks Structured Assessment 2022 R10: There is currently insufficient Board-level oversight of the condition of the estate and other significant related risks. The Health Board, therefore, should: a) ensure there is regular reporting on estates-related performance indicators and risks to the Planning, Performance, and Finance Committee NOT COMPLETED; b) update the committee's Terms of Reference to reflect these responsibilities; and c) establish a clear process for ensuring appropriate cross referral of estate issues which may have a significant health and safety impact with the Quality and Safety Committee NOT COMPLETED	On publication of Welsh Government's annual Estates, Facilities Performance Management System data, the findings are reported to the Planning, Performance and Finance (PPF) Committee. The report includes the Health Board's performance measured against the national estates key performance indicators which are Physical Condition, Statutory and Safety compliance, fire safety, functional suitability and space utilisation. In addition the report includes the estates operational planned and reactive performance data for statutory and mandatory jobs and also captures helpdesk request data, the reported data is compared against previous years so that trends can be analysed. The report also includes the organisations' energy performance and Carbon Dioxide (CO2) emissions which is measured and reported against the Welsh Government performance targets. At all of the Health Board's Health, Safety and Fire Sub Committees there is a standard agenda item for an Estates Safety and Compliance report and a fire safety report. These reports cover the critical infrastructure systems such as high and low voltage electricity, medical gases, ventilation and water. The Estates and Capital Directorate has its own risk register which is reported quarterly to the Estates / Capital Governance Board, the risks identified with a score above 15 are subsequently reported to Corporate Governance for inclusion on the Health Board's Organisational Risk register. The Health Board is also considering its approach to developing an Estates Strategy within the Health Board and how this will align with other key strategic documents and plans. The Planning, Performance & Finance Committee Terms of Reference will be reviewed to reflect the responsibility to receive Board level oversight of estates issues. The Health Board has a defined Committee Referral process which will be used if there are matters considered at either the PPF Committee or HS&F Sub Committee that require consideration at the Quality & Safety Committee. The HS&F Committee will also ensure any estates issues will be notified to the Q&S Committee through the Committee Highlight Report.	Finance Executive Director of Finance	31.10.2023	Revised Due Date - October 2023 (Original Due Date in accordance with the Committee Cycle of Business for the PPF Committee and Health, Safety and Fire Sub Committee – Circa April / May 2023)	Partially complete (Overdue)	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 received on this occasion. August 2023 Update - This recommendation is proposed for closure in light of the update provided in June 2023 June 2023 Update - Revised date to reflect expected publication of Estates and Facilities Performance Management System data.			
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.	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 PREHMs and PROMS data, digitally captured via MyMobility and through the HB website wherever possible. RGH did not have a system for PROMS or PREHMs. 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 Group and Unscheduled Care Group Chief Operating Officer	01.05.2023		Overdue	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 CTMUHB Clinical Strategy and alignment to the emerging UHB strategy. Further updates will be available in forthcoming meetings.			
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.	The Health Board will undertake the following in order to ensure the recommendations are achieved: • The fragility of a small CMATS team was recognised within physiotherapy. Since the merger with Bridgend the UHB has invested training and development into the band 7 clinical specialist team in order to increase the number of staff working at the advanced practice level, to meet the demand across CTM. • In PCH, CMATS is undertaken via digital referrals (started April 22). Referrals are received centrally and then pooled out within sub specialities, Nurse led, Consultant led and AHPs • A full workforce and demand and capacity analysis is being undertaken through the regional and local reconfiguration work • The UHB now has FCP clinicians across all GP clusters except Merthyr 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 Group and Unscheduled Care Group Chief Operating Officer	01.01.2024		Overdue	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.			

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.	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 Group and Unscheduled Care Group Chief Operating Officer	01.04.2024		In progress	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.			

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Inspection / Executive Lead	Date Due	Revised Due Date	Progress Status	Comments/Updates	Risks	Barriers	Theming
Internal Audit/2020/120	03/08/2020	Health & Safety Management_Final Internal Audit Report August 2020 (Review reference: CTMU-1920-16)	Health & Safety Management 06 The templates currently being used to undertake annual Health and Safety reviews should be reviewed to ensure they are accurately reflecting the Health and Safety issues within each department.	The Health and Safety Team are developing an audit package for use across the CTMUHB. The package will provide assurance to ILGs and the Board that policies and procedures are being followed in all Service Group Wards and Departments. Once completed, the audit package will be presented to the Health, Safety and Fire Committee for approval.	Health & Safety Executive Director of People	01.01.2021	Revised Due Date June 2024	Partially complete (Overdue)	March 2024 Update - The 2 trial audits using the new software are planned for April and June 2024 and a further evaluation of the software will then be undertaken. January 2024 Update - The Health and Safety Team will be undertaking 1 main audit and 2 flash audits using iPassport in 2024 to enable an evaluation of iPassport. These audits will take place in March, June and October and the outcomes will be provided to the Health Safety and Fire Sub Committee.			
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.	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.	Unscheduled Care Care Group Chief Operating Officer	01.04.2021	Revised Due Date July 2024	Overdue	March 2024 Update - Position remains the same. This will be picked up with the newly appointed Directorate managers. February 2024 Update - Position remains the same. Update received after deadline and not included in ARC Excel Report 22nd February 2024. December 2023 Update - position remains the same as a consequence of staffing resource. It is hoped that the resolution of the OCP process will mitigate this situation. Too early to make a commitment - so update will be available for the meeting in February 2024.			
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.	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.	Unscheduled Care Care Group Chief Operating Officer	01.12.2020	Revised Due Date April 2024	Overdue	March 2024 Update - Position remains the same. This will be picked up with the newly appointed Directorate managers. February 2024 Update - Position remains the same. December 2023 Update - situation remains the same as a consequence of lack of resource in staff. Anticipated that the OCP process will resolve this - but too early to make any commitment in this area. Update will be available in January 2024.			
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.	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.	Facilities Chief Operating Officer	01.04.2020	Revised Due Date January 2024	Partially complete (Overdue)	March 2024 Update - data migration of existing data to Track 2 performed and undergoing live testing and bug checking on existing server prior to switching to new server environment. Capital funding approved via WG digital funding for increased infrastructure and coverage in Feb 2024. Equipment received and to be installed ASAP. Wi-Fi limitations still an issue at POW for aspects surrounding any IOT Wi-Fi requirements, such as handheld scanners for cylinder tracking aspect. This will remain an issue until POW ICT de-segregation is completed. January 2024 Update – Request submitted for WG digital Capital Slippage with regard funding of phased expansion of coverage, await answer. No further update on POW ICT connectivity /desegregation status for IOT devices. Data migration and application server now progressing, data verification and proofing server environment in place to test, prior to live switch over to operational server. Target Date RF-ID migration 31-03-2024.			
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 01 Management should confirm revised governance arrangements via a Project Execution Plan including: • effective cost management; • contractual relationships, values and payment arrangements; • committee reporting of project risks; • scheduled outputs from sub-groups for scrutiny; and • stakeholder engagement.	The Health Board will work with the external project manager to develop a Project Execution Plan to be signed off at the Project Board, this will provide a formalised single record of all of the above criteria which have been approved separately by Project Board.	Capital and Estates Executive Director of Finance	01.09.2021	Revised Due Date June 2024	Overdue	March 2024 Update - As per previous update start date for the health centre has been agreed as 3rd June 2024. Linc's Employer's Agent and Contract Administrator (Expedite) can now prepare a PEP, which will be available before start on site June 2024. January 2024 Update - The contract between Linc and the main contractor (Wynne) has now been signed, and a start date for the health centre has been agreed as 3rd June 2024. Linc's Employer's Agent and Contract Administrator (Expedite) can now commence preparation of a PEP, which will be available before start on site which has been delayed to June 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 04 Management should ensure that individual cost provisions within the works information are reported to understand charges and adjustments to provisional sums.	The updated reporting template includes a section detailing provisional sums and contingencies and tracks through the release of provisional sums into actual costs, as well as all contingency items, these will be reported monthly to Project Board as part of the financial template. However there will need to be a further tender and revised provisional sums with the letting of a contract for completion therefore an extended target date is provided to ensure the most up to date information is captured	Capital and Estates Executive Director of Finance	01.03.2022	Revised Due Date July 2024	Overdue	March 2024 Update -No further update. Expedite, the Employer's agent and Contract Administrator will provide monthly reports detailing the required information regarding provisional sums and contingencies however this cannot be evidenced until after a month after the start on site in June. January 2024 Update - The delayed start on site has now been confirmed as 3rd June 2024 hence delay to the restart of this reporting Expedite, the Employer's agent and Contract Administrator will provide monthly reports detailing the required information regarding provisional sums and contingencies.			
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 05 Management should ensure provision of project manager and cost adviser reports, in support of the Welsh Government Dashboard return.	These will be included as required as soon as the project recommences, and a new contractor is appointed. This is likely to take at least a further 3-4 months hence the longer target date.	Capital and Estates Executive Director of Finance	01.01.2022	Revised Due Date August 2024	Overdue	March 2024 Update - No further update. Expedite, the Employer's agent and Contract Administrator will provide the required monthly reports however this cannot be evidenced until a month after the start on site in June. January 2024 Update - The delayed start on site has now been confirmed as 3rd June 2024 hence delay to the restart of this reporting Expedite, the Employer's agent and Contract Administrator will provide the required monthly reports.			
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 07 Management should obtain documentation to which the client is entitled under the contract, including collateral warranties, and a copy of the construction performance bond, and confirm assurances provided at the latter.	These are available and will be supplied by the developer.	Capital and Estates Executive Director of Finance	01.09.2021	Revised Due Date February 2024	Overdue	March 2024 Update - documents requested but still not received. Followed up 18th March. January 2024 Update - These documents have been requested now that the contract has been signed and a pre-start meeting has taken place. December 2023 Update - As above, funding approved in November, contract due to be signed and then all required documentation will be requested.			
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 10 Management should be provided with proposed contact variations and monitoring to facilitate timely Health Board scrutiny, in accordance with entitlements under the contract.	This will be provided when the project restarts and all design works are completed.	Capital and Estates Executive Director of Finance	01.12.2023	No original agreed Due by Date / Revised Due Date July 2024	Overdue	March 2024 Update - No further update. Any contract variations will be tracked and reported by Expedite, the Employer's Agent and Contract Administrator, and none will be agreed without explicitly confirmation from the HB. Cannot evidence this until scheme starts onsite. January 2024 Update - Any contract variations will be tracked and reported by Expedite, the Employer's Agent and Contract Administrator, and none will be agreed without explicitly confirmation from the HB. Cannot evidence this until scheme starts onsite			
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 11 The Health Board require the developer to remind the contractor of its contractual obligations to formally notify of any delays (and their associated time/cost impact within the contractual time frames).	With the original contractor there was confidence that much of the time could be recovered and therefore no formal application had been made. Clearly with the current contractor going into administration there will need to be a new contractor appointment. The Health Board will ensure that the need for a contractual. notification of future delays is communicated to the new contractor.	Capital and Estates Executive Director of Finance	01.03.2022	Revised Due Date December 2023	Fully complete (Awaiting approval)	March 2024 Update - Complete. January 2024 Update - This is explicit in the contract between Linc and the main contractor, Wynne and was reiterated at the pre-start meeting. The HB will be fully engaged and consulted on any notice of delay. December 2023 Update - Once the new contract is signed a reminder will be given to the contractor of the requirement for a contractual notification of any delays			
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 12 A costed risk register should be regularly maintained and reported to facilitate monitoring of the build.	A fully costed capital risk register is in existence and will continue to be kept up to date as risks are realised or not throughout the project, however this will be revisited with decision on process for and appointment of a new contractor.	Capital and Estates Executive Director of Finance	01.11.2021	Revised Due Date July 2024	Overdue	March 2024 Update - no further update. A costed risk register is maintained by Expedite, the Employer's Agent and Contractor Administrator, and will be reviewed at monthly progress meetings but evidence of this cannot be provided until further into the programme. January 2024 Update - A cost risk register is maintained by Expedite, the Employer's Agent and Contractor Administrator, and will be reviewed at monthly progress meetings. December 2023 Update - This will form part of monthly reporting to the Board which will restart in full detail from January in contract is signed in Nov/Dec.			
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 13 Management should actively monitor and report the value of residual construction cost risks v remaining contingency.	This is picked up in the appendix to the standard Highlight Report discussed in action 2.	Capital and Estates Executive Director of Finance	01.09.2021	Revised Due Date July 2024	Overdue	March 2024 Update - no further update. This will be actively monitored and managed as an integral part of the above action once project starts on site. January 2024 - This will be actively monitored and managed as an integral part of the above action once project starts on site. December 2023 Update - This will form part of monthly reporting to the Board which will restart in full detail from January in contract is signed in Nov/Dec.			
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 15 The Health Board should obtain engrossed and signed copies of all relevant developer adviser contracts in accordance with entitlements to inform of potential liabilities and costs, and report relevant implications to appropriate groups/committees.	This cannot be fully achieved without the appointment of a new contractor. The Health Board will ensure that all contracts have been received and filed centrally. The new contractor contract will be provided by the developer on signature .	Capital and Estates Executive Director of Finance	01.01.2021	Revised Due Date February 2024	Overdue	March 2024 Update - documents requested but still not received. Followed up 18th March. January 2024 Update - Now that the contract has been signed, the HB has requested copies of all relevant documentation. December 2023 Update - As soon as new contracts are signed (late Nov/Early Dec) these will be requested from the developer, reviewed and reported on as appropriate.			

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.	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	Revised Due Date June 2024	Overdue	March 2024 Update - discussions ongoing with GPs. January 2024 Update - Discussions have recommenced with GPs. December 2023 Update - At November Project Board, following confirmation of approved funding , it was agreed that Lease discussions with the GP practices can recommence . Draft Heads of Terms previously were previously shared between solicitors. October 2023 Update - Once the business case is agreed and costs known then Shared Services can re-commence lease discussions with the GP practices and work towards production of signed lease documents.			
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 19 Management should confirm an agreed service model with measurable outcomes for front line and support services.	The Bridgend Integrated Locality Group (ILG) will link with the Primary Care team over the service model and support functions. This will be developed during the construction period for the site and given that the completion is likely to slip to late 2/23 the target is to complete in order that any financial consequences are picked up in Integrated Medium Term Plan (IMTP) planning cycles.	Capital and Estates Executive Director of Finance	01.03.2022	Revised Due Date June 2024	Overdue	March 2024 Update - no further update. Recommendation will not be complete until service model is agreed. January 2024 Update - Recommendation will not be complete until service model is agreed. December 2023 Update - This will be led by the Primary and Community Care Group and the relevant steering group. At Project Board on the 23rd November Terms of Reference for the subgroups were shared with members for review with updates to be provided before the next meeting for review and sign off. This included as a key responsibility for the relevant group but as recommendation will not be complete until service model is agreed the revised implementation date has been moved to 6 months into the project.			
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.	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	Revised Due Date February 2024	Overdue	March 2024 Update - no further update. Benefits will be periodically reviewed as part of the Project Board agenda moving forward. January 2024 Update - Benefits will be periodically reviewed as part of the Project Board agenda moving forward. December 2023 Update - Benefits will be periodically reviewed as part of the Project Board agenda. The frequency of this will be discussed in February 2024 as there are other significant agenda items in Dec/Jan.			
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.	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	Revised Due Date February 2024	Overdue	March 2024 Update - no further update. Benefits will be periodically reviewed as part of the Project Board agenda moving forward. January 2024 Update - Benefits will be periodically reviewed as part of the Project Board agenda moving forward. December 2023 Update - Benefits will be periodically reviewed as part of the Project Board agenda. The frequency of this will be discussed in February 2024 as there are other significant agenda items in Dec/Jan.			
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 09 Performance of relevant parties should be monitored appropriately	The approved business case contained a Benefits Realisation Plan. This will be reviewed to ensure that the benefits are measurable and deliverable although there will be a delay with the appointment of a new contractor.	Capital and Estates Executive Director of Finance	01.09.2021	Revised Due Date February 2024	Overdue	March 2024 Update - no further update. Ongoing. Performance of the main contractor will be managed and monitored via the HB's appointed Clerk of Works (DRAC), the Employer's Agent and contract Administrator (Expedite) and via regularly progress meetings and reports. These in turn will be reported up to Project Board and its sub-groups. January 2024 Update - Performance of the main contractor will be managed and monitored via the HB's appointed Clerk of Works (DRAC), the Employer's Agent and contract Administrator (Expedite) and via regularly progress meetings and reports. These in turn will be reported up to Project Board and its sub-groups. KPI's will be lifted from the contract once received.			
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 17 Management should instigate a process for formal review and sign-off of any further design changes with relevant parties.	The Health Board already has in place processes for sign off of design by users and this process will be used in this scheme moving forward (also to be detailed in the Project Execution Plan).	Capital and Estates Executive Director of Finance	01.11.2021	Revised Due Date January 2024	Overdue	March 2024 Update -The HB is fully involved in any changes proposed and none will be made without formal HB sign off. This will be evidenced when the changes required for decarbonisations follow the agreed process. January 2024 Update - Now contract is signed this is controlled via the JCT Design & Build contract, and managed by the Employer's Agent and Contract Administrator. The HB is fully involved in any changes proposed and none will be made without formal HB sign off.			
Internal Audit/2022/161	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.	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.	Finance Executive Director of Finance	01.05.2022	Revised Due Date April 2024	Overdue	March 2024 Update - 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. February 2024 Update - Final answer awaited from Finance and the recommendation will then be closed down.			
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 1.1 Management should ensure that the correct data detailed within the outcome reports is produced for each of the Clinical Service Groups, especially where services and therefore data was previously the responsibility of a different ILG.	Discussion will be held with colleagues in Performance to ensure that this data is correct for each Service Group and fits in with the new operating model.	Acute Services General Management and Head of Information Chief Operating Officer	01.08.2022	Revised Due Date April 2024	Overdue	March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - this work has been the focus of joint working, is now nearing completion and a report will be available at the next meeting. December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper.			
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.	ILGs will ensure that they undertake this action.	Acute Services General Management and Head of Information Chief Operating Officer	01.08.2022	Revised Due Date April 2024	Overdue	March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - this work has been the focus of joint working, is now nearing completion and a report will be available at the next meeting. Update received after deadline and not included in ARC Excel Report 22nd February 2024. December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper.			
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.	Consideration will be given by ILGs to roll out electronic outcome forms by September 2022	Acute Services General Management and Head of Information Chief Operating Officer	01.09.2022	Revised Due Date April 2024	Overdue	March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - this work has been the focus of joint working, is now nearing completion and a report will be available at the next meeting. December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper.			
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.	ILGs will work with colleagues in Performance to make sure that this information is available and appropriate.	Acute Services General Management and Head of Information Chief Operating Officer	01.08.2022	Revised Due Date April 2024	Overdue	March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - this work has been the focus of joint working, is now nearing completion and a report will be available at the next meeting. December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper.			

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.	ILGs will work with colleagues in Performance to ensure that the appropriate staff are identified.	Acute Services General Management and Head of Information Chief Operating Officer	01.08.2022	Revised Due Date April 2024	Overdue	March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - this work has been the focus of joint working, is now nearing completion and a report will be available at the next meeting. December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper.			
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.	ILGs will ensure that they undertake this action	Acute Services General Management and Head of Information Chief Operating Officer	01.08.2022	Revised Due Date April 2024	Overdue	March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - this work has been the focus of joint working, is now nearing completion and a report will be available at the next meeting. December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper.			
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.	ILGs will work with colleagues in Performance to make sure that this information is available and appropriate.	Acute Services General Management and Head of Information Chief Operating Officer	01.09.2022	Revised Due Date April 2024	Overdue	March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - this work has been the focus of joint working, is now nearing completion and a report will be available at the next meeting. December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper.			
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 Rhondda Taf Ely and Merthyr Cynon ILGs areas can be provided with the same access to watch lists within WPAS as staff in Bridgend ILG, allowing all staff to be able to view and then monitor each other's watch lists. If this functionality is not available, then our original recommendation should be implemented. A review of the watch list process should be undertaken and following that guidance produced that ensures all Medical Secretaries are using a standard approach that is user friendly and does not restrict access, allowing visibility to other staff members.	This will be addressed by the ILG with colleagues from Performance	Acute Services General Management and Head of Information Chief Operating Officer	01.09.2022	Revised Due Date April 2024	Overdue	March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - this work has been the focus of joint working, is now nearing completion and a report will be available at the next meeting. December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper.			
Internal Audit/2022/40	07/02/2022	Fire Safety Management. Final Internal Audit Report February 2022 (Review reference: CTM_2021_01)	Fire Safety Management 2.1 Local procedures will be reviewed and updated within specified review periods - and associated uniform approval arrangements applied.	Agreed. A review is in progress to align and standardise procedures.	Health, Safety & Fire Executive Director for People	01.03.2022	Revised Due Date June 2024	Partially complete (Overdue)	March 2024 Update - 90% of site specific procedures for sites are complete and the Team are on course to complete the remainder by June 2024. January 2024 Update - Work continues within the Fire Team to update the Site Specific Documents where site changes have taken place. Completion should have taken place by the June 2024 deadline.			
Internal Audit/2022/40	07/02/2022	Fire Safety Management. Final internal Audit Report February 2022 (Review reference: CTM_2021_01)	Fire Safety Management 4.1 Management should develop an appropriate medium-term strategy to demonstrate co-ordination of efforts in managing the fire risk.	The Health Board will develop a medium term strategy for fire safety across its sites.	Health, Safety & Fire Executive Director for People	01.03.2022	Revised Due Date February 2024	Fully complete (Awaiting approval)	March 2024 Update - A draft 3 year Fire Strategy was ratified at the Health, Safety and Fire Sub Committee in March 2023. This action can now be closed. January 2024 Update - Outline Plan for 2024/25 will be presented to the next Health, Safety and Fire Sub Committee which has been changed to 4th March 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 3.1 The Health Board should ensure timely completion of contacts.	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.	Health, Safety & Fire Executive Director of Strategy & Transformation	01.01.2023	Revised Due Date January 2025	Overdue	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.	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.	Health, Safety & Fire Executive Director of Strategy & Transformation	01.01.2023	Revised Due Date March 2024	Overdue	March 2024 Update - Tender has been completed & returned for the design team, preferred bidder informed w/c 18 March. Discussions started with NHS England re: SBS framework, likely to be a mini competition rather than a direct award. February 2024 - An update has not been provided against this recommendation on this occasion. December 2023 Update - Preferred option now agreed by the project board . Tender will be completed for the design consultants, discussion to be held with NWSSP SES regarding appropriate procurement process for appointment of modular theatre supplier as Framework is available for direct award.			
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.	Agreed	Health, Safety & Fire Executive Director of Strategy & Transformation	01.08.2022	Revised Due Date January 2025	Overdue	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.	Agreed	Health, Safety & Fire Executive Director of Strategy & Transformation	01.08.2022	Revised Due Date January 2025	Overdue	March 2024 Update - As per Dec 2023. 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 6.1 Upon recommencement of the project, management should utilise Key Performance Indicators in accordance with the contract.	Agreed. These will be applied as required.	Health, Safety & Fire Executive Director of Strategy & Transformation	01.01.2023	Revised January 2025	Fully Complete (Awaiting approval)	March 2024 Update - Have terminated D4L contract, as per Oct 2023 entry this action can be closed as will be a traditional contract. 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 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.	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.	Health, Safety & Fire Executive Director of Strategy & Transformation	01.08.2022	Revised Due Date February 2024	Overdue	March 2024 Update - Progress has been reported to Project Board and costs will start being incurred from April now that a new design team has been appointed. February 2024 - An update has not been provided against this recommendation on this occasion. December 2023 Update - Now preferred option is agreed the fees required to develop the business case can be developed. Spend against current fee allocation will be reported to the project board once spend commences.			
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 re-provision remains within preferred option, the Project Board should re-assess procurement options to ensure value for money.	Agreed. This will be undertaken at the future procurement.	Health, Safety & Fire Executive Director of Strategy & Transformation	01.01.2023	Revised Due Date November 2024	Overdue	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. February 2024 - An update has not been provided against this recommendation on this occasion.			
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.	Agreed	Health, Safety & Fire Executive Director of Strategy & Transformation	01.08.2022	Revised Due Date January 2025	Overdue	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. 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 10.2 Management should actively monitor and report the value of residual risk v remaining contingency.	Agreed	Health, Safety & Fire Executive Director of Strategy & Transformation	01.08.2022	Revised Due Date January 2025	Overdue	March 2024 Update - As above will be within BIC process and once contract has commenced. February 2024 - An update has not been provided against this recommendation on this occasion. December 2023 Update - Action to be addressed once there is funded project - 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 10.3 Risks should be individually assigned to those best placed to control them, with time parameters for action.	Agreed	Health, Safety & Fire Executive Director of Strategy & Transformation	01.08.2022	Revised Due Date December 2023	Overdue	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 - 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.	Agreed	Health, Safety & Fire Executive Director of Strategy & Transformation	01.08.2022	Revised Due Date December 2023	Overdue	March 2024 Update - Exception reporting will form part of regular risk monitoring. February 2024 - An update has not been provided against this recommendation on this occasion. December 2023 Update - As above this will be actioned as part of project board.			
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.	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.	Health, Safety & Fire Executive Director of Strategy & Transformation	01.01.2023	Revised Due Date October 2024	Overdue	March 2024 Update - As per Dec 2023. February 2024 - 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.	Agreed	Health, Safety & Fire Executive Director of Strategy & Transformation	01.08.2022	Revised Due Date January 2024	Overdue	March 2024 Update - As per Dec 2023. February 2024 - 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/2022/66	15/06/2022	Financial Systems_Final Internal Audit Report June 2022 (Review reference: CTMUHB-2122-04)	Financial Systems 8.1 Management should ensure that staff responsible for approving requisitions and processing purchase orders are aware of the correct procurement process as stated in the Requisition of Goods and Services FCPO and the All-Wales No PO No Pay policy.	Procurement will increase the training and cascade information relating to the No PO No Pay policy. We will identify the areas of retrospective ordering, implement a plan and ensure bespoke training to these areas.	Finance & Procurement Executive Director of Finance	01.07.2022	Revised Due Date March 2024	Partially complete (Overdue)	March 2024 Update - This will be an ongoing action with collaborative working between procurement and finance. Discussions are currently being has on the governance arrangements for the All Wales P2P group which will agree updates to P2P policies. CTM are actively involved in these discussions and will ensure appropriate roll out of training following any update to No PO No Pay policies. February 2024 Update - No PO Policy, Communication plan and exemption list completed and presented to DDOFs in November by Head of Corporate Finance, further work prior to approval at NWSSP shared service committee. AW Launch planned for January 2024. As part of monthly P2P CTM group, plan in place and being monitored monthly. CTM already undertaking focused P2P training, Facilities and Estates completed, identifying further areas as part of No PO review (Top 3 monthly with systems). What does good Procurement session held with Care groups within Operational Management Board. AW P2P governance group disbanded by Finance Academy, proposed at NWSSP Shared services committee.			
Internal Audit/2022/66	15/06/2022	Financial Systems_Final Internal Audit Report June 2022 (Review reference: CTMUHB-2122-04)	Financial Systems 8.2 In cases where it is appropriate, management should explore the use of alternative mechanisms for raising orders and paying invoices, for example the use of 'call off' orders.	We will identify the areas where retrospective orders are raised and review alternative mechanisms for order or payment.	Finance & Procurement Executive Director of Finance	01.03.2023	Revised Due Date November 2023 pending AW P2P group	Partially complete (Overdue)	March 2024 Update - This will be an ongoing action with collaborative working between procurement and finance. Discussions are currently being has on the governance arrangements for the All Wales P2P group which will agree updates to P2P policies. CTM are actively involved in these discussions and will ensure appropriate roll out of training following any update to No PO No Pay policies. February 2024 Update - Alternative methods of payments being reviewed as part of AW PO exemption list T&F group. AW T&F group being led by Head of Corporate finance and Head of Procurement and Final exemption list presented at DDOFs in November 2023. Ongoing review into 24/25 through DDOFs/Shared services committee. December 2023 Update - An update has not been provided against this recommendation on this occasion			
Internal Audit/2022/66	15/06/2022	Financial Systems_Final Internal Audit Report June 2022 (Review reference: CTMUHB-2122-04)	Financial Systems 8.3 Where a retrospective order is deemed appropriate, staff should be encouraged to complete the notes section of Oracle explaining the reason for use of a retrospective order, including details of who requested the goods or service to be procured.	Where retrospective orders are deemed acceptable, further training will be given to end users to ensure notes are completed within Oracle	Finance & Procurement Executive Director of Finance	01.03.2023	Revised Due Date November 2023	Fully complete (Awaiting approval)	March 2024 Update - Retrospective orders now being actively reviewed and reported. February 2024 Update - Refer to the update provided for 8.1. Retrospective review being undertaken as part of AW P2P T&F group completion Sept 2023. Further training needs are being identified through local CTM P2P group monthly. Retrospective order over £5k being reported to Audit Committee. December 2023 Update - An update has not been provided against this recommendation on this occasion.			
Internal Audit/2022/66	15/06/2022	Financial Systems_Final Internal Audit Report June 2022 (Review reference: CTMUHB-2122-04)	Financial Systems 8.4 Documentation to support all orders should be retained made available if required	Documentation will be made available via SharePoint.	Finance & Procurement Executive Director of Finance	01.03.2023	Revised Due Date November 2023	Partially complete (Overdue)	March 2024 Update - No further update since February 2024. February 2024 Update - Documentation and information will be available through the development of the CTM SharePoint page which will be linked to the NWSSP SharePoint page with all relevant P2P information including virtual training guides. Stretched resource and increased demands on Savings engagement has delayed completion of CTM share point. NWSSP Buyers toolkit completed but awaiting sign off by NWSSP prior to implementation. On completion - communication will be cascaded through CTM finance systems updates to HB. December 2023 Update - An update has not been provided against this recommendation on this occasion.			
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.	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, Pharmacy & Specialities Chief Operating Officer	30.11.2022	Revised Due Date December 2023	Partially complete (Overdue)	March 2024 update - All 3 groups have met in relation to short/medium/long term workforce plans. Meeting needed with Sally Bolt and Sam Britton to consolidate work and strategy going forward. February 24 Update - The 3 T&F groups are currently meeting on a monthly basis (last meeting 22/01/23). The work has been divided up on a short/medium/long term priority setting basis. The Care Group Medical Director is the nominated sponsor. The work is currently ongoing. December 2023 Update - ToR have now been produced in draft format. A Site Superintendent has been nominated to lead this work. A further update will be provided in December 23.			
Internal Audit/2022/67	24/10/2022	Radiology Service Review Final Internal Audit Report October 2022 (Review reference: CTMUHB-2223-03)	Radiology Service Review 2.1 a) Where scheduled quarterly meetings fail to take place, to prevent large time gaps, consideration should be given to rearranging the meeting, as opposed to waiting to next scheduled quarterly meeting. b) To prevent Quality Improvement & Governance group meetings being cancelled when the Chair is not available, a Vice-Chair should be appointed.	a) The service management team have scheduled quarterly meetings from December 2022 through to April 2024. The Radiology Quality, Improvement & Governance Structure Meeting arranged on 9 November 2022 will address the quoracy structure and appointment of Vice Chair to ensure that the meetings are not cancelled unless there is not quorate. In the event of a cancellation the members will review the agenda to assess whether there are any urgent matters that require action and re arrange the meetings as necessary. b) The Terms of Reference for the Quality & Governance Group will be reviewed and updated on 9 November 2022. This will identify a Vice Chair for the meetings.	Diagnostics, Therapies, Pharmacy & Specialities Chief Operating Officer	30.11.2022	Revised Due Date December 2023 (as a consequence of Phase 2 and decisions to be taken)	Fully complete (Awaiting approval)	March 2024 update - Additional governance support has been provided. Governance meetings now diarised from 11/04/24 bimonthly. ToR will be reviewed on 11/04/24 and membership. Closed. February 2024 Update - ToR reviewed Feb 24. A New Chair has been appointed for QI&G and 4 meetings per year will be prospectively arranged. Additional governance support is in place to ensure there is a robust Radiology Governance framework. December 2023 Update - additional governance support has been provided to facilitate a review of the governance structure. A further update will be provided in December 2023.			
Internal Audit/2022/67	24/10/2022	Radiology Service Review Final Internal Audit Report October 2022 (Review reference: CTMUHB-2223-03)	Radiology Service Review 2.2 Consistent approaches to monitoring and governance arrangements should be in place across the localities. Where groups exist that operate on a locality basis, standardised terms of reference should be in place.	The Terms of Reference for all existing groups will be reviewed to ensure that there is a standardised approach.	Diagnostics, Therapies, Pharmacy & Specialities Chief Operating Officer	01.12.2022	Revised Due Date December 2023 (as a consequence of Phase 2 and decisions to be taken)	Fully complete (Awaiting approval)	March 2024 update - Additional governance support has been provided. ToR in place for each meeting group. Closed. February 2024 Update - ToR reviewed Feb 24. A New Chair has been appointed for QI&G and 4 meetings per year will be prospectively arranged. Additional governance support is in place to ensure there is a robust Radiology Governance framework. December 2023 Update - additional governance support has been provided to facilitate a review of the governance structure. A further update will be provided in December 2023.			

Internal Audit/2022/67	24/10/2022	Radiology Service Review Final Internal Audit Report October 2022 (Review reference: CTMUHB-2223-03)	Radiology Service Review 3.1 a) Due to the volume of policies and procedures that require reviewing, a plan should be developed with clear objectives, targets and responsible officers to ensure that all are reviewed and disseminated to staff in a timely manner. Once a list of all existing policies and procedures has been created, work needs to progress collectively across all localities to determine what needs to be updated, deleted, or amalgamated, while also recognising that some policies are site specific. b) Going forward, a policy and procedure register should be maintained identifying the document owner and the review dates in order to make it easier to keep them up to date.	a) A review of all policies and procedures will be scheduled and responsible officers identified to oversee the process of updating, deleting or amalgamating. A formal circulation list for review of any policies / procedures has been developed. A Radiology adapted Policy for the Management and Authorisation of Radiology documents has been drafted for ratification on 1 December 2022. b) A policy and procedure register is established and maintained to identify the owner and review dates. Investigation to try and automate reminders for policy review via SharePoint underway.	Diagnostics, Therapies, Pharmacy & Specialities Chief Operating Officer	30.06.2023	Revised Due Date December 2023 as structure is under review	Fully complete (Awaiting approval)	March 2024 update - Additional governance support in place. Process in place to request review of policies/SOPS. Database maintained and request sent for review and update by Superintendent. Closed. February 2024 update - a programme of review and ratification now in place. A follow up mechanism for non compliance and monitoring has also been implemented. December 2023 Update - additional governance support has been provided with a view to review the governance structure. A further update will be provided in December 2023.			
Internal Audit/2022/89	12/05/2022	Follow-up: Consultant Job Planning_Final Internal Audit Report May 2022 (Review reference: CTM 2122.16)	Consultant Job Planning Follow Up 5.1 Residual work in relation to the principals of the ADH rate card and its subsequent approval should be completed.	A paper discussing the principles on which a rate card will be developed has been submitted to Director of People. Agreement of these principles will then result in the engagement of interested parties to develop the rate card.	People Services Executive Director for People	01.12.2022	Revised Due Date Spring 2024	Partially complete (Overdue)	March 2024 Update - An update against this recommendation has not been provided on this occasion. January 2024 Update - The non-consultant rate card launched on the 19th October 2023. As per the previous update work is progressing to develop the Consultant Rate Card ready for launch in early 2024. A decision was taken to pause progress on this work due to the Junior Doctors Industrial Action in January 2024. It is still anticipated that the Consultant Rate card will be launched in Spring 2024. December 2023 Update - The non-consultant rate card launched on the 19th October 2023. As per the previous update work is progressing to develop the Consultant Rate Card ready for launch in early 2024.			
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.	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 Services Executive Medical Director Executive Director for People	01.11.2022	Revised Due Date April 2024	Partially complete (Overdue)	March 2024 Update - An update against this recommendation has not been provided on this occasion. January 2024 Update - Changes have been made to the policy which has now been sent for Equality Impact Assessment as well as fellow Lead Medics for review, after which we will be sending to LNC. December 2023 Update - Pending December 2023 LNC meeting - aim to have completed.			
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.	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		In progress	March 2024 Update: Monthly meetings now established. SOPs in place and shared with Care Groups in relation to the management of patients that have care delivered across the organisation. WPAS project governance structure revised and now has medical records and operational representatives at every level to ensure a consistent approach to the management of patients for the duration of the project. January 2024 Update - Work ongoing. Business Management meeting for Medical Records now in place to review procedures and KPIs. December 2023 Update: Started to collocate some of the Records staff at Bridgend but this is a significant piece of work which will run through 2024/2025.			
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.	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 be 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	Revised Due Date April 2024	Partially complete (Overdue)	March 2024 Update - Inquest audit tool completed, with weekly reports produced by the Business Intelligence team. The development of Claims and Redress dashboards have been delayed due to system issues and the need to prioritise more urgent matters. January 2024 Update - (SM revised implementation date required). A checklist has been developed outlining the current stages and requirements for closing records. This needs to be tested on Datix Cymru. Training with the team has been undertaken. AUDIT - A set of principles and a data validation document is being developed for Claims & Redress. Audits will commence in January 2024. An audit tool for validation of open Inquest Data has been developed and run on a weekly basis. Claims and Redress dashboards are being developed to support the timely identification of discrepancies in data. Further audits of open and closed cases will commence in February 2024. Revised Implementation date aligned to date of audits for assurance.			
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 2.1 Management should ensure that required documentation is submitted to the WRP within the specified timeframes, appropriately recorded on Datix Cymru, and monitoring takes place to ensure compliance with this requirement.	In respect of LFER's a new process and SOP is being drafted to ensure timely submission of LFER's. In respect of CMR's there is a process that currently picks up on upcoming CMR's. The process around monitoring CMR's will be solidified by the new dashboard which will allow a more robust monitoring process. Individuals who have missed deadlines will be reminded of importance of CMR deadlines and provided with additional training & support.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.06.2023	Revised Due Date March 2024	Fully complete (Awaiting approval)	March 2024 Update - LFER SOP developed and awaiting approval. Reports and audits regularly undertaken on LFER and CMR trigger dates vs submission dates. Bespoke reports are available on Datix to allow key stakeholders to access when required. This action can be closed. January 2024 Update - A process map has been completed following consultation. Assistant Director of Quality & Safety is awaiting an external report following a review of Legal Services, to allow for all comments to have been considered the process map remains in draft and will be finalised by the end of February 2024 therefore implementation date revised to March 2024.			
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.	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	Revised Due Date April 2024	Partially complete (Overdue)	March 2024 Update - Inquest audit tool completed, with weekly reports produced by the Business Intelligence team. The development of Claims and Redress dashboards have been delayed due to system issues and the need to prioritise more urgent matters. January 2024 Update - All actions are complete. A set of principles and a data validation document is being developed for Claims & Redress. Audits will commence in January 2024. An audit tool for validation of open Inquest Data has been developed and run on a weekly basis. Claims and Redress dashboards are being developed to support the timely identification of discrepancies in data. Further audits of open and closed cases will commence in February 2024. Revised Implementation date aligned to date of audits for assurance.			
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.	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 IPCN Decontamination Lead Executive Director of Nursing/Deputy Chief Executive Officer	01.11.2023	Revised Due Date 1a October 2023 Out for Comment / 1b December 2023 to Decontamination Committee/ IPCC March 2024 / 1c March 2024	Partially complete (Overdue)	March 2024 update - Part (1a) completed. The Decontamination Policy will be presented to IPC committee on the 16th April 2024 (1b). The briefing and advisory support will be issued following approval of the policy as above (1c). January 2024 Update - The Decontamination Policy was approved at Decontamination committee in December 2023: (1a completed) but will not be presented to IPC committee in January 2024 as planned due to the meeting being cancelled. No date for next meeting, awaiting feedback from Nurse Director: 1c) The briefing and advisory support will be issued following approval of the policy as above.			
Internal Audit/2023/107	08/08/2023	Decontamination_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-25)	Decontamination 2.0 A review of locally held decontamination procedures should be carried out to ensure standardised approach to the quality, content and approval.	2a Audit tools for approval in the next Decontamination Committee meeting (see action 5.1). 2b Audit programme to be carried out across all appropriate areas within CTM to inform local SOP status and revisions where required (see action 5.2). 2c All local SOPs are to have been reviewed and ratified for ongoing implementation.	Patient Care & Safety IPCN Decontamination Lead Executive Director of Nursing/Deputy Chief Executive Officer	01.09.2024		In progress	March 2024 update - Part (2a) completed. Audit program ongoing (2b). Service users have been asked to transfer current SOP's to the new SOP template. This is monitored via the local decontamination meetings (2c). January 2024 Update - The SOP template was agreed at Decontamination Committee and circulated to service users for use. Current SOPs to be transferred to new template and will be ratified at local site decontamination meetings. On target to meet 2b and 2c.			
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.	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 IPCN Decontamination Lead Executive Director of Nursing/Deputy Chief Executive Officer	01.10.2023	Revised Due Date 3a July 2023 / 3b October 2023 / 3c March 2024	Overdue	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.			
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.	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 IPCN Decontamination Lead Executive Director of Nursing/Deputy Chief Executive Officer	01.06.2024		In progress	March 2024 update - Part (5a) completed. Audit program ongoing (part 5b). February 2024 - An update has not been provided against this recommendation on this occasion. December 2023 Update - 3 audit tools agreed in September 2023 as planned. Action 5a completed.			
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.	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	Revised Due Date February 2024	Partially complete (Overdue)	March 2024 Update - Finalisation of the Training Strategy has been impacted by Datix Cymru system critical issues which required prioritisation. The strategy will be circulated for Consultation during April 2024. January 2024 Update - The Training Strategy is being finalised and will be presented to the Executive Quality & Safety meeting on the 05.02.24 for sign off. There is some slippage in full completion of a training needs analysis as a result of the implementation of the OCP process. Revised Implementation date now February 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 2.2 In the meantime, It should be ensured that at least one member of the investigation team on cases is RCA trained.	Ensure that a member of the Investigation Team has received the appropriate RCA Training. Remind Care Group Leads of the requirement to include one appropriately RCA trained member in the Investigation Team. Undertake checks during the Quality Assurance Process to confirm the requirement has been fulfilled. The quality assurance checklist will be uploaded to Datix and feedback will be provided to the responsible care group.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.09.2023	Revised Due Date February 2024	Partially complete (Overdue)	March 2024 Update - Finalisation of the Training Strategy has been impacted by Datix Cymru system critical issues which required prioritisation. The strategy will be circulated for Consultation during April 2024. January 2024 Update - The Training Strategy is being finalised and will be presented to the Executive Quality & Safety meeting on the 05.02.24 for sign off. There is some slippage in full completion of a training needs analysis as a result of the implementation of the OCP process. Revised implementation date now February 2024.				
Internal Audit/2023/113	08/08/2023	National Incident Framework_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-05)	National Incident Reporting Framework 1.1 Management should ensure all out of date guidance documents are removed from the intranet and only relevant policies and procedures are made available.	All policies and procedures relating to Incident & Concerns Management will be uploaded to SharePoint and previous versions removed.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.10.2023	Revised Due Date May 2024	Overdue	March 2024 Update - Work continues to be undertaken to update the SharePoint Pages. This will be an iterative process, however the approved documents have been uploaded to the SharePoint Pages. February 2024 - An update has not been provided against this recommendation on this occasion.				
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.	A review of the Standard Operating Procedure will be undertaken to ensure it comprehensively covers the activities required.	Digital & Data Director of Digital	01.01.2024	Revised Due Date - end of Qtr1 2024/25 (30/06/2024)	Overdue	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 WVG • 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. WVG quadruple aims, other national Indicators, internal Indicators.	The Health Board needs to formalise a Performance Framework. This review will consider the points listed above.	Digital & Data Director of Digital	01.01.2023	Revised Due Date - Revised Due Date end of Quarter 3 2024-2025 (31.12.2024)	Overdue	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. January 2024 Update - Performance Report continues to iterate - likely to continue into 2024/2025. Framework will be developed in parallel. December 2023 Update - Performance framework being produced / plan to complete by December 2023.				
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.	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	Revised Due Date May 2024	Partially complete (Overdue)	March 2024 Update - Finalisation of the Training Strategy has been impacted by Datix Cymru system critical issues which required prioritisation. The strategy will be circulated for Consultation during April 2024. January 2024 Update - The Incident Management Framework and Concerns Policy and Procedures were approved by the Quality & Safety Committee on the 23.01.24. The Training Strategy is being finalised and will be presented to the Executive Quality & Safety meeting on the 05.02.24 for sign off. There is some slippage in full completion of a training needs analysis as a result of the implementation of the OCP process. Revised Implementation date now February 2024.				
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.	CTMUHB Policy updated and circulated through service groups. Training will be carried out where required across service groups.	Planned Care Care Group Chief Operating Officer	01.09.2023		Overdue	March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - An update against this recommendation has not been provided on this occasion. December 2023 - An update has not been provided against this recommendation 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 1.2 A Standard Operation Procedure in relation to INNUs should be developed to provide guidance on consistent application of the INNU policy.	Standard Operating Procedure to be developed as part of the working group and provided to all service groups.	Planned Care Care Group Chief Operating Officer	01.01.2024		Overdue	March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - An update against this recommendation has not been provided on this occasion. December 2023 - An update has not been provided against this recommendation 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 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 WHS&C 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.	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.	Planned Care Care Group Chief Operating Officer	01.01.2024		Overdue	March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - An update against this recommendation has not been provided on this occasion. December 2023 Update - An update has not been provided against this recommendation 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 specialty/clinician so that trends and anomalies can be easily spotted and investigated. Sample checks back to patient records should be carried out to confirm all criteria had been met. The use of a checklist as recommended in Matter Arising 2 would aid this process. An	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.	Planned Care Care Group Chief Operating Officer	01.03.2024		Overdue	March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - An update against this recommendation has not been provided on this occasion. December 2023 - An update has not been provided against this recommendation 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.	Application of the above actions	Planned Care Care Group Chief Operating Officer	01.01.2024		Overdue	March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - An update against this recommendation has not been provided on this occasion. December 2023 - An update has not been provided against this recommendation 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 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.	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.	Planned Care Care Group Chief Operating Officer	01.03.2024		Overdue	March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - An update against this recommendation has not been provided on this occasion. December 2023 - An update has not been provided against this recommendation 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.	Daily report to be added to the performance runs with formal monthly reporting via Planning Performance and Finance.	Planned Care Care Group Chief Operating Officer	01.03.2024		Overdue	March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - An update against this recommendation has not been provided on this occasion. December 2023 - An update has not been provided against this recommendation 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 3.0 The importance of capturing accurate information on patient records should be reiterated to all staff, with the use of alternative names ceasing.	Review and update of waiting list 'holding names' to be undertaken	Planned Care Care Group Chief Operating Officer	01.03.2024		Overdue	March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - An update against this recommendation has not been provided on this occasion. December 2023 - An update has not been provided against this recommendation on this occasion.				
Internal Audit/2023/147	16/10/2023	Follow-up: Facilities Systems_Final Internal Audit Report October 2023 (Review reference: CTM-2022.23-42)	Facilities Systems Follow Up Review 2.4 Management should remind staff of the requirement that documentation to support all orders should be retained. Consideration should be given to including information on the retention of documentation to support orders on the action cards. This information should align to any relevant information contained in the FCPs.	We have reminded staff of their responsibilities in relation to the requirement that supporting documentation to support all orders should be retained. Further work is required. These procedures require monitoring monthly to ensure compliance. All procedures will be added to the Facilities Key Performance Indicators and will be monitored monthly. An Action Plan Tracker will follow this report which will include specific actions, accountability and completion dates. The Tracker will be submitted in November 2023.	Facilities Chief Operating Officer	01.02.2024		Partially complete (Overdue)	March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - Separate Report provided by the DoF. An action tracker has been developed within Facilities to address the required Management Actions raised in the internal audit. The action tracker has been submitted for consideration as a separate agenda item and contains a full update. December 2023 Update - Required Training is still underway. Over 75% of staff are now trained and several more training sessions planned. The Department is in the process of completing the action tracker and preparing key performance indicators to monitor progress. Date for completion stands.				
Internal Audit/2023/147	16/10/2023	Follow-up: Facilities Systems_Final Internal Audit Report October 2023 (Review reference: CTM-2022.23-42)	Facilities Systems Follow Up Review 6.0 Management should review and clarify purchasing and budgetary arrangements and responsibilities for Central Facilities Hub and ensure that they align to the Health Board's revised Operational Structure.	The Facilities Hub and non-hub no longer exist. Systems are now in place to track and monitor, however further review is required to reduce activity and achieve budget. The services se areas are significantly overspent. Further control measures need to be determined, implemented and monitored.	Facilities Chief Operating Officer	01.10.2023	Revised Due Date February 2024	Overdue	March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - Separate report to be made by DoF. An action tracker has been developed within Facilities to address the required Management Actions raised in the internal audit. The action tracker has been submitted for consideration as a separate agenda item and contains a full update. December 2023 Update - The review was not followed up correctly in October 2023. Preparation is underway to progress the matter accurately. Update will be available at the February Meeting.				
Internal Audit/2023/147	16/10/2023	Follow-up: Facilities Systems_Final Internal Audit Report October 2023 (Review reference: CTM-2022.23-42)	Facilities Systems Follow Up Review 1.0 Management should ensure that staff who are yet to attend training sessions identified as a requirement for their role, do so as soon as is practicable.	A change in the Facilities structure was implemented in September 2023. The hub and non-hub services have merged into one service. The ILG service Managers are no longer accountable for Facilities services. Leadership is new and all facilities services are under review. Training records will be amalgamated. Any employees who have missed the training will receive the recommended training. A total of 77% have completed Qlik Finance system training and 66% have completed P2P Procurement training. Further training to be arranged.	Facilities Chief Operating Officer	01.02.2024		Overdue	March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - Separate report to be made by DoF. An action tracker has been developed within Facilities to address the required Management Actions raised in the internal audit. The action tracker has been submitted for consideration as a separate agenda item and contains a full update.				

Internal Audit/2023/147	16/10/2023	Follow-up: Facilities Systems, Final Internal Audit Report October 2023 (Review reference: CTM-2022.23-42)	Facilities Systems Follow Up Review 2.2 2.2a Management should continue to work with Procurement to review arrangements with suppliers where large numbers of retrospective orders continue to be raised, with a view to using 'call off / open' orders instead (where practicable). 2.2b In liaison with Procurement, clear guidance should be developed for when it may be acceptable to use 'call off / open' orders and the process staff need to follow to ensure appropriate controls are in place. The FCP should be updated accordingly.	2.2a We will continue to work closely with Finance and Procurement colleagues to identify further opportunities for using call of orders instead of using retrospective orders. 2.2b We have developed and issued a new action card to remind staff of their responsibilities for attaching supporting information/documentation in respect to open/call off orders and to provide information on the retention of information/documentation to support orders. Although informative action cards have been designed there is no evidence that the cards are utilised and adhered to. A monitoring procedure will be added to Facilities Key Performance Indicators and will be monitored monthly.	Facilities Chief Operating Officer	01.02.2024		Overdue	March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - Separate report to be made by DoF. An action tracker has been developed within Facilities to address the required Management Actions raised in the internal audit. The action tracker has been submitted for consideration as a separate agenda item and contains a full update.			
Internal Audit/2023/147	16/10/2023	Follow-up: Facilities Systems, Final Internal Audit Report October 2023 (Review reference: CTM-2022.23-42)	Facilities Systems Follow Up Review 2.3 Management should clarify the access arrangements to the notes section in Oracle for requisitioning staff, in order for information to be captured on why a retrospective order has been used.	We have developed and issued a new action card to remind staff on how to access the notes section on Oracle reminding them of their responsibilities in relation to attaching and entering supporting information in respect of retrospective orders and providing the rationale for raising a retrospective order. Although staff have been advised, no monitoring has taken place. There is therefore no evidence that the procedures are being followed. This procedure will be added to the Facilities Key Performance Indicators and will be monitored monthly.	Facilities Chief Operating Officer	01.02.2024		Overdue	March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - Separate report to be made by DoF. An action tracker has been developed within Facilities to address the required Management Actions raised in the internal audit. The action tracker has been submitted for consideration as a separate agenda item and contains a full update.			
Internal Audit/2023/147	16/10/2023	Follow-up: Facilities Systems, Final Internal Audit Report October 2023 (Review reference: CTM-2022.23-42)	Facilities Systems Follow Up Review 4.0 The level of ongoing additional support provided by procurement to Facilities should be reviewed with an aim to reducing it over time as more Facilities staff complete training. Facilities staff should remind suppliers that queries should be directed through 'Action Point' in the first instance, and not directly with the department.	We have requested the reinstatement of the 'invoices on hold' reports with an agreed frequency from procurement. Reports are generated and distributed.	Facilities Chief Operating Officer	01.10.2023		Overdue	March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - Separate report to be made by DoF. An action tracker has been developed within Facilities to address the required Management Actions raised in the internal audit. The action tracker has been submitted for consideration as a separate agenda item and contains a full update.			
Internal Audit/2023/147	16/10/2023	Follow-up: Facilities Systems, Final Internal Audit Report October 2023 (Review reference: CTM-2022.23-42)	Facilities Systems Follow Up Review 5.0 Management to ensure that outstanding staff receive QlikView training as soon as practicable.	Additional training sessions will be arranged with Finance colleagues to ensure that the staff who require the training receive it and training records are updated accordingly.	Facilities Chief Operating Officer	07.10.2023		Overdue	March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - Separate report to be made by DoF. An action tracker has been developed within Facilities to address the required Management Actions raised in the internal audit. The action tracker has been submitted for consideration as a separate agenda item and contains a full update. Update received after deadline and not included in ARC Excel Report 22nd February 2024.			
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.	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		In progress	March 2024 Update - We have received further money further end of year slippage money from WG. This included £1m to improve wireless resilience, replacing older access points. £700k to replace iGels devices, and £1m to improve infrastructure across CTM, with a focus on Bridgend. February 2024 Update - CTM was awarded £990k in the recent Cyber bid - this money will be targeted at replacing older out of support devices. Welsh Government have written to boards and trusts indicating that there may be slippage for small value bids with a focus on digital opportunities. We have reiterated our all Wales Capital Bid, with a focus on End User Devices that will replace old equipment.			
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.	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		In progress	March 2024 Update - No further progress. Cyber staff aligned to networking and (as anticipated Solarwinds) is currently assigned to urgent firewall and routing reviews in relation to protecting the CTM perimeter and in particular the links in and out of SBU to The Princess of Wales site. Plans for Solarwinds training and ownership will require further review and potentially realignment or resourcing. February 2024 Update - The cyber team are now being onboarded, and activity on this action will start when team bedded in.			
Internal Audit/2023/148	09/10/2023	IT Infrastructure_Final Internal Audit Report October 2023 (Review reference: CTM-2324-19)	IT Infrastructure 4.1 The approach to patching and the mechanisms for undertaking this should be set out within formal documentation.	Create a patching policy and procedure document to cover patching of managed devices.	Digital & Data Director of Digital	31.12.2023		Overdue	March 2024 Update - Patching policy has been written and is now an accepted document within the department. February 2024 Update - Separate Report to be made by the Director of Digital.			
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.	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	Revised Due Date - end of Qtr 2 2024/2025	In progress	March 2024 Update - No further update this month. February 2024 Update - An assessment has been produced assessing ITSM Tooling - we will factor this into IMTP planning for the next FY. The current Asset/Configuration manager has now moved to another post, leaving us short on resource. Recommend a revised implementation date July 2024.			
Internal Audit/2023/148	09/10/2023	IT Infrastructure_Final Internal Audit Report October 2023 (Review reference: CTM-2324-19)	IT Infrastructure 6.1 The network topology and make up should be recorded outside of the monitoring tools.	Plans in place to review and document individual sites. Staffing levels will determine the time it will take to complete the work. Priority will be given to the critical sites, as this also supports the review work required for NIS-D assessment.	Digital & Data Director of Digital	31.03.2024	Revised Due Date - end of Qtr1 2024/2025	In progress	March 2024 Update - No further update this month. February 2024 Update - Staffing levels and other more urgent work is impacting delivery of this action. Discussions are in place to alleviate the resourcing issue. Recommend a revised implementation date of June 2024.			
Internal Audit/2023/151	28/11/2023	Deprivation of Liberty Safeguards (DoLS)_Final Internal Audit Report November 2023 (Review reference: CTMUHB-2324-07)	Deprivation of Liberty Safeguards 3.1 A review of the current application management system should be undertaken to determine what additional data should be captured that facilitates monitoring of applications, completion timeframes and the issues encountered that prevents timely completion.	Benchmarking with neighbouring Health Boards has been completed to establish what systems they use to monitor timeframes and issues experienced. Both SBUHB and ABUHB use a similar system to the one currently in place.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.11.2023		Fully complete (Awaiting approval)	March 2024 Update - Current management systems have been adapted to reflect recommendation. The consequential number is not yet in use and further work will be undertake to explore the use of an alternative management system in the future. All other criteria has been included in current system.			
Internal Audit/2023/151	28/11/2023	Deprivation of Liberty Safeguards (DoLS)_Final Internal Audit Report November 2023 (Review reference: CTMUHB-2324-07)	Deprivation of Liberty Safeguards 1.1 A standard operating procedure (SOP) should be developed for reference by current and future DoLS staff to ensure a consistent approach is in place for all applications. The SOP could include the process for reviewing applications ahead of logging on the spreadsheet, completion of the spreadsheet, processes for chasing outstanding information, quality checks and the authorisation process.	The DoLS team will develop a Standard Operating Procedure (SOP) for the following processes: • Identification of a Deprivation of Liberty and how to make a referral (ward Based) • Receiving, prioritising and recording applications. • Completion of Welsh Government datasheet and referral maintenance. The Role of the Best Interest Assessor, s12 Doctor, DoLS Administrator, DoLS Team Leader, Signatories, Relevant Persons Representative. • The ward responsibilities following authorisation. This SOP will complement the Health Board and Safeguarding Board DoLS policy.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.04.2024		In progress	March 2024 Update - The Standard Operating Procedure is currently out for consultation and due to be presented to April Executive Group for approval. January 2024 Update - The development of a standard operating procedure is in progress.			
Internal Audit/2023/151	28/11/2023	Deprivation of Liberty Safeguards (DoLS)_Final Internal Audit Report November 2023 (Review reference: CTMUHB-2324-07)	Deprivation of Liberty Safeguards 2.1 Management should monitor DoLS / MCA training completion rates at the various levels and take action to escalate concerns where training is not being completed.	CTMUHB compliance in MCA reset following work to allocate competencies to reflect new MCA/DoLS training. Since the audit the following changes have been implemented: • A scorecard has been developed to evidence numbers of staff who have received MCA and DoLS Training. This will continue to be monitored quarterly through the Safeguarding Operational and Executive Group (SEG). • The DoLS/MCA team now attend the CTMUHB monthly Core Learning Compliance Group to discuss compliance and highlight any areas of concern.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.01.2024		Fully complete (Awaiting approval)	March 2024 Update - MCA training is progressing well across services. MCA training has been made mandatory across CTMUHB at 3 levels. Bespoke sessions have also been delivered in primary care, maternity and district nursing to enhance awareness of MCA principles and develop skills to undertake MCA assessments. Level 1 - 52%, level 2 62%. A digital assessment form has been developed by CTMUHB Practice Facilitator and has been presented at al all Wales forum.			
Internal Audit/2023/151	28/11/2023	Deprivation of Liberty Safeguards (DoLS)_Final Internal Audit Report November 2023 (Review reference: CTMUHB-2324-07)	Deprivation of Liberty Safeguards 3.3 Consideration should be given to maintaining a log of returned applications, and the data used to identify if there are any training needs in certain wards or departments.	• Following the discussions prior to this report, a new returned applications log has been developed and trialled. This is completed on a daily basis and any returned applications are followed up the next day by the next BIA monitoring the inbox. • Quarterly quality assurance meetings will be held by the Head or Deputy Head of Safeguarding to review a selection of returned applications and assessments for the purposes of identifying themes and barriers. These meetings will also facilitate oversight of audits and action plans.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.01.2024	Revised Due Date April 2024	Partially complete (Overdue)	March 2024 Update - The TOR for the quality assurance group are complete, with a meeting scheduled for April. The agenda will include overview of the audit recommendations, future planned audits, MDT approach to quality assuring each step of the DoLS process. Colleagues from Care Groups and advocacy have been invited. Monthly reports are provided to the Head of Safeguarding detailing any quality and performance issues. January 2024 Update - The trial period for the updated applications log has resulted in these being utilised by the team on a permanent basis. The log allows the team leader to keep an overview of allocations, performance management, themes and trends. The development of the quality assurance meetings is delayed due to staff sickness. Terms of reference will be complete by February, with the first meeting scheduled to now take place at the start of the new year. It is requested that approval is given to move this completion date to April 2024.			

Internal Audit/2023/151	28/11/2023	Deprivation of Liberty Safeguards (DoLS)_Final Internal Audit Report November 2023 (Review reference: CTMUHB-2324-07)	Deprivation of Liberty Safeguards 4.3 Consideration should be given to capturing time in relation to casework stages to assist in identifying, quantifying and confirming areas where delays commonly occur.	The Health Board will undertake a retrospective review for the number of DoLS applications for the previous 4 years, when the MCA Amendment Act (2019) was passed. This data set will then be examined with a view to identifying possible trends in order to condition a respective trend for the forthcoming year. This will in turn decide on the ability to predict future flow and numbers for DoLS activity in CTMUHB.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.02.2024	Revised Due Date April 2024	Partially complete (Overdue)	March 2024 Update - This report is complete and will be presented to Safeguarding Executive Group in April 2024. January 2024 Update - A piece of work is ongoing to analyse four year data. A draft report will be produced by the end of February 2024 and submitted to the Deputy Director of Nursing for comment. A final version will be made available to the Safeguarding executive Group for April 24.			
Internal Audit/2023/151	28/11/2023	Deprivation of Liberty Safeguards (DoLS)_Final Internal Audit Report November 2023 (Review reference: CTMUHB-2324-07)	Deprivation of Liberty Safeguards 4.2 Consideration should be given to capturing time in relation to casework stages to assist in identifying, quantifying and confirming areas where delays commonly occur.	- Current performance management spreadsheets will be reviewed and amended to reflect the complete DoLS process from referral to authorisation. - The development of a quality assurance and monitoring group headed by the Deputy Head of Safeguarding will identify and deliver a process for escalating operational deficits which impact on time.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.01.2024	Revised Due Date February 2024	Partially complete (Overdue)	March 2024 Update - 6 of the 8 recommendations have been completed. Draft version of the SOP has been completed and is awaiting approval. First Quality Improvement Group planned for April 24 where the TOR will be discussed, preparatory work remains ongoing. January 2024 Update - Performance management spreadsheets have been amended to reflect all stages of DoLS authorisations, are completed monthly and discussed between the Team Leader and Deputy Head of Safeguarding. The development of the quality assurance meetings is delayed due to staff sickness. Terms of reference and any preparatory work will be completed by February, with the first meeting scheduled for April 2024. It is requested that approval is please given to move this completion date to April 2024. This action links with recommendation DoLS 3.3			
Internal Audit/2023/152	07/12/2023	PCH Redevelopment Programme: Supervisor Role_Final Internal Audit Report December 2023 (Review reference: CTM-SSU-2324-07)	PCH Redevelopment Supervisor Role 2.2 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).	Agreed	Finance, Capital & Estates Executive Director of Finance	01.01.2024		Overdue	March 2024 Update - there is no additional update to that provided as at February 2024. Reports are developed and presented on a monthly basis. This will be reviewed at the QI group moving forward. Quarterly scorecards have been adapted to ensure appropriate escalation through the Safeguarding Executive Group. February 2024 Update - Supervisor's report re-formatted to draw attention to priority of outstanding defects. Further consideration of presentation required.			
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.	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	Strategy & Transformation Executive Director of Strategy & Transformation	01.09.2023	Revised Due Date June 2024	Overdue	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. January 2024 Update - The SLA template has been reviewed and feedback provided by Procurement team. Final checks and approval of the template for use are required.			
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 2.0 Data in the register of agreements should be checked to confirm its accuracy and completeness. - Once the current completeness and accuracy of the register of agreements has been confirmed, procedures will need to be put in place to ensure that changes are promptly notified so that it remains accurate and up to date. - The register of agreements should be checked before setting up an SLA agreement with a provider to ensure that multiple SLAs are not set up with the same provider for the same.	The register of agreements will be reviewed by a process of sharing with all corporate and service (Care Groups) teams for review and supported by a structure of meetings between the Strategy and Transformation Team (Commissioning leads) and the Care Groups to manage and monitor SLAs. All third sector SLAs have been reviewed and the register will be updated to reflect the latest status.	Strategy & Transformation Executive Director of Strategy & Transformation	01.08.2023	Revised Due Date January 2024	Fully complete (Awaiting approval)	March 2024 Update - This action is complete. The register continues to be reviewed and any requirement for an agreement is checked against this register. January 2024 Update - The register of agreements has been reviewed by care groups and new agreements will be added as they are created.			
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.	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.	Strategy & Transformation Executive Director of Strategy & Transformation	01.09.2023	Revised Due Date June 2024	Overdue	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. January 2024 Update - Care group meetings take place regularly and there is a structure in place to support the monitoring of all 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 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.	The guidance to be developed, as described in the response to action one will include clarity on processes for signing and storing of agreements.	Strategy & Transformation Executive Director of Strategy & Transformation	01.09.2023	Revised Due Date June 2024	Overdue	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. January 2024 Update - Guidance documents are in development. A Head of Commissioning post is being recruited to, in order to provide capacity to facilitate oversight of all SLAs.			
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.	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.	Strategy & Transformation Executive Director of Strategy & Transformation	01.09.2023	Revised Due Date January 2024	Overdue	March 2024 Update - Monitoring and review of agreements is a constituent part of the regular commissioning meetings with care groups. January 2024 Update - Review timeframes to be determined for agreements in 2024. All NHS services are monitored via regular contracting and commissioning meetings with providers. December 2023 Update - SLA review is a component part of the commissioning meeting structure and the allocation of both service and planning/commissioning leads for each SLA will ensure this is undertaken. The review of the register of agreements that will deliver this is ongoing currently.			
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.	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.	Planned Care Care Group Chief Operating Officer	30.04.2023	Revised Due Date April 2024	Overdue	March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - as a consequence of staffing issues connected with OCP 2 there is no further action to report. December 2023 Update - Awaiting update from Director of Planned Care following update.			
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 specialties, 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.)	A review of the structures in Bridgend will take place. A plan for an organisational restructure with a standardised approach will be developed.	Planned Care Care Group Chief Operating Officer	30.06.2023	Revised Due Date April 2024	Overdue	March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - as a consequence of staffing issues connected with OCP 2 there is no further action to report. December 2023 Update - Awaiting the outcome of OCP 2 which has been delayed.			
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.	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.	Planned Care Care Group Chief Operating Officer	01.08.2023	Revised Due Date April 2024	Overdue	March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - as a consequence of staffing issues connected with OCP 2 there is no further action to report. December 2023 Update - Awaiting SOP update from Director of Operations Planned Care.			
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.	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"	Planned Care Care Group Chief Operating Officer	01.08.2023	Revised Due Date April 2024	Overdue	March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - as a consequence of staffing issues connected with OCP 2 there is no further action to report. December 2023 Update - as a consequence of the phase 2 OCP process, the position remains the same as that in October 2023. There will be an update in February 2024.			

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 3.0 In line with Welsh Government and Health Board targets, all staff should participate in a PDR on an annual basis. Staff should be reminded that it is their PDR and therefore they need to engage in the process and complete any relevant paperwork ahead of the meeting, allowing the actual meeting to be more meaningful and efficient.	Current compliance as at 10/07/23: • POW 82.5% • RGH 60.8% • PCH 66% Significant improvement noted at PCH with increased compliance from 39%. The team have booked and planned PDRs around incremental dates. All managers have been asked to review and ensure all dates are reflected accurately on ESR. It has been noted that some staff are lacking confidence in completing the new PDR document prior to the planned PDR. Staff are encouraged to engage in the process and work through the document with their line manager during the PDR or seek support prior to the PDR.	Diagnostics, Therapies, Pharmacy & Specialties Chief Operating Officer	01.02.2024	Revised Due Date February 2024	Fully complete (Awaiting approval)	March 2024 update - Radiology overall PDR compliance 75.08%. Plans in place across all 3 sites to maintain compliance. Closed. February 2024 Update - Current departmental compliance for January 2024 is 70.75%. Targeted work in PCH has been put into action to increase compliance. RGH 84.97% compliance, POW 68.97% compliance, PCH 52.50% compliance.				
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 4.1 Management at RGH should continue to liaise with the Learning and Development team to ensure the suggested amendments to learning profiles are implemented on ESR. It should be determined if similar exercises to refine learning requirements are required for staff at the PCH and POW sites.	Two members of staff have been assigned responsibility to review all Radiology staff core competencies as a focussed piece of work. They will liaise with learning and development.	Diagnostics, Therapies, Pharmacy & Specialties Chief Operating Officer	01.09.2023	Revised Due Date February 2024	Overdue	March 2024 update - work still underway. Learning and Development team have responded to state that they are short staffed but have signposted information on next steps to appeal against competencies which are felt unnecessary. February 2024 - Issues remain in terms of allocated competencies to M&D staff and levels of Safeguarding training expectations. To update March 24.				
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 4.2 The CSG should ensure that staff are reminded that undertaking level one training in the core skills modules is in line with Welsh Government expectations, and that training at higher levels is a Health Board expectation for that role. It should be ensured that all staff are provided with the opportunity to undertake their mandatory training.	Module of the month is promoted through the Staff Newsletter, reports regularly circulated to Superintendents.	Diagnostics, Therapies, Pharmacy & Specialties Chief Operating Officer	01.12.2023	Revised Due Date December 2023	Overdue	March 2024 Update - Current Overall Core Mandatory Training compliance 69.65%. Moving and Handling and Resus are lowest compliance due to lack of training available or staffs inability to attend due to clinical needs. The department has since trained the trainers to roll out both modules in house and are training 6 staff per month to improve compliance. February 2024 Update - Departmental Core Mandatory training compliance 63.12%. Further work is needed to address M&D core mandatory training compliance. This is also due to classroom training for Manual Handling and Resus. The department are in the process of training trainers to deliver in house training due shortages of courses.				
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.	Current compliance POW: • 7 signed off • 1 awaiting 1st sign off • 1 expired but booked – date arranged for 20/09	Diagnostics, Therapies, Pharmacy & Specialties Chief Operating Officer	30.09.2023	Revised Due Date December 2023	Overdue	March 2024 update - 17 with an up to date JP, 11 booked, 2 not booked. February 2024 update - a programme of job plan bookings has been implemented to drive compliance. RGH 76% compliance, POW 75% compliance, PCH 100% compliance.				
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.	Develop standardised approach to application of 4 hour clinical exception to include a pan CTM SOP for application of WG guidance.	[ADD] Chief Operating Officer	01.06.2024		In progress	March 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.	Develop a standardised set of codes to be used across all sites.	[ADD] Chief Operating Officer	01.06.2024		In progress	March 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.	Communicate through safety briefings the importance of fully completing CAS Cards and review implementation of summary table across all sites.	[ADD] Chief Operating Officer	01.06.2024		In progress	March 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.	Develop standardised CAS card for all sites in conjunction with Clinical Director and Lead Nurse.	[ADD] Chief Operating Officer	01.06.2024		In progress	March 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.	Ensure standardised approach to training across all ED's, monitor through Directorate Performance Meetings.	[ADD] Chief Operating Officer	01.06.2024		In progress	March 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.	Ensure standardised approach to training across all ED', monitor through Directorate Performance Meetings.	[ADD] Chief Operating Officer	01.06.2024		In progress	March 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.	*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.	[ADD] Chief Operating Officer	01.06.2024		In progress	March 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.	Implement a standardised approach to capturing any changes to records, monitor through Directorate Performance reviews	[ADD] Chief Operating Officer	01.06.2024		In progress	March 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.	5.2Undertake regular "snapshot" audits to ensure validation is correctly captured and monitor through Directorate Performance reviews.	[ADD] Chief Operating Officer	01.06.2024		In progress	March 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.	5.3Review validation approaches across all ED's and implement a standardised approach to reporting.	[ADD] Chief Operating Officer	01.06.2024		In progress	March 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.	Undertake review of outstanding cases at POW and determine if validation is required	[ADD] Chief Operating Officer	01.06.2024		In progress	March 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.	Re-instate weekly SM meetings at POW.	[ADD] Chief Operating Officer	01.06.2024		In progress	March 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.	Ensure agenda and action logs are retained.	[ADD] Chief Operating Officer	01.06.2024		In progress	March 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.	Site specific slide deck in place, ensure used to underpin discussions.	[ADD] Chief Operating Officer	01.06.2024		In progress	March 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.	Develop a more detailed report to include analysis of breach codes.	[ADD] Chief Operating Officer	01.06.2024		In progress	March 2024 Update - An update against this recommendation has not been provided on this occasion.				

Internal Audit/2024/163	02.08.2024	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.	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		In progress	March 2024 Update - Activity is underway to shape an updated Head of IT Service Management to go out for recruitment in April 2024.			
Internal Audit/2024/163	02.08.2024	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.	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		In progress	March 2024 Update - Activity is underway to shape an updated Head of IT Service Management to go out for recruitment in April 2024.			
Internal Audit/2024/163	02.08.2024	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.	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		In progress	March 2024 Update - Activity is underway to shape an updated Head of IT Service Management to go out for recruitment in April 2024.			
Internal Audit/2024/163	02.08.2024	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.	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		In progress	March 2024 Update - Activity is underway to shape an updated Head of IT Service Management to go out for recruitment in April 2024.			
Internal Audit/2024/163	02.08.2024	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.	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		In progress	March 2024 Update - Activity is underway to shape an updated Head of IT Service Management to go out for recruitment in April 2024.			
Internal Audit/2024/163	02.08.2024	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.	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		In progress	March 2024 Update - Activity is underway to shape an updated Head of IT Service Management to go out for recruitment in April 2024.			
Internal Audit/2024/163	02.08.2024	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.	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		In progress	March 2024 Update - Activity is underway to shape an updated Head of IT Service Management to go out for recruitment in April 2024.			
Internal Audit/2024/163	02.08.2024	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.	This action is dependent on the selection, procurement, and implementation of a new ITSM tool. There is an expectation that Service Point 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		In progress	March 2024 Update - Activity is underway to shape an updated Head of IT Service Management to go out for recruitment in April 2024			
Internal Audit/2024/163	02.08.2024	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.	This action is dependent on the selection, procurement, and implementation of a new ITSM tool. There is an expectation that Service Point 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		In progress	March 2024 Update - Activity is underway to shape an updated Head of IT Service Management to go out for recruitment in April 2024.			
Internal Audit/2024/163	02.08.2024	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.	This action is dependent on the selection, procurement, and implementation of a new ITSM tool. There is an expectation that Service Point 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		In progress	March 2024 Update - Activity is underway to shape an updated Head of IT Service Management to go out for recruitment in April 2024.			
Internal Audit/2024/163	02.08.2024	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 Service Point is reviewed and cleansed of duplications and are configured for all applicable services.	This action is dependent on the selection, procurement, and implementation of a new ITSM tool. There is an expectation that Service Point 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		In progress	March 2024 Update - Activity is underway to shape an updated Head of IT Service Management to go out for recruitment in April 2024.			
Internal Audit/2024/163	02.08.2024	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.	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		In progress	March 2024 Update - Activity is underway to shape an updated Head of IT Service Management to go out for recruitment in April 2024.			

Appendix 2 - Audit Tracker Development Work Programme

Development Required	Action Needed (Local or External)	Lead on Action	Implementation Timescale
1. Requirement for additional fields within the AMaT System to capture "Revised Dates" and rationale. Revised dates currently captured in progress update narrative.	External Development led by AMaT. Added to the system Development Log for approval. High priority has been assigned.	AMaT System developers	January 2025
2. Inspection actions to be defined as High Medium or Low in the system.	Local Development led by Clinical Audit Team. The current RAG Rating field can be customised to meet requirements.	CTMUHB Clinical Audit Team	June 2024
3. Introduce theming across inspections.	Local and External Development Quality Assurance & Compliance Team to add theme criteria list and share with Clinical Audit for inclusion. AMaT to design a report that captures recommendations by theme.	CTMUHB Clinical Audit Team and Quality Assurance & Compliance Team AMaT System/Report Developers	June 2024 January 2025
4. Read only access for Audit & Risk Committee Members to view full reports as and when required.	Local Development If Audit & Risk Committee members will find this beneficial individuals will be added as read only users.	CTMUHB Clinical Audit Team and Quality Assurance & Compliance Team	June 2024

Development Required	Action Needed (Local or External)	Lead on Action	Implementation Timescale
5. Requirement for additional fields / coding to capture "Paused" recommendations or individual actions	External Development To be added to AMaT's Development Log and if supported will be taken forward	CTMUHB Clinical Audit Team to request. AMaT System developers	March 2025
6. Requirement to capture in the system where recommendations have not been accepted generating a text box for rationale narrative to be added.	External Development To be added to AMaT's Development Log and if supported will be taken forward.	CTMUHB Clinical Audit Team to request. AMaT System developers	March 2025
7. Notification Alerts – further refinement of sign off stages and at what delegated level	Local Development CTMUHB Clinical Audit Team and Quality Assurance & Compliance Team to define what is required in terms of escalation and approval levels and set permissions accordingly.	CTMUHB Clinical Audit Team and Quality Assurance & Compliance Team	July 2024
8. Fully Automated report in pdf design style addressing all the above requirements.	Local and External Development Quality Assurance & Compliance Team to confirm report criteria AMaT to design a report that captures recommendations by theme.	CTMUHB Quality Assurance & Compliance Team	March 2025
9. Internal Audit Reports – Tracker introductory Sheet to include assurance rating	Completed – now added.	CTMUHB Quality Assurance & Compliance Team	Complete

Audit & Risk Committee

Medical Rostering Progress Report

Dyddiad y Cyfarfod / Date of Meeting	18/04/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Andrew Stocken, Medical & Dental E-Systems Manager; Nicholas Price, Senior HR Manager - Medical Workforce, Medical Personnel and Nerys Conway, Assistant Medical Director
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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	
AMD	Assistant Medical Director
BMA	British Medical Association
ED	Emergency Department
MD	Medical Director



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

MWSG	Medical Workforce Sustainability Group
LNC	Local Negotiating Committee

1. Situation / Background

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

2. Specific Matters for Consideration

2.1 Recommendation 3.1

Responsible person: AMD for Workforce

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

Update – In progress

The policy is currently being updated and will submitted back to the LNC for approval in June 2024.

2.2 Recommendation 4.1

Responsible person: Executive Medical Director (MD)

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

Update – In progress

The policy is currently being updated and will submitted back to the LNC for approval in June 2024.

3. Key Risks / Matters for Escalation

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

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 (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / 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 (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))	Not Applicable
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / 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 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 a policy
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	



Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.
Effaith Adnoddau <i>(Pobl / Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.

5. Recommendation

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

6. Next Steps

6.1 Both policies mentioned above to go to LNC Meeting in June 2024

Cwm Taf Morgannwg University Health Board

Audit & Risk Committee Internal Audit Progress Report

April 2024

NWSSP Audit and Assurance Services

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Appendix A – Tables showing detailed progress against 2023/24 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.

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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 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 April 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 February meeting of the Committee five reports have been finalised, one report is in draft, and we have ongoing fieldwork in relation to 11 reviews, of which a number are concluding. 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
Gastro-intestinal pathway	3	2	-	5	Limited
Decarbonisation	3	2	1	6	Limited
Follow up – Digital operating model	-	2	-	2	Reasonable
PCH - Financial management and change control	-	4	-	4	Reasonable
Management of Controlled Drugs	1	5	1	7	Reasonable

3 Delivering the Plan

- 3.1 Similar to last year, we plan to issue our annual report and year end opinion by 31 May.
- 3.2 Our agreed performance indicators are set out in table 2 below:

Table 2 – Performance Indicators 2023/24

Indicator	Status	Actual	Target	Red	Amber	Green
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	Green	78%	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days per Internal Audit Charter]	Red	38%	80%	v>20%	10%<v<20%	v<10%

Indicator	Status	Actual	Target	Red	Amber	Green
Report turnaround: time from management response to issue of final report [10 working days]	Green	100%	80%	v>20%	10%<v<20%	v<10%

4 Feedback

4.1 Our final reports are issued with a post audit questionnaire, which is our way of getting feedback on the audit process so that we can look to make improvements. This year, we have received one post audit questionnaire back from the Health Board.

5 Other activity

Meetings

- 5.1 We continue to meet regularly with the officers of the Health Board, Counter Fraud, and Audit Wales colleagues.
- 5.2 We have met with two new independent members as part of their induction process.
- 5.3 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.

Appendix A – 2023/24 Programme of work**Table 3: Core programme of work for Q1-Q4**

Plan Ref.	Review	Rating	Review period	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
22	Follow up – Radiology – workforce	Reasonable	Q1	Final	Y	N	Reported August
19	IT Infrastructure	Reasonable	Q1	Final	Y	N	Reported October
-	Interventions Not Normally Undertaken (INNU)	Limited	-	Final	Y	N	Reported October
7	Deprivation of Liberty Safeguards (DoLS)	Reasonable	Q2	Final	N	Y	Reported December
-	Arrangements for financial savings	Substantial/ Reasonable/ Limited	-	Final	N	N	Reported December
3	Performance management of 4-hour target	Limited	Q1	Final	Y	N	Report February
18	IT Service Management	Reasonable	Q2	Final	Y	Y	Report February
2	Gastro-intestinal pathway	Limited	Q1	Final	Y	N	Reporting in April
13	Decarbonisation	Limited	Q3	Final	Y	Y	Reporting in April

Plan Ref.	Review	Rating	Review period	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
24	Follow up – digital operating model	Reasonable	Q3	Final	Y	N	Reporting in April
6	Management of controlled drugs	Reasonable	Q2	Final	Y	N	Reporting in April
4	Estates Assurance / condition	Limited	Q1	Draft	N	-	Part of all Wales review - Updated draft report issued 18.10.23.
9	Adult mental health – CSG review	-	Q2	WIP	-	-	Delayed due to auditor sickness. Fieldwork concluding.
-	Follow up – Patient pathway appointment management	-	-	WIP	-	-	Review was brought into 23/24 as implementation date of management actions were revised. Fieldwork concluding
1	Leadership and management development	-	Q1 Q4	WIP	-	-	Management request to move to Q4 as internal development ongoing. Fieldwork concluding.
17	Risk management	-	Q4	WIP	-	-	Fieldwork started 01.02.24.

Plan Ref.	Review	Rating	Review period	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
23	Follow up – medical variable pay	-	~~Q2~~ Q4	WIP	-	-	Rescheduled as audit tracker identified implementation of actions moved to end of October 2023.
25	Follow up – reasonable offer	-	~~Q3~~ Q4	WIP	-	-	Rescheduled as audit tracker identified implementation of actions moved to end of October 2023.
20	Technical resilience	-	Q4	WIP	-	-	Fieldwork started 27.03.24
14	Welsh Risk Pool	-	Q4	WIP	-	-	Fieldwork started 27.03.24
15	Embedding the quality framework	-	Q4	Planning	-	-	Draft brief issued 27.03.24. Awaiting response.
8	Finance - Budgetary controls	-	Q2	Defer	-	-	To be considered in 2024/25.
16	New care group model	-	Q4	Defer	-	-	Request to move into 24/25 as care group model tier 2 governance recently established.

Table 4: Status of PCH plan work 2023/24

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

Assignment	Status	Assurance	Notes
Financial management and change control	Final	Reasonable	Reporting in April
Quality – Site supervisor role	Final	Substantial	Reported December
Validation of management actions	Final	Substantial	Reported December
Technical – Supply chain partner management	WIP	-	Fieldwork ongoing
Delivery of key project objectives	WIP	-	Fieldwork ongoing

Table 5: Hosted bodies programme of work

Plan Ref.	Review	Rating	Review period	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
1	WHSSC – Integrated commissioning plan (ICP)	Substantial	Q1	Final	Y	Y	Reported December
2	WHSSC – Welsh Kidney Network	Substantial	Q2	Final	Y	Y	Reported October

Plan Ref.	Review	Rating	Review period	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
4	EASC – Acute Critical Care Transfer Service (ACCTS)	-	-	WIP	-	-	Fieldwork started 28.03.24

PCH Redevelopment Programme: Financial Assurance

Final Internal Audit Report

April 2024

Cwm Taf Morgannwg University Health Board



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



Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board



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Review reference:	CTM-SSU-2324-06
Report status:	Final
Fieldwork commencement:	19 October 2023
Fieldwork completion:	2 February 2024
Draft report issued:	15 March 2024
Management response received:	25 March 2024
Final report issued:	3 April 2024
Auditors:	NWSSP: Audit & Assurance - Specialist Services Unit (SSu)
Executive sign-off:	Sally May, Director of Finance
Distribution:	Tim Burns, Assistant Director of Strategic & Operational Planning Jeremy Holifield, Responsible Officer, Prince Charles Hospital Construction Programme
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:

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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Executive Summary

Purpose

The objective of this audit was to review the adequacy of information provided in support of the level of Stage 4 (construction) defined costs claimed by the Supply Chain Partner (SCP), through selective testing of the monthly valuations and payments to provide assurance on the approach to date at the Prince Charles Hospital Phase 2 ground and first floor.

Overview

The project comprises six sections of works, and as of the fieldwork period (November/ December 2023), Sections 1, 2, and 6 had been completed, with the most significant activity being within Section 3. The audit specifically examined the valuation process within Section 3 (the Adjusted Target Cost for this section was £74,004,205). For review purposes, Valuation 33, amounting to £5,260,060.97 (inclusive of VAT), was selected.

A well-defined methodology was observed for the scrutiny of monthly valuations, aligning with the requirements of the New Engineering Contract (NEC). Consequently, appropriate scrutiny/ challenge was evident from the Health Board’s appointed Cost Adviser.

Fees imposed by the Supplier Chain Party (SCP) were found to be in accordance with the contract, and the application of staff rates was in line with the framework and contractual obligations etc.

Whilst general compliance with the contract was noted in other areas (e.g. subcontractor costs, equipment costs etc.), there are areas that require management attention, including:

- Concerns regarding the volume of hours claimed by individual contributors.
- Timeliness issues in the change management process.
- The need for improved compliance with contractual requirements for prompt payment.
- Greater compliance with the minimum criteria for payments to subcontractors, as outlined within the Welsh Government’s Project Bank Account Policy.

Based on the audit findings, reasonable assurance has been determined concerning this specific area of focus.

Report Classification

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary ¹

Assurance objectives	Assurance
1 Methodology	Substantial
2 Validation of Costs	Reasonable
3 Payments	Reasonable

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

Key Matters Arising		Assurance Objective	Control Design or Operation	Recommendation Priority
1	Improved monitoring controls surrounding the volume of hours worked on site.	2	Operation	Medium
2	A review of the timely completion of change control documentation.	2	Operation	Medium
3	Verification that payments align with contractual obligations.	3	Operation	Medium
4	Increased engagement with the Supply Chain Partner surrounding timely payments to subcontractors.	3	Operation	Medium

1. Introduction

- 1.1 This audit originated from the 2023/24 integrated audit plan for the Prince Charles Hospital (PCH) Redevelopment Programme, agreed with management and approved by the Audit and Risk Committee.
- 1.2 The PCH Phase 2 Ground and First Floor works were developed with six sections of works with a total approval of £220m (which includes an allowance of £23m for inflation) with completion anticipated in June 2026.
- 1.3 The audit focused on the adequacy of information provided in support of the Stage 4 (construction) costs claimed by the Supply Chain Partner (SCP) through selective testing of the monthly valuations.
- 1.4 The potential risks considered within this review included:
 - Expenditure was not appropriately supported.
 - The quality of works on the project was not subject to the required level of scrutiny and challenge.

2. Detailed Audit Findings

- 2.1 Our detailed audit findings are set out below. All matters arising and the related recommendations and management actions are detailed within Appendix A.

Methodology: *Appropriate processes were in place for agreeing the sums claimed to provide assurance in relation to project progression.*

- 2.2 The PCH Phase 2 Ground and First Floor Works project comprises six sections of works. THE NEC contract for the project has been amended to provide for Target Costs, sectional completion, gain share and associated defects periods for each defined section of works.
- 2.3 At the time of the audit fieldwork (November/ December 2023), Sections 1, 2, and 6 had been completed, with the most significant activity being within Section 3. This review focused on the valuation processes applied at section 3 of the contract with an adjusted Target Cost of £74,004,205.
- 2.4 It was evident that the UHB's appointed Cost Adviser applied a robust review and scrutiny methodology to the monthly valuations submitted by the SCP, with clear evidence of examination and challenge of the SCP's cost submissions.
- 2.5 Subsequent to the Cost Adviser's scrutiny of the monthly valuation of works completed, a signed payment certificate was issued by the externally appointed Project Manager to offer assurance to the Health Board that the costs were deemed appropriate, and payments to the SCP should proceed.
- 2.6 Recognising the above ensures the appropriate application of the contract, **substantial assurance** has been determined in this area.

Validation of Costs: *To gain assurance costs were supported by substantiating documentation and to verify that costs incurred were accurately recorded and arithmetically correct.*

- 2.7 Valuation 33 dated July 2023, in the sum of £5,260,061 (inclusive of VAT) was tested at the current audit.
- 2.8 Arithmetic checks were performed to verify the accurate transfer of formulas from source data and reconciliation with the original data.
- 2.9 Fees applied by the SCP were in accordance with the NEC contract and NHS Wales national framework conditions.
- 2.10 Accuracy checks were performed on staff rates utilised during the sampled valuation. The rates employed were reconciled with the annually increased staff rates as per the framework and contractual obligations.
- 2.11 Curriculum Vitae checks by the Cost Adviser on individuals employed by the SCP and Supply Chain were also evidenced, to ensure sufficient experience for the rates of pay being applied with no errors identified.
- 2.12 There was evidence of challenge and scrutiny to the hours being claimed within both staff and labour. However, anomalies were identified in the volume of hours being claimed by individuals (see **MA1**). This were raised with the Cost Advisor, and it was agreed that further monitoring would be implemented to validate these costs.
- 2.13 A total sample of £174,723 of Materials and Equipment was tested, representing 91% of the total cost claimed in the sample valuation. Invoices were provided in support of all the sampled costs.
- 2.14 The purpose of a change management process is to handle any modifications or alterations effectively and systematically to the project scope, design, budget, or schedule. Change management principles were outlined within the project's Project Execution Plan, however, the audit recommended that further focus is required to ensure that these processes operate in a timely manner (see **MA2**).
- 2.15 Recognising the above, **reasonable assurance** is determined in respect of validation of costs.

Payments: *Assurance that payments were made accurately, timely, and in compliance with relevant regulations and policies.*

- 2.16 The NEC contractual requirements outline the payment requirements (supported By the Project Execution Plan) While no issues were identified with the accuracy and authorisation processes applied, issues relating to the timeliness of payments are outlined below.

- 2.17 The review highlighted multiple occasions where the advisers were paid outside their contractual terms; ranging from one to nine days (see **MA3**).
- 2.18 A Project Bank Account was in operation at the project. The primary purpose of a Project Bank Account is to ensure prompt and fair payments to contractors, subcontractors, and suppliers.
- 2.19 One of the minimum requirements laid out within the Welsh Government's Project Bank Account Policy states that payments should typically be made within 3-5 working days. Over the period April – September 2023 regular delays for payments to subcontractors (up to 19 days) were highlighted (see **MA4**).
- 2.20 Recognising the above, **reasonable assurance** is determined in respect of the authorisation and timely processing of payments.

Appendix A: Management Action Plan

Matter Arising 1: Scrutiny of Hours Claimed (Operation)		Impact
It was evident within the valuation (33) report that there was a significant weekly labour commitment among several individuals. This is demonstrated by e.g. the weekly hours worked over a 5-week period by one supervisor: • Week 03/07/22: 77.5 Hours. • Week 26/06/23: 72 Hours. • Week 19/06/23: 70 Hours. • Week 12/06/23: 56 Hours. • Week 05/06/23: 72.5 Hours. The total hours charged to this project by the supervisor amounted to approximately 4000 hours, significantly surpassing the hours worked by any other individual (the closest individual logged below 3000 hours). While timesheets had been provided to support the above and are the only contractual requirement for documenting hours worked, the recorded hours appeared excessive. Given the substantial number of hours claimed, it has been recommended that enhanced monitoring controls be applied to enable greater scrutiny and challenge of the labour hours claimed. It has been agreed that the 'Datascope' biometric system, which the contractor uses to log entry and exit times from their site offices, will be used as an extra monitoring tool for gaining assurance on hours worked. This system has subsequently been applied by the Cost Adviser (during the January 2024 valuation) and should be further embedded within the valuation scrutiny process.		Potential risk of: • Expenditure is not appropriately supported leading to potential incorrect payments.
Recommendations		Priority
1	Improved monitoring protocols should be embedded within the valuation scrutiny process for individual hours worked on-site.	Medium
Agreed Management Action		Responsible Officer
Target Date		

1	Agreed. Enhanced monitoring measures have been adopted since the time of fieldwork, as noted above.	July 2024	Responsible Officer, PCH Construction Programme

Matter Arising 2: Change Management (Operational)		Impact
The change management processes applied at construction projects is crucial for maintaining control, minimising disruptions, managing risks, and ensuring that changes are well-documented and properly communicated. The change management process contributes to the overall success of the project by allowing it to adapt to evolving conditions, while maintaining a structured and controlled environment. An examination of 10 approved changes selected from the change control register (totalling £4,869,683) identified the following: 1. Delays were identified in the timeline from when the Project Manager initiated a request for the SCP to provide a quotation for the relevant change (two-week target). The duration of these delays varied, ranging from 4 days to several months over the two-week timescale. Although Clause 62.5 allows the Project Manager to extend the submission deadline with mutual agreement before the due date, documenting such extensions proved challenging due to the intricate nature of most changes. 2. Further delays were observed in the period between the receipt of the contractor's quotation and obtaining contractual approval (ranging from 2 weeks to several months). Clause 62.3 of the NEC form of contract stipulates a two-week response time from the Project Manager which can include acceptance of the quote, a requirement for a revised quote, or the Project Manager conducting their own assessment. Clear documentation of these processes was hindered by the complexity of most changes.		Potential risk of: • Contractual timescales not being met.
Recommendations		Priority
2	On a periodic basis, management should review the administration of compensation events against contractual requirements.	Medium
Agreed Management Action		Responsible Officer
		Target Date

2	Agreed Amendment will be introduced to reporting to monitor compensation event administration.	July 2024	Responsible Officer, PCH Construction Programme

Matter Arising 3: Timely Payments (Operational)						Impact
Prompt payment of invoices is essential for maintaining healthy relationships with suppliers, avoiding financial penalties, and preserving the UHBs reputation. During the audit, a subset of 12 invoices totalling approximately £20m was examined for adherence to approval processes and compliance with payment deadlines. Four invoices were processed outside the designated time parameters.						Potential risk of: Contractual timescales not being met leading to potential financial penalties.
Role	Invoice Date	Invoice Received	Invoice authorised	Payment Date (28 days from date of invoice)	Date Paid	
Supervisor	4 th July 2023	4 th July 2023	4 th July 2023	1 st August 2023	4 th August 2023	
Supervisor	3 rd August 2023	3 rd August 2023	7 th August 2023	31 st August 2023	1 st September 2023	
Project Manager	30 th May 2023	31 st May 2023	31 st May 2023	28 th June 2023	7 th July 2023	
Project Manager	31 st August 2023	31 st August 2023	31 st August 2023	28 th September 2023	29 th September 2023	
These delays ranged from one to 10 days. Notably, the nine-day delay was attributed to an error in recording the Purchase Order number on the invoice.						
Recommendations						Priority
3	Management should ensure compliance with payment timescales e.g. communicate with NWSSP Accounts Payable to confirm contractual obligations and ensure compliance.					Medium
Agreed Management Action				Target Date	Responsible Officer	

3	Agreed Contracted timescales will be emphasised to all parties concerned and compliance thereto monitored.	July 2024	Responsible Officer, PCH Construction Programme

Matter Arising 4: Project Bank Account (Operational)				Impact																												
WPPN 04/21 Guidance for Deploying Welsh Government Project Bank Account Policy includes Appendix 1 the Government’s Cabinet Office minimum requirements for the Project Bank Account (Minimum requirement 7 states): ‘All of the contractors and subcontractors signed up to the PBA Trust Deed should be paid at the same time, once authorisation has been given by the Trustee(s), payments are typically made within 3-5 working days.’ Over the period May 2023 – September 2023 the PBA statement highlighted the following: <table><tr><th>Month</th><th>Date Deposited Within PBA.</th><th>Latest Subcontractor Payment Run.</th><th>Cumulative days</th></tr><tr><td>1</td><td>11th April</td><td>25th April</td><td>14 Days</td></tr><tr><td>2</td><td>26th May</td><td>6th June</td><td>10 Days</td></tr><tr><td>3</td><td>27th June</td><td>30th June</td><td>3 days</td></tr><tr><td>4</td><td>21st July</td><td>28th July</td><td>7 Days</td></tr><tr><td>5</td><td>11th August</td><td>30th August</td><td>19 Days</td></tr><tr><td>6</td><td>11th September</td><td>29th September</td><td>18 Days</td></tr></table> Regular delays of greater than (3-5 days) from when monies deposited within the BPA to when subcontractors were paid were highlighted. Also, there was evidence of subcontractors being paid at different intervals i.e., differing payment runs throughout the month.				Month	Date Deposited Within PBA.	Latest Subcontractor Payment Run.	Cumulative days	1	11th April	25th April	14 Days	2	26th May	6th June	10 Days	3	27th June	30th June	3 days	4	21st July	28th July	7 Days	5	11th August	30th August	19 Days	6	11th September	29th September	18 Days	Potential risk of: Non-compliance with Project Bank Account Policy.
Month	Date Deposited Within PBA.	Latest Subcontractor Payment Run.	Cumulative days																													
1	11th April	25th April	14 Days																													
2	26th May	6th June	10 Days																													
3	27th June	30th June	3 days																													
4	21st July	28th July	7 Days																													
5	11th August	30th August	19 Days																													
6	11th September	29th September	18 Days																													
Recommendations				Priority																												
4	Management should engage with the Supply Chain Partner to ensure that subcontractors are promptly paid for certified work.			Medium																												
Agreed Management Action			Target Date	Responsible Officer																												

4	Agreed Further dialogue will be had with the SCP to ensure compliance with PBA terms.	July 2024	Responsible Officer, PCH Construction Programme

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

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



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Management of Controlled Drugs Final Internal Audit Report

April 2024

Cwm Taf Morgannwg University Health Board



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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

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Executive Summary

Purpose
To consider governance and control arrangements (Storage Security).

Overview
We have issued reasonable assurance on this area.
The matters requiring management attention include:

- Finalising a Health Board wide SOP for CD related incidents.
- Maintaining authorised signatory lists.
- Reinforcement of some processes such as safekeeping of CD order book and register and storage of keys.
- Completing weekly audit checks in line with the SOP.
- A system to monitor and review trends regarding CD incidents and general use across the sites.

Other recommendations / advisory points are within the detail of the report.

Report Opinion

Reasonable



Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary¹

Objectives	Assurance
1 Policies and procedures are in place.	Reasonable
2 Relevant staff have been a trained.	Reasonable
3 Ordering, delivery and receipt of controlled drugs is in with the procedures.	Reasonable
4 Controlled drugs registers are in place.	Reasonable
5 Controlled drugs are securely stored.	Reasonable
6 Appropriate checks and audits are performed.	Reasonable
7 Monitoring and reporting takes place.	Reasonable

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

Key Matters Arising		Objective	Control Design or Operation	Recommendation Priority
1	Access to procedures and guidance	1	Operation	Medium
2	Appropriate ordering, receipt and recording of controlled drugs	2,3,4	Operation	High
3	Storage and security of controlled drugs	5	Operation	Medium
4	Ward/ Theatre weekly audit checks	6	Operation	Medium
6	Monitoring and reporting of CD incidents and activity	7	Operation	Medium
7	Training records	2	Operation	Medium

1. Introduction

- 1.1 Our review of the management of controlled drugs process was undertaken in line with the 2023/24 Internal Audit Plan for Cwm Taf Morgannwg University Health Board ('CTMUHB' or 'the Health Board').
- 1.2 The Controlled Drugs (Supervision of Management and Use) (Wales) Regulations 2008 which came into force in Wales in January 2009 made provision under the Health Act 2006 to strengthen the systems for managing controlled drugs.
- 1.3 The Health Board, as a designated body, and its Controlled Drug Accountable Officer (CDAO) have statutory responsibilities laid out in the regulations to ensure robust arrangements for the management and use of Controlled Drugs (CDs) to minimise patient harm, misuse, and criminality across community, primary and secondary care.
- 1.4 In recent months CTMUHB and other health boards have obtained clarity from the Home Office in relation to controlled drug licences which organisations need when undertaking controlled drug activity. The Health Board is in the process of applying for the relevant controlled drug supply licences from the Home Office. Update reports have been provided to the Quality and Safety Committee in relation to this.
- 1.5 We focused our fieldwork in the following six areas:
 - Princess of Wales (PoW) Ward 7 & 8;
 - Ysbyty Cwm Cynon (YCC) Ward 6;
 - Royal Glamorgan Hospital (RGH) Ward 8;
 - Prince Charles Hospital (PCH) Ward 12;
 - Royal Glamorgan Hospital (RGH) Theatre; and
 - Princess of Wales (PoW) Theatre.
- 1.6 The potential risks considered in this review were:
 - Breach of legislation due to non-compliance with the policy.
 - Patient harm if controlled drugs are not being managed safely.
 - Reputational damage if there are ineffective controls or inaccurate records resulting in controlled drugs being lost or stolen.

2. Detailed Audit Findings

Objective 1: Policies and procedures are in place which set out the responsibilities for the management of controlled drugs and align to legislation. Policies and procedures are accessible to relevant staff.

- 2.1 The legislation that covers controlled drugs (CDs) is the misuse of Drugs Act 1971. The main purpose of the Act is to prevent the misuse of controlled drugs. This prevention is achieved by imposing a complete ban on the possession, supply, manufacture, import and export of controlled drugs except as allowed by regulations or by licence from the Secretary of State.

-
- 2.1 Within Wales the CD (Supervision of Management and Use) (Wales) regulations 2008 came into force in January 2009. These regulations relate to arrangements that support the safe management and use of CDs. They require the Health Board to have a named accountable officer, who has overall responsibility for CD management. The Chief Pharmacist is the named accountable officer for the Health Board.
- 2.2 The Health Board has a 'Use of Medicines' policy, which provides an overview of prescribing, administering and supplying medicines. The policy includes CDs, and is supported by two Standard Operating Procedures (SOPs). These SOPs are current, available in the Health Board's intranet, and relate to the management of CDs within wards and departments, and the management of CDs within theatres and ICU (Intensive Care Unit). However, we identified procedures that need to be removed from the intranet as they predate the establishment of the Health Board. **(Matter Arising 1)**
- 2.3 The is draft guidance for identifying, reporting and investigating CD incidents. We note that in August 2023 Ysbyty Cwm Rhondda (YCR) hospital published their own incident reporting SOP. It is not clear why this has been developed ahead of the Health Board wide SOP. **(Matter Arising 1)**

Conclusion:

- 2.4 Whilst the Health Board does not have a specific CD policy, there are a number of SOPs that provide the relevant information. The CD procedures align to relevant legislation and outline the responsibilities of key staff and departments. However, the SOP in relation to incident report remains in draft. We have provided **Reasonable Assurance** against this objective.

Objective 2: Relevant staff have been trained in the application of the policies and procedures.

- 2.5 New ward and theatre-based staff are required to participate in an induction session on the management of medicine, which includes management of CDs. The training is provided by the Lead Nurse Advisor for Medicines Management and Medication Safety. Records are maintained of those in attendance and staff are not added to the ward CD authorised signatory lists until training has taken place. However, we have not been able to confirm if a central record of training provision is retained. **(Matter Arising 7)**
- 2.6 In addition, the Lead Nurse Advisor provides tailored refresher training when requested by ward and theatre managers.
- 2.7 Our fieldwork identified that staff at PoW often refer to the more detailed Swansea Bay University HB procedure. **(Matter Arising 1)**
- 2.8 We identified that certain areas retain a copy of the relevant SOP and require new staff members to sign as confirmation that they have read the SOP and are aware of their CD responsibilities. However, this approach it not taken in all of the wards and theatres. **(Matter Arising 2)**

Conclusion:

- 2.9 Staff are trained at the point of induction with additional training takes place as a result of the need of the ward or theatre or incidents that has occurred. We have provided **Reasonable** against this objective.

Objective 3: The ordering, delivery and receipt of controlled drugs is carried out in accordance with the policy and procedures, by authorised individuals, ensuring records are completed as required.

- 2.10 Controlled drug ordering depends on the patient need and is not based on a reorder level. The CD order book is completed by an authorised signatory. The pharmacy department holds an authorised signatory lists for each area. The pharmacy checks CD orders against its signatory lists. It is the responsibility of ward and theatre managers to inform pharmacy of changes to the signatory list. For the six wards and theatres we tested, an up to date authorised signatory list was in place for four areas.
- 2.11 Ward staff or theatre staff, with the exception of students and agency staff, are able to sign for and collect completed CD orders from the pharmacy. At the ward or theatre the CDs are recorded on the CD register as received. This is a two-person process, by an authorised signatory and a witness.
- 2.12 We tested this process at the areas in our sample. We confirmed that order forms were completed with the required controlled drug information for all of the areas. However, for a small number of orders in our sample, relating to two wards, we were unable to confirm the order as staff were unable to find the order books containing the orders. Similarly, the relevant CD register was missing from one of the same two wards. In all other cases the controlled drugs were entered appropriately in the CD register and the stock balances were correctly updated.
(Matter Arising 2)
- 2.13 In relation to ensuring appropriately authorised staff are ordering and receipting controlled drugs, in two areas the authorised signatory lists were not up to date, which made this difficult to check. Furthermore, more widely, staff signatures were often not legible, and a printed version of their name is not required on the CD register. **(Matter Arising 2)**

Conclusion:

- 2.14 The systems and processes for ordering, delivering and receipt of CD are detailed in the Health Board's SOPs. While these processes were generally followed, some improvements need to be made in relation to retaining documentation and maintaining authorised signatory lists in order to ensure processes are carried out by appropriate staff. We have provided **Reasonable Assurance** against this objective.

Objective 4: There are controlled drugs registers in place in wards and theatres, which are completed accurately and reconciled to stock levels.

- 2.15 There were two types of CD registers in use in most of the wards and theatres we visited. One is used for recording the CDs ordered through the internal processes

described above. The second register records CDs that patients have brought from their home when admitted to a ward.

- 2.16 The CD register is updated when controlled drugs are received into the ward or theatre. As noted above, our testing identified one instance where the CD register could not be found. Furthermore, we were not able to confirm that the CD register had been updated by the required authorised signatories in all instances that we tested as there were instances where the lists were out of date or the signatures were illegible. **(Matter Arising 2)**
- 2.17 The CD register and drug chart is updated when patients are administered controlled drugs. Using the patient drug chart as reference, CDs are taken from the CD cabinet using a two-person check and administration process. The information within the CD register is completed including the stock quantity and patient name.
- 2.18 We tested a sample of the records of five drugs at the wards and theatres that we visited. Our testing confirmed the values recorded in the CD register reconciled to the CD stocks held, and that the stock levels of the drugs reconciled to the CD register. All information reconciled.

Conclusion:

- 2.19 Our testing identified a missing controlled drug register. While the registers that we traced were accurately completed in terms of stock details, we could not always confirm that they had been completed by an authorised signatory. However, we did not identify any matters when we reconciled a sample of stock to the CD register and vice versa. We have provided **Reasonable Assurance** against this objective.

Objective 5: Controlled drugs are securely stored with authorised and controlled access.

- 2.20 Our review of the storage of CDs at six wards and theatres identified:
- Keys to the cabinets are kept by an appropriate member of staff.
 - All CDs were kept secure and locked.
 - Patient owned drugs brought from home into the ward were stored in a separate section in the CD cabinet, separated from the other CDs.
 - CD registers were kept in a safe place, either in a locked drawer, or in the CD cabinet.
 - For four of the wards or theatres the keys to the CD cabinet were kept on a keyring with other keys. The SOP states that CD keys must be kept separate to other keys used by the ward or theatre. **(Matter Arising 3)**

Conclusion:

- 2.21 CDs are stored in a secure place within a key locked cabinet, with the keys retained by an appropriate member of staff. However, keys were not always held separately from other keys at most of the wards and theatres. We have provided **Reasonable Assurance** against this objective.

Objective 6: Appropriate checks and audits are performed by staff in line with the policy and follow up actions undertaken.

- 2.22 The SOPs set out the audit arrangements. Each week the ward or nurse manager should perform a CD balance check. Each quarter pharmacy should perform a check against the procedures. In both cases checklists for completion are appended to the SOP.
- 2.23 We confirmed that daily checks of CD stocks when ordered stock is added to the CD register and cabinet, and when a CD is dispensed, were happening. We also identified one ward undertaking daily full stock counts. We understand that this is common practice for wards with high daily CD use. At both theatres that we visited daily stock checks are performed at the point of the staff changing shift.
- 2.24 Whilst we saw evidence of weekly CD stock counts taking place on the CD register, the weekly checklist required by the SOP, which incorporates checks on other controls such as access to keys and reviewing for out-of-date stock, did not appear to be completed. **(Matter arising 4)**
- 2.25 We confirmed that pharmacy quarterly audits were undertaken for all of the areas that we reviewed, in 4/6 areas these were not always carried out within the required timeframe. **(Matter arising 5)**
- 2.26 The Health Board's new AMaT system is being rolled out to capture audit data and will allow information to be recorded, interrogated and monitored more effectively, especially where issues are identified. We understand that if issues are identified during the weekly or quarterly checks, these may be recorded on Datix, and the frequency of checks may be increased. From the checks that we saw, no issues had been identified.

Conclusion:

- 2.27 We confirmed that checks and audits were undertaken in the wards, theatres, and by pharmacy. Some areas are undertaking additional checks, however some checks are not being carried out in line the frequency or checklist set out in the SOP. We have provided **Reasonable Assurance** against this objective.

Objective 7: Appropriate monitoring and reporting take place to provide an effective oversight of controlled drugs within the Health Board, including when incidents occur.

- 2.28 The Controlled Drugs Local Intelligence Network (CDLIN) is a multi-agency forum, which each health board is required to have, as set out in the Controlled Drugs (Supervision of Management and Use) (Wales) Regulations 2008. Other representatives include the Police, Local Authorities and Health Inspectorate Wales.
- 2.29 CDLIN is a medium through which intelligence is shared around the use/misuse of CDs and to direct policies and procedures to ensure the safe use of CDs and to minimise risk to patients. CDLIN is chaired by the Chief Pharmacist, the CD Accountable Officer for the Health Board.

-
- 2.30 While we have seen an up-to-date terms of reference for the CDLIN, the version on the Health Board's intranet is an earlier version. **(Matter Arising 1)**
- 2.31 On an annual basis a report on CDLIN activity is reported to the Quality and Safety Committee of the Health Board. The last report was presented during the closed committee session in May 2023.
- 2.32 We confirmed that the CDLIN meetings are quarterly in line with its terms of reference. Highlight / occurrence reports are presented at each meeting from key areas such as primary care and secondary care. These reports set out the CD concerns for that area and the actions that have or are being taken.
- 2.33 We note that the secondary care highlight report that we reviewed was not complete as it did not include details of the wards or theatres related to the concern, and the analysis section and summary section of the reports were not completed, as required by the template report. **(Matter Arising 6)**
- 2.34 All CD related incidents should be reported on Datix, with an investigation taking place in line with the Health Board's incident reporting framework. Key staff within Medicines Management should be made aware of such incidents through Datix emails. Part of the investigation process involves incidents being reviewed at a scrutiny panel. Depending on the nature of the CD incident, the police may also be informed.
- 2.35 Whilst we were informed that all incidents are recorded on Datix, we were unable to undertake any sample testing in relation to this information or confirm that all cases are reported to the CDLIN as they should be. We understand that due to the way in which Datix has been set up at an all-Wales level, there are limitations on the ability to search for CD related incidents. As such, analysis is not undertaken. Similarly, as information in the highlight / occurrence reports is not always completed, we were unable to determine how patterns and trends in relation to CD incidents are being identified and used to inform training. **(Matter Arising 7)**

Conclusion:

- 2.36 The CDLIN is the forum through which monitoring and reporting of CDs and any related incidents takes place. There is the opportunity to enhance the information in the CDLIN reports and to explore the ability to be able to interrogate Datix information to allow more in-depth monitoring to take place. We have provided **Reasonable Assurance** against this objective.

Appendix A: Management Action Plan

Matter Arising 1: Access to procedures and guidance information (Operation)		Potential Impact	
There are two key Standard Operating Procedures (SOPs) in place. One for the management of CDs in theatres and ICU and one for wards and departments, both of which are available on the CTM intranet. However, the Health Board's intranet also includes: • Historic documents and procedures that pre-date the Health Board. • A CD Theatres Service SOP for Abertawe Bro Morgannwg. • The previous version of the terms of reference for the Controlled Drugs Local Intelligence Network (CDLIN). There is a draft Health Board guide for identifying, reporting and investigating CD incidents. We also note that Ysbyty Cwm Rhondda (YCR) has a CD Incident Reporting Standard Operating Procedure (SOP) in place.		Inconsistent approaches to the management of controlled drugs resulting in patient harm or breaches of legislation.	
Recommendations		Priority	
1.1a	Management should ensure there is a standardised approach to Controlled Drugs incident reporting. As such, the draft guidance should be reviewed and finalised as soon as possible, and made available to all relevant staff.	Medium	
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.		
1.2	Management should review the controlled drugs documents on the Health Board's intranet to ensure that only the correct procedures are available.	Low	
Agreed Management Action		Target Date	Responsible Officer
1.1a	CD Incident Reporting Standard Operating Procedure to be approved by Operational Management Board.	1/4/24	Hannah Wilton, Clinical Director Medicines Management

1.1b	Review of YCR SOP to see if still needed.	1/6/24	Rafia Jamil, Deputy Head of Pharmacy Community Hospitals / Leanne Davies Lead Nurse for Community Hospitals & HMP Parc
1.2	Review of searches for common controlled drugs search terms: CDs, Controlled Drug, Controlled Drugs, Gabapentin, opioid, opiate to be reviewed and flagged to IT for removal.	1/8/24	Huw Carson, Principal Pharmacist Quality and Safety

Matter Arising 2: Appropriate ordering, receipt and recording of controlled drugs (Operation)	Potential Impact
We tested a sample of 10 controlled drug orders at each of the areas that we visited during our fieldwork. We tested to ensure that controlled drugs were ordered by an authorised signatory, the order book was accurately completed, information was entered accurately into the CD register and signed by two authorised members of staff. Some of our sample related to controlled drug orders that were for patients to take home and not for the ward or theatre use. We have excluded these orders from our testing and in the reporting below: <u>PoW Ward 7 & 8</u> The authorised signatory list was dated 2013. An updated list was being prepared at the time of our audit fieldwork. • 7/9 order forms it was not clear if an authorised signatory had signed the order. • 6/9 entries onto the CD register it was not clear if they had been authorised appropriately. <u>YCC Ward 6</u> • 2/9 entries onto the CD register it was not clear if they had been authorised appropriately. <u>RGH Ward 8</u> Three authorised signatory lists were provided dated 2017, 2018 and 2020. • 6/8 the order book/s containing these orders could not be located. • For the 2 orders we sighted, we could not determine if they were authorised signatories. • For all 7 entries on the CD register, it was not clear if they had been authorised appropriately. <u>Ward 12 PCH</u> • 2/5 the order book/s and CD register/s containing these transactions could not be located. • 1/3 the name of the person that received the CD from Pharmacy and transported to the ward had not been recorded. • 1/3 entries on the CD register it was not clear if they had been authorised appropriately.	Patient harm and / or reputational damage if controlled drugs are not managed safely.

PoW Theatre

There are more than ten theatres and recovery areas with CD records, but the dispensing report uses the term 'PoW theatre' for all of these areas. As such, we were unable to identify the exact theatre holding the records. From our testing we identified that for 1/5 cases, one of the signatures on the CD register was illegible and the second signature could not be found on the authorised signatory list.

We also made the following observations:

- Ward managers are responsible for informing Pharmacy of changes to the authorised signatory list. Not all ward managers were aware of this requirement.
- The SOP requires requisition (order) books and CD registers to be retained for a minimum of two years after last entry. Not all managers that we spoke with during our fieldwork were aware of the correct retention period.
- The SOP is not clear if the manufacturers name or drug name should be recorded on the controlled drug order form. We saw instances where name types were used interchangeably to document the drug.
- Whilst the SOP requires printed names against signatures for CD orders, it does not require the printed name to be captured when CDs are collected from pharmacy or recorded in the CD register. Some areas captured this information, but most did not. As such, as many signatures were illegible and there was often no printed name, reconciling the collecting member of staff to the authorised signatory lists is not always possible.

Recommendations**Priority**

2.1a	A review of authorised signatory lists should take place to ensure they are up to date.
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.
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.
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.

High

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.	Medium	
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.	Low	
Agreed Management Action		Target Date	Responsible Officer
2.1a	A review of authorised signatory lists will take place to ensure they are up to date.	1/9/24	Heads of Nursing/Heads of Midwifery for Ward areas and David Hughes, Kathryn Howard, Rhian Carta (Heads of Pharmacy) for Pharmacy locations
2.1b	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.	1/5/24	Heads of Nursing/Heads of Midwifery

2.1c	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.	1/6/24	Andrew Davies, Lead Nurse Advisor Medicines Management and Medication Safety
2.1d	Pharmacy staff will be reminded of the importance of referring the authorised signatory lists to ensure order have been place by authorised staff.	1/5/24	David Hughes, Kathryn Howard, Rhian Carta (Heads of Pharmacy) for Pharmacy locations
2.2	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.	1/5/24	Heads of Nursing/Heads of Midwifery
2.3	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.	31/10/24	Huw Carson, Principal Pharmacist Quality and Safety

Matter Arising 3: Storage and security of CDs (Operation)			Potential Impact
The management of CDs procedure states ' <i>The controlled drug keys to both the outer and inner CD cabinets must be kept separate from all other keys used on the ward or department.</i> ' At four of the areas that we visited other keys were on the same keyring as the CD cabinet keys.			Patient harm and/ or reputational damage if controlled drugs are stolen due to ineffective security controls.
Recommendations			Priority
3.1	Management should ensure staff are reminded that the CD cabinet keys are to be kept separate and unattached to other keys.		Medium
Agreed Management Action		Target Date	Responsible Officer
3.1	Communication to ensure staff are reminded that the CD cabinet keys are to be kept separate and unattached to other keys.	1/5/24	For clinical areas: Heads of Nursing/Heads of Midwifery David Hughes, Kathryn Howard, Rhian Carta (Heads of Pharmacy) for Pharmacy locations

Matter Arising 4: Ward/ Theatre weekly audit checks (Operation)		Potential Impact	
The management of CDs SOP states '<i>The nurse manager will audit the CD procedures used in their area as part of the weekly CD balance check. The checklist in appendix 1 will be completed and kept as an audit record.</i>' We requested the most recent completed audit checklist for each ward and theatre in our sample. We note: - No completed appendix 1 checklists were provided during our fieldwork meaning that the audit requirements of the SOP were not being met. - PoW Ward 7&8 perform daily counts of CDs, with the CD register signed by two members of staff. However, these did not include evidence that other aspects of the weekly checklist had been considered, such as confirming security of the CD cabinet and keys or reviewing for out of date stock. - PoW Theatre – We understand that these theatres undertake a monthly audit check, in addition to daily counts. However, the most recent audit check we saw during our fieldwork was dated July 2023. The checklist used was from the Swansea Bay UHB SOP, although did cover similar points to the CTM SOP.		Issues in relation to controlled drugs not identified and corrective action not taken.	
Recommendations		Priority	
4.1a	Discussions should be held with wards and theatres managers to understand why the weekly checklists are not being completed and if necessary amendments should be made to the current checklist.	Medium	
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.		
Agreed Management Action		Target Date	Responsible Officer
4.1a	Discussions will be held with wards and theatres managers to understand why the weekly checklists are not being completed.	1/6/24	Andrew Davies, Lead Nurse Advisor Medicines Management and Medication Safety
	If necessary amendments will be made to the checklist during the review of the CD procedure.	31/10/24	Andrew Davies, Lead Nurse Advisor Medicines Management and

4.1b	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.	1/5/24	Medication Safety / Huw Carson, Principal Pharmacist Quality and Safety Andrew Davies, Lead Nurse Advisor Medicines Management and Medication Safety / Heads of Nursing/Heads of Midwifery

Matter Arising 5: Pharmacy quarterly checks (Operation)		Potential Impact
The SOPs state '<i>The pharmacy will undertake an audit of CD procedures at 3 monthly intervals. The checklist in appendix 2 will be completed and recorded on the Pharmacy CD database</i>'. We requested copies of the last completed audit checklist for each ward and theatre in our sample. While the checks were happening, we note the following: - At PoW Ward 7&8 - Pharmacy audits are recorded monthly within AMaT, but we were not provided with a copy of the AMaT report. Our review of the CD registers allowed us to identify pharmacy reviews were done in June & October 2023, however this is outside of the quarterly timeframe. - YCC - completed copies of a different checklist were provided, which is broadly the same as appendix 2, though does not include all of the areas required. We note there was a 5-month gap between last two audits being completed. - RGH Ward 8 - copies of their last two complete checklists were provided. There was a 4-month gap between them with the last one dated August 2023. - PoW theatres – from reviewing the CD register, we could evidence a review had taken place in December 2023, though the completed checklist in relation to the this was not provided, and we could not determine the frequency of audits.		Issues in relation to controlled drugs not identified and corrective action not taken.
Recommendations		Priority
5.1	Management should ensure Pharmacy audit checks are performed quarterly in line with the SOP.	Low
Agreed Management Action		Target Date
5.1	Management will ensure Pharmacy audit checks are performed quarterly in line with the SOP.	1/6/24
		David Hughes, Kathryn Howard, Rhian Carta (Heads of Pharmacy) for Pharmacy locations – via Medicines Management Planning and performance meeting

Matter Arising 6: Monitoring and reporting of CD activity and incidents (Operation)		Potential Impact
On a quarterly basis the CDLIN meet and receive highlight / occurrence reports recording any CD concerns from key service areas such as primary care, secondary care and HMP Parc. The highlight reports follow a set template, and we note that the last three secondary care reports had not been signed by the Accountable officer. None had the required analysis section which provides a summary of the number and type of incidents reported. We discussed with Lead Nurse Advisor Medicines Management and Medication Safety the ability to obtain a report from Datix of CD related incidents, to confirm if all are being reported to the CDLIN as they should be. Whilst data believed to be showing total numbers of reported CD incidents that are open, at investigation stage, awaiting closure and closed was provided, the Lead Nurse was concerned as to the accuracy of the data. We were informed that the functionality of the All-Wales Datix system, makes it difficult to accurately search and view only CD related incidents. The highlight / occurrence reports could therefore be an important tool for gathering data to allow analysis and monitoring trends on incident type or location, as it appears that this is not currently being done or possible due to the Datix system limitations. Furthermore, in order to identify wards and theatres for undertaking testing, we analysed a report of controlled drugs dispensed during the period April 2023 to September 2023. We note that some sites have a higher proportion of controlled drugs dispensed than other sites. When discussed with management, no explanation could be provided for the variation as it was something that they had never been aware of previously.		Patient harm if controlled drugs are not being managed safely.
Recommendations		Priority
6.1	The importance of fully completing the quarterly CDLIN highlight / occurrence reports, including the details of the ward or theatre, should be emphasised.	Low
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	Medium

	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.	
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.	Low
Agreed Management Action		Target Date
6.1	When the request for the occurrence reports are sent out before the CD LIN, the importance of fully completing the reports, including the details of the ward or theatre, will be emphasised.	1/4/24
6.2	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.	1/6/24
6.3	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.	1/5/24
		Meinir Davies, Meinir Davies, Controlled Drugs Support Officer
		Andrew Davies, Lead Nurse Advisor Medicines Management and Medication Safety
		Meinir Davies, Controlled Drugs Support Officer
		Huw Carson, Principal Pharmacist Quality and Safety
		Hannah Wilton, Clinical Director Medicines Management

Matter Arising 7: Training records (Operation)		Potential Impact	
We were provided with evidence to support staff attendance at training sessions run by the Lead Nurse Advisor Medicines Management and Medication Safety. However, we are not clear if a central electronic record is in place to capture the details of those staff that have attended training and when.		Inability to evidence that staff have been appropriately trained in the use of Controlled Drugs.	
Recommendations		Priority	
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.	Medium	
Agreed Management Action		Target Date	Responsible Officer
7.1	A central electronic record is retained for staff trained since 2020, however consideration will be given to using ESR for this purpose.	1/9/24	Andrew Davies, Lead Nurse Advisor Medicines Management and Medication Safety

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

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



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Gastro-Intestinal Pathways – Demand Management Final Internal Audit Report

April 2024

Cwm Taf Morgannwg University Health Board



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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.

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Executive Summary

Purpose

Our review looked to identify how referrals and the demand for Lower GI services are being managed across the Health Board sites.

Overview

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

- Absence of Health Board policy and procedures in respect of lower GI referral and demand management processes.
- Accurate recording and retention of referral and clinician triage information and documentation on Welsh Clinical Portal (WCP) and Welsh Patient Administration System (WPAS).
- Inefficiencies of lower GI patient referrals submitted to clinicians for triage.
- Quality checking of GI clinicians’ referral triage process and outcomes.
- Monitoring of lower GI referral demand and reporting to Care Group management teams.

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	Policy and procedures	Limited
2	Receiving and capturing referrals	Reasonable
3	Clinician triage of referrals and recording of outcome actions	Reasonable
4	Quality checking of clinician triage	Unsatisfactory
5	Monitoring and reporting of referral demand	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	Policies and procedures	1	Design	High
2	System to allow timely processing of referrals	2	Operation	Medium
3	Triage process	3	Operation	Medium
4	Quality checks	4	Design	High
5	Monitoring and reporting	5	Operation	High

1. Introduction

- 1.1 Our audit of Gastro-Intestinal (GI) pathways demand management was undertaken in line with the 2023/24 Internal Audit Plan for the Cwm Taf Morgannwg University Health Board ('CTMUHB' or the 'Health Board').
- 1.2 The Health Board is in the process of moving away from an Integrated Locality Group model of operation to a Care Group model. GI services will form part of the Planned Care Group, and work is underway to create a single GI service provision that is aligned across the Health Board's three main hospital sites.
- 1.3 Our review focussed on the management of referrals, and considered if the demand for lower GI services (gastroenterology and colorectal surgery) is being managed across the three Health Board hospital sites.
- 1.4 To obtain an understanding of the lower GI referral pathway, and the patient triage processes, where a preliminary assessment of symptoms is carried out to determine potential waiting list activity, we met with gastroenterologists and colorectal surgeons at Prince Charles Hospital (PCH), Royal Glamorgan Hospital (RGH) and Princess of Wales Hospital (PoW).
- 1.5 Our understanding of the lower GI referral pathway was furthered by meeting with the Clinical Nurse Specialist who runs the nurse led rapid access colorectal clinic at PCH.
- 1.6 Additionally, we met with staff in the medical records department and undertook testing on a sample of records. We used the Welsh Clinical Portal (WCP) and Welsh Patient Administration Systems (WPAS) to confirm the timeliness and recording of referrals and the triage outcomes.
- 1.7 The relevant lead for this review was the Chief Operating Officer. The review has links to strategic risk one: 'sufficient capacity to meet emergency and elective demand', and strategic risk two: 'ability to deliver improvements which transform care and enhance outcomes'.
- 1.8 We also considered the following risks during our review:
 - Failure to deliver services potentially resulting in patient harm and associated financial and reputational implications.
 - Unclear structures or responsibilities resulting in inconsistent service delivery.

2. Detailed Audit Findings

Objective 1: A policy is in place setting out the approach and responsibilities for demand management of GI pathways, which aligns to national guidance. Procedures are in place to support implementation of the policy and ensure consistency across sites.

- 2.1 Guidance for managing patients on GI pathways is available from a number of sources including the NICE suspected cancer guidelines, the Welsh Government 'Guidelines for Managing Patients on the Suspected Cancer Pathway' and the NHS Wales Health Collaborative – Wales Cancer Network 'National Optimal Pathway' (NOP) documents. However, the Health Board does not have a policy in place for GI pathway referrals that reflects national guidance, which sets out an approach to be followed to ensure consistency across the three main hospital sites where GI referrals are received and processed. **(Matter Arising 1)**
- 2.2 The NOP documents refer to the application of local protocols. However, at the time of our fieldwork there was no approved Standard Operating Procedure (SOP) or set of procedures in place setting out how patients on lower GI pathways should be managed across the Health Board. We note that some guidance has been developed for specific elements of the lower GI pathway at certain sites. For example, a medical records process map for referrals received at PCH and RGH. A SOP for referral and triage processes at the nurse led rapid access 'One Stop' colorectal clinic based at PCH. However, the document appears to be in draft as there is no approval information and it contains information not usually included in a SOP. Similarly, we saw a draft SOP for patient triage processes for use by colorectal surgeons and gastroenterologists, but its content was incomplete. **(Matter Arising 1)**
- 2.3 We understand that no specific guidance has been provided to GPs in relation to the process for general or non-Urgent Suspected Cancer (USC) related lower GI referrals. Whereas guidance has been issued in relation to USC referrals. **(Matter Arising 1)**
- 2.4 Furthermore, there is no formal guidance for hospital departments across the three sites in respect of processes to be undertaken for internal lower GI referrals. **(Matter Arising 1)**

Conclusion:

- 2.5 While all Wales guidance is available the Health Board does not have its own policy setting out the approach and responsibilities for GI pathways demand management. Whilst some SOPs have been developed, they remain in draft and we are unclear if these cover all aspects of the GI pathways. We have provided limited assurance against this objective.

Objective 2: A suitable system is in place for receiving and capturing referral information.

- 2.6 There are numerous referral methods in relation to GI patients, though the majority come from GPs and are received electronically via the Welsh Patient Referral System (WPRS). Other referral methods include internal paper-based referrals from other departments within the Health Board.
- 2.7 The process followed for receipting referrals and the initial stages before triage varies across sites, and between gastroenterology and colorectal specialities. The variations are largely driven by the interfaces between different IT systems. For example, at PoW WPRS is fully integrated with the WCP and the WPAS. Whereas at PCH and RGH there is no interface, so referrals are manually extracted from WPRS and scanned into WCP/WPAS by staff within the Medical Records department. Whilst the need to manually scan files did not appear to impact the timeliness of clinicians receiving referrals, the approach maybe inefficient. **(Matter Arising 2)**
- 2.8 We tested a sample of referrals to confirm if the triage process had been completed by an appropriate medic and within a reasonable timeframe. As there is no guidance setting out how quickly the triage process should be undertaken, we met with consultants working in the area to identify a reasonable timeframe. Following these discussions, we applied a two working day timeframe to each stage of the process. Our testing identified a small number of cases where there was no documentation available, as records had not been scanned into WCP/WPAS. However, in these cases we confirmed that the referrals had been triaged, despite the missing documentation. **(Matter Arising 2)**
- 2.9 For 60/80 (75%) of the files that we reviewed there was evidence that the clinician received the referral on the day the referral was made. This number increased to 81% within two working days. We identified a small number of instances where the referral took longer to be received by the clinician, with 29 days being the longest timeframe in our sample. From our analysis of those where the time between referral being made and being received by the clinician was longer than expected, most related to paper based internal referrals. **(Matter Arising 2)**

Conclusion:

- 2.10 Suitable systems are in place for receiving and capturing referral information. However, the manual intervention approach at PCH and RGH to transfer data between systems is inefficient. Our testing identified a small number of delays that, mostly related to paper-based referrals. We have provided reasonable assurance against this objective.

Objective 3: Referrals to both medical and surgical GI specialties are vetted against set standards, decisions recorded and waiting lists updated accordingly. Patients are informed of the outcome.

- 2.11 The triage process followed by clinicians is in line with NICE guidelines. Our testing of those cases where records and triage information had been saved to WCP/WPAS, identified that in the majority of cases, triage took place by the clinician within two

working days of receipt. However, in a small number of cases, at the nurse led service operated at PCH, triage was undertaken within 7 to 24 working days. In addition, we identified two cases submitted to a clinician while they were on a known leave of absence. While these cases were reviewed for urgency by another clinician, they were not formally triaged until the clinician returned from absence, meaning a delay of nearly two months in one case. **(Matter Arising 3)**

- 2.12 During our testing it was not always clear who had undertaken the triage as either the triage form was not held on WCP/WPAS, there was no signature on the triage form, or the signature was not legible. **(Matter Arising 3)**
- 2.13 In all of the cases we sampled, the GP and the patient were informed of the triage outcomes in a reasonable timeframe. The patients in our sample that needed to be added to a waiting list as a result of the triage process, were added the same or following day.

Conclusion:

- 2.14 The majority of referrals submitted to clinicians are efficiently triaged in a timely manner, with decision outcomes retained on WCP/WPAS and provided to GPs and patients. However, work needs to be undertaken to further improve the efficiency in certain areas, ensure suitable processes to cover clinician absence and ensure information is retained to support the triage process. We have provided reasonable assurance against this objective.

Objective 4: Quality checks are carried out to validate the triage process and monitoring consistency in approach.

- 2.15 At the time of our fieldwork lower GI clinicians do not undertake quality assurance work to validate the triage process or compare triage outcomes and share their experiences. This relates to both patients who are added to a pathway and those that are referred back to their GP. **(Matter Arising 4)**

Conclusion:

- 2.16 Clinicians working on lower GI pathways do not do quality checks to validate their respective approaches to patient triage and review inconsistencies in the approach and process. An unsatisfactory assurance opinion is provided against this objective.

Objective 5: There are appropriate governance arrangements in place to ensure data in relation to demand is collected and used for monitoring and reporting purposes.

- 2.17 There is monitoring of lower GI referrals and demand across the three hospital sites, but this does not appear to be consistent across the services. For example, some officers review data via the QlikView reporting tool, whereas others do not have access to QlikView.
- 2.18 We note that in some service areas reports are generated, for example in relation to demand referrals not progressed. These are at a local service level, with the data used at departmental meetings. However, monitoring reports were not available for all of the service areas we reviewed. We are not aware of any reporting or monitoring at a wider Care Group level. **(Matter Arising 5)**

- 2.19 Whilst the Medical Records department produces daily reports that facilitate monitoring of delayed referrals and referrals yet to be triaged, these are not run in respect of lower GI referrals. (**Matter Arising 5**)
- 2.20 There appears to be a number of areas where data is collected and could be analysed to identify trends that could improve service delivery. For example, where referrals are deemed as inappropriate, a review of this data may highlight if a number of those originate from the same source (such as a GP practice) which may allow the Health Board to target information and training to ensure the correct referral process and criteria are used.

Conclusion:

- 2.21 The approach to governance arrangements in respect of referral demand management monitoring and reporting within lower GI departments appears to be inconsistent. We have provided limited assurance against this objective.

Appendix A: Management Action Plan

Matter Arising 1: Policy and procedures (Design)		Potential Impact
The Health Board does not have a policy that sets out an approach and responsibilities to ensure a consistent service provision across its sites in respect of GI demand management. We saw several procedure documents for specific parts of the service at certain sites during our fieldwork, we note the following: - A Standard Operating Procedure (SOP) in respect of the Nurse Led Rapid Access 'One Stop' Colorectal Clinic run at PCH. Our review of the SOP suggests it is in a draft format, as it contains no information approved or date information. We also note that the document contains information that you would not expect to see in an operating procedure, such as background information about the nurse currently in post and in charge of the service. - A draft SOP formulated by RGH Colorectal Surgeons called 'Single CTM Colorectal USC Pathway GP Referral Triage'. Whilst called a SOP, the draft document actually sets out the variations in current processes across sites and a planned triage pathway process that could be adopted to create a unified approach. We were also made aware that there is a lack of documented procedures for: - Departments to follow when making internal GI referrals. - GPs in relation to general and /or non-urgent suspected cancer (USC) referrals, however we acknowledge guidance has recently been issued for USC and FIT testing.		Unclear structures or responsibilities resulting in inconsistent service delivery.
Recommendations		Priority
1.1a	A policy that outlines the Health Board's approach and responsibilities for GI pathways including demand management should be put in place.	High
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.		
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.		Medium
Agreed Management Action		Target Date	Responsible Officer
1.1a & 1.1b	A CTM Standardised LGI SOP to be developed, reviewed and agreed.	30.06.24	Joy Singh - Consultant Colorectal Surgeon (Clinical Director) Parin Shah - Consultant Colorectal Surgeon (Clinical Director) David Samuels - Consultant Gastroenterologist (Clinical Director)
1.2	Following completion of the LGI SOP - this will include flow/process charts and referral criteria to support internal and external referral process.	30.06.24	Joy Singh - Consultant Colorectal Surgeon (Clinical Director) Parin Shah - Consultant Colorectal Surgeon (Clinical Director) David Samuels - Consultant Gastroenterologist (Clinical Director)

Matter Arising 2: System to allow timely processing of referrals (Operation)	Potential Impact
The Welsh Patient Referral System (WPRS) is the main platform used for referring GI patients, however there is also a paper-based system in place for referrals generated from within the Health Board. The Welsh Clinical Portal (WCP) and Welsh Patient Administration System (WPAS) are used to manage patients through their pathway. The interface between the WPRS and WCP/WPAS varies across sites. At PoW the systems are fully integrated. At PCH and RGH information must be manually extracted from WPRS and scanned into WCP/WPAS for a clinician to triage, which may use more resources than other processes. We reviewed a sample of 80 Gastroenterology and Colorectal cases. In the absence of a SOP setting out target timeframes for triage to take place, we applied a two working day timeframe to our testing. We established the following in relation to the timeliness of the clinician receiving the referral for triage: - For 5/80 (6%) of cases, paperwork had not been scanned to WCP/WPAS to allow us to determine the dates the referral was passed to the clinician for triage. - For 14/75 (19%) of cases, the time between the referral being made and the clinician receiving it was more than 2 working days. More specifically, eleven of the cases were received between three and ten working days, with the remaining three cases taking more than 10 working days to be received by the clinician. The longest time was 29 working days. From our review of cases, we note 12/14 instances where the time delay originated from the time taken for the referral to be recoded on the system after it had been made. Eleven of these referrals were paper referrals, as opposed to electronic ones, as they originated from internal departments within the Health Board.	Failure to deliver services potentially resulting in patient harm and associated financial and reputational implications.
Recommendations	Priority
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.	Medium

	Consideration should be given to an alternative approach for internal paper-based GI referrals that would ensure they are received by clinicians in a timelier manner.	
Agreed Management Action		Target Date
2	1. Need confirmation for go live date for LGI/Surgery. 2. Set up meeting with Records and Digital Team.	30.04.25
		Gareth Blandford- Directorate Manager for Surgery / GI Stewart Duncan- Service Manager

Matter Arising 3: Triage process (Operation)	Potential Impact
We tested a sample of cases to confirm the timeliness of the triage process from the date the referral was received. We also looked at the time taken for both the GP and the patient to be informed of the triage outcome. As per our previous testing a two-day timescale was applied for each stage in the process. For 5/80 cases we were unable to determine the length of time it took to undertake the triage as either the documentation was not stored on WPAS (4/5), or the date information was not recorded on the triage form. 12/75 (16%) of cases the triage took more than two working days to complete. From the 12 cases we note: • 6/12 all related to PCH Colorectal, where the time delays varied between 7 working days up to 24 working days. There was no known reason for these delays documented on WPAS. • 2/12 relate to PCH Gastroenterology, and occurred when the clinician was absent from work, so the referrals were not vetted until their return. The time delays were 12 and 38 working days respectively. We understand that both of these referrals were reviewed by another clinician when received but not deemed as requiring triage at that time. However, this information and the justifications to defer triage was not documented on WCP/WPAS. 14/80 (17%) of cases we were unable to determine who undertook the triage: • 4/14 the form was missing. • 10/14 the form was either not signed or the signature was ineligible. All of the 14 cases originate from areas where paper-based triage is carried out, with forms having to be manually signed and scanned into WCP/WPAS once completed. There were also a very small number of other cases where information was missing from WPAS to determine when the GP and /or patient were informed of the triage outcomes where appropriate.	Failure to deliver services potentially resulting in patient harm and associated financial and reputational implications.
Recommendations	Priority
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	Medium

	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.		
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.		Medium
Agreed Management Action		Target Date	Responsible Officer
3.1	1. Complete and roll out new CTM LGI SOP. 2. Produce referral and vetting process in line with SOP.	30.09.24	Joy Singh - Consultant Colorectal Surgeon (Clinical Director) Parin Shah - Consultant Colorectal Surgeon (Clinical Director) David Samuels - Consultant Gastroenterologist (Clinical Director)
3.2	1. Understand go live date for E-Refs for LGI/Surgery. 2. link in with Records/Digital team.	30.09.24	Gareth Blandford- Directorate Manager for Surgery / GI Stewart Duncan- Service Manager

Matter Arising 4: Quality checks (Design)		Potential Impact	
We met with five GI Consultants (three Gastroenterologists and two Colorectal Surgeons), and a Colorectal Clinical Nurse Specialist from across the three acute hospital sites. We identified that there are currently no processes in place to quality check the triage and decision-making process. A formalised 'peer review' quality assurance exercise would enable the GI clinicians to compare and discuss the approach to triage and decision-making outcomes as a means of ensuring a consistency of approach to the triage processes in place.		Unclear structures or responsibilities resulting in inconsistent service delivery.	
Recommendation		Priority	
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'.	High	
Agreed Management Action		Target Date	Responsible Officer
4	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.	30.06.24	Joy Singh - Consultant Colorectal Surgeon (Clinical Director) Parin Shah - Consultant Colorectal Surgeon (Clinical Director) David Samuels - Consultant Gastroenterologist (Clinical Director)

Matter Arising 5: Monitoring and reporting (Operation)	Potential Impact
We spoke to the six Service Managers for the respective Gastroenterology and Colorectal Surgery departments at PCH, RGH and PoW to understand what GI referral and demand reports are produced, and what monitoring takes place. We note that while there is some monitoring, but this appears to vary by service area. For example: • There is departmental monitoring of referral demand levels in Gastroenterology in PCH. • There are referral reports for Gastroenterology at PoW, but these were not progressed further along the lower GI pathway. • One service manager had access to reports via QlikView. We were unable to establish any other monitoring of GI demand taking place at either a service level or at a wider Care Group level. From our testing and review of referral data we identified a number of instances where monitoring of data may be beneficial. For example: • The April to October 2023 referral data shows that approximately 20% of cases were classified as 'inappropriate referrals'. Many of these relate to cases where GPs have made referrals, but the triage criteria has not been met. Analysis of this data may enable the Health Board to identify GPs who have higher return rates, allowing refresher training or additional guidance to be targeted. • In Matter Arising 2 we identified that delays in clinicians receiving referrals was largely attributable to internally submitted paper referrals. Analysis of the data relating to the times taken during each stage of the triage process would enable trends, patterns and potential issues to be identified. • The identification of cases that have been passed to a clinician for triage, but an outcome has not been logged after a reasonable amount of time. While the Medical Records department has a procedure for the production of daily reports to monitor delayed referral responses, this process was not undertaken for Gastroenterology and Colorectal surgery referrals.	Failure to deliver services potentially resulting in patient harm and associated financial and reputational implications.

Recommendations		Priority	
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.	Medium	
Agreed Management Action		Target Date	Responsible Officer
5	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.	31.12.24	Gareth Blandford- Directorate Manager for Surgery / GI Stewart Duncan- Service Manager

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

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



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High	Project Name - GI Pathways Action and Transformation Plan	Start Date	01/03/2024
	Executive Sponsor: Gathin Hughes	End Date	31/03/2025
	Senior User - Gareth Blandford	Version	v1
	Senior Clinical User: Joy Singh, Parin Shah, David Samuel		
Medium			
Low			

Matter Arising 1: Policy and procedures (Design)											Potential Impact
The Health Board does not have a policy that sets out an approach and responsibilities to ensure a consistent service provision across its sites in respect of GI demand management. We saw several procedure documents for specific parts of the service at certain sites during our fieldwork, we note the following: •A Standard Operating Procedure (SOP) in respect of the Nurse Led Rapid Access 'One Stop' Colorectal Clinic run at PCH. Our review of the SOP suggests it is in a draft format, as it contains no information approved or date information. We also note that the document contains information that you would not expect to see in an operating procedure, such as background information about the nurse currently in post and in charge of the service. •A draft SOP formulated by RGH Colorectal Surgeons called 'Single CTM Colorectal USC Pathway GP Referral Triage'. Whilst called a SOP, the draft document actually sets out the variations in current processes across sites and a planned triage pathway process that could be adopted to create a unified approach. We were also made aware that there is a lack of documented procedures for: •Departments to follow when making internal GI referrals. GPs in relation to general and /or non-urgent suspected cancer (USC) referrals, however we acknowledge guidance has recently been issued for USC and FIT testing.											Unclear structures or responsibilities resulting in inconsistent service delivery.
Scheme	Recommendations	Agreed Action/Designated Outcome/Target/Performance Metric	Management Lead	Clinical Lead	Costings	Timescales					Progress Update
1.0	Policy & Procedures						Qtr 1	Qtr 2	Qtr 3	Qtr 4	
1.1a	A policy that outlines the Health Board’s approach and responsibilities for GI pathways including demand management should be put in place.	A CTM Standardised LGI SOP to be developed, reviewed and agreed.		Joy Singh, Parin Shah, David Samuels							28/03/2024 - SOP draft completed - next steps for colorectal and Gastro clinical leads to review, discuss and finalise
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.	A CTM Standardised LGI SOP to be developed, reviewed and agreed.		Joy Singh, Parin Shah, David Samuels							28/03/2024 - SOP draft completed - next steps for colorectal and Gastro clinical leads to review, discuss and finalise
1.2	Specific guidance should be developed and made available in 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.	Following completion of the LGI SOP - this will include flow/process charts and referral criteria's to support internal and external referral process		Joy Singh, Parin Shah, David Samuels							

Matter Arising 2: System to allow timely processing of referrals (Operation)											Potential Impact
The Welsh Patient Referral System (WPRS) is the main platform used for referring GI patients, however there is also a paper-based system in place for referrals generated from within the Health Board. The Welsh Clinical Portal (WCP) and Welsh Patient Administration System (WPAS) are used to manage patients through their pathway. The interface between the WPRS and WCP/WPAS varies across sites. At PoW the systems are fully integrated. At PCH and RGH information must be manually extracted from WPRS and scanned into WCP/WPAS for a clinician to triage, which may use more resources than other processes. We reviewed a sample of 80 Gastroenterology and Colorectal cases. In the absence of a SOP setting out target timeframes for triage to take place, we applied a two working day timeframe to our testing. We established the following in relation to the timeliness of the clinician receiving the referral for triage: •For 5/80 (6%) of cases, paperwork had not been scanned to WCP/WPAS to allow us to determine the dates the referral was passed to the clinician for triage. •For 14/75 (19%) of cases, the time between the referral being made and the clinician receiving it was more than 2 working days. More specifically, eleven of the cases were received between three and ten working days, with the remaining three cases taking more than 10 working days to be received by the clinician. The longest time was 29 working days. From our review of cases, we note 12/14 instances where the time delay originated from the time taken for the referral to be recoded on the system after it had been made. Eleven of these referrals were paper referrals, as opposed to electronic ones, as they originated from internal departments within the Health Board.											Failure to deliver services potentially resulting in patient harm and associated financial and reputational implications.
Scheme	Recommendations	Agreed Action/Designated Outcome/Target/Performance Metric	Management Lead	Clinical Lead	Costings	Timescales					Progress Update
2.0	System to allow timely processing of referrals (Operation)										
2.0	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. Consideration should be given to an alternative approach for internal paper-based GI referrals that would ensure they are received by clinicians in a timelier manner.	1. Need confirmation for go live date for LGI/Surgery. 2. Set up meeting with Records and Digital Team	Gareth Blandford, Stewart Duncan								

Matter Arising 3: Triage process (Operation)											Potential Impact

We tested a sample of cases to confirm the timeliness of the triage process from the date the referral was received. We also looked at the time taken for both the GP and the patient to be informed of the triage outcome. As per our previous testing a two-day timescale was applied for each stage in the process. For 5/80 cases we were unable to determine the length of time it took to undertake the triage as either the documentation was not stored on WPAS (4/5), or the date information was not recorded on the triage form. 12/75 (16%) of cases the triage took more than two working days to complete. From the 12 cases we note: •6/12 all related to PCH Colorectal, where the time delays varied between 7 working days up to 24 working days. There was no known reason for these delays documented on WPAS. •2/12 relate to PCH Gastroenterology, and occurred when the clinician was absent from work, so the referrals were not vetted until their return. The time delays were 12 and 38 working days respectively. We understand that both of these referrals were reviewed by another clinician when received but not deemed as requiring triage at that time. However, this information and the justifications to defer triage was not documented on WCP/WPAS. 14/80 (17%) of cases we were unable to determine who undertook the triage: •4/14 the form was missing. •10/14 the form was either not signed or the signature was ineligible. All of the 14 cases originate from areas where paper-based triage is carried out, with forms having to be manually signed and scanned into WCP/WPAS once completed. There were also a very small number of other cases where information was missing from WPAS to determine when the GP and /or patient were informed of the triage outcomes where appropriate.											Failure to deliver services potentially resulting in patient harm and associated financial and reputational implications.

Scheme	Recommendations	Agreed Action/Designated Outcome/Target/Performance Metric	Management Lead	Clinical Lead	Costings	Timescales					Progress Update
3.0	Triage process (Operation)										
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.	1. Complete and roll out new CTM LGI SOP. 2. Produce referral and vetting process inline with SOP		Joy Singh, Parin Shah, David Samuels							
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.	1. Understand go live date for E-Refs for LGI/Surgery. 2. link in with Records/Digital team	Gareth Blandford, Stewart Duncan								

Matter Arising 4: Quality checks (Design)											Potential Impact
We met with five GI Consultants (three Gastroenterologists and two Colorectal Surgeons), and a Colorectal Clinical Nurse Specialist from across the three acute hospital sites. We identified that there are currently no processes in place to quality check the triage and decision-making process. A formalised 'peer review' quality assurance exercise would enable the GI clinicians to compare and discuss the approach to triage and decision-making outcomes as a means of ensuring a consistency of approach to the triage processes in place.											Unclear structures or responsibilities resulting in inconsistent service delivery.

Scheme	Recommendations	Agreed Action/Designated Outcome/Target/Performance Metric	Management Lead	Clinical Lead	Costings	Timescales					Progress Update
4.0	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'.	1. to become part of the GI Directorate agenda - date of first meeting to be confirmed. 2. replicate endoscopy peer review inline with JAG guidelines.	Gareth Blandford, Stewart Duncan	Joy Singh, Parin Shah, David Samuels							

Matter Arising 5: Monitoring and reporting (Operation)											Potential Impact
We spoke to the six Service Managers for the respective Gastroenterology and Colorectal Surgery departments at PCH, RGH and PoW to understand what GI referral and demand reports are produced, and what monitoring takes place. We note that while there is some monitoring, but this appears to vary by service area. For example: •There is departmental monitoring of referral demand levels in Gastroenterology in PCH. •There are referral reports for Gastroenterology at PoW, but these were not progressed further along the lower GI pathway. •One service manager had access to reports via QlikView. We were unable to establish any other monitoring of GI demand taking place at either a service level or at a wider Care Group level. From our testing and review of referral data we identified a number of instances where monitoring of data may be beneficial. For example: •The April to October 2023 referral data shows that approximately 20% of cases were classified as 'inappropriate referrals'. Many of these relate to cases where GPs have made referrals, but the triage criteria has not been met. Analysis of this data may enable the Health Board to identify GPs who have higher return rates, allowing refresher training or additional guidance to be targeted. •In Matter Arising 2 we identified that delays in clinicians receiving referrals was largely attributable to internally submitted paper referrals. Analysis of the data relating to the times taken during each stage of the triage process would enable trends, patterns and potential issues to be identified. •The identification of cases that have been passed to a clinician for triage, but an outcome has not been logged after a reasonable amount of time. While the Medical Records department has a procedure for the production of daily reports to monitor delayed referral responses, this process was not undertaken for Gastroenterology and Colorectal surgery referrals.											Failure to deliver services potentially resulting in patient harm and associated financial and reputational implications.

Scheme	Recommendations	Agreed Action/Designated Outcome/Target/Performance Metric	Management Lead	Clinical Lead	Costings	Timescales					Progress Update

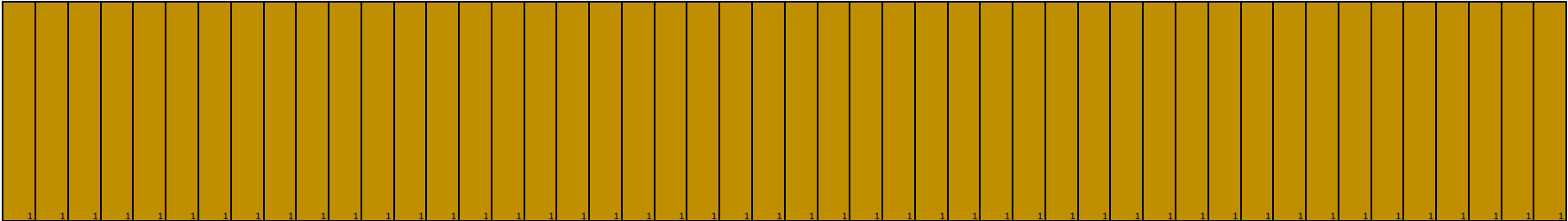
5.0	There should be a consistent approach to reviewing and monitoring referral and demand activity across the Gastroenterology and Colorectal GI services. This could be supported further by the use of the Medical Records reports that outline delayed and unvetted referrals. Regular reporting at a Care 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.	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.	Gareth Blandford, Stewart Duncan							

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Decarbonisation Internal Audit Report

April 2024

Cwm Taf Morgannwg University Health Board

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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.

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Executive Summary

Purpose

To consider progress against the NHS Wales Decarbonisation Strategic Delivery Plan and the Health Board’s Decarbonisation Action Plan. Following on from the advisory review delivered in 2022/23, the proposed scope includes governance, strategy progress and implementation.

Overview

Whilst a decarbonisation action plan is in place and there is a governance structure to support implementation, significant matters require management attention including:

- A lack of dedicated decarbonisation resourcing.
- The action plan is currently not costed as such a funding strategy has not been developed.
- Monitoring and reporting requires greater clarity.

Report Opinion

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Assurance summary¹

Objectives	Assurance
1 Governance	Reasonable
2 Localised strategies	Limited
3 Funding Strategy	Limited
4 Monitoring and Reporting	Limited
5 Project Delivery	Substantial

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	Environmental Sustainability	Group	governance arrangements	1	Operation	Medium
3	Dedicated resources			1	Design	High
4	Costed plan and funding strategy			2 & 3	Design	High
5	Carbon consideration in decision making			2	Design	Medium
6	Monitoring and reporting			4	Operation	High

1. Introduction

- 1.1 The Welsh Government (WG) is party to international agreements to reduce carbon emissions and control climate change, most notably as arising from the 2016 Paris Accord. Accordingly, they have sought to create a framework of controls, guidance and support to achieve these aims.
- 1.2 Targets include waste reduction, and reductions in supply chain carbon as part of the overall carbon footprint.
- 1.3 To support these aims, the Welsh Government published a number of strategic documents entitled *Prosperity for All – Economic Action Plan*, *Prosperity for All – A Low Carbon Wales* and *Prosperity for All – A Climate Conscious Wales*.
- 1.4 In March 2021, the Welsh Government approved a net zero target for the public sector of 2030. Net zero means balancing the greenhouse gas emissions with the amount of gases being removed from the atmosphere. For NHS Wales, an accompanying ‘*Strategic Delivery Plan*’ was published, setting interim targets (from a 2018/19 base) of:

	Carbon budget reduction
2025	16%
2030	34%

- 1.5 Category targets were also set for:
 - buildings;
 - procurement;
 - fleet and business travel; and
 - staff, patient, and visitor travel.
- 1.6 All Wales activity support streams have been created, including estates planning, and approaches to healthcare.
- 1.7 In 2023/24 the Welsh Government made funding available of *circa*. £19.9m via the Estates Funding Advisory Board (EFAB). A similar amount will be available for 2024/25. Approximately £3m of the funding in each year will be for decarbonisation schemes, though there may be decarbonisation elements identified from other schemes funded by EFAB. This funding is based on each organisation matching 30% of the WG contribution from their own discretionary programme.
- 1.8 This audit is part of the Cwm Taf Morgannwg University Health Board (CTMUHB or the ‘Health Board’) 2023/24 audit plan. It seeks to build upon our 2022/23 all Wales advisory review, which identified that the implementation plans across Wales had not been sufficiently developed to allow meaningful testing to be able to provide an assurance rating to respective audit committees. Accordingly, we provided an overview of the overarching position across NHS Wales and an action plan of common themes which were considered by the Health Board. Noting the advisory nature of the report, the recommendations were not included formally on the Health Board’s Internal Audit recommendation tracker.

- 1.9 All NHS organisations now report progress against their own Decarbonisation Action Plan (DAP), supporting delivery of the national NHS Wales decarbonisation strategic delivery plan.
- 1.10 The risks considered during this review were:
- Regulatory/legislative risk through not achieving mandated reductions in carbon emissions.
 - Reputational risk by failing to meet emission targets.
 - Failing key stakeholders by not reducing carbon emissions which have a detrimental effect on health. In so doing, not meeting the requirements of the Wellbeing of Future Generations Act (2016).
- 1.11 The wider role of NHS Wales Shared Services Partnership (NWSSP) Procurement, in the decarbonisation agenda, has not been audited as part of this review. Additionally, verifying the accuracy of carbon emission declarations and estimates was excluded from the scope of this audit; and we note that the baseline position for CTMUHB has not been adjusted to take account of the impact of the significant boundary/area change that has occurred to the Health Board since the baseline figures were established.

2. Detailed Audit Findings

Objective 1: Governance – appropriate governance arrangements have been established in relation to decarbonisation that integrate with existing organisational accountability and reporting structures.

- 2.1 The 'NHS Wales Decarbonisation Strategic Delivery Plan 2020-2030' published in March 2021 lays out 46 initiatives across six work streams that will facilitate reducing carbon emissions. These initiatives should form the basis of health board decarbonisation action plans. Each health board has to implement actions to achieve these initiatives in support of the NHS Wales carbon reduction targets as part of the Welsh Government's 'Net Zero' agenda.
- 2.2 The 'CTM Decarbonisation Strategy 2022-2030' was approved by the Board in March 2022. The Health Board's strategy identifies five themes and sets out the current work in relation to sustainability and its future vision for each goal. The strategy identifies an executive team member responsible for the delivery of each of the five themes.
- 2.3 In June 2023 the executive team and Independent Members had training from the Centre for Sustainable Healthcare which focused on the need to embed sustainability into all areas of Health Board operations and make sure sustainability goals fully align with organisational goals.
- 2.4 The Learning and Development team have developed an ESR training module on 'Achieving Net Zero in Wales'. The module is available to all staff and was launched in November 2022 to coincide with Wales Climate Week. We note that the Health Board has not monitored the level of uptake of the module. **(Matter Arising 2)**

-
- 2.5 In 2022 the Health Board set up an Environment Sustainability Group (ESG). The group's remit is wider than just decarbonisation. However, they are the Health Board's primary driver for its decarbonisation agenda, and they play a key role in advising, guiding and monitoring the development and implementation of:
- CTM's decarbonisation strategy and implementation plan.
 - Programmes and projects delivering decarbonisation and environmental sustainability.
 - Annual carbon emission (CO2e) reporting to Welsh Government.
- 2.6 The terms of reference (ToR) for the ESG is dated November 2022. The ToR identifies a broad range of members from across the Health Board, but some of those named no longer work for CTMUHB, and other roles are recorded as 'TBC'. We note that while executive team members have responsibility for the five decarbonisation themes, none attend the ESG although some have appointed representatives to attend. **(Matter Arising 1)**
- 2.7 Our review of minutes of the group identified that many of those identified as members were not in attendance. While other staff were in attendance, their role and the area of the Health Board and the theme they represented was not clear. **(Matter Arising 1)**
- 2.8 Information about the group's activities, reporting requirements and governance structure is contained within the ToR. We note reference to bi-annual reporting to the Planning, Performance and Finance Committee, but we have seen that reporting takes place via the Population Health and Partnerships Committee. As environmental sustainability is one of the Health Board's transformation portfolios, we understand there is quarterly reporting to the CTM Transformation Board. We have also seen reporting on decarbonisation into the CTM Board.
- 2.9 The Health Board has representation on other forums that are intended to promote and support the decarbonisation agenda. For example, the Health and Social Care Climate Emergency National Programme - Community of Experts, which is a forum where peers from across NHS Wales can learn from each other by either sharing good practice or raising issues for discussion. We are aware of a range of other all-Wales sustainability groups specific to certain topics, such as travel and transport. However, we have been unable to determine if the Health Board is represented.
- 2.10 Although responsibilities within the decarbonisation strategy have been assigned at Board level, there are relevant groups within the Health Board, and there are links with relevant external groups that are intended to drive decarbonisation, there is no specific resource dedicated to decarbonisation within the Health Board. Despite 2025 being the date set by WG for achieving a 16% reduction in carbon emissions, up to now responsibilities for overseeing the decarbonisation work have been undertaken in addition to existing responsibilities. **(Matter Arising 3)**
- 2.11 The Health Board has identified a strategic risk, 'Fulfilling our Environmental and Social Duties and Ambitions', which relates to decarbonisation. We note that the Health Board has recognised there is an element of tolerating this risk, especially in terms of the pace of mitigation to its desired level due to workforce and financial
-

capacity constraints. There are however ongoing risk treatment activities to mitigate the risk, especially around the Health Board's decarbonisation plans.

Conclusion:

2.12 The Health Board has taken steps to establish a strategy and plan for decarbonisation. Governance arrangements have been established to provide oversight on the overall environmental and sustainability goals, however these need to be reviewed. At the time of our fieldwork the Health Board did not have dedicated specialist staff to drive the decarbonisation strategy. We have provided reasonable assurance against this objective.

Objective 2: Localised Strategies – a tailored decarbonisation strategy and action plan has been developed in accordance with available legislation and guidance. Documents have been appropriately scrutinised and approved prior to submission to Welsh Government. The strategy and plan are adequately reflected within wider organisational documentation such as the IMTP.

2.13 In addition to the 'CTM Decarbonisation Strategy 2022-2030', a 2022-24 Decarbonisation Action Plan (DAP) is in place. This lists 137 actions, each linked to one of 30 of the 46 referenced initiatives identified in the NHS Wales Decarbonisation Action Plan. We note that 16 initiatives do not apply to the Health Board as other parties, such as NWSSP Procurement services, are responsible for their delivery.

2.14 The 2022-24 DAP was prepared and agreed by members of the Strategy Implementation Group (former name of the ESG) ahead of submission to Welsh Government. We understand that wider approval was not sought due to the timescales needing to be adhered to for submission. A revised DAP for 2024-26 was presented to the March 2024 Population Health and Partnership Committee meeting for endorsing, ahead of submitting to Board approval in late March 2024. The format of the Welsh Government monitoring return template is used to capture the Health Board's DAP.

2.15 We note that decarbonisation reporting to the Board makes reference to the need for a significant investment to achieve decarbonisation plans and targets. However, we have not seen a value identified in the reports. We understand that as the financial impact of implementing the DAP has not been identified. **(Matter Arising 4)**

2.16 Whilst each action captured in the DAP does not have an expected carbon emission saving attributed to it, for each initiative, early iterations of the template identified a carbon impact score, providing guidance to the Health Board on the actions that may have the greatest impact. Awareness of the impact is important as many of the initiatives indicated that their implementation would have a minimal impact on directly reducing carbon emissions.

2.17 The Health Board's 2023-2026 IMTP contains a 'Green 2030' commitment as part of its 'Sustaining our Future' strategic goal. Reference is made to the decarbonisation strategy and key priorities for the period are set out as:

- Establish a clear learning and development support offer for staff focused on embedding climate change action into continuous service improvement.
- Develop tools and support mechanisms to help individuals and teams set and achieve localised decarbonisation goals setting for group work.
- Continue to expand our apprenticeship scheme in order to grow our workforce locally, reducing commuting and establishing CTMUHB as an anchor stone to the local economy.

The ongoing delivery of the DAP and the Biodiversity and Ecosystem Resilience plan are also listed as key areas of focus for 2023/24.

- 2.18 In addition to the specific information within the 'Green 2030' section of the IMTP, some consideration is also given to the decarbonisation agenda at other points in the document. However, there is no reference to decarbonisation in the overview of the major transformation schemes. If targets are to be achieved, a Health Board wide approach is needed. We would expect major transformation schemes and future projects of the Health Board to include greater consideration of impact on decarbonisation. **(Matter Arising 5)**
- 2.19 We note that over the past year a number of wider strategies and policies have been published that have given consideration to the decarbonisation agenda. This includes the Active Travel Charter and the Transport, Travel and Car Parking Policy.
- 2.20 To help embed the decarbonisation ethos among staff and encourage local work, the Health Board has established an informal 'green team' which meets periodically to discuss environmental issues. This group has around 80 members of staff from all areas and levels of the Health Board. The purpose of the group is to keep decarbonisation at the forefront of peoples thinking and to challenge staff to think of new and better ways of working that will help patients improve their health outcomes while reducing waste and variation across the healthcare system.
- 2.21 The Health Board has created a SharePoint site, 'Green CTM', which is home to the Health Board's climate change work and is accessible to staff.

Conclusion:

- 2.22 The Health Board has actively engaged with relevant staff to produce a DAP and therefore local initiatives that align with decarbonisation and sustainability objectives. Whilst there is a detailed plan that contains aims, objectives and initiatives, the initiatives do not identify the investment required. We have provided limited assurance against this objective.

Objective 3 Funding Strategy – There is an appropriate funding strategy targeting discretionary, EFAB and All-Wales funding.

- 2.23 Our 2022/23 report recommended that the DAP should be costed and supported by funding strategies. While we acknowledge that a costed DAP was not a requirement of the initial plans submitted to Welsh Government, the lack of a costed DAP means a strategy setting out how initiatives will be funded is not in place. **(Matter Arising 4)**

- 2.24 The Health Board has an ongoing programme of three major decarbonisation projects. These are being delivered through £1.06m of funding from EFAB. We note that the Health Board's Estates Capital Management Group (ECMG) have approved the £0.42m Health Board share of the projects from discretionary funds.
- 2.25 Other funding has also been made available from the Health and Social Care Climate Emergency Programme funding scheme and has been used by the Health Board to deliver smaller scale projects.
- 2.26 The Health Board is also working with Re:Fit, a government run local partnerships scheme, to tender for a service provider under the 'National Framework Agreement for Energy Performance'. The Health Board aims to appoint a provider by April 2024. They will aid the Health Board in its decarbonisation work including helping in optimising the energy efficiency of selected premises and improving the energy performance of its assets.
- 2.27 We understand that the service provider also will supply the expertise to aid the costing of initiatives and then identify and apply for external funding sources to support the Health Board's in implementing those initiatives.

Conclusion:

- 2.28 The Health Board has successfully obtained funding for some larger and smaller scale projects and is seeking to procure a specialist service provider to aid its decarbonisation work. However, the lack of a costed DAP and the financial shortfalls and wider financial pressures across NHS Wales, impacts the development of a long-term financial model and the ability to deliver the decarbonisation agenda. We have provided limited assurance against this objective.

Objective 4: Monitoring & Reporting – appropriate monitoring and reporting arrangements are in place to provide ongoing assurance on the implementation of the strategy and action plan.

- 2.29 Monitoring progress on implementing the DAP is the responsibility of the ESG, which meets quarterly. While reviewing each action on the DAP may not be practical, we did not see a report to ESG providing an overview of progress against the DAP. We acknowledge that updates are provided on specific activities, and understand that for each area of the DAP the relevant responsible team will assess their completion percentage for input on monitoring returns. But we did not see how this is fed back to the ESG. It is unclear who has oversight of the DAP at an operational level. **(Matter Arising 6)**
- 2.30 Each workstream of the ESG should provide a highlight report to the ESG twice a year. Whilst there were regular updates from departments such as pharmacy, facilities corporate and ICT, we did not see clear alignment between the reports received and all six workstreams. **(Matter Arising 6)**
- 2.31 We note that the work required to produce the 2024/26 refreshed DAP was regularly discussed at ESG meetings.

- 2.32 Quarterly monitoring returns are submitted to Welsh Government using a template. Our testing of a sample of returns confirmed that they were submitted in line with the required timeframes. The most recent monitoring return is structured with the 46 initiatives grouped on tabs under the prescribed six workstreams, such as carbon management, buildings, estates and planning and transport. Each initiative may have one or more actions to complete. The return identifies information such as the action owners, responsible officers and accountable officers, comments on delivery and the RAG status and overall delivery confidence per action and initiative.
- 2.33 Early iterations of the returns were supported by a summarised narrative report setting out overall RAG status on progress and delivery confidence and made comparisons to the previous reported position. Key achievements and risks to delivery were also captured. For the most recent version of the DAP return template, the narrative report is no longer a requirement. We acknowledge this is the prescribed format set by WG, however the loss of the narrative report and the lack of a summary page in the monitoring report, makes it difficult for the reader to decipher the Health Board's current overall position.
- 2.34 The Executive Leadership Group receive a quarterly report and a copy of the monitoring return (DAP), for approval ahead of submission to Welsh Government. The report is submitted via the NWSSP Decarbonisation Coordination Reporting (DCR) team. While the quarter two 2023/24 monitoring return cover report refers to 'varying degrees of success' for individual actions and notes the main risks (finance, people, time) to delivery, a high-level view of current position is not clear from the current reporting format. We have not seen reported anywhere, how far off the 16% reduction the Health Board is. Our analysis of the monitoring return shows that for 12/30 initiatives that are relevant to the Health Board, the overall delivery confidence for 12 initiatives (40%) has been classed as 'feasible'¹ or 'in doubt'². **(Matter Arising 6)**
- 2.35 While the 2022/23 quarter four monitoring report was presented to the Population, Health and Partnership Committee in May 2023, we have not seen evidence of subsequent quarterly reports to the Committee. We acknowledge that related reports have been presented at the committee during this time such as the previous all-Wales Internal Audit report and a presentation on a recycling project. **(Matter Arising 6)**
- 2.36 The Health Board is required to produce an Annual Carbon Report. The last annual report was presented to the Board in September 2023 ahead of being submitted to WG. The report contained data on the Health Board's carbon emissions and included comparisons to previous years. The report is clear in stating that despite the reported reduction, which may be due to changes in the reporting template, the Health Board will not meet its 16% carbon reduction target by 2025 or 34%

¹ WG Definition of 'feasible': Successful delivery appears feasible but significant risks and issues already exist requiring management attention. These appear resolvable at this stage and, if addressed promptly.

² WG Definition of Successful delivery of the action / initiative is in doubt with major risks or issues apparent in a number of key areas. Urgent action is needed to ensure these are addressed and establish whether resolution is feasible.

reduction by 2030. We are aware that is in line with what other health boards and trusts reported in their 2022/23 annual reports.

- 2.37 The baseline carbon emission positions for all health boards were established in 2018/19. This predates the boundary changes to the Health Board area. We understand that Welsh Government have confirmed there will be a move to a different reporting methodology to allow for the boundary change.

Conclusion:

- 2.38 The Health Board has appropriately completed its monitoring returns to WG on time. While we have seen some reporting internally, we have not seen evidence that detailed reporting of progress against the DAP is reported to the ESG, who are the key group responsible for overseeing its implementation. Furthermore, we have not seen reported anywhere, how far off the 16% reduction the Health Board is. We have provided limited assurance against this objective.

Objective 5: Project Delivery - suitable progress has been made on projects included within the 2023/24 funding commitments, and that appropriate arrangements are in place to secure available funding during 2024/25.

- 2.39 In 2022/23, using funding from the Health & Social Care Climate Committee Programme scheme, the Health Board has established a 'Sustainable Innovation Scholar Programme'. Staff were invited to suggest initiatives to be implemented that would start to address the healthcare contribution to the climate crisis. A number of potential schemes were considered with six initiatives selected and delivered. For example, a pilot partnership between the Health Board and a local third sector employer to reduce cardboard waste and CO₂e by providing a sustainable and ongoing solution to cardboard waste management. The costs, primarily staff time of one day per week for six months, were appropriately recorded and allocated back to the staff member's main departmental cost centre.
- 2.40 These appear to have had a positive and direct impact on the Health Board activities and their success has been shared with staff via newsletters on the intranet. Reports have also been presented at the Population Health and Partnerships Committee. However, we have been informed that there were no further programmes or initiatives in 2023/24, but work is underway to identify funding streams for 2024/25.
- 2.41 There were three EFAB funded projects during 2023/24. The projects use the Health Board's capital programme management structure with scheduled budget, performance measures, and progress reports produced and considered by the group. In relation to the EFAB funding, we note that the funding approach intentionally does not compare full VFM and cost per tonne of carbon emission saved. The Health Board considers EFAB as appropriate for the longer-term projects that do not necessarily deliver instant returns and benefits, but have long term value to achieving decarbonisation, such as solar panels to generate electricity.

2.42 We saw evidence of benefits realisation being monitored and tracked and where necessary a project being suspended to allow a full review to take place where a scheme appeared to be failing in producing the proposed carbon saving.

Conclusion:

2.43 There is enough evidence to confirm proper use of EFAB project funding and monitoring of the realisation of the benefits of those projects. We consider substantial assurance appropriate for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Environmental Sustainability Group governance arrangements (Operation)		Potential Impact
The Health Board has established an Environmental Sustainability Group (ESG) whose remit includes overseeing the implementation of the Health Board’s decarbonisation strategy and action plan. We note that the terms of reference for the group were due to be reviewed in November 2023, but had not been. Our review of the terms of reference identified: • Members of the group are no longer Health Board employees. • Roles had ‘TBC’ recorded against member name. • Not all of the Executive leads with responsibility for aspects of the decarbonisation strategy had named representatives on the group. • The reporting structure states the group reports to the Planning, Performance and Finance Committee, when this should say the Population, Health and Partnerships Committee. Our review of minutes of the group identified that many of the named members were not in attendance, however in contrast numerous other staff were in attendance, but it was not always possible to determine their role or the area of the Health Board or workstream that they were representing.		Inappropriate governance arrangements are in place leading to lack of ownership and oversight of decarbonisation work and failure to achieve Welsh Government targets.
Recommendations		Priority
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.	Medium
1.2	The minutes of the ESG should capture the department / workstream that members are representing to ensure there is clear representation.	Medium

Agreed Management Action		Target Date	Responsible Officer
1.1	This recommendation is accepted and the terms of reference for the Environmental Sustainability Group will be updated to reflect this.	July 2024	Vicki Wallace – Deputy Director of Strategy and Partnerships
1.2	This recommendation is accepted and changes will be made to how the minutes record representation.	July 2024	Vicki Wallace – Deputy Director of Strategy and Partnerships

Matter Arising 2: Training and awareness (Operational)			Potential Impact
The Health Board used Green Scholar funding to aid the development of an ESR training module on 'Achieving Net Zero in Wales'. The module was launched in November 2022, however we have been unable to determine if any monitoring has been undertaken of the uptake of the module.			Training is not undertaken and staff awareness on decarbonisation is not raised.
Recommendations			Priority
2	Data in relation to the uptake of the 'Achieving Net Zero in Wales' ESR training module should be obtained reviewed to determine if additional work needs to be carried out to raise awareness of the availability of training module.		Low
Agreed Management Action		Target Date	Responsible Officer
2	This recommendation is accepted. Work will be done with the People Team to understand the uptake of the ESR training module.	December 2024	Vicki Wallace – Deputy Director of Strategy and Partnerships

Matter Arising 3: Dedicated resources (Design)			Potential Impact
The breadth and depth of the decarbonisation requirements are complex and far reaching. At the time of our fieldwork the Deputy Director Strategy and Partnerships had responsibility for overseeing the Health Board’s decarbonisation work in addition to existing responsibilities. We understand that there are no resources dedicated to the decarbonisation strategy or action plan delivery.			Lack of exclusive resource could mean that projects and initiatives are not delivered and further opportunities for decarbonisation are missed.
Recommendations			Priority
3	Management should review the resource dedicated to decarbonisation to identify if it can meet the Health Board’s requirements.		High
Agreed Management Action		Target Date	Responsible Officer
3	Additional resources have now been identified from within the Deputy Director of Strategy and Partnerships team with the establishment of a Sustainability Manager post which is currently being recruited to.	July 2024	Vicki Wallace – Deputy Director of Strategy and Partnerships

Matter Arising 4: Costed plan and funding strategy (Design)			Potential Impact
Whilst reports to the Board inform them of the investment that will be required to implement the initiatives and achieve the targets set out in the Decarbonisation Action Plan, a costed plan is not in place. The Health Board has not identified the likely future commitment needed to meet the requirements of decarbonisation.			The Health Board is unable to invest sufficient resources to achieve the decarbonisation programme meaning they fail to achieve the WG targets.
Recommendations			Priority
4.1	A fully costed plan should be developed to allow the Health Board to identify the commitment required to meet the WG 2030 target.		High
4.2	A long-term model for the funding required to support the decarbonisation programme should be developed.		High
Agreed Management Action		Target Date	Responsible Officer
4.1	The principle of the recommendation is accepted by the Health Board. However, the reality of being able to develop a fully costed plan is currently unrealistic. This is due to resource constraints, such as staff time and information on costs being available. It is also impacted on by elements beyond the control of the health board, as some actions are dependent upon national initiatives e.g. EV charging infrastructure and therefore as the detail is currently unknown, it is not possible to fully assign a cost to it. Action will be undertaken to cost appropriate elements of the plan as resources and available information allow.	December 2024	Mandy Pady – Head of Finance
4.2	The principle of the recommendation is accepted by the Health Board. However, the reality of developing a long-term funding model will be challenging due to the financial constraints that the Health Board is currently working within. For example, many of the actions set out within the plan will need capital funding and it is unlikely that this will be available due to the pressures nationally on capital funds and the prioritisation pipeline. Many actions will also need to access external funding which	March 2025	Mandy Pady – Head of Finance

	will require robust, fully costed business cases outlining the investment required and the financial (and other) benefits, set within the strategic context of the overall programme and realistically, the availability of these funds is limited.		

Matter Arising 5: Carbon consideration in decision making (Design)			Potential Impact
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 IMTP 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.			Decarbonisation is not considered in all activities and decision making and the Health Board fails to achieve the Welsh Government targets.
Recommendations			Priority
5	Carbon impact assessments should form part of the decisions made and actions taken by the Health Board, especially in larger scale transformational projects.		Medium
Agreed Management Action		Target Date	Responsible Officer
5	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.	March 2025	Vicki Wallace – Deputy Director of Strategy and Partnerships

Matter Arising 6: Monitoring and reporting (Operation)	Potential Impact
<u>Environmental Sustainability Group meetings</u> 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. <u>Board and Committee reporting</u> 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.	Effective monitoring and reporting of progress against the DAP does not take place, meaning corrective actions cannot be taken and the Board are unable to gain appropriate assurance.
Recommendations	Priority
6.1 Reporting arrangements for the Environmental Sustainability Group should be reviewed to ensure that it receives the necessary information to have oversight of the DAP implementation, including clear reporting from each workstream, to allow meaningful updates on progress to be reported to the Board and its committees.	High
6.2 The reporting format should be supplemented to include a narrative report that allows readers to gain a clear understanding of the current position of the Health Board in achieving the initiatives in place for each workstream and the overall position against the Welsh Government targets. Reporting on progress in	High

	implementation of the DAP to the Population Health and Partnership Committee should take place at regular intervals, as set out in the ESG terms of reference.	
Agreed Management Action		Responsible Officer
6.1	The Health Board accepts this recommendation and the reporting arrangements for the Environmental Sustainability Group will be reviewed.	Vicki Wallace – Deputy Director of Strategy and Partnerships
6.2	The Health Board accepts this recommendation and the reporting arrangements for the Environmental Sustainability Group will be reviewed.	Vicki Wallace – Deputy Director of Strategy and Partnerships

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

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



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Follow-up: Digital Operating Model Final Internal Audit Report

April 2024

Cwm Taf Morgannwg University Health Board



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Auditors:	Martyn Lewis, IT Audit Manager
Executive sign-off:	Stuart Morris, Director of Digital
Committee:	Audit and 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

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

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 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.

Executive Summary

Purpose

To provide the Health Board with assurance regarding the implementation of the agreed management actions from our Digital Operating Model (2223-01) review.

Overview of findings

Progress has been made in implementing the digital operating model.

There has been a review of the structure of the Digital department, with increased resource provided, in particular at the leadership level, and for change and project management skills. We also note increased development resource within the department.

There has been an increase in digital clinical leadership with the establishment and continued development of a digital clinical directorate.

We also note increased funding provided for the updating of digital equipment which has cleared some of the backlog of older equipment.

Of the original eight matters raised, for two the actions are still ongoing and where we have raised matters within this report, they relate to:

- establishing a steering / ownership level for digital once the organisational governance structures are finalised; and
- defining and stating a minimum required digital literacy for all staff.

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

Progress Summary¹

Previous Matters Arising	Previous Priority Rating	Direction of Travel	Current Priority Rating
1 Steering Level	High		Medium
2 Digital Clinical Leadership	High		Closed
3 Digital Resource	High		Closed
4 Development Resource	Medium		Closed
5 Skills	Medium		Closed
6 Digital Equipment	High		Closed
7 Digital Literacy	Medium		Medium
8 Support	Medium		Closed

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

1. Introduction

- 1.1 The follow-up review of the Digital Operating Model has been completed in line with the 2023/24 Internal Audit Plan for Cwm Taf Morgannwg University Health Board (the 'Health Board'). The opinion provided through this review is a key component, which will inform the Head of Internal Audit's Annual Opinion.
- 1.2 The objective of this audit was to provide the Health Board with assurance regarding the implementation of the agreed management actions from the Digital Operating Model (2223-01) review that was reported as part of our 2022/23 work programme. The original report identified eight issues and resulted in an overall assurance rating of 'Limited Assurance'.
- 1.3 The scope of this follow-up review does not aim to provide assurance against the full review scope and objective of the original review. The 'follow-up review opinion' provides an assurance level against the implementation of the agreed action plan only.
- 1.4 The risks considered as part of the original audit were:
 - Health Board staff do not have adequate support to enable objectives to be met; and
 - the Digital Directorate cannot fulfil the Health Board's requirements.

2. Findings

- 2.1 The table below provides an overview of progress in implementing the previous internal audit recommendations:

Original Priority Rating	Number of Recommendations	Implemented (Closed - No Further Action Required)	Action Ongoing (Further Action Required)	Not implemented (Further Action Required)
High	4	3	1	-
Medium	4	3	1	-
Low	-	-		-
Total	8	6	2	-

- 2.2 Full details of the recommendations requiring further action are provided in the **Management Action Plan** in **Appendix A**. Where action is ongoing we have re-assessed the priority rating for the recommendation and revised these where appropriate.
- 2.3 For the recommendations that have been closed or partially closed, management have taken action to address the matters arising in our original report. This includes:

- The Digital Clinical directorate has been created and expanded with additional clinical resource provided.
- There have been improvements in the links between digital and services, with representation from across the varying clinical groups. We understand that management intend to develop this network further.
- The structure within the Digital Directorate has been reviewed and updated, with additional resource in key areas such as digital leadership, change management and project management.
- Management has increased development capability. Future capability is assessed on a programme basis going forward, balanced against the financial position and provision of bought in, or all Wales, provided services.
- There has been an assessment of the digital need required to deliver an appropriate service. This skills requirement is being further defined as the Health Board moves forward with its digital plans.
- Despite the current financial constraints, there has been increased funding provided which has led to some of the backlog of older equipment to be updated. A backlog of older equipment still exists and we also note ongoing bids for further investment in digital equipment both as part of ongoing digital projects, and as a specific bid for updating legacy equipment.
- Digital support processes have been improved, with more 'how to' guides, better knowledge management, and training provided to service desk staff.

2.4 The actions listed above have either resulted in the recommendation being implemented, or partially implemented. one of the four recommendations originally categorised as high priority has been reassessed, and now has a residual priority rating of medium (Previous Matter Arising 1, Appendix A).

Appendix A: Management Action Plan

Previous Matter Arising 1: Steering Level		
Original Recommendation		Original Priority
An appropriate steering and ownership governance tier should be established that enables stakeholders to own, steer and oversee the delivery of digital objectives.		High
Management Response	Target Date	Responsible Officer
A new governance and ownership arrangement will be created to align to the Health Board Transformation Change Programme and delivery board created as part of the Care Group Model Implementation.	Qtr 3 2022/2023	Director of Digital
Current findings		Residual Risk
The Health Board has undergone a restructuring, and is currently undertaking a review of the governance structures of the organisation. As part of this the transformation agenda is being reviewed and will feed into the new governance structure. As such there has been limited change at the steering and ownership level of digital, as this will need to fit into the revised structure, with digital weaved into transformation rather than separate. Ownership is maintained for specific digital items, such as patient contact and e-prescribing via reporting into the Operational Management Board. Conclusion: Partial / Action Ongoing		Digital stakeholders do not own, or sufficiently feed into the direction of digital.
New Recommendations		Priority
1.1	Once the organisational governance structures are finalised a steering / ownership structure for digital should be defined.	Medium

Management Response		Target Date	Responsible Officer
1.1	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	End of Qtr 3 2024/2025	Director of Digital

Previous Matter Arising 7: Digital Literacy			
Original Recommendation			Original Priority
The Health Board should clearly state that minimum digital literacy is a requirement, with provision of training if required.			Medium
Management Response		Target Date	Responsible Officer
Digital literacy to be included within the workforce and organisational development plan as part of the IMTP		Qtr 4 2022/ 2023	Director of Digital
Current findings			Residual Risk
As part of the establishment of the care group model a requirement for digital literacy within the job requirements for the leadership level has been included. However there is no organisation wide definition or statement of requirement for a minimum standard of digital literacy for all staff. Conclusion: Partial / Action Ongoing			Staff may not be able to effectively use digital solutions.
New Recommendation(s)			Priority
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.		Medium
Management Response		Target Date	Responsible Officer
2.1	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	Qtr 3 2024/2025	Director of Digital

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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



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Annual Internal Audit Plan

Internal Audit Charter

April 2024

Cwm Taf Morgannwg University Health
Board



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1. Introduction

This document sets out the Internal Audit Plan for 2024/25 (the Plan) detailing the audits to be undertaken and an analysis of the corresponding resources. It also contains the Internal Audit Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

The Accountable Officer (the Health Board Chief Executive) is required to certify, in the Annual Governance Statement, that they have reviewed the effectiveness of the organisation's governance arrangements, including the internal control systems, and provide confirmation that these arrangements have been effective, with any qualifications as necessary including required developments and improvement to address any issues identified.

The purpose of Internal Audit is to provide the Accountable Officer and the Board, through the Audit and Risk Committee (the 'Audit Committee'), with an independent and objective annual opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control. The opinion should be used to inform the Annual Governance Statement.

Additionally, the findings and recommendations from internal audit reviews may be used by Health Board management to improve governance, risk management, and control within their operational areas.

The Public Sector Internal Audit Standards (the Standards) require that 'The risk-based plan must take into account the requirement to produce an annual internal audit opinion and the assurance framework. It must incorporate or be linked to a strategic or high-level statement of how the internal audit service will be delivered in accordance with the internal audit charter and how it links to the organisational objectives and priorities.'

Accordingly, this document sets out the risk-based approach and the Plan for 2024/25. The Plan will be delivered in accordance with the Internal Audit Charter and the agreed KPIs which are monitored and reported to you. All internal audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP).

1.1 National Assurance Audits

The proposed Plan includes assurance audits on some services that are provided by DHCW, NWSSP, and the NHS Wales Joint Commissioning Committee (JCC) on behalf of NHS Wales. These audits will be included in Appendix A when agreed formally. These audits are part of the risk-based programme of work for Digital Health and Care Wales (DHCW), NWSSP and the Health Board (for the JCC) but the results, as in previous years, are reported to the Health Board and relevant trusts and are used to inform the overall annual Internal Audit opinion for those organisations.

1.2 NHS Wales Joint Commissioning Committee (JCC)

The proposed Plan includes time to undertake work within the newly formed JCC. In previous years we completed audits within the hosted bodies that preceded the JCC: Welsh Health Specialised Services Committee (WHSSC); and the Emergency Ambulance Services Committee (EASC). These audits are included as an additional section in Appendix A. Similarly to previous years, the results of these audits are reported to the relevant health boards and trusts and are used to inform the overall annual Internal Audit opinion for those organisations.

2. Developing the Internal Audit Plan

2.1 Link to the Public Sector Internal Audit Standards

The Plan has been developed in accordance with Standard 2010 – Planning, to enable the Head of Internal Audit to meet the following key objectives:

- the need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals;
- provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement;
- audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks;
- improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work;
- confirmation of the audit resources required to deliver the Internal Audit Plan;
- effective co-operation with Audit Wales as external auditor and other review bodies functioning in the organisation; and
- provision of both assurance (opinion based) and consulting engagements by Internal Audit.

2.2 Risk based internal audit planning approach

Our risk-based planning approach recognises the need for the prioritisation of audit coverage to provide assurance on the management of key areas of risk, and our approach addresses this by considering:

- the organisation's risk assessment and maturity;
- the organisation's response to key areas of governance, risk management and control;
- the previous years' internal audit activities; and

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- the audit resources required to provide a balanced and comprehensive view.

Our planning takes into account the NHS Wales Planning Framework and other NHS Wales priorities, such as the duties of Quality and Candour, and is mindful of significant national changes that are taking place. In addition, the plan aims to reflect any significant local changes occurring as identified through the Integrated Medium-Term Plan (IMTP), and other changes within the organisation, assurance needs, identified concerns from our discussions with management, and emerging risks.

We will ensure that the plan remains fit for purpose by recommending changes where appropriate and reacting to any emerging issues throughout the year. Any necessary updates will be reported to the Audit Committee in line with the Internal Audit Charter.

While some areas of governance, risk management and control will require annual consideration, our risk-based planning approach recognises that it is not possible to audit every area of an organisation's activities every year. Therefore, our approach identifies auditable areas (the audit universe). The risk associated with each auditable area is assessed and this determines the appropriate frequency for review.

In addition, we will, if requested, also agree a programme of work through both the Directors of Corporate Governance and Directors of Finance networks. These audits and reviews may be undertaken across all NHS bodies or a particular sub-set, for example at health boards only.

Therefore, our audit plan is made up of a number of key components:

- 1) Consideration of key governance and risk areas: We have identified a number of areas where an annual consideration supports the most efficient and effective delivery of an annual opinion. These cover Governance and the Board Assurance Framework, Risk Management, Clinical Governance and Quality, Financial Sustainability, Performance Monitoring & Management and an overall IM&T assessment. In each case we anticipate a short overview to establish the arrangements in place including any changes from the previous year with detailed testing or further work where required.
 - 2) Organisation based audit work – this covers key strategic risks and priorities from the Organisational Risk Register together with other auditable areas identified and prioritised through our planning approach. This work combines elements of governance and risk management with the controls and processes put in place by management to effectively manage the areas under review.
 - 3) Follow up: this is follow-up work on previous limited and no assurance reports as well as other high priority recommendations. Our work here also links to the organisation's recommendation tracker and considers the impact of their implementation on the systems of governance and control.
 - 4) Work agreed with the Directors of Corporate Governance, Directors of
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Finance, other executive peer groups, or Audit Committee Chairs in response to common risks faced by a number of organisations. This may be advisory work in order to identify areas of best practice or shared learning.

5) The impact of audits undertaken at other NHS Wales bodies that impacts on the Health Board, namely NWSSP, DHCW, and the JCC.

6) Where appropriate, Integrated Audit & Assurance Plans will be agreed for major capital and transformation schemes and charged for separately. Health bodies are able to add a provision for audit and assurance costs into the Final Business Case for major capital bids.

These components are designed to ensure that our internal audit programmes comply with all of the requirements of the Standards, supports the maximisation of the benefits of being an all-NHS Wales wide internal audit service, and allows us to respond in an agile way to requests for audit input at both an all-Wales and organisational level.

2.3 Link to the Health Board's systems of assurance

The risk based internal audit planning approach integrates with the Health Board's systems of assurance; therefore, we have considered the following:

- a review of the Board's vision, values and forward priorities as outlined in the three year Integrated Medium Term Plan (IMTP);
- an assessment of the Health Board's governance and assurance arrangements and the contents of the organisational risk register;
- risks identified in papers to the Board and its committees (in particular the Audit and Risk Committee, the Quality and Safety Committee, and the Planning, Performance and Finance Committee);
- strategic risks identified within the Board Assurance Framework and significant risks identified within the organisational risk register and assurance processes;
- discussions with directors regarding risks and assurance needs in areas of corporate responsibility;
- cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions);
- new developments and service changes;
- legislative requirements to which the organisation is required to comply;
- planned audit coverage of systems and processes provided through NWSSP, DHCW, and the JCC;
- work undertaken by other supporting functions of the Audit Committee including Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV) where appropriate;

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- work undertaken by other review bodies including Audit Wales and Healthcare Inspectorate Wales (HIW); and
 - coverage necessary to provide assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit has met and spoken with a number of Health Board executives and independent members to discuss current areas of risk and related assurance needs. Meetings have been held, and planning information shared, with the Health Board's executive team, the Chair of the Audit and Risk Committee and the Chair of the Board.

The draft Plan has been provided to the Health Board's executive management team to ensure that Internal Audit's focus is best targeted to areas of risk.

3. Audit risk assessment

The prioritisation of audit coverage across the audit universe is based on both our, and the organisation's, assessment of risk and assurance requirements as defined in the Health Board's risk management policy, Board Assurance Framework and organisational risk register.

The maturity of these risk and assurance systems allows us to consider both inherent risk (impact and likelihood) and mitigation (adequacy and effectiveness of internal controls). Our assessment also takes into account corporate risk, materiality or significance, system complexity, previous audit findings, and potential for fraud.

4. Planned internal audit coverage

4.1 Internal Audit Plan 2024/25

The Plan is set out in Appendix A and identifies the audit assignments, lead executive officers, outline scopes, and proposed timings. It is structured under the six components referred to in section 2.2.

Where appropriate the Plan makes cross reference to key strategic risks identified within the organisational risk register and related systems of assurance together with the proposed audit response within the outline scope.

The scope, objectives and audit resource requirements and timing will be refined in each area when developing the audit scope in discussion with the responsible executive director(s) and operational management.

The scheduling takes account of the optimum timing for the performance of specific assignments in discussion with management, and Audit Wales requirements if appropriate.

The Audit Committee will be kept apprised of performance in delivery of

the Plan, and any required changes, through routine progress reports to each Audit Committee meeting.

The majority of the audit work will be undertaken by our regionally based teams with support from our national Capital & Estates team, in terms of capital audit and estates assurance work, and from our Digital and IT team, in terms of Information Governance, IT security and Digital work.

4.2 Keeping the plan under review

Our risk assessment and resulting Plan is limited to matters emerging from the planning processes indicated above.

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. As in any given year, our Plan will be kept under review and may be subject to change to ensure it remains fit for purpose.

Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Audit Committee for approval.

Regular liaison with Audit Wales as your External Auditor will take place to coordinate planned coverage and ensure optimum benefit is derived from the total audit resource.

5. Resource needs assessment

The plan has been put together on the basis of the planning process described in this document. The plan includes sufficient audit work to be able to give an annual Head of Internal Audit Opinion in line with the requirements of Standard 2450 – Overall Opinions.

Audit & Assurance Services confirms that it has the necessary resources to deliver the agreed plan.

Provision has also been made for other essential audit work including planning, management, reporting and follow-up.

If additional work, support or further input necessary to deliver the plan, we will look to deliver it from within our resources. It is possible, in exceptional cases, that a fee may be charged. Any change to the plan will be based upon consideration of risk and need and presented to the Audit Committee for approval.

The Standards enable Internal Audit to provide consulting services to management. The commissioning of these additional services by the Health Board, unless already included in the plan, is discretionary. Accordingly, a separate fee may need to be agreed for any additional work.

In addition, as in previous years, capital audit work in relation to the Prince Charles Hospital refurbishment project will be charged for separately on the basis of a separately agreed Integrated Audit & Assurance Plan. A provision for this work was included by the Health Board in its business case submission.

6. Action required

The Audit Committee is invited to consider the Internal Audit Plan for 2024/25 and:

- approve the Internal Audit Plan for 2024/25;
- approve the Internal Audit Charter; and
- note the associated Internal Audit resource requirements and Key Performance Indicators.

Paul Dalton

Head of Internal Audit
NHS Wales Shared Services Partnership

Appendix A: Internal Audit Plan 2024/2025

Planned output	Audit Ref	Risk Reference	Outline Scope	Executive Lead	Outline Timing
New care group model	1	SRR2	To consider scheme of delegation, clinical governance arrangements, and governance and risk management arrangements.	Chief Operating Officer	Q2
Cancer tracking process	2	SRR1	Focus on effective implementation and adherence to optimal clinical pathways and how the MDTs are functioning. Focus on two areas (potential gynae and urology).	Chief Operating Officer	Q3
Elective care criteria - Access to diagnostics	3	SRR1	Consideration of new criteria for access to diagnostics. Compliance review - booking patients in line with policy. Ensuring that patients that are listed meet the threshold.	Chief Operating Officer	Q3
End of life care management	4	SRR2	To consider the application of the strategy and arrangements in place. Focus on advanced care planning and DNRC.	Chief Operating Officer / Director of Nursing/ Medical Director	Q3

Planned output	Audit Ref	Risk Reference	Outline Scope	Executive Lead	Outline Timing
Discharge planning	5	SRR2/SRR5	Consideration of how well new policy and procedures are embedding to ensure the timely and safe discharge of patients.	Chief Operating Officer	Q4
Primary Care	6	SRR5	Focus on either accelerated cluster development, or dentistry development of community services.	Chief Operating Officer / Director of Therapies	Q4
Information provision / Use of Data	7	SRR6	To review the capabilities in place, from a people, process and technology perspective, for the Health Board to manage and transform its data to deliver the appropriate and accurate intelligence to inform better decisions. Work to be undertaken by our Digital team.	Director of Digital	Q1
Digital benefits realisation	8	SRR2/SRR6	Is the Health Board gaining the anticipated value from investment in digital solutions. Consideration of digital transformation team function, who have benefits realisation as part of their remit. To be undertaken by our digital team.	Director of Digital	Q4

Planned output	Audit Ref	Risk Reference	Outline Scope	Executive Lead	Outline Timing
Clinical coding	9	SRR6	To consider the structure, process and plan in place for timely and accurate clinical coding. Focus on waiting list patients. Work to be undertaken by our digital team.	Director of Digital	Q3
Duty of Candour	10	SRR2	To consider the process and procedure implemented by CTM to ensure compliance with the Duty of Candour.	Director of Nursing	Q1
Continuing Health Care	11	-	To provide assurance over the arrangements the Health Board has in place for managing Continuing Health Care.	Director of Nursing	Q3
Ensuring quality when commissioning care services	12	SRR2/ SRR5	To consider ensuring quality has visibility in services commissioned by CTM from external care providers.	Director of Nursing	Q3
Service user experience	13	SRR2	To consider how patient feedback process is operating across CTM. Note - PALS officers in all sites and Civica feedback system across Health Board.	Director of Nursing	Q4

Planned output	Audit Ref	Risk Reference	Outline Scope	Executive Lead	Outline Timing
Welsh risk pool	14	-	Work required by WRP guidance. Will include element relating to learning from events (LFER).	Director of Nursing	Q4
New PDR process	15	SRR8/ SRR4	Consideration of the implementation of the new PDR process. Ensuring the new process is being followed across CTM.	Director of People	Q1
Pay rates/ Additional duty hours	16	SRR1	Implementation of new system to manage ADHs. To consider compliance and monitoring. Pay rate cards - the need for uniformity and consistency of application across CTM, with consideration of out of hours periods. To consider including Waiting List Initiatives payments.	Medical Director/ Director of People	Q1
Medical job planning	17	SRR4	Consideration of procedures for job planning. Link of job planning to pay and to demand and capacity planning within service groups. Deferred from 2023/24.	Medical Director	Q2
Capital systems	18	-	To review the control framework, systems and processes in place to manage discretionary, EFAB or other capital/ estates funded schemes (not	Director of Finance	Q1

Planned output	Audit Ref	Risk Reference	Outline Scope	Executive Lead	Outline Timing
			progressed through integrated audit plans (IAP) – ensuring compliance with minimum requirements. The focus of the audit for 2024/25 will include: •initial governance arrangements, •tendering and/or selection, and •approval to award and contract completion. Work to be undertaken by our capital team		
Energy management	19	SRR9	To gain assurance that appropriate arrangements are in place to manage energy consumption within the Health Board. Whilst the specific scope is to be agreed with management, the proposed coverage may include: • Roles and responsibilities clearly assigned. • An assessment will be undertaken to ensure appropriate energy contract arrangements are in place and compliance with any resulting requirements/ clauses.	Director of Finance	Q2

Planned output	Audit Ref	Risk Reference	Outline Scope	Executive Lead	Outline Timing
			- Appropriate systems are in place to gather data on energy consumption. - Adequate checks are undertaken to verify the quality/ reliability of the data. - The audit will also look at resulting monitoring and reporting arrangements to ensure that anomalies are understood, benchmarking is undertaken where appropriate, and any resulting management action is appropriately tracked. Work to be undertaken by our capital team		
Charitable funds	20	-	To consider controls and governance arrangements.	Director of Finance	Q2
Core financial systems	21	SRR3	To consider the controls in place to manage key risk areas across the main financial systems. Detailed focus to be agreed.	Director of Finance	Q3

Planned output	Audit Ref	Risk Reference	Outline Scope	Executive Lead	Outline Timing
Vaccination policy implementation	22	SRR10	Review of the strategy implementation process and plans for ensuring equity for vaccine uptake (MMR, flu Covid).	Director of Public Health	Q2
Regional integration fund	23	SRR5	Consideration of the delivery of project work identified in the pillars of the model of care.	Director of Strategy	Q2
Stroke management process	24	SRR1	Focus on process and outcomes. Possible consideration of deployment of action plans to improve stroke performance and risk mitigations.	Director of Therapies	Q3
Llantrisant Health Park	25	-	The focus on the timely action taken by management to address the recommendations raised at the recent Project Assessment Review (PAR) undertaken by the Welsh Government's Integrated Assurance Hub. Work to be undertaken by our capital team.	Chief Executive Officer	Q3
Risk management	26	All		Director of Corporate Governance	Q4

Planned output	Audit Ref	Risk Reference	Outline Scope	Executive Lead	Outline Timing
			Wide approach to risk is settled. Proposal to focus on more granulated risk arrangements.		
Follow up work					
Follow up – Facilities governance arrangements	27	-	Previous year limited assurance report.	Chief Operating Officer	Q1
Follow up – Performance management 4 hour target	28	-	Previous year limited assurance report.	Chief Operating Officer	Q2
Follow up – Interventions not normally used (INNU)	29	-	Previous year limited assurance report.	Chief Operating Officer	Q2
Follow up – GI pathways management	30	-	Previous year limited assurance report.	Chief Operating Officer	TBC
Follow up – Financial savings in care groups	31	-	Previous year limited assurance report.	Director of Finance/ Chief Operating Officer	Q1

Planned output	Audit Ref	Risk Reference	Outline Scope	Executive Lead	Outline Timing
Follow up - Decarbonisation	32	-	Previous year limited assurance report.	Director of Strategy	TBC
Annual Governance Statement	N/A	N/A	To provide commentary on key aspects of Board Governance to underpin the completion of the statement.	Director of Corporate Governance	Q4
Follow Up Action Tracker	-	-	To review the systems in place to monitor progress with the implementation of actions in response to internal audit reports.	-	-
Other activity					
NHS Wales - Joint Commissioning Committee (JCC)	-	-	We plan to meet with the JCC to identify a programme of work for 2024/25.	-	-
NHS Wales national audit work	N/A	N/A	To collate the assurances derived from the review of NHS Wales bodies that provide services to this organisation and contribute to its overall system of control. This will cover some of our work at Health Education & Improvement Wales, Public Health Wales NHS Trust, NWSSP, and DHCW.	Director of Corporate Governance	Q4

Planned output	Audit Ref	Risk Reference	Outline Scope	Executive Lead	Outline Timing
Integrated Audit & Assurance Plans					
Management of Prince Charles Hospital capital project	-	-	See Separate Integrated Audit & Assurance Plan (IAAP).	Director of Finance	Q1-Q4

Please note: National audits undertaken at DHCW and NWSSP will be added later.

Appendix B: Key performance indicators (KPI)

KPI	SLA required	Target 2024/25
Audit plan 2024/25 agreed/in draft by 30 April	✓	100%
Audit opinion 2023/24 delivered by 31 May	✓	100%
Audits reported versus total planned audits, and in line with Audit Committee expectations	✓	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 days]	✓	95%
Report turnaround management response to draft report [15 working days maximum]	✓	80%
Report turnaround draft response to final reporting [10 days]	✓	95%

Appendix C: Internal Audit Charter

1 Introduction

- 1.1 This Charter is produced and updated annually to comply with the Public Sector Internal Audit Standards. The Charter is complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions.
- 1.2 The terms 'board' and 'senior management' are required to be defined under the Standards and therefore have the following meaning in this Charter:
- Board means the Board of Cwm Taf Morgannwg University Health Board with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit Committee in terms of providing a reporting interface with internal audit activity; and
 - Senior Management means the Chief Executive as being the designated Accountable Officer for Cwm Taf Morgannwg University Health Board. The Chief Executive has made arrangements within this Charter for an operational interface with internal audit activity through the Board Secretary.
- 1.3 Internal Audit seeks to comply with all the appropriate requirements of the Welsh Language (Wales) Measure 2011. We are happy to correspond in both Welsh and English.

2 Purpose and responsibility

- 2.1 Internal audit is an independent, objective assurance and advisory function designed to add value and improve the operations of Cwm Taf Morgannwg University Health Board. Internal audit helps the organisation accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes. Its mission is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.
- 2.2 Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit Committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. In addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.
- 2.3 The organisation's risk management, internal control and governance arrangements comprise:

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- the policies, procedures and operations established by the organisation to ensure the achievement of objectives;
 - the appropriate assessment and management of risk, and the related system of assurance;
 - the arrangements to monitor performance and secure value for money in the use of resources;
 - the reliability of internal and external reporting and accountability processes and the safeguarding of assets;
 - compliance with applicable laws and regulations; and
 - compliance with the behavioural and ethical standards set out for the organisation.

2.4 Internal audit also provides an independent and objective consulting service specifically to help management improve the organisations risk management, control and governance arrangements. The service applies the professional skills of internal audit through a systematic and disciplined evaluation of the policies, procedures and operations that management have put in place to ensure the achievement of the organisations objectives, and through recommendations for improvement. Such consulting work contributes to the opinion which internal audit provides on risk management control and governance.

3 Independence and Objectivity

3.1 Independence as described in the Public Sector Internal Audit Standards as the freedom from conditions that threaten the ability of the internal audit activity to carry out internal audit responsibilities in an unbiased manner. To achieve the degree of independence necessary to effectively carry out the responsibilities of the internal audit activity, the Head of Internal Audit will have direct and unrestricted access to the Board and Senior Management, in particular the Chair of the Audit Committee and Accountable Officer.

3.2 Organisational independence is effectively achieved when the auditor reports functionally to the Audit Committee on behalf of the Board. Such functional reporting includes the Audit Committee:

- approving the internal audit charter;
- approving the risk based internal audit plan;
- approving the internal audit resource plan;
- receiving outcomes of all internal audit work together with the assurance rating; and
- reporting on internal audit activity's performance relative to its plan.

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- 3.3 While maintaining effective liaison and communication with the organisation, as provided in this Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.
 - 3.4 Internal Auditors shall have no executive or direct operational responsibility or authority over any of the activities they review. Accordingly, they shall not develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be audited.
 - 3.5 This Charter makes appropriate arrangements to secure the objectivity and independence of internal audit as required under the standards. In addition, the shared service model of provision in NHS Wales through NWSSP provides further organisational independence.
 - 3.6 In terms of avoiding conflicts of interest in relation to non-audit activities, Audit & Assurance has produced a Consulting Protocol that includes all of the steps to be undertaken to ensure compliance with the relevant Standards that apply to non-audit activities.

4 Authority and Accountability

- 4.1 Internal Audit derives its authority from the Board, the Accountable Officer and Audit Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.
- 4.2 The Minister for Health and Social Services has determined that internal audit will be provided to all health organisations by the NHS Wales Shared Services Partnership (NWSSP). The service provision will be in accordance with the Service Level Agreement agreed by the Shared Services Partnership Committee and in which the organisation has permanent membership.
- 4.3 The Director of Audit & Assurance leads the NWSSP Audit and Assurance Services and after due consultation will assign a named Head of Internal Audit to the organisation. For line management (e.g. individual performance) and professional quality purposes (e.g. compliance with the Public Sector Internal Audit Standards), the Head of Internal Audit reports to the Director of Audit & Assurance.
- 4.4 The Head of Internal Audit reports on a functional basis to the Accountable Officer and to the Audit Committee on behalf of the Board. Accordingly, the Head of Internal Audit has a direct right of access to the Accountable Officer, the Chair of the Audit Committee and the Chair of the organisation if deemed necessary.
- 4.5 The Audit Committee approves all Internal Audit plans and may review any aspect of its work. The Audit Committee also has regular

private meetings with the Head of Internal Audit.

- 4.6 In order to facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend any committee or sub-committee of the Board charged with aspects of governance.

5 Relationships

- 5.1 In terms of normal business the Accountable Officer has determined that the Board Secretary will be the nominated executive lead for internal audit. Accordingly, the Head of Internal Audit will maintain functional liaison with this officer.
- 5.2 In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with the organisation's Board Secretary in planning its work programme.
- 5.3 Co-operative relationships with management enhance the ability of internal audit to achieve its objectives effectively. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.
- 5.4 Internal Audit will meet regularly with the external auditor, Audit Wales, to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work. In particular, Internal Audit will make available their working files to the external auditor for them to place reliance upon the work of Internal Audit where appropriate.
- 5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.
- 5.6 The Head of Internal Audit will take account of key systems being operated by organisation's outside of the remit of the Accountable Officer, or through a shared or joint arrangement, such as the Digital Health and Care Wales, NHS Wales Shared Services Partnership, WHSSC and EASC.
- 5.7 Internal Audit strives to add value to the organisation's processes and help improve its systems and services. To support this Internal Audit will obtain an understanding of the organisation and its activities, encourage two-way communications between internal audit and operational staff, discuss the audit approach and seek feedback on work undertaken.
- 5.8 The Audit Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit Committee will remain the final reporting line for all our audit and consulting reports.
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6 Standards, Ethics, and Performance

- 6.1 Internal Audit must comply with the Definition of Internal Auditing, the Core Principles, Public Sector Internal Audit Standards and the professional Code of Ethics, as published on the NHS Wales e-governance website.
- 6.2 Internal Audit will operate in accordance with the Service Level Agreement and associated performance standards agreed with the Audit Committee and the Shared Services Partnership Committee. The Service Level Agreement includes a number of Key Performance Indicators, and we will agree with each Audit Committee which of these they want reported to them and how often.

7 Scope

- 7.1 The scope of Internal Audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. It includes but is not limited to:
- reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information;
 - reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance;
 - reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets;
 - reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice;
 - reviewing operations or programmes to ascertain whether results are consistent with the organisation's objectives and goals and whether the operations or programmes are being carried out as planned;
 - reviewing specific operations at the request of the Audit Committee or management, this may include areas of concern identified in the organisational or corporate risk register;
 - monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance;
 - ensuring effective co-ordination, as appropriate, with external

- auditors; and
 - reviewing the Annual Governance Statement prepared by senior management.
- 7.2 Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation’s risk environment.
- 7.3 If the Head of Internal Audit or the Audit Committee consider that the level of audit resources or the Charter in any way limit the scope of internal audit or prejudice the ability of internal audit to deliver a service consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

8 Approach

- 8.1 To ensure delivery of its scope and objectives in accordance with the Charter and Standards, Internal Audit has produced an Audit Manual (called the Quality Manual). The Quality Manual includes arrangements for planning the audit work. These audit planning arrangements are organised into a hierarchy as illustrated in Figure 1.

Figure 1: Audit planning hierarchy

NHS Wales Level	NWSSP overall audit strategy	Arrangements for provision of internal audit services across NHS Wales
Organisation Level	Entity strategic 3-year audit plan	Entity level medium term audit plan linked to organisational objectives
	Entity annual internal audit plan	Annual internal audit plan detailing audit engagements to be completed in year ahead leading to the overall HIA opinion
Business Unit Level	Assignment plans	Assignment plans detail the scope and objectives for each audit engagement within the annual operational plan

- 8.2 NWSSP Audit & Assurance Services has developed an overall audit strategy which sets out the strategic approach to the delivery of audit services to all health organisations in NHS Wales. The strategy also includes arrangements for securing assurance on the national transaction processing systems including those operated by DHCW and NWSSP on behalf of NHS Wales.
- 8.3 The main purpose of the Strategic 3-year Audit Plan is to enable the Head of Internal Audit to plan over the medium term on how the

assurance needs of the organisation will be met as required by the Standards and facilitate:

- the provision to the Accountable Officer and the Audit Committee of an overall opinion each year on the organisation's risk management, control and governance, to support the preparation of the Annual Governance Statement;
- audit of the organisation's risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisation's objectives and risks;
- improvement of the organisation's risk management, control and governance by providing management with constructive recommendations arising from audit work;
- an assessment of audit needs in terms of those audit resources which 'are appropriate, sufficient and effectively deployed to achieve the approved plan';
- effective co-operation with external auditors and other review bodies functioning in the organisation; and
- the allocation of resources between assurance and consulting work.

8.4 The Strategic 3-year Audit Plan will be largely based on the Board Assurance Framework where it is sufficiently mature, together with the organisation-wide risk assessment.

8.5 An Annual Internal Audit Plan will be prepared each year drawn from the Strategic 3-year Audit Plan and other information and outlining the scope and timing of audit assignments to be completed during the year ahead.

8.6 The strategic 3-year and annual internal audit plans shall be prepared to support the audit opinion to the Accountable Officer on the risk management, internal control and governance arrangements within the organisation.

8.7 The annual internal audit plan will be developed in discussion with executive management and approved by the Audit Committee on behalf of the Board.

8.8 The NWSSP Audit Strategy is expanded in the form of a Quality Manual and a Consulting Protocol which together define the audit approach applied to the provision of internal audit and consulting services.

8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the relevant objectives and risks to be covered. In order to ensure the scope of the review is appropriate it will require agreement by the

relevant Executive Director or their nominated lead and will also be copied to the Board Secretary.

9 Reporting

9.1 Internal Audit will report formally to the Audit Committee through the following:

- An annual report will be presented to confirm completion of the audit plan and will include the Head of Internal Audit opinion provided for the Accountable Officer that will support the Annual Governance Statement.
- The Head of Internal Audit opinion will:
 - a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes;
 - b) Disclose any qualification to that opinion, together with the reasons for the qualification;
 - c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies;
 - d) Draw attention to any issues Internal Audit judge as being particularly relevant to the preparation of the Annual Governance Statement;
 - e) Compare work actually undertaken with the work which was planned and summarise performance of the internal audit function against its performance measurement criteria; and
 - f) Provide a statement of conformity in terms of compliance with the Public Sector Internal Audit Standards and associated internal quality assurance arrangements.
- For each Audit Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Audit Committee requirements; and
- The Audit Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will include an action plan on any recommendations for improvement agreed with management including target dates for completion.

9.2 The process for audit reporting is summarised below:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational

managers to confirm understanding and shape the reporting stage through issue of a discussion draft report;

- Operational management will receive discussion draft reports which will include any proposed recommendations for improvement within 10 working days following the closure of fieldwork. Operational management will be required to respond to the discussion draft report within 5 working days of issue.
- The discussion draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B (unless it is a consulting review). The discussion draft report will also indicate priority ratings for individual report findings and recommendations;
- Following the receipt of comments on the discussion draft (for factual accuracy etc), operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 15 working days of issue, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken;
- Reminder correspondence will be issued to the Executive Director and the Board Secretary 5 working days prior to the set response date.
- Where management responses are still awaited after the 20 working days deadline, or are of poor quality, the matter will be immediately escalated to the Executive Director and copied to the Board Secretary and Chair of the Audit Committee.
- If non-compliance continues, the Board Secretary and the Chair of the Audit Committee will decide on the course of action to take. This may involve the draft report being submitted to the Audit Committee, with the Executive Director being called to the meeting to explain the situation and why no responses/poor responses have been received;
- Internal Audit issues a Final report to Executive Director within 10 working days of receipt of complete management response. Within this timescale Internal Audit will quality assess the responses, and if necessary, return the responses, requiring them to be strengthened.
- Responses to audit recommendations need to be SMART:
 - Specific
 - Measurable
 - Achievable
 - Relevant / Realistic
 - Timely.

-
- The relevant Executive Director, Board Secretary and the Chair of the Audit Committee will be copied into any correspondence.
 - The final report will be copied to the Accountable Officer and Board Secretary and placed on the agenda for the next available Audit Committee.
- 9.3 Internal Audit will make provision to review the implementation of agreed action within the agreed timescales. However, where there are issues of particular concern provision may be made for a follow-up review within the same financial year. Issue and clearance of follow up reports shall be as for other assignments referred to above.
- 9.4 Timescales are to be included in all initial scopes sent prior to commencing an audit.

10 Access and Confidentiality

- 10.1 Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation.
- 10.2 All information obtained during the course of a review will be regarded as strictly confidential to the organisation and shall not be divulged to any third party without the prior permission of the Accountable Officer. However, open access shall be granted to the organisation's external auditors.
- 10.3 Where there is a request to share information amongst the NHS bodies in Wales, for example to promote good practice and learning, then permission will be sought from the Accountable Officer before any information is shared.

11 Irregularities, Fraud & Corruption

- 11.1 It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.
- 11.2 Internal Audit shall not be relied upon to detect fraud or other irregularities. However, Internal Audit will give due regard to the possibility of fraud and other irregularities in work undertaken. Additionally, Internal Audit shall seek to identify weaknesses in control that could permit fraud or irregularity.
- 11.3 If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's Local Counter Fraud Service (LCFS) in accordance with the organisation's Counter Fraud Policy & Fraud Response Plan and the agreed Internal Audit and Counter Fraud Protocol.

12 Quality Assurance

- 12.1 The work of internal audit is controlled at each level of operation to ensure that a continuously effective level of performance, compliant with the Public Sector Internal Audit Standards, is being achieved.
- 12.2 The Director of Audit & Assurance will establish a quality assurance and improvement programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Public Sector Internal Audit Standards and to achieve its objectives. A commentary on compliance against the Standards will be provided in the Annual Audit Report to the Audit Committee.
- 12.3 The Director of Audit & Assurance will monitor the performance of the internal audit provision in terms of meeting the service performance standards set out in the NWSSP Service Level Agreement. The Head of Internal Audit will periodically report service performance to the Audit Committee through the reporting mechanisms outlined in Section 9.

13 Resolving Concerns

- 13.1 NWSSP Audit & Assurance was established for the collective benefit of NHS Wales and as such needs to meet the expectations of client partners. Any questions or concerns about the audit service should be raised initially with the Head of Internal Audit assigned to the organisation. In addition, any matter may be escalated to the Director of Audit & Assurance. NWSSP Audit & Assurance will seek to resolve any issues and find a way forward.
- 13.2 Any formal complaints will be handled in accordance with the NWSSP complaint handling procedure. Where any concerns relate to the conduct of the Director of Audit & Assurance, the NHS organisation will have access to the Managing Director of Shared Services.

14 Review of the Internal Audit Charter

- 14.1 This Internal Audit Charter shall be reviewed annually and approved by the Board, taking account of advice from the Audit Committee.

Simon Cookson
Director of Audit & Assurance
NHS Wales Shared Services Partnership
April 2024



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Cwm Taf Morgannwg University Health Board

Internal Audit 2024-25 – Indicative
days

April 2024

NWSSP Audit and Assurance Services

1 Overview

- 1.1 This document sets out the indicative days for the Internal Audit Plan for 2024/25, as requested by the management of the Health Board.
- 1.2 We use indicative day information to help us plan our resourcing across the year. As we note in our plan, as part of our planning process we undertake a resource needs assessment to confirm that we have the necessary resources to deliver the plan.
- 1.3 The days used to complete an individual audit may vary from the indicative days identified during the annual planning process for a number of reasons. For example, at the start of each individual audit we undertake detailed scoping work which may identify that more time needs to be allocated to an audit due to complexities within the area under review or different systems operating across sites. Similarly, delays during an individual audit due to a lack of engagement and the provision of information will often mean that more time is taken during our fieldwork stage.
- 1.4 The information set out in Table 1 below identifies the total budgeted days for the programme of work for the Health Board granulated to reflect the indicative days allocated to each planned review. The table also shows the time we have allocated to our follow up work, management time, and a contingent amount of time.

Table 1 - Internal Audit Plan 2024/2025 – Indicative days

Planned output	Audit Ref	Risk Ref.	Executive Lead	Outline Timing	Indicative days
New care group model	1	SRR2	Chief Operating Officer	Q2	25
Cancer tracking process	2	SRR1	Chief Operating Officer	Q3	30
Elective care criteria - Access to diagnostics	3	SRR1	Chief Operating Officer	Q3	25
End of life care management	4	SRR2	Chief Operating Officer / Director of Nursing/	Q3	25

Planned output	Audit Ref	Risk Ref.	Executive Lead	Outline Timing	Indicative days
			Medical Director		
Discharge planning	5	SRR2/ SRR5	Chief Operating Officer	Q4	25
Primary Care	6	SRR5	Chief Operating Officer / Director of Therapies	Q4	25
Information provision / Use of Data	7	SRR6	Director of Digital	Q1	20
Digital benefits realisation	8	SRR2/ SRR6	Director of Digital	Q4	20
Clinical coding	9	SRR6	Director of Digital	Q3	20
Duty of Candour	10	SRR2	Director of Nursing	Q1	20
Continuing Health Care	11	-	Director of Nursing	Q3	25
Ensuring quality when commissioning care services	12	SRR2/ SRR5	Director of Nursing	Q3	25
Service user experience	13	SRR2	Director of Nursing	Q4	20
Welsh risk pool	14	-	Director of Nursing	Q4	20
New PDR process	15	SRR8/ SRR4	Director of People	Q1	20

Planned output	Audit Ref	Risk Ref.	Executive Lead	Outline Timing	Indicative days
Pay rates/ Additional duty hours	16	SRR1	Medical Director/ Director of People	Q1	25
Medical job planning	17	SRR4	Medical Director	Q2	20
Capital systems	18	-	Director of Finance	Q1	25
Energy management	19	SRR9	Director of Finance	Q2	20
Charitable funds	20	-	Director of Finance	Q2	20
Core financial systems	21	SRR3	Director of Finance	Q3	25
Vaccination policy implementation	22	SRR10	Director of Public Health	Q2	20
Regional integration fund	23	SRR5	Director of Strategy	Q2	20
Stroke management process	24	SRR1	Director of Therapies	Q3	25
Llantrisant Health Park	25	-	Chief Executive Officer	Q3	10
Risk management	26	All	Director of Corporate Governance	Q4	20
Follow up – Facilities governance arrangements	27	-	Chief Operating Officer	Q1	10

Planned output	Audit Ref	Risk Ref.	Executive Lead	Outline Timing	Indicative days
Follow up – Performance management 4 hour target	28	-	Chief Operating Officer	Q2	10
Follow up – Interventions not normally used (INNU)	29	-	Chief Operating Officer	Q2	10
Follow up – GI pathways management	30	-	Chief Operating Officer	TBC	10
Follow up – Financial savings in care groups	31	-	Director of Finance/ Chief Operating Officer	Q1	10
Follow up - Decarbonisation	32	-	Director of Strategy	TBC	10
Annual Governance Statement	N/A	N/A	Director of Corporate Governance	Q4	5
Follow Up Action Tracker	-	-	-	-	10
NHS Wales national audit work	N/A	N/A	-	Q4	10
Management time – Includes planning, annual reporting, committee, liaison meetings, review time.					75
Contingency					55
Total					790

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

Date issued: April 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	Certification
The Health Board’s 2023-24 Annual Report and Accounts	Executive Director of Finance	The statutory audit of the Annual Report and Accounts ¹ .	We have commenced our audit planning.	By 15 July 2024.

¹ The Performance Report, Accountability Report and Financial Statements, in accordance with the Welsh Government's Manual for Accoounts.

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
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 also plan to review progress being made in managing unscheduled care demand by helping patients access	Part 1 – Regional report drafting Part 2 – Project brief issued in March 2024	June 2024 To be confirmed

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
		services which are most appropriate for their unscheduled care needs (Part 2).		
All-Wales thematic on workforce planning arrangements	Executive Director of People	This review assess the workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. It examines how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs.	Report finalised and included in today's committee papers	April 2024
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 Drafting	June 2024

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
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.	Fieldwork underway	June 2024
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
Review of the Temporary Closure of the Ysbyty Cwm Cynon Minor Injuries - Follow up	Director of Nursing, Midwifery and Patient Care & Chief Operating Officer	This work focusses on reviewing the Health Board's progress in implementing the four recommendations made in our 2022 review of the temporary closure of the Ysbyty Cwm Cynon Minor Injuries Unit.	Fieldwork underway	June 2024

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
Quality Governance Arrangements Joint Review Follow-up - Progress update	Chief Executive	In our joint report published in August 2023, we signalled our intention to ask the Health Board for a written update on its progress in addressing the areas the joint review follow-up team felt that further work was necessary. These areas were set out in the report. We will assess the Health Board's progress jointly with Healthcare Inspectorate Wales with the aim of determining whether the outstanding recommendations can be closed.	Fieldwork underway	June 2024
All-Wales thematic review of planned care	Chief Operating Officer	This work will follow on from the national report on <u>tackling the planned care backlog</u>. Whilst the exact focus of this work is still to be determined, it is likely to consider: • 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.	Scoping	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>Supporting Ukrainians in Wales</u>	March 2024
<u>From Firefighting to Future-proofing – the Challenge for Welsh Public Services</u>	February 2024
<u>Board effectiveness follow-up – Betsi Cadwaladr University Health Board</u>	February 2024
<u>Corporate Joint Committees – commentary on their progress</u>	November 2023

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 There are no relevant Audit Wales consultations currently underway.

Exhibit 4 – Audit Wales corporate documents

Title	Publication Date
<u>Fee Scheme 2024-25</u>	January 2024



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telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a
galwadau ffôn yn Gymraeg a Saesneg.

Review of Workforce Planning Arrangements – Cwm Taf Morgannwg University Health Board

Audit year: 2023

Date issued: February 2024

Document reference: 4157A2024

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.

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Summary report

Introduction

- 1 An effectively planned workforce is fundamental to providing good quality care services. The NHS employs a range of clinical and non-clinical staff who deliver services across primary, secondary and community care, representing one of the largest NHS investments. Over the years there have been well documented concerns about the sustainability of the NHS workforce. And workforce challenges are routinely highlighted to us in our audit reviews and ongoing engagement with health bodies. Despite an overall increase in NHS workers, these concerns remain. The workforce gaps are particularly acute for certain professions such as GPs, nurses, radiologists, paediatricians and ophthalmologists ([A Picture of Healthcare, 2021](#)). In nursing alone, the Royal College of Nursing Wales reported 2,700 vacancies in their [2023 Nursing in Numbers](#) analysis. In addition, the social care sector, which is complimentary to the health sector, is also facing its own workforce issues. These challenges have been exacerbated by the pandemic as the health sector looks to recover services.
- 2 Given the current challenges, robust and innovative workforce planning is more important than ever. Effective workforce planning ensures that both current and future services have the workforce needed to deliver anticipated levels of service effectively and safely. Planning is especially important given the length of time required to train some staff groups, particularly medical staff.
- 3 National and local workforce plans need to anticipate service demand and staffing levels over a short, medium, and long term. But there are a range of complex factors which impact on planning assumptions, these include:
 - workforce age profile, retirement, and pension taxation issues;
 - shifts in attitudes towards full and part-time working;
 - developing home grown talent and the ability to attract talent from outside the country into Wales; and
 - service transformation which can change roles and result in increasing specialisation of roles.
- 4 At the time of writing this report, Cwm Taf Morgannwg University Health Board (the Health Board) continues to face significant workforce challenges. Staff vacancies coupled with high sickness absence creates greater workload pressures and over-reliance on bank and agency staff. In 2022-23, the Health Board workforce spend was £690 million, increasing from £628 million over a three-year period. The Health Board has recently invested in its strategic workforce planning with this commissioned work indicating that the Health Board is starting from a relatively low baseline position. At the time of our review, the Health Board was in the process of developing its strategic 'People Plan'.
- 5 The key focus of our review has been on whether the Health Board's approach to workforce planning is helping it to effectively address current and future NHS workforce challenges. Specifically, we looked at the Health Board's strategic approach to workforce planning, operational action to manage current and future

workforce challenges, and monitoring and oversight arrangements. Operational workforce management arrangements, such as staff/nurse rostering and consultant job planning, fall outside the scope of this review.

- 6 The methods we used to deliver our work are summarised in **Appendix 1**.

Key findings

- 7 Overall, we found that **the Health Board is sufficiently focused on its significant workforce challenges. Its recently commissioned work on strategic workforce planning has increased overall understanding of current data shortfalls. Whilst starting from a low baseline, this presents an opportunity to both address data needs and support longer term workforce transformation. The Health Board needs to finalise its People Plan and consolidated workforce implementation plans, deliver them and measure overall impact across the short- to medium-term.**

Key workforce planning challenges

- 8 The workforce indicators presented in **Appendix 2** highlight the significant workforce challenges facing the Health Board, as outlined in **paragraph 4**. The workforce indicators presented in **Appendix 2** also highlight that workforce staffing levels appear to be relatively stable over the past 3 years (**Exhibit 6**). However, the Health Board continues to face significant workforce challenges with high staff turn-over currently at 13.3%, potentially impacting on service continuity. Workforce vacancies at 3% are low compared to other health boards; however, the percentage of vacancies for Medical and Dental staff is currently high at 29.5%. There has been a sharp rise in the use of agency staff, which cost the Health Board just over £60 million in 2022-23 (an increase from £48 million in 2021-22), further exacerbating an already pressured financial situation (**Exhibit 8**). A sickness rate of 6.3%, whilst in line with other health boards, still presents a significant workforce issue in terms of days lost (**Exhibit 11**).

Strategic approach to workforce planning

- 9 **The Health Board's strategic workforce planning approach is improving; however, further progress is dependent on a having a deployable, prioritised People Plan.**
- 10 The Health Board does not have a current overarching strategic workforce plan. However, it is starting to take action to develop a clearer People Plan to achieve its intent for workforce in its long-term strategy - CTM2030. The Health Board has utilised external consultancy to support strategic workforce improvements. Once this work is complete, it will need to develop underpinning operational workforce plans which are based on financially sustainable service models.

- 11 The organisation has an improving understanding of current and future service demand and capacity trends. However, this is starting from a relatively low baseline position. Consequently, the Health Board needs to do more to ensure that it properly understands its funded workforce establishment which, in part, will require strengthening of the quality of data that underpins it. The Health Board has improving arrangements for engaging internal and external stakeholders to inform workforce strategy and plan development.

Operational action to manage workforce challenges

- 12 **The Health Board is working hard to address its operational workforce challenges. However, to ensure maximum impact, it needs to target its resources better and accurately evaluate the actions it is taking.**
- 13 The levels of corporate resources committed to supporting strategic workforce improvement are reasonable. The Health Board has recently committed more time and resources towards scoping long-term workforce planning and service transformation. However, the Health Board needs to do more to determine whether its workforce planning capacity is sufficient to support its evolving operational clinical services workforce plan development.
- 14 The organisation has a good high-level understanding of the risks that might prevent the delivery of its workforce ambitions and its wider operational workforce risks. However, it is currently hard to determine the local impact of the actions it is taking to mitigate these, although we have noted that a number of workforce risk ratings remaining fairly static over time and above their target risk rating.
- 15 The Health Board is attempting to tackle its current workforce challenges. It is proactively recruiting staff, but its approach to staff retention and its sickness absence challenges are too reactive. Nevertheless, we note more mature approaches established to help address nursing workforce recruitment and retention challenges. We also recognise some of the positive staff wellbeing work that the Health Board is delivering, including flexible working and a number of health and wellbeing measures.

Monitoring and oversight of workforce plan/strategy delivery

- 16 **The Health Board demonstrates reasonable oversight of operational workforce issues, but this could be strengthened to focus more on the impact of strategic workforce improvements and long-term transformation.**
- 17 The Board and its People and Culture Committee appropriately oversee progress of ongoing workforce development initiatives and actions. However, given the importance of the strategic workforce challenges facing the Health Board, the committee needs to strengthen its focus on the 'system impact' resulting from delivery of the Health Board's workforce strategy.

18 The Health Board has benefited from its recent consultancy support to improve benchmarking. It benchmarks with other health bodies in Wales and has also reviewed some examples from 'best in class' organisations and clinical models from across the UK. However, it now needs to capitalise on this by using its workforce benchmarking as a basis for adopting best workforce practice and workforce models, to inform frontline workforce transformation.

Recommendations

19 **Exhibit 1** details the recommendations arising from this audit. These include timescales and our assessment of priority. The Health Board's response to our recommendations is summarised in **Appendix 3**. [Appendix 3 will be completed once the report and organisational response have been considered by management.]

Exhibit 1: Recommendations arising from this audit

Recommendations	
R1	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 (Page 10). As part of this, the Health Board should ensure that its intent to reconfigure services focussing more on prevention, population health, and digitally enabled health services is appropriately built into long term service workforce design and transformation plans (Page 14).
R2	The Health Board should assess and agree its funded workforce establishment for 2024-25 and then introduce arrangements to update this annually (Page 11).
R3	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 (Page 14).
R4	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 (Page 15).

Recommendations

- R5 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 (Page 17).
-
- R6 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 (Pages 17 & 18).

Detailed report

Our findings

- 20
- The following three tables set out the areas that we have reviewed and our findings. These focus on:
- the Health Boards approach to strategic workforce planning (**Exhibit 2**);
 - operational action to manage workforce challenges (**Exhibit 3**); and
 - monitoring and oversight of workforce plan/strategy delivery (**Exhibit 4**).

Exhibit 2: strategic approach to workforce planning

- 21
- This section focusses on the Health Board’s approach to strategic planning. Overall, we found **that the Health Board’s strategic workforce planning approach is improving; however, further progress is dependent on a having a deployable, prioritised People Plan.**

What we looked at	What we found
We considered whether the Health Board’s workforce strategy and plans are likely to address the current and future workforce risks. We expected to see a workforce strategy or plan which: - identifies current and future workforce challenges. - has a clear vision and objectives. - is aligned to the organisation’s strategic objectives and wider organisational plans.	We found that the Health Board does not have a current overarching strategic workforce plan. However, it is starting to take positive action to develop a clearer People Plan to achieve its intent for workforce as set out in CTM2030 and to align it to the new clinical service model being developed by the Health Board. This includes external consultancy support to re-energise its strategic workforce agenda and update strategic workforce plans. The Health Board has a good approach for identifying its key workforce challenges, although these are overly focussed on the short-term at present. We found a general consensus around the potential benefits of the new Care Group model and underpinning directorate structures. However, at the time of our work, the second phase of the Health Board’s Organisational Change Policy process was taking some time to complete with a number of Band 8c and 8b still in the process of

What we looked at	What we found
• is aligned to relevant national plans, policies, and legislation. Including the national workforce strategy for health and social care. • is supported by a clear implementation plan.	being filled. The Health Board is also utilising external consultants who have helped it to address its strategic workforce requirements at a greater pace. It is promising that the Health Board has committed to improving workforce planning, supported by this external consultancy, and is demonstrating a willingness to openly discuss the learning from their joint findings. The Health Board now needs to bring the workstreams together and produce a plan that tackles the key themes and fully addresses the 65 recommendations contained within the external commissioned workforce review. The Health Board has set clear workforce objectives which align to its three-year plan and wider Health Board strategy, CTM2030. The strategic workforce objectives, identified and agreed by the People and Culture Committee in August 2023, should help the Health Board to address its key workforce challenges. These include recruitment and retention notably for medical and dental staff but also for nursing and some health sciences professions. The Health Board's overarching strategy, CTM2030, encompasses its Clinical Strategy and its vision to build healthier communities, creating health, improving care, inspiring people, sustaining their future, and living the organisation's values. In addition, we understand that the Health Board's ten people priorities will form part of the People Plan that the Health Board is currently developing. Once the strategic People Plan is complete, the Health Board will need to translate that strategic intent into operation plans across the Care Groups and Directorates as they become more established and begin to mature (Recommendation 1). Whilst the Health Board's People Plan is in development, it appears to be sufficiently taking account of wider national plans and legislative requirements including the National Workforce Strategy for Health and Social Care¹, Well-being of Future Generations Act, and Welsh language standards.

¹ In October 2020, HEIW and Social Care Wales launched the 10-year Workforce Strategy for Health and Social Care. This was developed in response to [A Healthier Wales](#).

What we looked at	What we found
We considered whether the Health Board has a good understanding of current and future service demands. We expected to see: • use of reliable workforce information to determine workforce need and risk in the short and longer term; and • action to improve workforce data quality and address any information gaps.	We found that the Health Board has an improving understanding of current and future service demands and trends. However, this is starting from a relatively low baseline position. The Health Board’s workforce planning capacity and demand analysis is relatively more mature in nursing and medical staffing compared to other staffing areas, with these having a focus on value, efficiency, and productivity. In early 2022, all health boards conducted a nursing workforce modelling exercise², with nationally agreed planning assumptions aligned to the Nurse Staffing Levels (Wales) Act 2016³. However, baseline establishment data (other than for nursing) needs strengthening for most staff groups. This is inevitably making workforce resource planning more challenging. The recent work supported by external consultants has underlined weaknesses in current workforce data availability and quality. It has also positively raised awareness around workforce data requirements and the need to understand its establishment levels and ensure it is based on good quality data (Recommendation 2). In addition, the Health Board needs to reconcile data inaccuracies between the Electronic Staff Record System⁴ and the financial ledger⁵ to verify baseline establishment figures for all staff across the organisation. The consequence is that it is currently difficult to establish the overall workforce position in relation to vacancies against establishment. The Health Board has started to improve its use of workforce data to inform forward planning and a longer-term perspective on both workforce need and workforce risks but there remains some way to

² To feed into the all-Wales strategic workforce plan for nursing, in early 2022, all health boards in Wales were asked to conduct a workforce modelling exercise for nursing and midwifery, based on a set of nationally agreed planning assumptions.

³ The Nurse Staffing Levels (Wales) Act 2016 became law in March 2016 and requires health service bodies to have regard for the provision of appropriate nurse staffing levels.

⁴ The Electronic Staff Record (ESR) is a payroll database system commissioned by the Department of Health and Social Care (England) that all health bodies in Wales use.

⁵ The financial ledger is the record-keeping system for the Health Boards financial data and transactions.

What we looked at	What we found
	go. The Health Board's Strategic Workforce Improvement Model (SWIM)⁶ aids its understanding of wider service requirements. The Health Board now needs to increase data accuracy and ensure a more targeted approach in design, capture, and data usage. This would help to shape improvement and innovation in the ongoing roll-out of the Health Board's new Care Group model. This work is also being progressed through the Clinical elements of CTM 2030 including the Inspiring People workstream⁷.
We considered whether the Health Board is working with partners to help resolve current and anticipated future workforce challenges. We expected to see: • effective and timely engagement and working with key internal and external stakeholders to tackle current and future workforce issues; and • shared solutions identified with key stakeholders to help address workforce challenges.	We found that the Health Board's arrangements for engaging internal and external stakeholders to inform aspects of workforce planning is improving. The way the Health Board is engaging key public sector partners to develop workforce opportunities is improving. The Health Board is increasingly involving relevant stakeholders and partners, including staff, trade unions, local authorities, and education commissioning partners in the ongoing development of its workforce strategy and workforce opportunities. But, to further strengthen opportunities for integrated working, the Health Board should continue to build on its communication and sharing of data and analysis with partners with the aim of agreeing strategic joint workforce transformation goals. The Health Board has indicated that it has some concerns about Health Education and Improvement Wales's (HEIW) lack of transparency around the decision-making process for commissioned health education places. We found increasing tensions relating to the number of student education

⁶ The SWIM Model is an internationally recognised and utilised maturity assessment method that assesses organisational maturity against 9 key themes including seamless workforce models and attraction and recruitment.

⁷ The Inspiring People work stream has been established with a focus on Leadership and Culture, embedding Values and Behaviours and Strategic Workforce planning.

What we looked at	What we found
	placements requested by the Health Board and the numbers ultimately commissioned by HEIW, which are lower. This appears to be part of wider a national challenge that could impact on relations with HEIW. Levels of university recruitment into health training places and attrition rates during course delivery also present further ongoing challenges. Overall, further work is still needed to find shared solutions that will transform the current workforce to meet longer-term service need. The Health Board has identified recent best practice case studies which, while encouraging, will require further work to verify local applicability.

Exhibit 3: operational action to manage workforce challenges

This section focusses on the actions the Health Board is taking to manage workforce challenges. Overall, we found that **the Health Board is working hard to address its operational workforce challenges. However, to ensure maximum impact, it needs to target its resources better and accurately evaluate the actions it is taking.**

What we looked at	What we found
We considered whether the Health Board has identified sufficient resources to support workforce planning over the short, medium and long term. We expected to see: • clear roles and responsibilities for workforce planning; • appropriately skilled staff to ensure robust workforce planning; • sufficient workforce capacity across the organisation to plan and deliver the workforce strategy or plan; and • sufficient financial resources to deliver the workforce strategy or plan.	We found that the Health Board’s levels of corporate resources supporting strategic workforce improvement are reasonable, but it needs to identify and put in place appropriate skills and capacity to support operational clinical services workforce planning. The Health Board has clear workforce roles and responsibilities at the corporate level. It recently committed more time and resources towards scoping long-term workforce planning and service transformation. This has included creating a new Assistant Director of Workforce post and as mentioned previously, commissioning external support to help the Health Board develop its strategic workforce planning approach. The Health Board has trained workforce planners and there appears to be sufficient corporate workforce planning capacity. It has recently started to make use of business partners. However, the Health Board recognises that it needs to verify whether or not it has sufficient workforce planning resources to support longer-term operational workforce plans across its new Care Group model and also support for professional groups (Recommendation 3). We also identified a lack of alignment between strategic workforce management and the developing operational Care Groups. This is needed to ensure that the Health Board’s intent to reconfigure services focussing more on prevention, population health, and digitally enabled health services is appropriately built into long term service workforce design and transformation plans (Recommendation 1). As a result, operational-level workforce plans now need to be developed and deployed at pace. As part of this, the Health Board will need to determine whether its workforce models are affordable and that associated services are financially sustainable, with appropriate consideration of potential growth in service demand in coming years.

What we looked at	What we found
We considered whether the Health Board has a good understanding of the short and longer-term risks that might prevent it from delivering its workforce strategy or plan. We expected to see: • a good understanding of the barriers that might prevent delivery of the workforce strategy or plan; • plans to mitigate risks which may prevent the organisation from achieving its workforce ambitions; and • clearly documented workforce risks that are managed at the appropriate level.	We found that the Health Board has a good high-level understanding of the risks that might prevent the delivery of its workforce ambitions. However, it is currently hard to determine the local impact of the mitigating actions with a number of risks ratings remaining fairly static and above their target risk rating. The Health Board has identified several workforce resourcing risks including recruitment, retention, and service sustainability which could affect its ability to improve workforce planning and implement sustainable workforce models. The Health Board is capturing and managing these at the strategic and operational level through its Board Assurance Framework and Corporate Risk Framework. Whilst the Health Board has a good high-level understanding of the risks that might prevent the delivery of its workforce ambitions, it is hard to determine the impact of mitigating actions due to the lack of sufficient underpinning baseline data. In addition, a lack of local detail on workforce risks appears to be limiting the ability to assess operational impact of changes over time. There is a lack of detailed narrative in the organisational risk register to describe the gap between current and target ratings, and it is concerning that despite historic action to address workforce risks, some risks appear relatively static (Recommendation 4). More positively, we have found examples where the Health Board makes a good connection between service continuity risks and workforce actions to address them. For example, under <i>'risk 4491 - Failure to meet the demand for patient care at all points of the patient journey'</i>, the Planned Care Group identified workforce insourcing to ensure continuity of operating theatres services. The Planned Care Group Director of Nursing had also confirmed their 'intention on launching a series of risk and compliance huddles' to determine what sits behind existing risks, whilst also recognising that 'there was still more to do to ensure mitigating actions are impactful'.

We considered whether the Health Board is effectively addressing its current workforce challenges. We expected to see:

- effective reporting and management of staff vacancies;
- action to improve staff retention;
- efficient recruitment practices;
- commissioning of health education and training which is based on true workforce need; and
- evidence that the organisation is modernising its workforce to help meet current and future needs.

We found that **the Health Board is attempting to tackle its current workforce challenges. It applies a proactive approach to recruitment, but its approach to staff retention and sickness absence challenges are too reactive.**

The Health Board's reported vacancy rates are low in relation to other health boards (**Exhibit 10**). However, as noted previously, the recent work undertaken by consultants has exposed shortcomings on establishment data that need to be addressed to ensure accurate vacancy management is in place. The Health Board is taking ongoing action to improve recruitment and retention, but this is often reactive. Although we note there is a clear attraction, recruitment, and retention approach in place for nursing. Sickness and staff turnover rates amongst the highest in Wales suggesting the need for a much greater focus on staff wellbeing. The Health Board is exploring a range of flexible working and health and wellbeing measures, for example, the nurse hydration initiative and virtual reality⁸ to help tackle stress via the Health Board's Employee Wellbeing Service. Collectively, these actions may help to improve staff and students' workplace experience. However, at the appropriate interval the Health Board should consider the impact of these arrangements to determine whether to expand, continue as is, or disinvest.

The Health Board continues to work with key partners across national and local government. Most notably, it has worked with HEIW on commissioning student numbers for key clinical professions. As noted previously, HEIW commissions education placements for around 80% of what the Health Board requests annually, which may present challenges for the Health Board if workforce demand continues to grow.

The Health Board is looking to further modernise with workforce planning across traditional professional boundaries. This is intended to address skills shortages and build more sustainable workforce models. Whilst the Health Board expresses its strategic intent to further diversify the workforce to ensure full utilisation of different models and roles such as Physicians Associates and Advanced Practitioners across both acute and community pathways, there remains some way to go to introduce these approaches system wide. A focus on core strategic priorities including Critical Care, the Community Hospital Programme, Primary Care Cluster Development, transformation of Health Visiting Services, and the review of School Nursing Services are outlined in the Health Board's three-year plans/IMTP.

Exhibit 4: monitoring and oversight of workforce plan/strategy delivery

This section of the report focusses on the robustness of corporate oversight of workforce risks. We found that **the Health Board demonstrates reasonable oversight of operational workforce issues, but this could be strengthened to focus more on the impact of strategic workforce improvements and long-term transformation.**

What we looked at	What we found
We considered whether delivery of the Health Board workforce strategy or plan is supported by robust monitoring, oversight, and review. We expected to see: • arrangements in place to monitor the progress of the workforce strategy or plan at management and committee levels; • effective action where progress on elements of the workforce strategy or plan are off-track; • performance reports showing the impact of delivering the workforce strategy or plan; and • the organisation benchmarking its workforce performance with similar organisations.	We found that given the importance of the strategic workforce challenges facing the Health Board, there needs to be a stronger focus on the progress and impact of workforce improvements and long-term transformation. The Health Board has benefited from its recent consultancy support to improve benchmarking but now needs to capitalise on this to inform frontline workforce transformation. The Board and its People and Culture Committee appropriately oversee progress of ongoing workforce development initiatives and actions. However, the committee needs to seek assurance on the ‘system impact’ resulting from delivery of the Health Board’s workforce strategy and ensure arrangements are in place to oversee progress against the recommendations set out in the recent strategic workforce planning review (Recommendation 5). We were also told of variable attendance at the committee from senior officers, suggesting the need for greater senior officer engagement with the People and Culture Committee. Whilst workforce management monitoring structures are in place, the quality of many operational workforce improvement plans and associated reports on progress is currently limited. Although we note it is most mature for nurse workforce planning. The Health Board places a strong emphasis on

⁸ The Health Board has introduced virtual reality headsets as means to help staff reduce stress see [Virtual reality headsets - Cwm Taf Morgannwg University Health Board \(nhs.wales\)](#)

reporting nursing and medical staff value, efficiency, and productivity. Narrative progress reports are RAG rated⁹ but could be improved by including appropriate data and run charts¹⁰ to illustrate progress over time.

The Health Board benchmarks with other health bodies in Wales and has also reviewed some examples from 'best in class' organisations and clinical models from across the UK. The Health Board needs to incorporate the best examples, ensuring similar system conditions, demographics, and population characteristics to inform its developing medium-term plans for workforce redesign and service transformation (**Recommendation 6**).

⁹ A RAG (Red, Amber, Green) report is an approach for assessing and reporting progress using a traffic light colour coding approach.

¹⁰ Run Charts provide data in a time sequence that provides a visual illustration of changes in performance over time.

Appendix 1

Audit methods

Exhibit 5: audit methods

Exhibit 5 sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

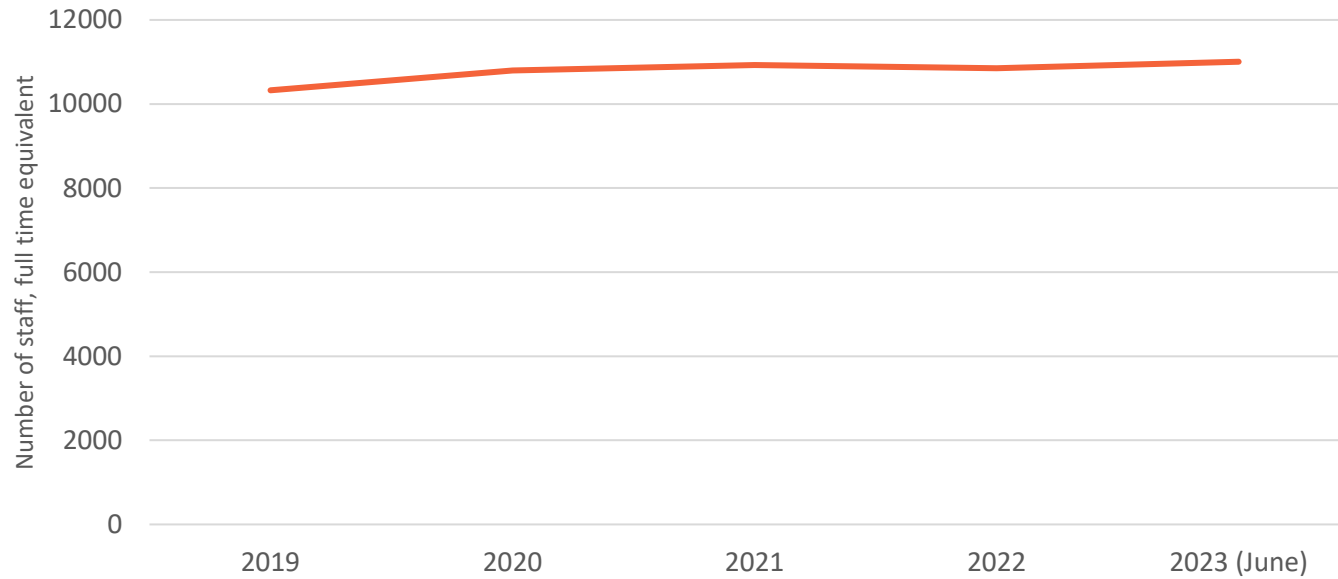
Element of audit approach	Description
Documents	We reviewed a range of documents, including: • Workforce strategy and associated workforce plan(s); • Implementation/delivery plans for workforce strategy – high level and operational; • Evidence of evaluation of workforce strategy and/or associated initiatives; • Information feeding into workforce strategy development e.g. needs assessment, workforce data, benchmarking exercises, demand and capacity planning, skills gap analysis, horizon scanning; • Evidence of stakeholder engagement; • Structure charts for workforce planning functions; • Examples of workforce planning training offered to staff e.g. CIPD, other training formal or informal; • Workforce finance and resource plans; • Corporate and operational risk registers; • Document showing recruitment process and recruitment and retention initiatives; • Corporate and operational level oversight and monitoring of workforce metric and strategy delivery.
Interviews	We interviewed the following: • Executive Director of Nursing & Midwifery; • Executive Director for People;

Element of audit approach	Description
	• Deputy Director for People; • Executive Director of Therapies and Health Science; • Independent Member – Trade Union; • Head of Data and Business Intelligence. People Directorate Data, and Corporate / Operational Officers; • People and Culture Committee, Committee Chair; • Consultant in Acute Medicine / Assistant Medical Director for Medical Workforce; • Head of Finance (Workforce); and • Assistant Director for Strategic Workforce Planning.
Focus groups	We ran two focus groups with: • a selection of service leads involved in clinical workforce planning; and • a selection of service leads involved in the workforce planning of enabler services.

Appendix 2

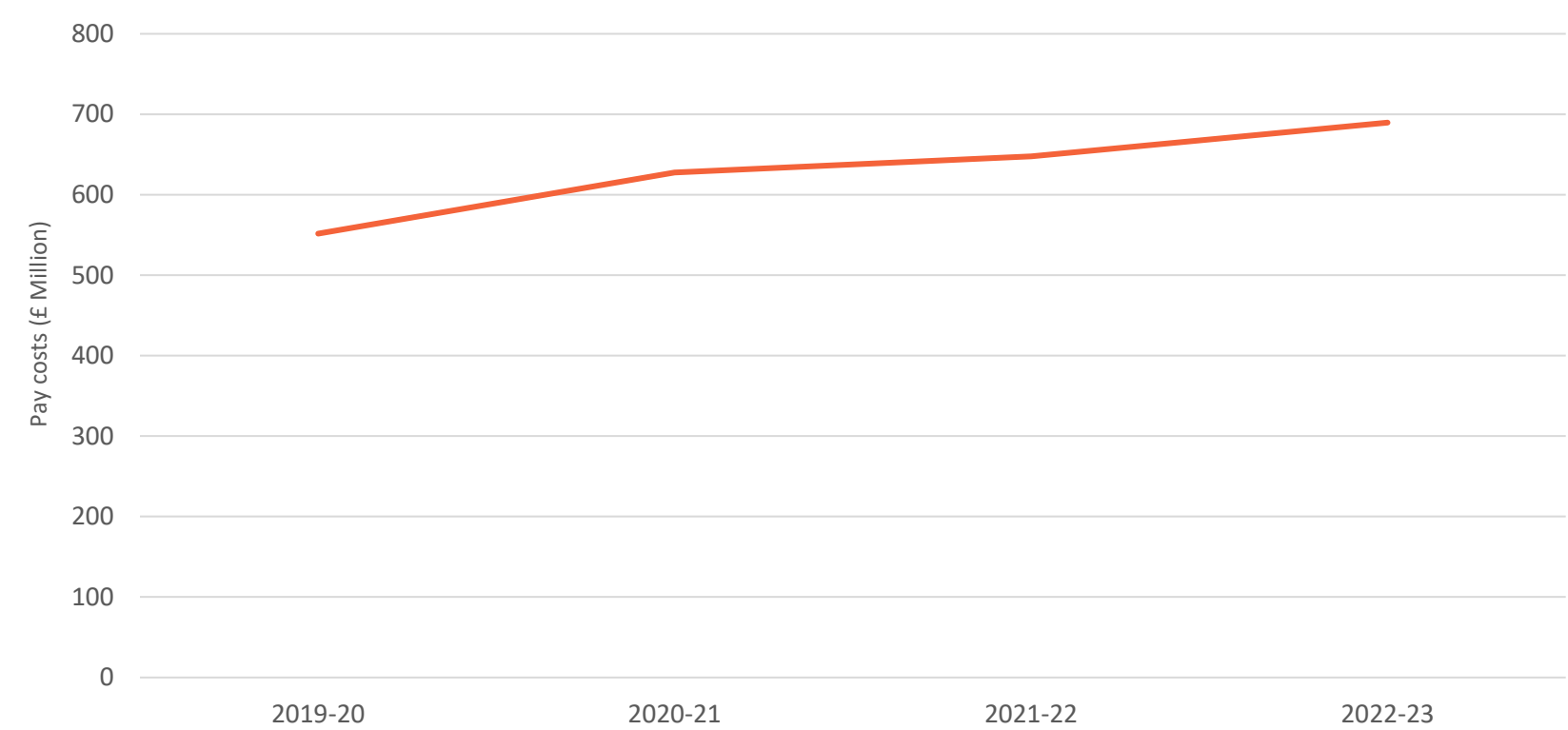
Selected workforce indicators

Exhibit 6: trend in workforce staffing levels (full time equivalent), Cwm Taf Morgannwg University Health Board



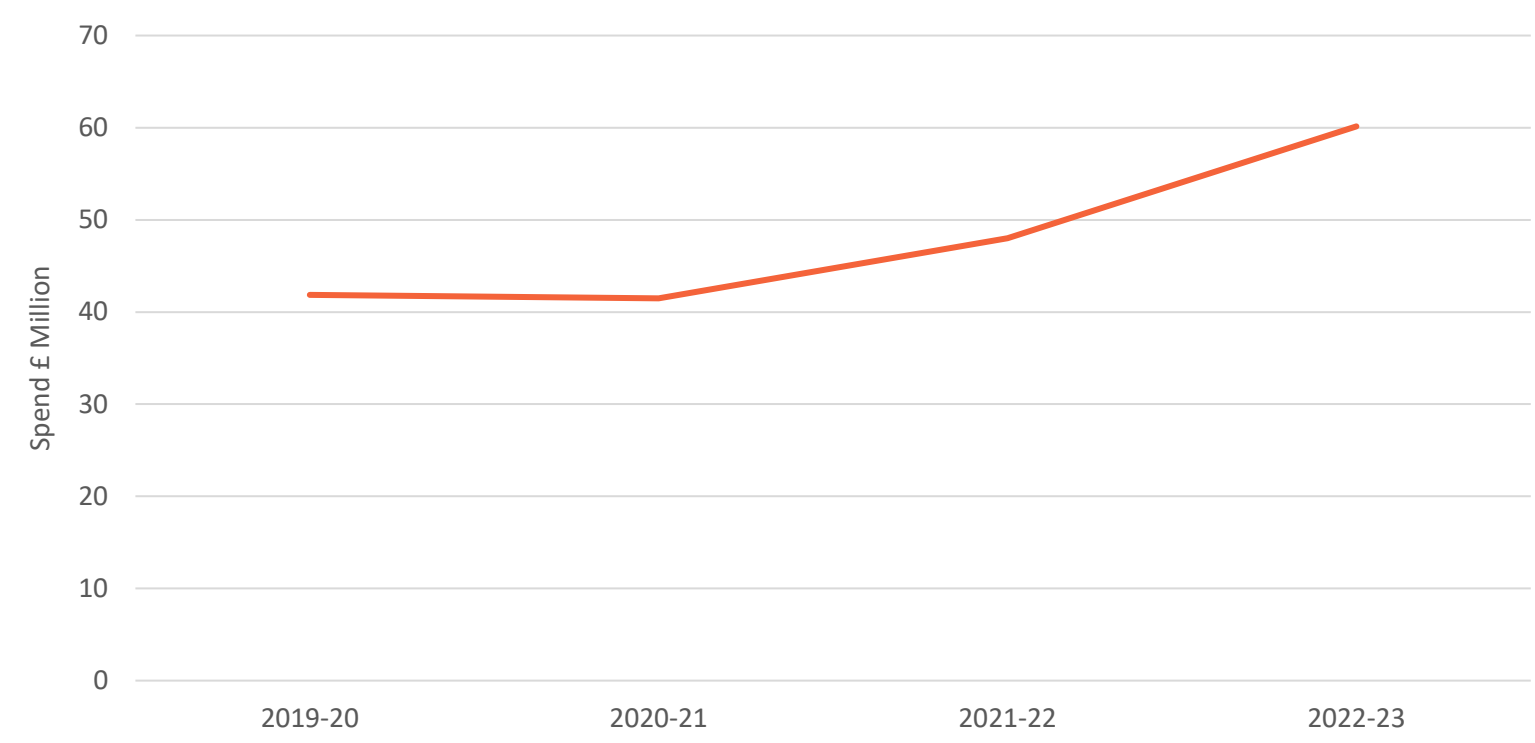
Source: Welsh Government, Stats Wales

Exhibit 7: trend in actual workforce costs, Cwm Taf Morgannwg University Health Board



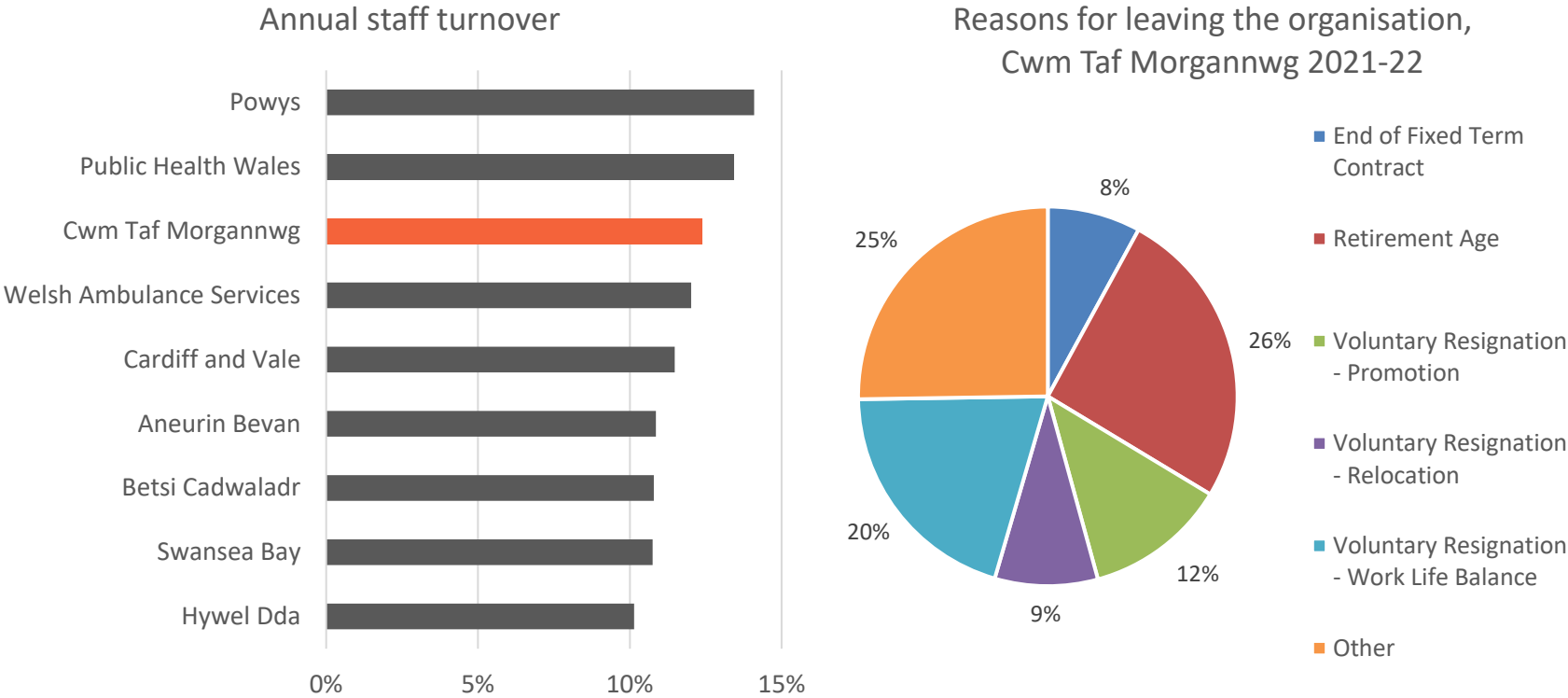
Source: Monthly Monitoring Returns reported to the Welsh Government

Exhibit 8: Expenditure on workforce agency (£ million), Cwm Taf Morgannwg University Health Board



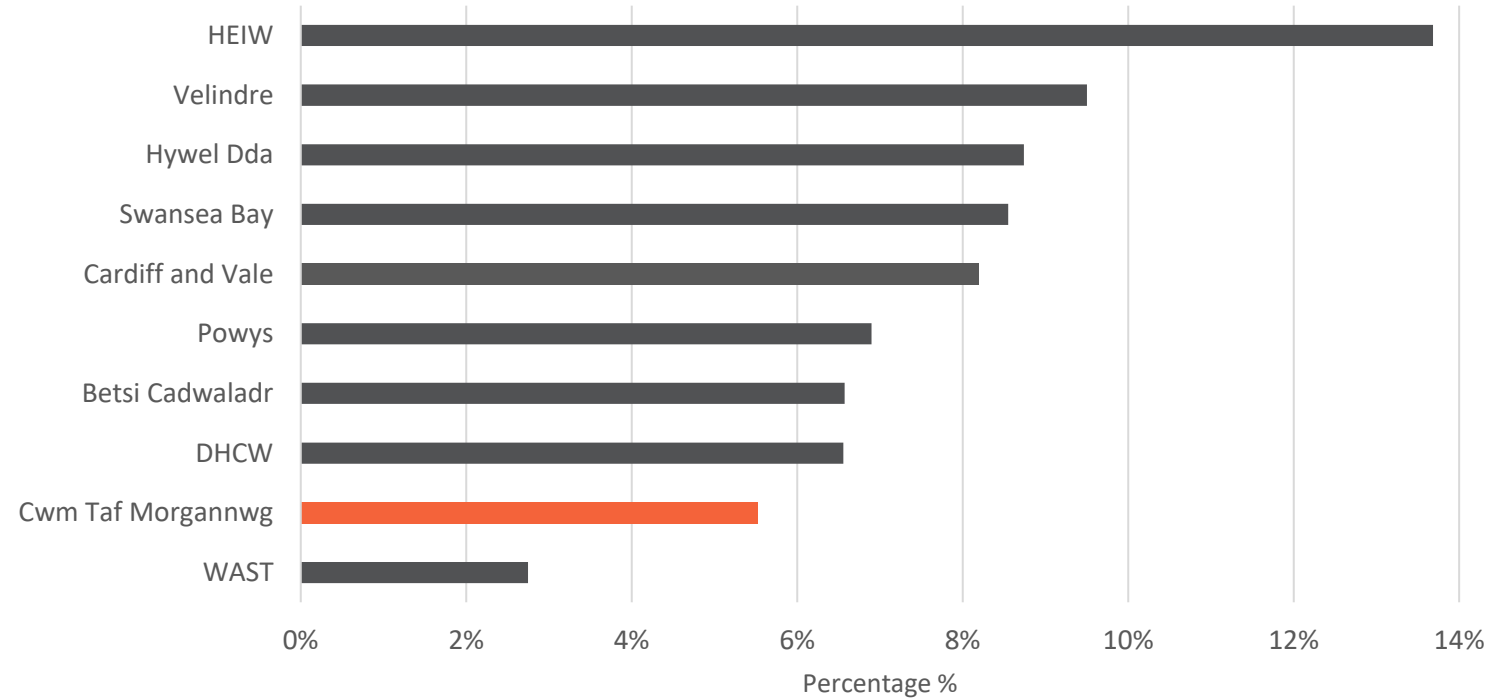
Source: Monthly Monitoring Returns reported to the Welsh Government

Exhibit 9: annual staff turnover and reason for leaving, 2021-22, Cwm Taf Morgannwg University Health Board



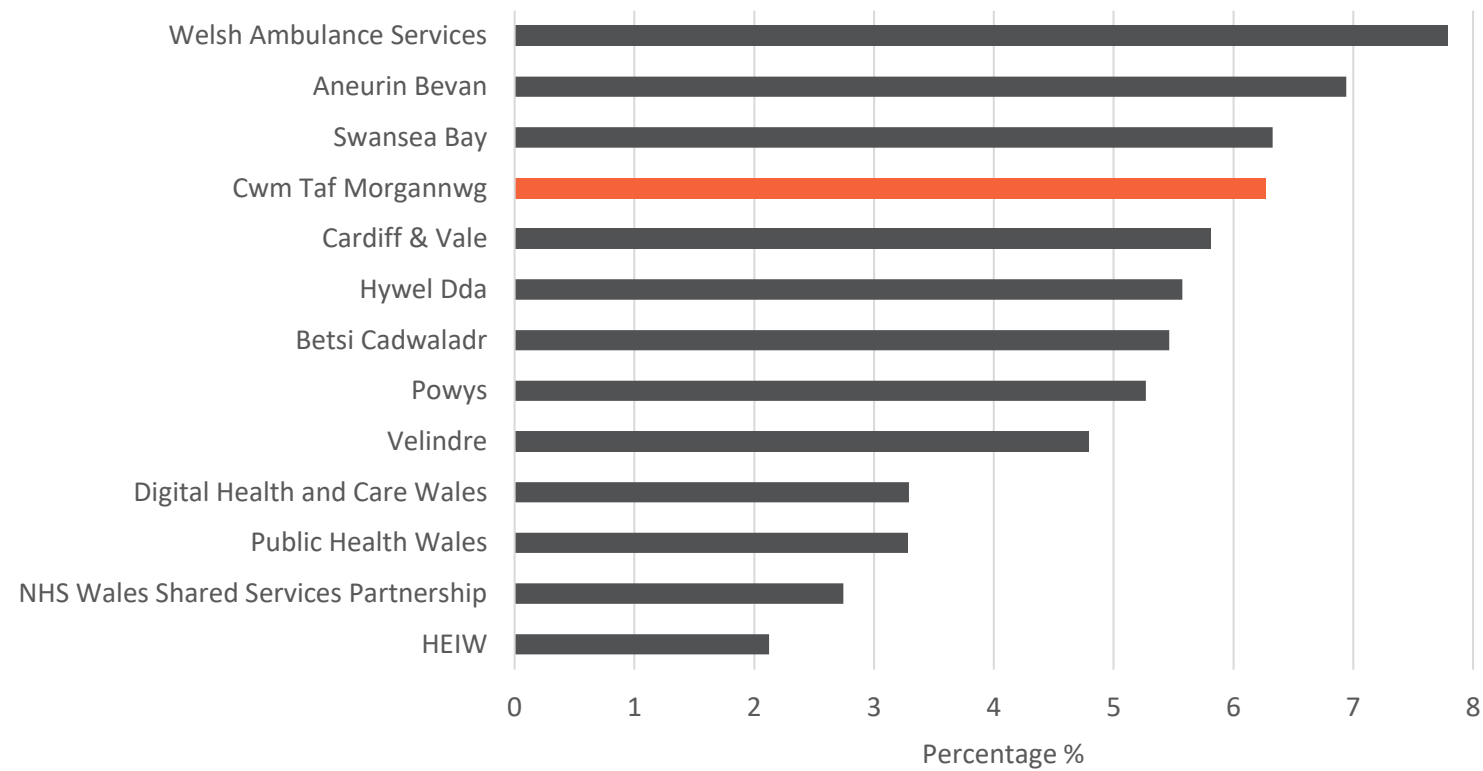
Source: staff turnover data sourced from Health Education and Improvement Wales. Reason for leaving data sourced from health body data request.

Exhibit 10: vacancies as a percentage of total establishment, as of March 2022



Source: health body data request

Exhibit 11: Sickness absence by organisation, Quarter 2, 2023



Source: Welsh Government, Stats Wales

Appendix 3

Organisational response to audit recommendations

Exhibit 12: 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	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 focussing more on prevention, population health, and digitally enabled health services is appropriately built into long term service workforce design and transformation plans. (High priority)	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:	March 2025	Assistant Director of Strategic Workforce Planning

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)
		- 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	March 2025	
R2	The Health Board should assess and agree its funded workforce establishment for 2024-25 and then introduce arrangements to update this annually. (High priority)	- 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.	May 2024 for decision on options appraisal, with revised assessment of timeline for implementation.	Assistant Director of Strategic Workforce Planning
R3	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. (High priority)	- 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.	September 2024 September 2024 September 2024	Assistant Director of Strategic Workforce Planning

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)
		Develop workforce planning materials and toolkits to support workforce planning delivery.	September 2024	
R4	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. (High priority)	- 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.	October 2024 October 2024 October 2024	Assistant Director of Strategic Workforce Planning
R5	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. (High priority)	- Assessment of progress and impact of recommendations to be on the agenda for PCC June 2024. - Regular progress updates to the relevant Board Committee.	June 2024 , with further updates to future PCCs	Assistant Director of Strategic Workforce Planning

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)
R6	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. (Medium priority)	- 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	October 2024	Assistant Director of Strategic Workforce Planning



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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.