# Audit, Risk & Assurance Committee

*Thu 22 May 2025, 10:00 - 13:30*

**Virtual Via Teams**

## Agenda

**10:00 - 10:05**
5 min

### 1. PRELIMINARY MATTERS

#### 1.1. Welcome and Introductions

*Patsy Roseblade, Committee Chair*

#### 1.2. Apologies for Absence

*Information* *Patsy Roseblade, Committee Chair*

#### 1.3. Declarations of Interest

*Information* *Patsy Roseblade, Committee Chair*

**10:05 - 10:10**
5 min

### 2. CONSENT AGENDA BUSINESS

*Patsy Roseblade, Committee Chair*

The Committee Chair will ask if there any items from the Consent Agenda (Item 8) that Committee Members wish to bring forward to the Main Agenda for discussion

**10:10 - 10:15**
5 min

### 3. COMMITTEE GOVERNANCE ARRANGEMENTS

#### 3.1. Action Log

*Discussion* *Patsy Roseblade, Committee Chair*

3.1 Action Log ARAC 22 May 2025 v1.pdf (2 pages)

#### 3.2. Matters Arising not Captured on the Action Log

*Discussion* *Patsy Roseblade, Committee Chair*

**10:15 - 10:45**
30 min

### 4. COMMITTEE GOVERNANCE ARRANGEMENTS

#### 4.1. Declarations of Interest and Gifts, Hospitality & Sponsorship Report

*Discussion* *Gareth Watts, Director of Corporate Governance / Board Secretary*

4.1 DOI and GHS Cover Report ARC 22 May 2025.pdf (4 pages)
4.1a App 1 DOI Register 24-25 Board and Non Board.pdf (11 pages)
4.1b App 2 Register of Gifts Hospitality and Sponsorship 2024 2025.pdf (1 pages)

#### 4.2. Approval of the Annual Review of the Risk Management Framework / Board Assurance Framework

*Decision* *Gareth Watts, Director of Corporate Governance / Board Secretary*

- 4.2a Annual Review of the RMS and BAF - May 2025.pdf (5 pages)
- 4.2b Appendix 1 - Risk Management Strategy - Draft 19525.pdf (24 pages)
- 4.2c Appendix 2 - Risk Management Policy - Draft 19525.pdf (14 pages)
- 4.2d App 3 - Risk Assessment Procedure Draft 19.5.25.pdf (29 pages)

### 4.3. Organisational Risk Register

*Discussion* *Gareth Watts, Director of Corporate Governance / Board Secretary*

- 4.3a Org Risk Register - May 2025 CP ARAC.pdf (6 pages)
- 4.3b Appendix 1 - Org RR May 2025 - ARAC.pdf (8 pages)

**10:45 - 11:15**
30 min

## 5. FINANCIAL GOVERNANCE ACTIVITY

### 5.1. Losses and Special Payments Report

*Discussion* *Sally May, Executive Director of Finance & Procurement*

Please note that the appendices to this report are attached in the documents folder for the 22 May Meeting

- 5.1 Losses Special Payments Report ARAC 22 May 25.pdf (11 pages)

### 5.2. Procurement and Scheme of Delegation Report

*Discussion* *Sally May, Executive Director of Finance & Procurement*

- 5.2 Procurement and SoD ARAC 22.05.25.pdf (9 pages)

### 5.3. Post Payment Verification Annual Report

*Discussion* *Amanda Legge, Post Payment Verification Manager*

- 5.3 PPV End of Year Audit Report 2024-2025.pdf (5 pages)
- 5.3a CTMuHB End of Year PPV Report 2024-2025(1).pdf (5 pages)
- 5.3.b Additional Information Across Wales.pdf (2 pages)

**11:15 - 12:00**
45 min

## 6. COUNTER FRAUD ACTIVITY

### 6.1. Local Counter Fraud Report

*Discussion* *Matthew Evans, Local Counter Fraud Officer*

- 6.1 Local Counter Fraud Update Report.pdf (3 pages)
- 6.1a Local Counter Fraud Update Report ARAC 22 May 25.pdf (3 pages)
- 6.1b Appendix - Counter Fraud Investigations Update.pdf (15 pages)

### 6.2. Counter Fraud Annual Report

*Discussion* *Matthew Evans, Local Counter Fraud Officer*

- 6.2 Counter Fraud Annual Report 2024-25.pdf (3 pages)
- 6.2a CTMUHB Counter Fraud Annual Report 2024-25.pdf (21 pages)

### 6.3. Counter Fraud Functional Standard Return 2024-25

*Discussion* *Matthew Evans, Local Counter Fraud Officer*

- 6.3 Counter Fraud Functional Standard Return 2024-25.pdf (3 pages)
- 6.3a Counter Fraud Functional Standard Return 2024-25.pdf (24 pages)

### 6.4. Counter Fraud Draft Work Plan

*Discussion* *Matthew Evans, Local Counter Fraud Officer*

- 6.4 Counter Fraud Work Plan 2025-26.pdf (3 pages)
- 6.4a CTMUHB Counter Fraud Work Plan 2025-26.pdf (15 pages)

### 6.5. National Fraud Initiatives Progress and Outcomes

*Discussion* *Matthew Evans, Local Counter Fraud Officer*

- 6.5 National Fraud Initiative Progress and Outcomes.pdf (3 pages)
- 6.5a National Fraud Initiative Progress and Outco.pdf (6 pages)

**12:00 - 13:20**
80 min

## 7. AUDIT REVIEWS AND ASSURANCE ACTIVITY

### 7.1. Audit Recommendations Tracker

*Discussion* *Gareth Watts, Director of Corporate Governance/Board Secretary*

- 7.1 Audit Recs Tracker ARAC 22 May 2025.pdf (8 pages)
- 7.1a App 1 - Audit Recommendations Tracker_ARAC 22.05.2025.pdf (15 pages)

### 7.2. NWSSP Internal Audit Services – Progress Report

*Discussion* *Paul Dalton, Head of Internal Audit*

- 7.2 IA Progress Report ARAC 22 May 2025.pdf (10 pages)

### 7.3. NWSSP Internal Audit Services – Annual Audit Plan 2025-26

*Discussion* *Paul Dalton, Head of Internal Audit*

- 7.3 Internal Audit Plan 2025-26 ARAC 22 May 2025.pdf (25 pages)

### 7.4. NWSSP Internal Audit Review Reports (Limited Assurance Reports)

*Discussion* *Paul Dalton, Head of Internal Audit*

#### 7.4.1. IA Review - Estates Assurance Condition

*Discussion* *Huw Richards, Head of Internal Audit*

- 7.4.1 Estates Condition Final Internal Audit Report.pdf (16 pages)

#### 7.4.2. IA Review - Capital Systems

*Discussion* *Murray Guard, Audit Manager*

- 7.4.2 Capital Systems Final IA Report.pdf (12 pages)

#### 7.4.3. IA Review - GI Pathways Progress Update - Follow Up

*Discussion* *Emma Samways, Deputy Head of Internal Audit*

- 7.4.3 GI Pathways Progress Update Final IA report.pdf (5 pages)

#### 7.4.4. IA Review - Digital Benefits Realisation

- 7.4.4 IA Digital Benefits IA Report ARAC 22.05.25.pdf (7 pages)

### 7.5. Audit Wales - Audit, Risk & Assurance Committee Update

*Discussion* *Nathan Couch, Audit Wales*

- 7.5 AW Audit Update ARAC 22 May 2025.pdf (12 pages)

### 7.6. Audit Wales – Audit Review Reports

7.6 Audit Wales National Reports ARAC 22 May 2025.pdf (4 pages)

### 7.6.1. Audit Wales Report - Cancer Services in Wales

*Discussion* *Dave Thomas, Audit Wales*

7.6.1 AW Cancer Services in Wales.pdf (72 pages)
7.6.1a Cancer Policy AW Mmt Response Form.pdf (9 pages)

## 7.7. Audit Wales 2025 Audit Plan

*Discussion* *Dave Thomas, Audit Wales*

7.7 AW 2025_Detailed_Audit_Plan.pdf (28 pages)

---

**13:20 - 13:25**
5 min

# 8. CONSENT AGENDA

## 8.1. FOR APPROVAL

### 8.1.1. Unconfirmed Minutes of the Meeting held on 13 February 2025

*Decision* *Gareth Watts, Director of Corporate Governance/Board Secretary*

8.1.1 Unconfirmed Minutes 13.02.25 ARAC 22 May 2025 v3 PR.pdf (14 pages)

### 8.1.2. Unconfirmed In Committee Minutes of the Meeting held on 13 February 2025

*Decision* *Gareth Watts, Director of Corporate Governance/Board Secretary*

8.1.2 Unconfirmed IC Minutes 13.02.25 ARAC 22 May 2025.pdf (3 pages)

### 8.1.3. Standards of Good Governance & Probity

*Decision* *Gareth Watts, Director of Corporate Governance / Board Secretary*

8.1.3 Standards of Good Governance & Probity.pdf (5 pages)
8.1.3a Draft Policy.pdf (21 pages)

## 8.2. FOR NOTING

### 8.2.1. Committee Annual Cycle of Business 2025

*Information* *Gareth Watts, Director of Corporate Governance/Board Secretary*

8.2.1a Annual Cycle of Business ARAC 22 May 2025.pdf (3 pages)
8.2.1b Annual Cycle of Business ARAC 22 May 2025.pdf (5 pages)

### 8.2.2. Committee Forward Work Plan

*Information* *Gareth Watts, Director of Corporate Governance/Board Secretary*

8.2.2 Forward Work Plan ARAC 22 May 2025.pdf (4 pages)

### 8.2.3. Cwm Taf Morgannwg University Health Board (CTMUHB) National Clinical Audit ProgrammeQuarter 3 Update 2024-25

*Information* *Dom Hurford, Executive Medical Director*

8.2.3 Clinical Audit Quarterly Report ARAC 22 May 2025.pdf (7 pages)

### 8.2.4. Cwm Taf Morgannwg University Health Board (CTMUHB) Clinical Audit Forward Plan for 2025-26

*Information* *Dom Hurford, Executive Medical Director*

- 8.2.4 Clinical Audit Annual Forward Plan ARAC 22 May 2025.pdf (5 pages)
- 8.2.4a Appendix 1 National Clinical Audit Annual Plan.pdf (11 pages)

### 8.2.5. Standing Orders – Variation or Breach Report

*Information* *Gareth Watts, Director of Corporate Governance/Board Secretary*

- 8.2.5 Breaches to Standing Orders ARC 22 May 2025.pdf (5 pages)

### 8.2.6. NWSSP Internal Audit Review Reports (Reasonable and Substantial Assurance Reports)

*Information*

8.2.6a Duty of Candour

8.2.6b Cancer Tracking Process

8.2.6c 4 Hour ED Performance - Follow Up

8.2.6d Service User Experience

8.2.6e New Care Group Model

8.2.6f PCH Delivery of Key Project Objectives

8.2.6g Arrangements for Financial Savings - Follow Up

8.2.6h New PDR Process

8.2.6i Electronic White Boards

- 8.2.6a IA Review Duty of Candour Audit Report Final.pdf (22 pages)
- 8.2.6b Cancer Tracking Process Final IA Report.pdf (14 pages)
- 8.2.6c 4-hr ED Performance Follow Up Final Internal Audit Report (2).pdf (16 pages)
- 8.2.6d Service User Experience Final Report.pdf (7 pages)
- 8.2.6e New Care Group Model Final IA Report.pdf (8 pages)
- 8.2.6f PCH Delivery of Key Project Objectives.pdf (11 pages)
- 8.2.g Arrangements for Financial Savings Follow Up.pdf (13 pages)
- 8.2.6h New PDR Process Final Internal Audit Report.pdf (11 pages)
- 8.2.6i IA Report Electronic White Boards.pdf (15 pages)

**13:25 - 13:30**
5 min

## 9. CLOSE OF BUSINESS

### 9.1. Any Other Urgent Business

*Discussion* *Patsy Roseblade, Committee Chair*

### 9.2. Committee Highlight Report to Board

*Discussion* *Patsy Roseblade, Committee Chair*

### 9.3. How did we do in this meeting?

*Discussion* *Patsy Roseblade, Committee Chair*

**13:30 - 13:30**
0 min

## 10. PRIVATE IN COMMITTEE SESSION

*Discussion* *Patsy Roseblade, Committee Chair*

1. CTM Draft Annual Report 2024-25
2. CTM Draft Annual Accounts 2024-25

3. Audit Wales: Audit of the Financial Statements - Verbal Update
4. CTM Audit Enquiries Letter
5. Organisational Risk Register - Business Senstive Risks
6. Financial Control Procedure - Medical Variable pay - Summary of Authorised Breaches

**13:30 - 13:30**
0 min

## 11. DATE AND TIME OF NEXT MEETING

*Information* *Patsy Roseblade, Committee Chair*

25 JUNE 2025 - 15:00 PM - TO APPROVE THE ANNUAL ACCOUNTS AND ACCOUNTABILITY REPORT

Bwrdd Iechyd Prifysgol e
Cwm Taf Morgannwg
University Health Board

**Audit Risk & Assurance Committee - Action Log (as at 07.05.25)**

| the action originated from | reference | Reference Page Number | m Title / Summary | Nature of Action | Lead Officer | Lead Executive | Timescale for action to be completed | Status of Action | Narrative Progress Update |
|---|---|---|---|---|---|---|---|---|---|
| Audit Risk & Assurance Committee - February 2025 | 4,1 | **3** | Local Counter Fraud Report | To highlight any new updates in the Cases Report in a different colour so these can be flagged for the Committee's attention. | Local Counter Fraud Officer | Executive Director of Finance & Procurement | mai-25 | Propose to close | Report to be brought to May 2025 meeting to include coloured text to highlight last updates. |
| | 4,1 | **3** | Local Counter Fraud Report | To bring an update to a future meeting of the Committee on the long standing case with regard to the dispensing practice | Local Counter Fraud Officer | Executive Director of Finance & Procurement | mai-25 | Propose to close | Primary Care review in progress. Update to be brought to May 2025 meeting as part of the Local Counter Fraud Report |
| Audit Risk & Assurance Committee - February 2025 | 4,2 | 4 | Losses and Special Payments Report | To implement a cross Committee Referral to Quality, Safety & Experience Committee on the concern raised regarding the increases in medical negligence claims | Head of Corporate Governance & Board Business | Director of Corporate Governance/ Board Secretary | mai-25 | Open | Referral will be received by the Quality, Safety & Experience Committee on the 20th May, the outcome of which will be presented to the Committee at the August 2025 meeting.. |
| Audit Risk & Assurance Committee - February 2025 | 5.3.2 | 8 | IA Review - Medical Job Planning | To bring further detail on the job planning work back to a future meeting of the Committee. | Medical Director | Medical Director | aug-25 | Open | On Forward Plan for August 2025 |
| Audit Risk & Assurance Committee - February 2025 | 5.3.5 | 9 | IA Review - Vaccination Policy Implementation | To consider where the reporting of the Vaccination Policy Implementation should sit. | Director of Corporate Governance/ Board Secretary | Director of Corporate Governance/Board Secretary | mai-25 | Propose to close | This will be reported via the Integrated Performance Dashboard to Operational Delivery Committee, but assurance will also be given to the Quality, Safety and Experience Committee at the appropriate given that Committee's legitimate interest in this area. |
| Audit Risk & Assurance Committee - February 2025 | 5.4.2 | 11-des | Audit Wales Report - Structured Assessment | To further discuss the content of the report offline prior to it being presented to board. | Audit Wales | Director of Corporate Governance/Board Secretary | mai-25 | Propose to close | Received at the Health Board Meeting 27.03.25 |
| Audit & Risk Committee December 2024 | 5,1 | 6 | Organisational Risk Register | To request an update on Risk 5417 Paediatric Dentistry out of the meeting and provide an update | Director of Corporate Governance/Board Secretary | Chief Operating Officer | feb-25 | Open | To address the backlog, a cohort of patients has been identified, with plans to allocate funds from the planned care recovery to commission services from a private provider. Currently, we are exploring the scheduling of adhoc theatre sessions, including on weekends. **Update required following meeting held on 13.02.25 where it was agreed to keep on the Action Log with timescales for actions and completion to provide assurance to the Committee via a substantive update later in the year.** |
| Audit & Risk Committee December 2024 | 5,2 | 7 | Audit Recommendations Tracker | To include the feeback received for the next iteration of the Tracker | Director of Corporate Governance/Board Secretary | Director of Corporate Governance/Board Secretary | feb-25 | Propose to close | The actions from the last meeting will be built into the improvement programme for the development of the Audit Tracker |
| Audit & Risk Committee December 2024 | 5.3.2 | 10 | IA Review - Additional Medical Pay | To discuss the February 2025 timescales with colleagues from the People Directorate and update the Committee following this | Deputy Medical Director | Executive Medical Director | feb-25 | Propose to close | A meeting has been held with the People Services team to discuss timescales where it was agreed they were all considered reasonable. A plan is being developed on how the timescales will be met. |
| **PREVIOUSLY CLOSED ACTIONS** | | | | | | | | | |
| Audit & Risk Committee December 2024 | 5,1 | 6 | Organisational Risk Register | To bring an update to the Committee on the Corporate Governance Risk in respect of sustained effective Policy management | Director of Corporate Governance/Board Secretary | Director of Corporate Governance/Board Secretary | feb-25 | Closed | Project Initiation Document – "Non-Clinical Policy Management Review -- received and signed off by Executive Leadership Group. The scope of the project is to undertake a robust review of Non-Clinical Written Control Documents within the Health Board in order to establish a baseline compliance figure. The review will also include a review of the "Policy on Policies", development of a new system to support robust policy management and a redesign of the Health Boards policy pages on its internal and external web pages.<br><br>It is anticipated that this programme of work will commence in January 2025 and conclude at the end of the calendar year (31 December 2025). This timeframe is considered realistic due to the resource limitations afforded to the project which will impact upon the pace of delivery.<br><br>Project monitoring will be undertaken by the Executive Leadership Group via the Corporate Governance Dashboard updates. **Update following last meeting** |
| Audit & Risk Closed In Committee October 2024 | 3,1 | 3 | Action Log | Further re-assurance to be sought from the previous Committee Referral to the People & Culture Committee with regard to the Local Counter Fraud Report - Recruitment of Agency Staff | Director of Corporate Governance/Board Secretary | Executive Director for People | des-24 | Closed | Outcome of the Committee Referral discussed by the People & Culture Committee at their meeting held on 5th December 2024 was received by the Committee at their meeting held on the 17 December 2024/ |
| Audit & Risk Committee December 2024 | 4,1 | 3 | Local Counter Fraud Report | To add any key items to flag to the risk section of the report so that members are aware prior to the meeting. | Local Counter Fraud Officer | Director of Finance & procurement | feb-25 | Closed | Nothing to flag within papers for this meeting. Noted for future drafting. |
| Audit & Risk Committee December 2024 | 4,1 | 3 | Local Counter Fraud Report | To flag any changes to the open cases with a different colour so that Members can easily see the changes. | Local Counter Fraud Officer | Director of Finance & procurement | feb-25 | Closed | Table has an additional column to highlight actions since last report. Happy to review formatting for future meetings if Committee would prefer different style. |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Audit & Risk Committee October 2024 | 5,1 | 6 | Organisational Risk Register | To review Risk 5755 - Princess of Wales (POW) Air handling unit and electrical infrastructure for Labour ward and Neonatal Unit – no correlation between reduced consequence and explanation used for the method of reducing the target risk score. | Director of Corporate Governance/Board Secretary | Director of Corporate Governance | des-24 | Closed | Emails have been exchanged between C. Hamblyn and the ARC Chair clarifying the reasons for the residual risk score. Query now resolved and no further work proposed |
| Audit & Risk Committee October 2024 | 5.6.2 | 10 | Internal Audit Review - Reasonable offer | To review the management response in relation to staff training with Internal Audit outside of the meeting | Director of Corporate Governance/Board Secretary | Director of Corporate Governance/Internal Audit | des-24 | Closed | G. Watts and E. Samways have exchanged emails and agreed that the recommendation can be taken off the tracker for 12 months. While there remains 2 systems in place, training for new (and existing staff) still needs to be provided and that is what is happening, tailored to the different WPAS systems at the different sites |

| Agenda Item |
| --- |
| 4.1 |

# Audit, Risk & Assurance Committee

## Declarations of Interest & Gifts, Hospitality and Sponsorship Register

| | |
| --- | --- |
| **Dyddiad y Cyfarfod / Date of Meeting** | 22/05/2025 |
| **Statws Cyhoeddi / Publication Status** | Open/ Public<br>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** |
| Executive Leadership Group | 06/05/2025 | *PENDING* |

| **Acronyms / Glossary of Terms** | |
| --- | --- |
| | |
| | |

## 1. Situation /Background

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

## 2. Specific Matters for Consideration

2.1 The form in the Standards of Behaviour Framework policy or online via SharePoint should be used to declare interests and/or seek approval for receiving hospitality/sponsorship/gifts and this should help or prevent the omission of crucial information that the authorising officer requires making an informed decision on approval or rejection. The authorised signatories should also be scrutinising the declarations prior to authorisation, in order to ensure the correct information is captured on the form before it is submitted to the Corporate Governance Team.

2.2 In May 2024, all Board Members were formally asked to review and update, where appropriate, their declarations for the new financial year 2024-2025. A response from all Board Members was received and is captured in Appendix 1. A further update was sought from Board Members as part of the end of year Financial Checks in March 2025 asking them to revisit their declarations and any amendments received have been captured in the register as appropriate.

2.3 A targeted email was also issued by the Corporate Governance Team in May 2024 to 548 members of staff, which included all Consultants, Very Senior Managers and Staff at Band 8d and Band 9). It should be noted that some of the returns received to date and captured in Appendix 1 are from individuals that did not receive the targeted email as there is a responsibility for all employees to declare interests. This exercise will be repeated in May 2025 for the 2025-2026 reporting period.

2.4 As at 31 March 2025:

- 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".
- 271 declarations of interest received from staff (excluding Board Members / Executive Team colleagues). Please see Appendix 1 – Sheet 2 - "Non Board Members".
- To date there have been four declarations of gifts, hospitality and sponsorship received and approved – please see Appendix 2. It should be noted that some colleagues capture this information in their declaration of interest form. Please note there are a further two declarations that are awaiting Executive approval. These will be captured in the next iteration of the report.

2.5 Previous advice received from Information Governance is that any information published on the register, which is then published in the public domain, excludes first and last names and includes job titles only (for non-Board Members). This has been actioned in terms of the appendices to this report.

## 3. Key Risks / Matters for Escalation

3.1 Please refer to the register for the Declarations of Interest included at Appendix 1.

3.2 Please refer to the register for Gifts, Hospitality and Sponsorship included at Appendix 2.

## 4. Assessment

| **Objectives / Strategy** | |
|---|---|
| **Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)** | Sustaining Our Future |
| | If more than one applies please list below: |
| **Dolen i Feysydd Strategol BIP CTM /Link to CTMUHB Strategic Areas** | Not Applicable |
| | If more than one applies please list below: |
| **Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals** *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)* | Not Applicable |
| | If more than one applies please list below: |
| **Dolen i Hwyluswyr Ansawdd** *(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** | Yes: ☐ | No: ☒ |

| | | |
|---|---|---|
| *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /*<br>**Quality**<br>*Have you undertaken a Quality Impact Assessment Screening?* | Outcome: | If no, please include rationale below:<br><br>Not required for this report |
| **Cydraddoldeb a'r Gymraeg**<br>*Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /*<br>**Equality and Welsh Language**<br>*Have you undertaken an Equality and Welsh Language Impact Assessment Screening?* | Yes: ☐ | No: ☒ |
| | Outcome for Equality (delete as appropriate):<br><br>POSITIVE/NEUTRAL<br>NEGATIVE<br><br>Outcome for Welsh Language (delete as appropriate):<br>POSITIVE/NEUTRAL<br>NEGATIVE | If no, please include rationale below:<br><br>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**<br>*(Pobl /Ariannol) /*<br>**Resource Impact**<br>*(People / Financial)* | There is no direct impact on resources as a result of the activity outlined in this report. | |
| | | |

## 5. Recommendation

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

## 6. Next Steps

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

| Targeted DOI Request Sent | Full Name | Designation | Date DOI Approved | Nature of Declaration | Period of Involvement "From" | Period of Involvement "to" | Financial Benefits /Benefits in Kind |
|---|---|---|---|---|---|---|---|
| Change Declared April 2024 and New Financial Year request 20.5.2024 | Jonathan Morgan | Chair | 25.4.2024 - Via hard copy form. | Trustee and Director of the NHS Confederation | Since April 2024 | ongoing | Travel Expenses reimbursed |
| | | | | Director of Insight Wales Consulting Limited | Since 2012 | ongoing | Nil |
| | | | | 100% Share Ownership of Insight Wales Consulting Limited | Since 2012 | ongoing | Dividend |
| | | | | Associate Consultant with Practice Solutions Ltd | aug-11 | ongoing | Fees for work undertaken |
| | | | | Wife employed as a Welsh Government Lawyer | Since 2010 | ongoing | Salaried. |
| | | | Updated declaration received and approved 17.12.2024 | Independent Member on the Hendre Limited Board | 16th December 2024 | Ongoing | Remunerated |
| New Member - request on commencement and New Financial Year request 20.5.2024 | Rachel Rowlands | Independent Member Community | 30.04.2024 - via hard copy form. | Chief Executive / Company Secretary, Age Connects Morgannwg | 2005 | ongoing | Annual Salary |
| | | | | Trustee / Director, Age Connects Wales | 2017 | ongoing | Nil |
| Change Declared April 2024 and New Financial Year request 20.5.2024 | Carolyn Donoghue | Independent Member University | 07.05.2024 - via hard copy form. | Chair, Welsh Innovation Centre | 9 Years | 31.05.2024 | Payment for each Board meeting |
| | | | | Independent Member of the Board of Governors, University West of England | 2 Years | ongoing | None |
| | | | | Special Advisor Joint Commissioning Committee | 11th April 2024 | 30th June 2024 | Remunerated position x1 day per month |
| | | | | Chair, South East Wales Student Mental Health Partnership | 4 Years | 31.07.2024 | Consultancy Fee |
| | | | | Magistrate, Newport Bench | 4 Years | 31.05.2024 | None |
| | | | | Senior Professional Fellow, Cardiff University | 4 Years | ongoing | None |
| | | | | Member of Health and Care Research Wales Advisory Board | From May 2024 | ongoing | None |
| | | | Via email 27.3.2025 | Trustee Staple Hill Community Hub | 20-mar-25 | 20-mar-25 | 3 Years initially. Nil remuneration or Benefits in Kind. |
| | | | | Son (ED) employed as a Business Development Manager for Seating Matters | | | |
| 20.05.2024 | Gethin Hughes | Chief Operating Officer | 11.06.2024 - Via Email | Nil Interests declared.<br><br>Gethin Hughes confirmed resignation from School Governor and Trustee Ditch am Park School on the 9th April 2024. | Not applicable | Not applicable | Not applicable |
| 20.05.2024 | Sally May | Executive Director of Finance | 11.06.2024 - Via Email | Cousin is Director of DECIPHER; Professor in Social Interventions and Health, Cardiff University Ongoing Salaried position | Ongoing | Ongoing | Salaried |
| | | | | Cousin is Regional Sales Manager South West Arthrex Ltd Ongoing Salaried position | Ongoing | Ongoing | Salaried |
| | | | | Cousin is Partner, Knight Frank Project and Building Consultancy Ongoing Salaried position | Ongoing | Ongoing | Salaried |
| | | | | Daughter appointed to Lead Physiologist role for In Health South West Community Diagnostic Centre | 1.5.2024 | Ongoing | Salaried |
| 20.05.2024 | Paul Mears | Chief Executive | 11.06.2024 - Via Email | Member of Advisory Board, Awen Cultural Trust | sep-22 | Present | Nil |
| | | | | Observer Member, Board of Life Sciences Hub Wales | jun-22 | Present | Nil |
| 20.05.2024 | Nicola Milligan | Independent Member - Trade Union | 11.06.2024 - Via Email | Board Member - Royal College of Nursing Wales | jan-16 | Term ends December 2024 | Nil |
| 20.05.2024 | Stuart Morris | Director of Digital | 11.06.2024 - Via Email | ~~Chair of Governors for Penylai Primary School, Bridgend~~<br><br>Nil Interests declared. | ~~jul-17~~ | Ceased - Confirmed 6.2.2025 that no longer Chair of Governors | Not applicable |
| 20.05.2024 | Dom Hurford | Executive Medical Director | 11.06.2024 - Via Email | Nil interests declared | Not applicable | Not applicable | Not applicable |
| 20.05.2024 | Simon Blackburn | Director of Communications, Engagement & Fundraising | 11.06.2024 - Via Email | Nil interests declared. | Not applicable | Not applicable | Not applicable |
| 20.05.2024 | Lauren Edwards | Executive Director of Therapies & Health Science | 11.06.2024 - Via Email | Trustee and Director of Royal College of Speech and Language Therapists | 08-nov-23 | Ongoing | Nil |
| Amendment via email 25.9.2024 | | | 25.9.2024 via email | Visiting Professor at the University of South Wales | 1st October 2024 | 1st October 2027 | Nil |
| 20.05.2024 | Linda Prosser | Executive Director of Strategy & Transformation | 11.06.2024 - Via Email | Director Altyn Tepe Ltd | Since 2019 | Ongoing | Yes |
| | | | | Son (1) Chief Operating Officer Salisbury NHS Foundation Trust | Since Feb 2024 (previously RUH Bath) | Ongoing | Yes |
| | | | | Son (2) Service manager (Urology and Ophthalmology) Royal United Hospital Bath | Since 2021 | Ongoing | Yes |
| 20.05.2024 | Anne Morris | Associate Board Member - Chair of the Stakeholder Reference Group | 21.05.2024 - Via hard copy form. | Deputy Chief Executive of Interlink | 2009 | Ongoing | Yes - Salaried. |
| 20.05.2024 | Philip Daniels | Interim Executive Director of Public Health | 11.06.2024 - Via Email | Board Member / Welsh Chair - Faculty of Public Health | jun-23 | Ongoing | Nil |
| | | | | Partner is Director - The Performance Centres | 2011 | Ongoing | Owner / Chief Executive |
| 22.05.2024 | Hywel Daniel | Executive Director for People | 11.06.2024 - Via Email | Nil interests declared. | Not applicable | Not applicable | Not applicable |
| 22.5.2024 | Greg Dix | Executive Director of Nursing / Deputy Chief Executive | 11.06.2024 - Via Email | Trustee - Royal College of Nursing Foundation | September 2021 | Ongoing | Voluntary role, travel / accommodation paid for by the charity |
| | | | | Board Director - Welsh Wound Innovation Centre | jan-22 | ~~Ongoing~~<br>In Year amendment - email 11.11.2024 - Ceased May 2024 - WWIC went into Liquidation. | No financial or benefits in kind |
| | | | | Visiting Professor, University of South Wales | 2020 | Ongoing | Nil |
| | | | | ~~Associate Professor, University of Plymouth~~ | ~~2015~~ | ~~Ongoing~~<br>In year amendment - Email 5.8.2024 - Associate Professor Role with the University of Plymouth has lapsed. | ~~Nil~~ |

| 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 |
|---|---|---|---|---|---|---|---|
| 20.05.2024 | Dilys Jouvenat | Independent Member - Third Sector | 11.06.2024 - via email | Chair of the Rhondda Cynon Taff Citizens Advice | jun-15 | 26th November 2023 | Not applicable |
| | | | | Trustee Newport Citizens Advice | 2 Years | Ended. Email 11.11.2024 advising resigned from Newport Citizens Advice in October and received notification of removal from the Charity Commission register on 21st October | Not applicable |
| | | | | Trustee South East Wales Citizens Advice | 1 Year | Present | Not applicable |
| | | | | Trustee Interlink | 6 months | Present | Not applicable |
| | | | | Trustee Rhondda Cynon Taff Citizens Advice | 27th November 2023 | Present | Not applicable |
| | | | 11.9.2024 - Via email | Trustee of the Cymru Older Peoples Alliance (COPA) It's a charity trustee appointment. | 3rd September 2024 | Present | Not applicable |
| 28.05.2024 | Kath Palmer | Vice Chair | 11.06.2024 - via email | Natural Resources Wales – Board member and Chair of Audit, Risk and Assurance committee. | feb-23 | Present | Paid Position |
| | | | | Trustee of Crisis (national homelessness charity) and chair of the client services governance committee. | des-22 | Present | Voluntary (Expenses Paid) |
| | | | | Member of the Residential Decarbonisation Implementation Group for Welsh Government. | sep-19 | Confirmed in declaration on the 28th May that this Group ceased in April 2024. | Voluntary |
| | | | 12.07.2024 | Board Member (Crisis Trustee) for Pathway UK (Subsidiary of Crisis) | 8th July 2024 | Present | Voluntary (Expenses Paid) |
| 29.05.2024 | Lynda Thomas | IM Corporate | 11.06.2024 - via email | Chair of Norfolk Community Health and Care NHS Trust. | Since February 2023 | Present | Remunerated. |
| | | | | Trustee of Age UK | jan-23 | jan-26 | None - Voluntary role |
| 03.06.2024 | Lisa Curtis-Jones | Associate Member - Third Sector | 5th June 2024 - via hard copy form. | Statutory Director of Social Services in Merthyr Tydfil<br><br>Member of the regional partnership board (RPB) – RIF funding to local authorities through RPB. | apr-15 | Ongoing | |
| 03.06.2024 | Gareth Watts | Director of Corporate Governance / Board Secretary | 11.06.2024 - Via Email | Board Member of Coleg Gwent (Further Education College) Since 2015 onwards | 2015 | Present | Voluntary |
| | | | | Member of the Joint Audit Committee of Gwent Police and the Police and Crime Commissioner for Gwent | 2022 | Present | Daily rate for meeting attendance and preparation |
| | | | | Chair of the Joint Audit Committee of the Office of the Police and Crime Commissioner for Gwent and Gwent Police. | 13-mar-25 | Present | Daily rate for meeting attendance and preparation |
| 05.06.2024 | Geraint Hopkins | Independent Member (Local Authority) | 19.6.2024 - Via Email. | Llanharan Community Development Project Limited | 10 years + | 18.3.2024 - Resigned. | Not applicable |
| | | | | Clerk to Llantrisant Community Council. | okt-21 | Present | Remunerated |
| | | | | Elected Member, Rhondda Cynon Taff County Borough Council. | 19 years | Present | Not applicable |
| 05.06.2024 | Helen Lentle | Independent Member (Legal) | Via Email- 5.6.2024 | Non-Executive Director: CISWO (the Coal Industry Social Welfare Organisation). | Since September 2022 | Present | Voluntary role. |
| | | | | Trustee - Dyslecsia Cymru/Wales Dyslexia Charity - Charity Number 114416 | Since September 2022 | Present | Voluntary role. |
| 06.06.2024 | Patsy Roseblade | Independent Member (Finance & Audit) | 11.06.2024 - via email | ~~Non Executive Director Tennis Wales~~<br><br>Nil interest declared. | ~~2020~~ | ~~Ongoing~~<br>Ended 24 September 2025 | ~~Voluntary~~ |
| 10.06.2024 | Ian Wells | Independent Member (Digital) | 11.06.2024 - via email | ~~Director of the Wales Institute of Digital information which undertakes research with Digital Health and Care Wales/NHS Wales Informatics Service in collaboration of University of Wales Trinity St David and the University of Wales. Research projects also undertaken for various health boards including CTM.~~<br><br>Nil Interests Declared | ~~3 days per week From 1/2/20~~ | ~~Ongoing.~~<br><br>Notified in June 2024 that this can now be removed from the declaration as I Wells no longer undertakes the 3 days per week as described. | ~~Nil financial transactions or benefits in kind.~~ |

| Date Approved | Designation | Department | Nature of Declaration | Period of Involvement | Financial Transaction or Benefits in Kind | Management Action Taken | In Year Amendments |
|---|---|---|---|---|---|---|---|
| 02.04.2024 | Education and Training and Paediatric Pharmacist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 02.04.2024 | Pharmacist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 04.04.2024 | Physiotherapist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 04.04.2024 | Physiotherapist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 08.04.2024 | Physiotherapy Assistant | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 09.04.2024 | Community Pharmacy Facilitator | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Community pharmacist (and IP) without managerial responsibilities at Valleys Link Pharmacy Ltd (Cilfynydd and Gelli)<br><br>Husband works as Placements Lead for Cardiff University School of Pharmacy, and is responsible for allocating students to placement sites across CTMUHB. I am not involved in the decision making and would be unlikely to benefit in any way from this association. | 6 months (started October 2023)<br><br>Approx. 1 year in role | Permanent salaried role<br><br>None | Any contractual or performance issues relevant to Valleys Link Pharmacies located in CTMUHB will be managed by Jason Carroll and/or Meinir Davies. Carys will avoid any circumstances which ,may present a conflict of interest. | |
| 15.04.2024 | Consultant in Radiology | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Chief Medical Officer<br>Adaptix Imaging<br>Centre for Innovation and Enterprise<br>Oxford University Begbroke Science Park<br>Woodstock Road<br>Oxford OX5 1PF | Since July 2021 | Salaried half day/ week | None Identified. | |
| 18.04.2024 | Senior Healthcare Science Practitioner | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 19.04.2024 | Registered General Nurse | Primary Care and Community Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 23.04.2024 | Speech and Language Therapist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Working with the Neurodevelopment Service. Noted as no conflict with current position held. | 8 hours across the month of April | Not stated. | | |
| 23.04.2024 | Clinical Technologist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 23.04.2024 | Planning Assistant | Planning & Partnerships Directorate | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 23.04.2024 | Healthcare Science Associate | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 23.04.2024 | Superintendent Radiographer | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 24.04.2024 | Speech & Language Therapist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 25.04.2024 | Academy Office and Events Manager | National Imaging Academy Wales | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 25.04.2024 | Speech and Language Therapist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 29.04.2024 | Registered General Nurse | Primary Care and Community Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 3.05.2024 | Superintendent Radiographer | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 6.5.2024 | Deputy Ward Manager | Primary Care and Community Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 7.5.2024 | Primary Care Therapist | Primary Care and Community Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 8.5.2024 | Advanced Pharmacist for Cardiology and Anticoagulation | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 8.5.2024 | Registered General Nurse | Primary Care and Community Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 13.5.2024 | Project Manager | Mental Health & Learning Disabilities Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 14.5.2024 | Rotational Physiotherapist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 16.5.2024 | District Nurse | Primary Care and Community Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 16.5.2024 | District Nurse | Primary Care and Community Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 16.5.2024 | Healthcare Support Worker | Primary Care and Community Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 21.5.2024 | Academy Administrator | National Imaging Academy Wales | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 22.05.2024 | Pharmacist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |

| Date Approved | Designation | Department | Nature of Declaration | Period of Involvement | Financial Transaction or Benefits in Kind | Management Action Taken | In Year Amendments |
|---|---|---|---|---|---|---|---|
| 26.05.2024 | Registered General Nurse | Primary Care and Community Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 28.05.2024 | Information Analyst | Digital & Data Directorate | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 28.05.2024 | Healthcare Support Worker | Primary Care and Community Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 29.05.2024 | Medicines Management Support Officer | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 29.05.2024 | Clinic Co-ordinator | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 29.05.2024 | Head of Assets, Governance & Technical Services | Estates Directorate | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 31.05.2024 | Staff Nurse | Primary Care and Community Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 03.06.2024 | Medicines Management Support Officer | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 05.06.2024 | Consultant Old age Psychiatrist and Clinical Director for Older Adult Mental Health Services CTMUHB | Mental Health & Learning Disabilities Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 05.06.2024 | Lead Nurse - Angelton Clinic | Mental Health & Learning Disabilities Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 05.06.2024 | Nurse Director - MHLD Care Group | Mental Health & Learning Disabilities Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 06.06.2024 | Consultant Urologist | Planned Care Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 06.06.2026 | Strategy Group Clinical Director | Planning & Performance Directorate | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 06.06.2024 | Consultant ENT Surgeon | Planned Care Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 06.06.2024 | Consultant General Surgeon | Planned Care Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 06.06.2024 | LHP Infrastructure Programme Director | Estates Directorate | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 06.06.2024 | Consultant Gastroenterologist | Unscheduled Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 06.06.2024 | Assistant Director Capital & Estates | Estates Directorate | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 06.06.2024 | Microbiology Consultant | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 06.06.2024 | Consultant Haematologist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 06.06.2024 | Consultant Surgeon | Planned Care Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 06.06.2024 | Consultant Pathologist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 06.06.2024 | Consultant Haematologist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 06.06.2024 | Consultant Ophthalmologist | Planned Care Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 06.06.2024 | Care Group Service Director | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 06.06.2024 | Directorate Manager | Mental Health & Learning Disabilities Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 06.06.2024 | Directorate Lead Psychologist OPMH/Consultant Clinical Psychologist OPMH | Mental Health & Learning Disabilities Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 06.06.20024 | Consultant Breast Surgeon and Clinical Director for Breast Services | Planned Care Care Group | 1. Two Togethers Limited (undertaking my private practice) 2. Moondance Cancer Foundation Clinical Advisory Board 3. Medical advisor for ITV and Netflix 4. Raise Healthcare consultant | 1. Since January 2021 2. Since June 2023 3. Since June 2021 4. Since August 2023 | 1. Salary/Dividends and Shareholder 2. Unpaid 3. Paid Consultancy Rates 4. Paid Consultancy Rates | Not applicable | |
| 06.06.2024 | Consultant Hepatologist/Clinical Director Gastroenterology and Endoscopy | Diagnostics, Therapies, Pharmacy and Sciences Care Group | 1. Trustee of Brynawel Rehabilitation Centre, Llanharry Road, Llanharan, CF72 9RN 2. Member of the British Society of Gastroenterology clinical Standards Committee which drafts national policy and guidelines | 1. 2 Years 2. 2 Years | 1. No financial or benefits in kind 2. None | Not applicable | |
| 06.06.2024 | Deputy Director Commissioning Ambulance and 111 | Joint Commissioning Committee | 1. Bank Paramedic Contract with the Welsh Ambulance Service 2. Acting corporal British Army Reserves 3. Spouse is advanced clinical practitioner Swansea Bay | 1. Since February 2016 2. From October 2017 3. Since March 2018 | 1. Paid per shift 2. Paid per hours worked 3. Salaried Employee | Not applicable | |
| 06.06.2024 | Consultant Child & Adolescent Psychiatrist | Mental Health & Learning Disabilities Care Group | 1. Second Opinion Approved Doctor (SOAD), Health Inspectorate Wales 2. Sole Director of SL Healthcare Solutions Ltd | 1. 2018-present 2. 2017- present | 1. Remunerated at the nationally agreed rate plus expenses for SOAD visits undertaken 2. 2017- present | Not applicable | |
| 06.06.2024 | Consultant Gastroenterologist | Unscheduled Care Care Group | Sponsorship 2023 by AbbVie drugs company for digital attendance at ECCO IBD conference. | 2023 | Paid conference fee. | Not applicable | |

| Date Approved | Designation | Department | Nature of Declaration | Period of Involvement | Financial Transaction or Benefits in Kind | Management Action Taken | In Year Amendments |
|---|---|---|---|---|---|---|---|
| 06.06.2024 | Consultant Intensivist and Clinical Director for ICU | Planned Care Care Group | 1. School Governor - YGG Aberdare 2. Regional Clinical Lead for Organ Donation | 1. February 2023 2. April 2022 | 1. None 2. 1 PA (NHSBT Funded) | Not applicable | |
| 06.06.2024 | Assistant Director of Facilities | Facilities Directorate | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 07.06.2024 | Assistant Director of Governance & Risk | Corporate Governance - Central Function | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 07.06.2024 | Consultant in Acute Medicine | Unscheduled Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 07.06.2024 | Advanced Pharmacist - Formulary and Interface | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 07.06.2024 | Medical Director | Mental Health & Learning Disabilities Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 07.06.2024 | Consultant in Emergency Medicine | Unscheduled Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 07.06.2024 | Consultant | Mental Health & Learning Disabilities Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 07.06.2024 | Consultant | Medical Director Function | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 07.06.2024 | Deputy Chief Operating Officer | Chief Operating Officer Function | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 07.06.2024 | Consultant Cardiologist | Unscheduled Care Group | 1. Trustees for Swansea Chinese Christian Church 2. Joint working project to run pharmacist led heart failure 3. Hold Cardiff University Honorary Lecturer Post clinic | 1. Since 2011 2. 2023-2024 3. Since 2017 | 1. Nil 2. Pharmaceutical Company 3. 1 PA from HEIWs | Not applicable | |
| 07.06.2024 | Consultant Physician | Unscheduled Care Group | Spouse is a Director of limited liability company | | Nil financial transactions | Not applicable | |
| 07.06.2024 | Consultant Anaesthetist/ Associate Clinical Director | Planned Care Care Group | School governor - Caldicot School, and Durand Primary School, Caldicot | Since 2018 | Nil financial transactions | Not applicable | |
| 08.06.2024 | Consultant Anaesthetist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Honorary Tutor title with Cardiff University, Medical School | Renewed 01/05/2024 | Nil financial transactions | | |
| 10.06.2024 | Healthcare Support Worker | Primary Care and Community Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 10.06.2024 | Consultant Radiology | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 10.06.2024 | Assistant Director of Finance | Finance Directorate | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 10.06.2024 | Deputy Director for People | People Service Directorate | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 10.06.2024 | Public Health Consultant | Public Health | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 10.06.2024 | Committee Secretary / Deputy Director Corporate | National Collaborative Commissioning unit | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 10.06.2024 | Consultant Gastroenterologist | Unscheduled Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 10.06.2024 | Stroke Consultant | Unscheduled Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 10.06.2024 | Assistant Director of Transformation | Planning & Partnerships Directorate | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 10.06.2024 | Consultant Radiologist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 10.06.2024 | Deputy Director of Finance | Finance Directorate | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 10.06.2024 | Deputy COO | Chief Operating Officer Function | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 10.06.2024 | Consultant Dermatologist | Medical Director Function | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 10.06.2024 | Consultant Paediatrician | Children & Families Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 10.06.2024 | Locum Consultant Radiologist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 10.06.2024 | Consultant Paediatrician | Children & Families Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 10.06.2024 | Consultant Physician | Unscheduled Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 10.06.2024 | Consultant Physician | Unscheduled Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 10.06.2024 | Chief of Staff | Corporate Functions | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 10.06.2024 | Locum Consultant in General and Acute Medicine | Unscheduled Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 10.06.2024 | Consultant in Palliative Medicine | Unscheduled Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 10.06.2024 | Locum Consultant Maxillofacial Surgeon | Planned Care Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 10.06.2024 | Service Director | Mental Health & Learning Disabilities Care Group | 1. Chair of West Wales Care & Repair 2. Board Member ATEB 3. Spouse is a Clinical Nurse Specialist at Hywel Dda Health Board 4. Daughter is a nurse at Aneurin Bevan UHB | 1. Since 20 March 20223 2. Since 1 April 2024 3. Since March 2023 4. Since September 2023 | 1. Voluntary role 2. Salaried role 3. Not applicable 4. Not applicable | Not applicable | |
| 10.06.2024 | Head of Psychology | Mental Health & Learning Disabilities Care Group | 1. Trustee at Adferiad 2. Glamorgan Psychotherapy & Consultation Private psychotherapy and consultation | 1. Since 2021 2. Since 2013 | 1. Voluntary 2. private healthcare systemic organisational consultation | Not applicable | |
| 10.06.2024 | Consultant Physician & Site Clinical Lead | Unscheduled Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 10.06.2024 | Consultant Gastroenterologist | Unscheduled Care Group | 1. Director of Minesh Gastro Ltd 2. Spouse is Director of Minesh Gastro Ltd 3. Works at Nuffield Hospital in Cardiff Bay to do a clinic and endoscopy | 1. Since 2022 2. Since 2022 3. Since 2018 | 1. Share options 2. Share options | Not applicable | |

| Date Approved | Designation | Department | Nature of Declaration | Period of Involvement | Financial Transaction or Benefits in Kind | Management Action Taken | In Year Amendments |
|---|---|---|---|---|---|---|---|
| 10.06.2024 | Consultant Anaesthetist | Planned Care Care Group | 1. Director Private Limited Company 2. Spouse is Director of Private Limited Company | 1. Since October 2016 2. Since October 2016 | 1. Receive dividends 2. Receive dividends | Not applicable | |
| 10.06.2024 | Consultant Anaesthetist | Planned Care Care Group | 1. Deputy Regional Advisor Royal College of Anaesthetics 2. Examiner for the Royal College of Anaesthetist | 1. Since April 2024 2. Since April 2024 | 1. Nil financial transactions 2. Nil financial transactions | Not applicable | |
| 11.06.2024 | Consultant General and Colorectal Surgeon | Planned Care Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 11.06.2024 | Consultant Physician | Unscheduled Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 11.06.2024 | Consultant Anaesthetist | Planned Care Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 11.06.2024 | Consultant Respiratory and General Internal Medicine | Unscheduled Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 11.06.2024 | Locum Consultant Rheumatologist | Unscheduled Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 11.06.2024 | Consultant Urologist | Planned Care Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 11.06.2024 | Deputy Director of Strategy and Partnerships | Planning & Performance Directorate | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 11.06.2024 | Consultant in Acute Medicine | Unscheduled Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 11.06.2024 | Consultant Cardiologist | Unscheduled Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 11.06.2024 | Consultant Anaesthetist | Planned Care Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 11.06.2024 | Consultant Physician | Unscheduled Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 11.06.2024 | Clinical Director | National Collaborative Commissioning unit | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 11.06.2024 | Consultant Gastroenterologist | Unscheduled Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 11.06.2024 | Consultant Anaesthetist | Planned Care Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 11.06.20241 | Consultant in Community Paediatrics | Children & Families Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 11.06.2024 | Assistant Director of Finance | Finance Directorate | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 11.06.2024 | Care group medical director | Medical Director Function | 1. Director of a limited Company 2. Spouse is a Director of a limited Company | 1. From October 2022 2. From October 2022 | 1. Dividends share 2. Dividends share and monthly salary | Not applicable | |
| 12.06.2024 | Head of Health Psychology Service | Diagnostics, Therapies, Pharmacy and Sciences Care Group | 1. Spouse is Principal Solicitor / Private Law Practice 2. Professor of Health Psychology (Honorary - unpaid) | 1. 36 Years 2. 10 Years | 1. Not applicable 2. Nil | Not applicable | |
| 12.06.2024 | Director of Planning, Vaccination Programme Wales (currently on secondment) | Planning & Performance Directorate | 1. Spouse is GP Partner, Afon Elai Partnership 2. Spouse is Director, Cardiff Southwest Cluster Community Interest | 1. Since August 2015 2. Since January 2022 | 1. Not applicable 2. Not for profit organisation | Not applicable | |
| 13.06.2024 | Consultant Oral Surgeon / Clinical Service Director | Planned Care Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 13.06.2024 | Consultant Paediatrician | Children & Families Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 13.06.2024 | Consultant Obstetrician & Gynaecologist | Children & Families Care Group | Honorary Professor Reproductive Medicine and Gynaecological Oncology Swansea University | Since 2018 | Nil financial transactions | Not applicable | |
| 13.06.2024 | Consultant Surgeon | Planned Care Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 13.06.2024 | Speech and language admin | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 13.06.2024 | Deputy Medical Director | Medical Director Function | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 14.06.2024 | Consultant Anaesthetist | Planned Care Care Group | President of Society of Anaesthetists of Wales | March 2023 to present | None | Not applicable | |
| 14.06.2024 | Consultant in Restorative Dentistry | Planned Care Care Group | 1. Directorship in a limited company providing private dental care in Cardiff and Bristol 2. Spouse has Directorship in a limited company providing private dental care in Cardiff and Bristol | 1. 2018 to present 2. 2018 to present | 1. Financial transactions 2. Financial transactions | Not applicable | |
| 17.06.2024 | Consultant Radiologist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 17.06.2024 | Consultant in Sports Medicine | Unscheduled Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 17.06.2024 | Directorate Manager CAMHS and specialist services | Mental Health & Learning Disabilities Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 17.06.2024 | Energy Support Officer | Estates Directorate | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 17.06.2024 | Emergency Medicine Consultant | Unscheduled Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 18.06.2024 | Consultant Orthogeriatrician | Planned Care Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 18.06.2024 | Consultant Gynaecologist | Children & Families Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 18.06.2024 | Consultant Histopathologist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 18.06.2024 | Consultant Paediatrician | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 18.06.2024 | Nurse | Primary Care and Community Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 18.06.2024 | Pelvic Health Physiotherapist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Private Practice Work | Since April 2024 | Financial | Not applicable | |
| 18.06.2024 | Registered General Nurse | Primary Care and Community Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 18.06.2024 | Director of Nursing | Unscheduled Care Group | 1. Trustee in City Hospice Cardiff 2. Spouse works in DTPS Directorate within Health Board | 1. Since 2020 | 1. Not applicable 2. Not applicable | Not applicable | |
| 19.06.2024 | Family Psychotherapist | Mental Health & Learning Disabilities Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 19.06.2024 | Responsible Office PCH Construction Programme | Estates Directorate | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 21.06.2024 | Dietetic Support Worker | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Secondary employment through Direct Payment in Neath Port Talbot Council as a Personal Assistant in Care for an individual. Contract will only be on the weekend | Once a month until contract terminates | Paid role. Paid via Neath Port Talbot Council | Not applicable | |
| 24.06.2024 | Physiotherapy Assistant | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not Applicable | Not applicable | |

| Date Approved | Designation | Department | Nature of Declaration | Period of Involvement | Financial Transaction or Benefits in Kind | Management Action Taken | In Year Amendments |
|---|---|---|---|---|---|---|---|
| 24.06.2024 | Physiotherapy Assistant | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 24.06.2024 | Healthcare Support Worker | Primary Care and Community Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 24.06.2024 | Speech and Language Therapist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Soon to begin a second paid employment as a specialist speech and language therapist at a private company "Cardiff Speech Therapy" operating outside of the health board area only. | From 20th July 2024 - onwards | Paid employment | Not applicable | |
| 25.06.2024 | Highly Specialist Speech and Language Therapist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 25.06.2024 | Speech and Language Therapist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 25.06.2024 | Community Speech and Language Therapist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 25.06.2024 | Highly Specialist Speech and Language Therapist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 25.06.2024 | Specialist Speech and Language Therapist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 25.06.2024 | Speech and Language Therapist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 25.06.2024 | Highly Specialist Speech and Language Therapist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interest Declared | Not applicable | Not applicable | Not applicable | |
| 25.06.2024 | Professional Lead Speech and Language Therapist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interest Declared | Not applicable | Not applicable | Not applicable | |
| 25.06.2024 | Specialist Speech and Language Therapist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interest Declared | Not applicable | Not applicable | Not applicable | |
| 25.06.2024 | Staff Nurse | Primary Care and Community Care Group | Nil Interest Declared | Not applicable | Not applicable | Not applicable | |
| 26.06.2024 | Healthcare Support Worker | Primary Care and Community Care Group | Nil Interest Declared | Not applicable | Not applicable | Not applicable | |
| 26.06.2024 | Healthcare Support Worker | Primary Care and Community Care Group | Nil Interest Declared | Not applicable | Not applicable | Not applicable | |
| 26.06.2024 | Staff Nurse | Primary Care and Community Care Group | Nil Interest Declared | Not applicable | Not applicable | Not applicable | |
| 26.06.2024 | Healthcare Support Worker | Primary Care and Community Care Group | Nil Interest Declared | Not applicable | Not applicable | Not applicable | |
| 26.06.2024 | Healthcare Support Worker | Primary Care and Community Care Group | Nil Interest Declared | Not applicable | Not applicable | Not applicable | |
| 26.06.2024 | Speech and Language Technical Instructor | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interest Declared | Not applicable | Not applicable | Not applicable | |
| 26.06.2024 | Anaesthetics Consultant | Planned Care Care Group | Director of Bridgend Anaesthetists limited. | Current | None | Not applicable | |
| 27.06.2024 | Specialist Speech and Language Therapist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interest Declared | Not applicable | Not applicable | Not applicable | |
| 27.06.2024 | Specialist Speech and Language Therapist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interest Declared | Not applicable | Not applicable | Not applicable | |
| 27.06.2024 | Speech and Language Assistant | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interest Declared | Not applicable | Not applicable | Not applicable | |
| 28.06.2024 | Consultant Acute Medicine | Unscheduled Care Group | Nil Interest Declared | Not applicable | Not applicable | Not applicable | |
| 01.07.2024 | Cancer Services MDT Coordinator | Patient Care & Safety Directorate | Nil Interest Declared | Not applicable | Not applicable | Not applicable | |
| 01.07.2024 | Speech and Language Therapist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interest Declared | Not applicable | Not applicable | Not applicable | |
| 01.07.2024 | Director of Improvement & Innovation | Patient Care & Safety Directorate | 1. Independent Member St John Ambulance Cymru 2. Trustee Brynawel House Rehab 3. Spouse is Trustee St John Ambulance Cymru | 1. 2 Years 2. 3 years 3. 5 Years | None | Not applicable | |
| 02.07.2024 | Advanced Pharmacist - HIV & HOMECARE | Diagnostics, Therapies, Pharmacy and Sciences Care Group | 1. Co-applicant on a Fellowship grant Project<br>2. Co-Investigator and Member of the Patient and Public Involvement Team<br>3.Secondment with Health Education & Improvement Wales<br>4. Awarded scholarship to complete a PGCert in Advanced Management with Swansea University | 1. July 2023 - ongoing<br>2. May 2023-Ongoing<br>3. NIL<br>4. February 2024-Present (Intend completion date September 2024) | 1. NIL at time of completing declaration<br>2. Financial transaction<br>3. NIL<br>4.NIL | | |
| 2.07.2024 | Specialist Speech and Language Therapist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interest Declared | Not applicable | Not applicable | Not applicable | |
| 2.07.2024 | Healthcare Support Worker | Primary Care and Community Care Group | Nil Interest Declared | Not applicable | Not applicable | Not applicable | |
| 2.07.2024 | Speech & Language Therapist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interest Declared | Not applicable | Not applicable | Not applicable | |
| 2.07.2024 | Healthcare Support Worker | Primary Care and Community Care Group | Nil Interest Declared | Not applicable | Not applicable | Not applicable | |
| 3.07.2024 | Professional Manager Speech and Language Therapist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interest Declared | Not applicable | Not applicable | Not applicable | |

| Date Approved | Designation | Department | Nature of Declaration | Period of Involvement | Financial Transaction or Benefits in Kind | Management Action Taken | In Year Amendments |
|---|---|---|---|---|---|---|---|
| 3.07.2024 | Highly Specialist Speech and Language Therapist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | I will be working independently for a new company South Wales Psychology as part of their MDT conducting Autism Diagnostic assessments. I have made it clear that I am employed by Cwm Taf UHB and therefore will not be able to work with any children living in the Cwm Taf area. | Commencing September 2024 | Paid role | Not applicable | |
| 3.07.2024 | Healthcare Support Worker | Primary Care and Community Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 3.07.2024 | ENT Consultant | Planned Care Care Group | 1. Director of Vale ENT Ltd. 2. Spouse is Director of Vale ENT Ltd. 3. Principal Investigator in PoWH for the UK national TALGiTS (Trial of Alginates in Throat Symptoms) Trial.I multi 4. RCSEdinburgh QI Director 5. Expert panel member of the International QI WONDER Study 6. Cardiff University HSL for Phase 1 students in PoWH | 1. Since 2018 2. Since 2018 3. Since 2022 (Trial launch) 4. Since 2017 5. Since 2023 6. Since 2022 | 1. Financial as provider of private ENT services 2. Admin support for provider of private ENT services 3. Registered with CTMUHB R&D Study sponsored by Reckitt-Benckiser as Gaviscon is Alginate in trial. CTMUHB R&D receive payment for each patient recruited. 4. No financial gain 5. No financial gain 6. HSL stipend from University | The conflict of interest is noted from a service perspective and happy to confirm this will not affect the role within ENT. | |
| 03.07.2024 | Radiographer | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 4.07.2024 | Consultant Anaesthetist | Planned Care Care Group | 1. Director of Specsavers Penarth Store 2. Spouse is Director of Specsavers Penarth Store (50% shareholder) | 1. One Year 2. One Year | 1. None 2. None | Not applicable | |
| 5.07.2024 | Healthcare Support Worker | Primary Care and Community Care Group | Nil Interest Declared | Not applicable | Not applicable | Not applicable | |
| 5.07.2024 | Community Registered Nurse | Primary Care and Community Care Group | Nil Interest Declared | Not applicable | Not applicable | Not applicable | |

| Date Approved | Designation | Department | Nature of Declaration | Period of Involvement | Financial Transaction or Benefits in Kind | Management Action Taken | In Year Amendments |
|---|---|---|---|---|---|---|---|
| 5.07.2024 | Staff Nurse | Primary Care and Community Care Group | Nil Interest Declared | Not applicable | Not applicable | Not applicable | |
| 10.7.2024 | Community Staff Nurse | Primary Care and Community Care Group | Nil Interest Declared | Not applicable | Not applicable | Not applicable | |
| 11.07.2024 | Speech & Language Therapist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | 1. Working on as a Bank Speech and Language Therapist for Betsi Cadwalader Health Board 2. Extra Hours for the Neurodevelopmental Service for Cwm Taf Morgannwg Health Board | 1. 8 July 2024 2. February 2024 | 1. Salary from Betsi Cadwaladr Health Board 2. Salary received for extra hours | Not applicable | |
| 15.07.2024 | Superintendent Radiographer | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil interests declared | Not applicable | Not applicable | Not applicable | |
| 16.07.2024 | Principle Pharmacist Mental Health | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil interests declared | Not applicable | Not applicable | Not applicable | |
| 16.07.2024 | Clinical Psychologist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Offering consultation to Youth Justice Services as part of the Youth Endowment Fund. This includes offering clinical supervision to staff, attendance at meetings and support to the project manager. | Until March 2025 | Financial Payment | Not applicable | |
| 16.07.2024 | Professional Speech and Language Therapy Manager | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interest Declared | Not applicable | Not applicable | Not applicable | |
| 16.07.2024 | District Nurse | Primary Care and Community Care Group | Nil Interest Declared | Not applicable | Not applicable | Not applicable | |
| 16.07.2024 | Staff Nurse | Primary Care and Community Care Group | Nil Interest Declared | Not applicable | Not applicable | Not applicable | |
| 16.07.2024 | Healthcare Support Worker | Primary Care and Community Care Group | Nil Interest Declared | Not applicable | Not applicable | Not applicable | |
| 23.07.2024 | Speech and Language Therapist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interest Declared | Not applicable | Not applicable | Not applicable | |
| 23.07.2024 | Community Staff Nurse | Primary Care and Community Care Group | Nil Interest Declared | Not applicable | Not applicable | Not Applicable | |
| 23.07.2024 | Staff Nurse | Primary Care and Community Care Group | Nil Interest Declared | Not applicable | Not applicable | Not applicable | |
| 23.07.2024 | Healthcare Support Worker | Primary Care and Community Care Group | Nil Interest Declared | Not applicable | Not applicable | Not applicable | |
| 29.07.2024 | Speech & Language Therapist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Nil Interest Declared | Not applicable | Not applicable | Not applicable | |
| 29.07.2024 | Healthcare Support Worker | Primary Care and Community Care Group | Nil Interest Declared | Not applicable | Not applicable | Not applicable | |
| | Consultant Clinical Scientist & Assistant Director for Research & Development | Clinical Biochemistry Department (PCH) | 1. Visiting Professor of Clinical Science: University of South Wales (Research and Education)<br>2. Visiting Professor of Clinical Science: University of South Wales (Research and Education)<br>3, Honorary Professor of Clinical Biochemistry: Cardiff Metropolitan University (Research and Education)<br>4. Vice Chair of the Welsh Scientific Advisory Committee (WSAC) | 1. 2012<br>2. 2019<br>3. 2018<br>4. 2022 | 1. NONE<br>2. NONE<br>3.Health Board receives funding for x1 session/week from the National Pathology Programme<br>4. NONE | Not applicable | |
| 31.07.2024 | Dental Teaching Unit Manager | Primary Care & Communities Care Group | Nil interest declared | Not applicable | Not applicable | Not applicable | |
| 01.08.2024 | Specialist Speech & Language Therapist | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Soon to begin a second paid employment as a specialist speech and language therapist at Cardiff Speech Therapy. I will be working around two Saturdays per month for half a day. My client base will be children only outside of the Cwm Taf Morgannwg Health Board areas. | From 3 August 2024 - ongoing | Paid employment | Already agreed that caseload should not include children who reside in the UHB. | |
| 07.08.2024 | District Nurse Team Leader | Primary Care and Community | Nil interest declared | Not applicable | Not applicable | Not applicable | |
| 07.08.2024 | Consultant Clinical Psychologist | Princess of Wales Hospital | Self-employment into Hillside Secure Children's Home offering psychological assessment, consultation and advice to inform staff on how to support children in their care. | until 25.09.2024 | None | Not applicable | |
| 12.08.2024 | Dental Nurse | Primary Care and Communities | Nil interest declared | Not applicable | Not applicable | Not applicable | |
| 14.08.2024 | Consultant | Diagnostics, Therapies, Pharmacy and Sciences Care Group | ERH PATH LTD; Private limited company; Nature of business: specialists medical practice activities | Incorporated May 2022 | Director (ad hoc payments) | Not applicable | |
| 28.08.2024 | Lead Systemic Psychotherapist | Mental Health & Learning Disabilities | 1. Centre for Systemic Studies 2. CTM UHB - employee supervision 3. Private supervision arrangements | 1. Sept 2023 2. June 2023 3. June 2017 | 1. Paid Tutor 2. Paid external supervisor 3. Paid | Not applicable | |
| 02.09.2024 | Macmillan Advanced Oncology Pharmacist | Therapies & Health Sciences | Sponsorship from Pfizer Ltd to attend British Oncology Pharmacy Association Annual Conference 2024 | 11/10/2024-13/10/2024 | Pfizer covering costs of registration fee and accommodation costs which would otherwise be paid for by CTMUHB | Not applicable | |
| 12.09.2024 | Assistant Director Digital Systems | ICT Department | Nil interest declared | Not applicable | Not applicable | Not applicable | |
| 18.09.2024 | Rotational Physiotherapist | Therapies & Health Sciences | Nil interest declared | Not applicable | Not applicable | Not applicable | |

| Date Approved | Designation | Department | Nature of Declaration | Period of Involvement | Financial Transaction or Benefits in Kind | Management Action Taken | In Year Amendments |
|---|---|---|---|---|---|---|---|
| 19.09.2024 | Healthcare Support Worker | Primary & Community Care | Nil interest declared | Not applicable | Not applicable | Not applicable | |
| 23.09.2024 | National Workforce Lead | Urgent and Emergency Care | Nil Interest Declared | Not applicable | Not applicable | Not applicable | |
| 23.09.2024 | HCSW | Rhondda Taf, Ely integrated locality group | Nil Interest declared | Not applicable | Not applicable | Not applicable | |
| 23.09.2024 | Consultant Orthogeriatrician | Bridgend Integrated Locality Group | Nil Interest declared | Not applicable | Not applicable | Not applicable | |
| 23.09.2024 | Cardiologist | Rhondda Taf, Ely integrated locality group | Nil interest declared | Not applicable | Not applicable | Not applicable | |
| 23.09.2024 | Department of Rheumatology | Retire and Return Locum Consultant | Nil interest declared | Not applicable | Not applicable | Not applicable | |
| 23.09.2024 | Academy Administrator | Radiology | Nil Interest declared | Not applicable | Not applicable | Not applicable | |
| 23.09.2024 | Head of Employee Engagement & Involvement | Corporate Functions | Nil interest declared | Not applicable | Not applicable | Not applicable | |
| 23.09.2024 | Employee Experience Lead | Workforce & OD | Nil interest declared | Not applicable | Not applicable | Not applicable | |
| 23.09.2024 | Consultant Public Health | Public Health | Nil interest declared | Not applicable | Not applicable | Not applicable | |
| 23.09.2024 | Head of Corporate Governance | Corporate Governance | Nil interest declared | Not applicable | Not applicable | Not applicable | |
| 23.09.2024 | Staff Nurse | Rhondda Taf, Ely integrated locality group | Nil interest declared | Not applicable | Not applicable | Not applicable | |
| 23.09.2024 | Healthcare Science Assistant | Facilities | Nil interest declared | Not applicable | Not applicable | Not applicable | |
| 23.09.2024 | HCSW Band 4 | Primary Care | Nil interest declared | Not applicable | Not applicable | Not applicable | |
| 23.09.2024 | HCSW | Rhondda Taf, Ely integrated locality group | Nil interest declared | Not applicable | Not applicable | Not applicable | |
| 23.09.2024 | Staff Nurse | Rhondda Taf, Ely integrated locality group | Nil interest declared | Not applicable | Not applicable | Not applicable | |
| 23.09.2024 | HCSW | Rhondda Taf, Ely integrated locality group | Nil interest declared | Not applicable | Not applicable | Not applicable | |
| 23.09.2024 | HCSW | Rhondda Taf, Ely integrated locality group | Nil interest declared | Not applicable | Not applicable | Not applicable | |
| 23.09.2024 | Principle Pharmacist Specialist Therapies and High Cost Medicines | Therapies & Health Sciences | Nil interest declared | Not applicable | Not applicable | Not applicable | |
| 23.09.2024 | Community Staff Nurse | Primary Care | Nil interest declared | Not applicable | Not applicable | Not applicable | |
| 23.09.2024 | Consultant | Merthyr Cynon Integrated Locality Group | Nil interest declared | Not applicable | Not applicable | Not applicable | |
| 23.09.2024 | Consultant Physician | Rhondda Taf, Ely integrated locality group | Nil interest declared | Not applicable | Not applicable | Not applicable | |
| 23.09.2024 | Consultant | Rhondda Taf, Ely integrated locality group | Nil interest declared | Not applicable | Not applicable | Not applicable | |
| 23.09.2024 | Therapies Admin Support Officer | Therapies & Health Sciences | Nil interest declared | Not applicable | Not applicable | Not applicable | |
| 14.10.2024 | Radiographer | Radiology | Nil interest declared | Not applicable | Not applicable | Not applicable | |

| Date Approved | Designation | Department | Nature of Declaration | Period of Involvement | Financial Transaction or Benefits in Kind | Management Action Taken | In Year Amendments |
|---|---|---|---|---|---|---|---|
| 14.10.2024 | Radiographer | Radiology | Nil interest declare | Not applicable | Not applicable | Not applicable | |
| 14.10.2024 | Dental Nurse | primary care | Nil interest declared | Not applicable | Not applicable | Not applicable | |
| 25.10.2024 | Dietician | Therapies & Health Sciences | Nil interests declared | Not applicable | Not applicable | Not applicable | |
| 31.10.2024 | Head of Quality Assurance and Compliance | Corporate Governance | I am a Peer reviewer with HIW however I am not permitted to take part in any inspection activity involving CTM | 7 years | I obtain expenses for inspections that I take part in | Not applicable | |
| 21.11.2024 | Pharmacist | Therapies & Health Sciences | Nil interests declared | Not applicable | Not applicable | Not applicable | |
| 22.11.2024 | Advanced Pharmacist | Therapies & Health Sciences | Nil interest declared | Not applicable | Not applicable | Not applicable | |
| 25.11.2024 | Allied Health Profession Lead for Long Term Conditions | Therapies & Health Sciences | 1. Volunteer board member of Coproduction Network for Wales 2. Spouse is Deputy Head of Children's Services in Bridgend CBC | 1. From November 2024 2. From 2022 | 1. None 2. Standard pay | Not applicable | |
| 10.12.2024 | Consultant Urologist and Andrological Surgeon | Planned Care Care Group | 1. Director in Private Practice Company 2. Spouse is Director in Private Practice 3. Honorary Professor title with The University of South Wales 4. Programme Leader for Urology Masters Course with the Learna Group | 1. Since 2018 2. Since 2018 3. Since 2017 4. Since 2024 | 1. Private Income 2. Private Income 3. Unpaid title 4. Private Income | Of Note:<br>I questioned when specifically Gareth undertakes work for his role as lead of the Urology Masters course as this is not reflected in his current job plan. Gareth confirmed that this is variable and inconsistent. If he is needs to undertake any activities for this role, Gareth has confirmed that he undertakes this on week nights or at weekends. | |
| 17.12.2024 | Speech and Language Paeds Admin Team Lead | Therapies & Health Sciences | Nil interests declared | Not applicable | Not applicable | Not applicable | |
| 19.12.2024 | GTAP - Falls Prevention Team | Therapies & Health Sciences | Nil interests declared | Not applicable | Not applicable | Not applicable | |
| 28.01.2025 | Senior Pharmacy Technician | Therapies & Health Sciences | Nil interests declared | Not applicable | Not applicable | Not applicable | |
| 30.01.2025 | Pharmacist | Therapies & Health Sciences | Nil interests declared | Not applicable | Not applicable | Not applicable | |
| 06.02.2025 | AHP Lead for Long Term Conditions | Therapies & Health Sciences | 1. Offering private Physiotherapy 2. Volunteer Mentor for Children and Young People at "The Bridge" Community Enterprise | 1. From 5/02/2025 2. Since October 2024 | 1. Financial 2. None | No action required - common practice for physiotherapists to undertake private work alongside NHS employment | |
| 12.02.2025 | Physiotherapy Team Lead | Therapies & Health Sciences | Nil interests declared | Not applicable | Not applicable | Not applicable | |
| 13.02.2025 | Assistant Director of improvement Culture Capability and Delivery | Improvement Team | 1. Health Foundation 2. Morph Consultancy 3. Aural Apothecary Podcast | 1. Ongoing 2. Ongoing 3. Ongoing | 1. Expenses plus small fee for time spent assessing 2. Expenses and honorarium for providing training 3. Expenses and occasional Appearance fee | Not applicable | |
| 19.02.2025 | Speech & Language Therapist | Therapies & Health Sciences | Nil interests declared | Not applicable | Not applicable | Not applicable | |
| 19.02.2025 | Speech & Language Therapist | Therapies & Health Sciences | Nil interests declared | Not applicable | Not applicable | Not applicable | |
| 20.02.2025 | Interim Head of Nutrition and Dietetics | Therapies & Health Sciences | Nil interest declared | Not applicable | Not applicable | Not applicable | |
| 21.02.2025 | Clinical Specialist Physiotherapist | Therapies & Health Sciences | Working with Boots Online Doctor, in advisory role as clinical specialist physio. | For duration of one project (approx. 6 weeks total), work completed in own time not impacting Full Time role | Paid work (one off invoice for work / payment) | Not applicable | |
| 21.02.2025 | Assistant Head of Assets, Governance & Technical Services | Estates Directorate | Part time teaching / lecturing with Eastwood Park Training | 2019 - to present and ongoing | Paid a daily rate (approx. 8 days per year on weekends) | Not applicable | |
| 21.02.2025 | Compliance Officer | Estates Directorate | Nil interests declared | Not applicable | Not applicable | Not applicable | |
| 24.02.2025 | Dietetic Support Worker | Therapies & Health Sciences | Nil interests declared | Not applicable | Not applicable | Not applicable | |
| 24.02.2025 | Dietetic Assistant Practitioner | Therapies & Health Sciences | Nil interests declared | Not applicable | Not applicable | Not applicable | |
| 24.02.2025 | Employee Dietician | Therapies & Health Sciences | Partner is physiotherapist at Princess of Wales Hospital | Not applicable | Not applicable | Not applicable | |
| 24.02.2025 | Specialist Community Dietician | Therapies & Health Sciences | Living with team lead in community team YCC | Not applicable | Not applicable | Not applicable | |
| 25.02.2025 | Community Dietitian | Therapies & Health Sciences | 1. Consultancies on a self-employed basis 2. Director and shareholder of 747 Airport Cars, an airport transfers company operates in the south of England. No contract held with the NHS | 1. Since 30/05/2022 2. Since 30/05/2022 | 1. Weekly wage 2. Financial | Clarification sought - the above directorships etc are not dietetic / NHS related and relates to a taxi firm. No action required. | |
| 25.02.2025 | Dietetic Assistant Practitioner | Therapies & Health Sciences | 1. Partner is Quality Assurance Manager, NHS Wales Shared Services Partnership | 1. 21 Years | Not applicable | Not applicable | |
| 04.03.2025 | Registered General Nurse | Ward B2 YCR | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 04.03.2025 | Interim Ward Manager | Ward 3 Angelton | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 25.03.2025 | Community Staff Nurse | Parc Canol Team | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| 31.03.2025 | Energy / Carbon Project Manager | Estates Directorate | Nil Interests Declared | Not applicable | Not applicable | Not applicable | |
| | | | | | | | |
| | | | | | | | |

| Date Declaration Made | Date Received by Corporate Governance | Designation / Department | Provided by / From | Date Received | Details | Gift/Hospitality and or Sponsorship | Accepted or Declined |
|---|---|---|---|---|---|---|---|
| 30.08.2024 | 02.09.2024 | Macmillan Advanced Oncology Pharmacist | Pfizer Limited | 11th October 2024-13th October 2024 | Sponsorship for the registration fee and accommodation costs to be paid directly by sponsor. Approximate value: Accommodation £200-£300 and Conference / Registration Fees £300. | Sponsorship | Accepted. Approved by H Wilton, Chief Pharmacist. |
| | 01.10.2024 | Dermatology | Sanofi | Cica Start date of 1.7.2024 to have library established by 1.10.2024 | Donation of monies in the value of £2441.79 to purchase Dermatology books for trainees at POWH. Sanofi was contacted by the Trainee who have an educational fund for the books. The objective being: Development of a contemporary departmental library of dermatology reference books<br>- to support the education and professional development of our doctors and nurses<br>- to facilitate the management of challenging cases | Sponsorship | Accepted. Approved by Clinical Director Dermatology<br><br>Supported by Deputy Executive Medical Director 8.10.2024. |
| 17.12.2024 | 17.12.2024 | Chair CTMUHB | DXC Technology | 7.12.2024 | Invited by DXC to Manchester United v Nottingham Forrest football match at Old Trafford. I was invited in my capacity through Insight Wales although NHS colleagues from England were present along with senior leaders from tech companies who also work in Wales.<br><br>Should DXC enter into any discussions or activity with CTMUHB then the declare would ensure that they would not be party to any discussions or activity.<br><br>The declare is aware of CTMUHB's position on the acceptance of hospitality for sporting events. This related to their role as Director of Insight Wales Consulting Limited. The declaration is made to ensure full transparency. | Hospitality | Accepted.<br><br>Approved by: Chief Executive 17.12.2024 |

| Agenda Item |
| --- |
| 4.2 |

# Audit, Risk & Assurance Committee

## Annual Review: Risk Management Framework

| | |
| --- | --- |
| **Dyddiad y Cyfarfod / Date of Meeting** | 22/05/2025 |
| **Statws Cyhoeddi / Publication Status** | Open/ Public<br>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 Development Session | 15 May 2025 | Detailed Review Completed |
| Audit, Risk & Assurance Committee | 22 May 2025 | Endorsement pending |
| Executive Management Board | 27 May 2025 | For Noting |
| Health Board Meeting | 29 May 2025 | Approval 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
    - Risk Appetite Statement
    - Risk Domain & Scoring Matrix
    - Board Assurance Framework
2. Risk Management Policy
3. Risk Assessment Procedure

1.2 A Board Development Session was held on the 15 May 2025, which focussed on the Risk Management Strategy for CTMUHB and its continued adoption for a further 12 months.

1.3 The Risk Management Policy and Risk Assessment Procedure were reviewed and approved in 2022, other than minor changes they remain extant and are therefore proposed for further approval with the next review date set for May 2028.

## 2. Specific Matters for Consideration

2.1 This section is broken down into the review of the relevant component parts of the framework as identified in section 1 above.

2.2 ***Risk Management Strategy*** *(Appendix 1 to this report)*
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.

Considering the detailed review at the Board Development Session on the 15 May 2025, the following changes were made:

- ***Risk Appetite Statement*** *(Appendix 2 of the Risk Management Strategy)*
    - To avoid confusion the "Assets and Estates" risk was updated to include just one appetite which is "Open".
    - The 'Technological advances" risk was updated to capture research and innovation in its descriptor.

- ***Risk Domain Scoring Matrix*** *(Appendix 2 of the Risk Management Strategy)* - There were no changes proposed in this year's review to the matrix or risk score escalation threshold.

- ***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.

  Considering the detailed review at the Board Development Session in May 2025, the Strategic/Principal risks have been updated and the updated Risk Management Strategy reflects the position agreed at the Board Development Session.

  The Strategic/Principal Risks are subject to change following their regular review by the Board at all routine meetings.

2.3 **Risk Management Policy** (Appendix 2 to this report)

The Risk Management Policy remains extant. Minor changed were made in terms of name changes for the Board Committee meetings.

2.4 **Risk Assessment Procedure** (Appendix 3 to this report)

The Risk Assessment Procedure remains extant.

## 3. Key Risks / Matters for Escalation

3.1 The principal risks are outlined in the BAF as outlined in section 2.2, which is reviewed at all routine public meetings of the Health Board.

## 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: |
| | A Healthier Wales |

| | |
|---|---|
| **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)* | 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))* | 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:<br><br>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):<br><br>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** *(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 & Assurance Committee is asked to endorse the following:

- **APPROVAL** of the Risk Management Strategy (Appendix 1), which includes:
  - **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 and the risk escalation threshold.
  - **APPROVAL** that the Board Assurance Framework remains fit for purpose and appropriately reflects the strategic risk profile of the Health Board as discussed in detail at the Board Development Session on the 15th May 2025.
- **APPROVAL** of the Risk Management Policy (Appendix 2).
- **APPROVAL** of the Risk Management Procedure (Appendix 3).

## 6. Next Steps

6.1 If endorsed for approval this framework will be presented to the Health Board Meeting on the 29th May 2025 for formal approval.

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

# 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:** | |
| **Review Date:** | |
| **Version:** | Version 11 - 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 | 18th April 2024 | Endorse for Board Approval |
| Health Board | 30th May 2024 | Approved |
| Executive Leadership Group | 7th October 2024 | Approved an updated risk escalation process |

| **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 |

Contents

1. Introduction and Aims ..... 3
2. Scope ..... 4
3. Risk Management Organisational Structure ..... 5
4. Duties ..... 9
5. Risk Management Process ..... 12
6. Information / Support ..... 16
7. Appendix 1 - Definitions ..... 17
8. Appendix 2 - Risk Domain and Scoring Matrix ..... 19
9. Appendix 3 – Risk Management Process – Service to Board Escalation Service to Board Risk Escalation in CTMUHB ..... 21
10. Appendix 4 – Risk Appetite Statement ..... 22
11. Appendix 5 – Board Assurance Framework (Strategic / Principal Risks) ..... 24

## 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, Risk & Assurance 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 Executive Leadership Group (ELG)/ Executive Management Board (EMB), 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 & Assurance Committee

3.2 The Audit, Risk & Assurance 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, Risk & Assurance 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 CTMUHB'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) / Executive Management Board (EMB)**

3.5 The ELG/EMB undertake the following duties:

- Promote a culture within CTMUHB, 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 CTMUHB.
- 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 Directorate 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 CTMUHB's 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 ELG/EMB 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 CTMUHB'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/EMB on the management and mitigation of risk for their area;
- provide reports to the ELG/EMB 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 CTMUHB to avoid duplication, ensure compliance and alignment with the Risk Management Strategy and ensure shared learning across CTMUHB;
- 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, Risk & Assurance 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 CTMUHB's strategic objectives and ensure that Care Group, Clinical Service Group and Corporate Directorates 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 CTMUHB 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 CTMUHB needs to identify risks through the completion of risk assessments and ensure that risk assessments are completed and regularly reviewed on an ongoing basis.

5.4 The management of risk in terms of Service to Board escalation is articulated in Appendix 3.

**Board Assurance Framework (BAF)**

5.9 CTMUHB's Board Assurance Framework was last approved by the Board in May 2024. The BAF is reviewed on annual basis by the Audit, Risk & Assurance 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<br>• Includes only nine principal risks<br>• Risks identified advised by the Executive Team and agreed by Board ('top down')<br>• Decisions to add, remove or re-score risks are taken by the Board<br>• Risks are organisation-wide in scope | • Mostly operational risks arising from the CTMUHB's day-to-day activities<br>• Includes over 50 of the highest level (currently scored over 15) risks<br>• Risks usually identified by individual services or departments ('bottom up')<br>• Agreed by Executive Leadership Group following triage by Care Group / relevant leads<br>• Some are organisation-wide, others are specific to services or directorates, but require involvement by the Executive Team or other services |

5.15 CTMUHB 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, Risk & Assurance 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, Risk & Assurance 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. Please refer to Appendix 3.

**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 CTMUHB'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://ctuhb-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:<br>(1)= Management Reviewed Assurance<br>(2)= Board Reviewed Assurance<br>(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.<br>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.<br>Risk identification is a process that is used to find, recognize, and describe the risks that could affect the achievement of objectives.<br>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.<br>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.<br>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.<br>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).<br>Consequence: is the outcome of an event and has an effect on objectives.<br>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.<br>Treatment options include;<br>Avoidance / Remove the source of the risk<br>Reduction<br>Transference<br>Retain / Accept the risk<br>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.<br>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.<br>No time off work.<br>Physical injury to self/others that requires no treatment or first aid.<br>Minimum psychological impact requiring no support.<br>Low vulnerability to abuse or exploitation - needs no intervention.<br>Category 1 pressure ulcer. | Minor injury or illness, requiring minor intervention.<br>Requires time off work for >3 days Increased hospital stay 1-3 days.<br>Slight physical injury to self/others that may require first aid.<br>Emotional distress requiring minimal intervention.<br>Increased vulnerability to abuse or exploitation, low-level intervention.<br>Category 2 pressure ulcer. | Moderate injury/professional intervention.<br>Requires time off work 4-14 days.<br>Increased hospital stay 4-15 days.<br>RIDDOR/Agency reportable incident.<br>Impacts on a small number of patients.<br>Physical injury to self/others requiring medical treatment.<br>Psychological distress requiring formal intervention by MH professionals.<br>Vulnerability to abuse or exploitation requiring increased intervention.<br>Category 3 pressure ulcer. | Major injury leading to long-term disability.<br>Requires time off work >14 days.<br>Increased hospital stay >15 days.<br>RIDDOR Reportable.<br>Regulation 4 Specified Injuries to Workers.<br>Patient mismanagement, long-term effects.<br>Significant physical harm to self or others.<br>Significant psychological distress needing specialist intervention.<br>Vulnerability to abuse or exploitation requiring high levels of intervention.<br>Category 4 pressure ulcer. | Incident leading to death.<br>RIDDOR Reportable.<br>Multiple permanent injuries or irreversible health effects.<br>An event, which impacts on a large number of patients. |
| **Quality/ Complaints/ Assurance/ Patient Outcomes** | Peripheral element of treatment or service suboptimal.<br>Informal complaint/inquiry. | Overall treatment/service suboptimal.<br>Formal complaint (Stage 1).<br>Local resolution.<br>Single failure of internal standards.<br>Minor implications for patient safety.<br>Reduced performance. | Treatment/service has significantly reduced effectiveness.<br>Formal complaint (Stage 2). Escalation.<br>Local resolution (poss. independent review).<br>Repeated failure of internal standards.<br>Major patient safety implications. | Non-compliance with national standards with significant risk to patients.<br>Multiple complaints/independent review.<br>Low achievement of performance/delivery requirements.<br>Critical report. | Totally unacceptable level or quality of treatment/service.<br>Gross failure of patient safety.<br>Inquest/ombudsman/inquiry.<br>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.<br>Unsafe staffing level (>1 day)/competence.<br>Low staff morale.<br>Poor staff attendance for mandatory/key professional training. | Uncertain delivery of key objective/ service due to lack/loss of staff.<br>Unsafe staffing level (>5 days)/competence.<br>Very low staff morale.<br>Significant numbers of staff not attending mandatory/key professional training. | Non-delivery of key objective/service due to loss of several key staff.<br>Ongoing unsafe staffing levels or competence/skill mix.<br>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.<br>Reduced performance levels if unresolved. | Single breach in statutory duty.<br>Challenging external recommendations/improvement notice. | Enforcement action. Multiple breaches in statutory duty.<br>Improvement notices.<br>Low achievement of performance/ delivery requirements.<br>Critical report. | Multiple breaches in statutory duty.<br>Zero performance rating. Prosecution. Severely critical report. Total system change needed. |
| **Adverse Publicity or Reputation** | Rumours.<br>Low-level negative social media.<br>Potential for public concern. | Local media coverage - short-term reduction in public confidence/trust.<br>Short-term negative social media.<br>Public expectations not met. | Local media coverage - long-term reduction in public confidence & trust.<br>Prolonged negative social media. Reported in local media. | National media coverage <3 days, service well below reasonable public expectation.<br>Prolonged negative social media, reported in national media, long-term reduction in public confidence & trust.<br>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.<br>Total loss of public confidence/trust.<br>Escalation of scrutiny status by WG. |
| **Business Objectives or Projects** | Insignificant cost increase/ schedule slippage. | <5 per cent over project budget.<br>Schedule slippage. | 5–10 per cent over project budget.<br>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.<br>Schedule slippage.<br>Key objectives not met. |
| **Financial Stability & Impact of Litigation** | Small loss.<br>Risk of claim remote. | Loss of 0.1–0.25% of budget<br>Claim less than £10,000. | Loss of 0.25–0.5% of budget.<br>Claim(s) between £10,000 and £100,000. | Uncertain delivery of key objective. Loss of 0.5-1.0% of budget.<br>Claim(s) between £100,000 and £1 million.<br>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.<br>Minor disruption. | Loss/interruption of >8 hours.<br>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.<br>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.<br>If scored 20 or above the risk should be reviewed on a monthly basis. |

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

This process should be read in conjunction with the Risk Assessment Procedure available here: Risk Assessment Procedure.docx

Further tools and support for undertaking risk assessments is available on the dedicated Risk page on SharePoint available here: Risk Assessment - Undertaking Risk Assessments.

Training on risk is available to book on ESR please search for course: **110 Risk Management Strategy and Risk Assessment and Training Awareness**.

A step-by-step guide for completing a risk assessment on the Datix Web Module is available here: Risk Assessment - Undertaking Risk Assessments – "DatixRiskWeb User Guide V6". The Risk Scoring & Domain Matrix is a key reference point when scoring risks and is available in the Risk Assessment Procedure

### 1. Risk Assessment

Risk identified and a risk assessment needs to be undertaken. A risk assessment should be completed directly into the Datix Risk Web Module or via completing a hard copy of the risk assessment form to upload to Datix Web Module following completion.

### 2. Risks scored with a risk score of between 1 and 6 (Low) and 8 and 10 (Moderate)

Any risks identified and evaluated as having a low/moderate rating, can be managed locally within the relevant area i.e., local/Directorate level risk register.

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/Directorate risk register within each service area/department.

All risks should be reviewed and updated as per the frequency captured in the Risk Assessment Procedure and Risk Scoring and Domain Matrix.

Escalation via Care Group / Central Directorate Senior Team is not required unless there is a novel or contentious matter that should have visibility or further input, or support is needed.

### Risk scored with a risk score of 12 (Moderate)

Risks identified as having a moderate rating i.e., a score of 12 are managed at a local level but should also be escalated to Care Group / Central Directorate Senior Team for visibility and review.

Risk owners should also add a note to the "Escalation Status" in the Datix Web Module indicating where in the process the risk is i.e. escalated and to be considered by the Care Group Senior Leadership Team.

The review at the escalated level should be undertaken on at least a quarterly basis.

The forums for which these risks are monitored will be at the discretion of the Care Group / Central Directorate, although it is suggested that this is undertaken via the QSRE meetings, Health, Safety & Fire meetings or equivalent in Care Groups and Governance Meetings, at a Central/Corporate Directorate Level.

### Risk scored with a risk score of 15 and above and/or is novel and contentious

Risks identified as having a high rating i.e. a score of 15 and above and/or is novel and contentious, will still be managed in the service/area for which they were identified, however they should be escalated immediately to a Care Group / Central Directorate level.

High level risks should be monitored at least monthly if scored 20 and above or bi-monthly if 15 and above. The forums for which these risks are monitored will be at the discretion of the Care Group / Central Directorate, although it is suggested that this is undertaken via the QSRE meetings or equivalent in Care Groups and Governance Meetings, at a Central/Corporate Directorate Level.

Once escalated, it will be for the Care Group Senior Team / Central Corporate Director to consider if the risk should also be escalated to the Organisational Risk Register, managed via the Assistant Director of Governance & Risk.

If the Care Group/Central Director consider that this risk should be escalated to the Organisational Risk Register, it will do so as follows:

- Include in highlight report / update report to the next Operational Management Board meeting which meets monthly;
- Once the Operational Management Board have reviewed the risk and support escalation the "Yes to escalate" in the Datix Web Module, the box should be ticked which will generate a notification to the Assistant Director of Governance & Risk; and
- Risk owners should also add a note to the "Escalation Status" in the Datix Web Module, indicating where in the process the risk is i.e. escalated and to be considered at Operational Management Board on (date). Once approved for escalation, the date it was escalated to the Organisational Risk Register should also be captured in this box.

The risk should continue to be reviewed by the area for which it has been identified and in addition on a bi-monthly basis updates for the Organisational Risk Register will be requested.

Once escalated to the Organisational Risk Register, these risks will be reviewed at Public Board Committees, where assurance as to the robust monitoring and review will be sought.

### De-escalation of Risks from the Organisational Risk Register

If because of successful mitigation, a risk score can be reduced below the threshold for escalation, "Datix Web Module escalation status" should be updated, as well as the rationale for risk score changes. This demonstrates robust and proactive management.

**Endorsed by the Operational Management Board on the 2nd October 2024**

**Approved by the Executive Leadership Group on the 7th October 2024**

## 10. 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.

The risk appetite statement was last reviewed on the 15 May 2025.

- **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.

- **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.

[1] Government Finance Function – Risk Appetite Guidance Note – August 2021 – V2.0
[2] The Orange Book – Section A

- **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 an **Open** stance 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 (Research and Innovation)-** the Health Board has adopted an **Open** stance for risks associated with technological advances recognising that advances in research and innovation in relation to 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)

A detailed review of the Strategic / Principal risks was completed at the Board Development Session on the 15th May 2025. There is a dynamic approach to the review of the Strategic / Principal risks and is therefore is subject to change following approval at Board meetings throughout the year. At the time of updating this Strategy, the Board have identified the following key Strategic Risks:

The latest Board Assurance Framework report will be available from the Health Board's Public Board Meeting papers available here: Board Meetings & Papers - Cwm Taf Morgannwg University Health Board

| Risk no | Strategic Goal | Strategic / Principal Risk | Lead(s) for this Risk | Assurance committee |
|---|---|---|---|---|
| 1 | **Improving Care, Sustaining our Future** | **a) Enough capacity to meet emergency and <u>elective</u> demand**<br>**b) Enough capacity to meet <u>emergency</u> demand** | Chief Operating Officer | Quality, Safety & Experience Committee<br>Operational Delivery Committee |
| 2. | **Improving Care, Sustaining our Future** | **Ability to deliver improvements which transform care and enhance outcomes** | Executive Director of Nursing<br>Executive Medical Director | Quality, Safety & Experience Committee<br>Operational Delivery Committee |
| 3. | **Sustaining our Future, Improving Care and Inspiring People** | **Enough workforce to deliver the activity and quality ambitions of the organisation** *(including Culture, Values and Behaviours)* | Executive Director for People | Quality, Safety & Experience Committee<br>Operational Delivery Committee |
| 4. | **Creating Health, Sustaining our Future.** | **Effective Community and Partner Engagement in service changes and developments** | Executive Director of Strategy & Transformation<br>Director of Communications, Engagement & Fundraising | Strategic Development Committee |
| 5. | **Improving Care, Sustaining our Future** | **Delivery of a digital and information infrastructure to support organisational transformation** | Director of Digital | Operational Delivery Committee<br>Strategic Development Committee |
| 6. | **Improving Care, Sustaining our Future** | **Ability to maintain a safe and fit for purpose estate infrastructure** | Executive Director of Finance | Operational Delivery Committee |
| 7. | **Sustaining our Future, Creating Health** | **Fulfilling our Environmental and Social Duties and ambitions** | Executive Director of Strategy & Transformation | Strategic Development Committee |
| 8. | **Creating Health, Sustaining our Future** | **Prevention and early Intervention to support Healthy Life Expectancy** | Executive Director of Public Health | Strategic Development Committee |
| 9. | **Sustaining our Future** | **Failure to plan and manage revenue resources within the Revenue Resource limits set by Welsh Government** | Executive Director of Finance | Operational Delivery Committee |
| 10. | **Sustaining our Future, Improving Care** | **Ability to develop a fit for the future estate to reflect our future clinical service model** | Executive Director of Finance | Strategic Development Committee |
| 11. | **Creating Health, Sustaining our Future, Improving Care** | **Delivery of an Integrated Care Model** | Chief Operating Officer | Strategic Development Committee |

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

# RISK MANAGEMENT POLICY

| | |
|---|---|
| **Document Type:** | Non Clinical Organisational Wide Policy |
| **Ref:** | RM 02 |
| **Author:** | Cally Hamblyn, Assistant Director of Governance & Risk |
| **Executive Sponsor:** | Director of Corporate Governance |
| **Approved By:** | |
| **Approval / Effective Date:** | |
| **Review Date:** | |
| **Version:** | Version 6 - Draft |

**Target Audience:**

| | |
|---|---|
| **People who need to know about this document in detail** | Risk Handlers, Owners and Managers. |
| **People who need to have a broad understanding of this document** | All employees of the Health Board. |
| **People who need to know that this document exists** | All employees of the Health Board. Board Members, Stakeholders. |

**Integrated Impact Assessment:**

| | |
|---|---|
| **Equality Impact Assessment Date & Outcome** | **Date:** 20.11.2020<br>**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 |

| **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 |

Contents


1. **PURPOSE** ..... 3
2. **POLICY STATEMENT** ..... 3
3. **POLICY COMMITMENT** ..... 4
4. **SCOPE OF POLICY** ..... 4
5. **RESPONSIBILITIES** ..... 5
6. **CORE ELEMENTS OF RISK MANAGEMENT** ..... 9
7. **LEGISLATIVE REQUIREMENTS** ..... 12
8. **IMPLEMENTATION/POLICY COMPLIANCE** ..... 12
9. **EQUALITY IMPACT ASSESSMENT STATEMENT** ..... 12
10. **TRAINING IMPLICATIONS** ..... 13
11. **REVIEW AND MONITORING ARRANGEMENTS** ..... 13
12. **GETTING HELP** ..... 13
13. **RELATED POLICIES** ..... 14
14. **REFERENCES** ..... 14

## 1. PURPOSE

1.1 The purpose of this Policy is to lay the foundations for an effective risk management system and ensure that:

- all risks that could cause harm are identified and that control mechanisms are implemented;
- that satisfactory management arrangements are in place for assessing the risk;
- staff know how to undertake a risk assessment and are able to identify and take action to mitigate risk;
- all legal requirements are met.

1.2 This Policy sets out the approach to risk management in Cwm Taf Morgannwg University Health Board (CTMUHB).

1.3 The Policy aligns to all the Health and Care Standards, however, specifically:

- Governance, Leadership & Accountability;
- Standard 2.1 – Managing Risk and Promoting Health & Safety.

1.4 In accordance with the Values and Behaviours of the organisation, CTMUHB will:

- *All work together as one team* to ensure that the culture of risk management is effectively promoted to staff ensuring that they understand that the '**risk taker is the risk manager**' and that risks are owned and managed appropriately;
- embed both the principles and mechanisms of risk management into the organisation;
- *We will listen and learn* and involve staff at all levels in the process;
- *We will treat everyone with respect in the implementation and management of this policy.*

## 2. POLICY STATEMENT

2.1 CTMUHB recognises that no organisation can operate in a risk-free environment. Risk however is not something to be feared, rather if it is understood and managed properly it can benefit the organisation, its staff and key stakeholders.

2.2 CTMUHB will manage risks at all levels. Strategic risks will be identified by the Board and managed by the Executive Team, whereas operational risks will be identified and managed at the most appropriate level.

2.3 The organisation will maintain a risk management system which will enable and empower staff to identify, assess, manage and appropriately treat risks.

## 3. POLICY COMMITMENT

3.1 CTMUHB is committed to the effective management of risk throughout the organisation and will develop and maintain the appropriate systems to allow such management.

3.2 The organisation will lay out clearly the roles and responsibilities of all staff when it comes to the management of risk, and these can be found both here and in the Risk Management Procedure, or where appropriate in the relevant process document.

3.3 All staff are required to understand their role and responsibilities and to comply with the requirements of both this policy and all relevant processes.

3.4 All staff will be expected to use the appropriate corporate systems for risk management. At the time of developing this policy, risk is managed through the Datix platform and the use of risk registers (for operational risk) and the Board Assurance Framework for strategic risks.

3.5 Whilst there is no specific mandatory training requirement for staff in Risk Management, those staff who have specific responsibilities will have the appropriate training in order to allow them to carry out the roles.

## 4. INTRODUCTION

4.1 This policy introduces the CTMUHB position and expectations in relation to risk management. The document outlines the Board responsibilities and expectations, describes the way CTMUHB categorises risk and the risk architecture of the organisation. For more detail in the procedures to be followed for managing risk, please refer to the associated document 'Risk Management Procedure'.

## 5. SCOPE/AIMS AND OBJECTIVES OF POLICY

**Scope**

5.1 This is a Policy which is intended to cover the identification, assessment and management of risk in all forms. The policy and associated procedures relating to risk will apply to all staff, contractors and visitors. In the interests of brevity, the term staff is used throughout this document to refer to staff, contractors, agency staff, volunteers, secondees and visitors.

5.2 Organisations hosted by CTMUHB e.g. Joint Commissioning Committee and the National Imaging Academy for Wales, are responsible for ensuring that structures and reporting mechanisms are in place to implement the requirements of this Policy.

5.3 Due to CTMUHB's contractual relationship with independent contractors, e.g. General Practitioners, dentists, optometrist etc. the Health Board

clinical governance processes will provide assurance to the Board that these services are safe and meet set standards.

5.4 Contractors and Contracted Services: before contracts are finalised, the competence of contractors will be assessed in relation to health and safety as detailed in CTMUHB's Control of Contractors Policy.

**Aim**

5.5 The aim of this document is to outline the high-level arrangements within which CTMUHB will achieve a holistic and effective approach to risk management.

**Objectives**

5.6 This policy will:

- Explain the role and expectations of the Board in relation to risk management;
- Detail the high-level responsibilities for implementing this policy;
- Signpost the specific policies and procedures which CTMUHB will publish to ensure that all staff understand what is required of them;
- Explain the arrangements for complying with all relevant legislation.

## 6. STRATEGIC CONTEXT

6.1 CTMUHB has developed and agreed Strategic Goals which Strategic/Principal risks have been set against

6.2 In order to deliver against the Strategic Goals and Strategic Priorities, it is necessary to understand the environment in which we operate, and to have clear visibility on what might get in the way of delivering them. Therefore, an effective Risk Management System is necessary. Risk Management starts at the top of the organisation, with the Board setting our direction and our risk appetite, and then permeates down through every level.

## 7. ROLES AND RESPONSIBILITIES

### The Board

7.1 In order for the Board to discharge its responsibilities, it needs to receive assurances that the organisation is effectively managing its risks to ensure delivery of its mission and objectives. The principle assurance tools for the Board are the Board Assurance Framework Report and the Organisational Risk Register.

7.2 The Board will scrutinise the Board Assurance Framework Report at all routine meetings for the purpose of challenge and receiving assurance.

**Audit, Risk & Assurance Committee**

7.3 The role of the Committee is to provide the Board with assurances that appropriate arrangements for effective internal control, and for the identification and management of risk.

7.4 In order to undertake this role the Audit, Risk & Assurance Committee receives routine risk reports in accordance with the organisations Risk Management Strategy.

7.5 The functions and membership of the Committee is set out in the terms of reference and standing orders.

**Other Board Committees / Board Sub Committees**

7.6 Board Committees and Board Sub Committees will receive routine reports on risks assigned to them as the assuring committee.

7.7 The functions and membership of the Committee is set out in the terms of reference and standing orders.

**Chief Executive**

7.8 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.

7.9 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 that is in-line with our organisational values;
- 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.

7.10 The Welsh Government requires the Chief Executive to sign an Annual 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.

7.11 Operationally, the Chief Executive has designated responsibility for implementation of this policy and associated procedure to the Director of Corporate Governance.

**Director of Corporate Governance**

7.12 The Director of Corporate Governance with the support of the Assistant Director of Governance & Risk will:

- work closely with the Chair, Chief Executive, Chair of the Audit, Risk & Assurance 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 Health Board's strategic objectives;
- develop and communicate the Board's risk awareness, appetite and tolerance;
- develop and oversee the effective execution of the Board Assurance Framework 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 / Other Board Level Directors**

7.13 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.

7.14 Specifically they will:

- act as strategic risk owner for risks within their remit escalated to the Organisational Risk Register;
- 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 or contribute to 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; and
- 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.

**All Staff**

7.15 All members of staff are accountable for maintaining risk awareness and identifying and reporting risks as appropriate to their line manager.

7.16 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.

7.17 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 and Board Assurance Framework and processes and the local strategy and procedures and comply with them.

**Internal Audit**

7.18 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.

## 8. CATEGORIES OF RISK

*8.1* ***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 Executive Leadership Group / Executive Management Board, Board Committees and the Board.

8.2 ***Organisational Risks:*** are risks that are mainly operational in nature and arise from the CTMUHB's day-to-day activities.

## 9. CORE ELEMENTS OF RISK MANAGEMENT

9.1 **Risk Management** is the assessment, analysis and management of risks. It is simply a way of recognising which events (hazards) may lead to harm in the future and minimising their likelihood of occurrence (how often?) and consequence(s) (how bad).

9.2 **Acceptable / tolerable risk** is defined based on the following principles:

- tolerability does not mean acceptability. It refers to a willingness to live with risk to secure certain benefits, but with the confidence that it is being properly controlled. To tolerate risk does not mean to disregard it, but rather that it is reviewed with the aim of reducing further risk;
- no person should knowingly be exposed to serious avoidable risk;

- it is reasonable to accept a risk that under normal circumstances would be unacceptable if the risk of all other alternatives, including nothing is even greater.

9.3 Given that acceptable risk is defined as:
"A risk is deemed acceptable when there are adequate control mechanisms in place and the risk has been managed as far as is considered to be reasonably practicable. The potential benefits should outweigh the potential harm."

9.4 **Identification and reporting of risk:** the identification of risk within CTMUHB must be addressed in a proactive as well as a reactive way. The proactive approach to the identification of risk relies upon robust risk assessment and a comprehensive dynamic organisational risk register. Risks must be reported via the Datix Risk Management System. The organisation relies upon the accurate reporting of incidents by all its staff. The data analysis of this source of risk identification will continue to be a crucial part of monitoring progress and lessons learnt from incidents. Evaluation, audit, service reviews, complaints and litigation must also be utilised as a source of data for the identification and reporting of risk.

9.5 CTMUHB must ensure that the **processes to identify and report risk are open and accessible to all staff, patients and public**. This may result in an increase in the number of incidents identified within the Health Board. Any media interest will be managed in a positive way, by reassuring the public that increased reporting is essential to the prevention of serious incidents and the increase in incident reporting is a major step forward in improving the quality and safety of patient care.

9.6 The **Risk Assessment Procedure** sets out the process to be followed. The Risk Assessment Procedure will support this Policy by explaining:

- when to undertake a risk assessment;
- how to undertake a risk assessment;
- what is a generic risk assessment;
- the principles of risk assessment; and
- the risk assessment process.

9.7 **Learning lessons** from risk identification and other concerns (incidents, claims and complaints) is key to preventing and minimising the likelihood of reoccurrence. Please refer to the Health Board's Being Open Policy. Lessons learned can be shared using the newly

established Shared Listening and Learning Forum with the Health Board which supports the values of CTMUHB that *We Listen, Learn and Improve* and *We Treat everyone with Respect.* This will mean that staff feel reassured that the investigation of incidents will be undertaken in a fair and open way.

9.8 As part of a **Just and Learning Culture**, on occasion there may potentially be a serious breach of professional practice, or possible criminal activity revealed, indicating the need for further investigation under the Health Board's Disciplinary or Capability Policies (agreed at an all Wales level). All such cases will be considered individually, however, formal disciplinary action may result where:

- an individual persists in unsafe practice;
- there is a deliberate failure to report, or attempt to cover up an incident;
- there have been repeated unreported errors or violations;
- there is evidence of malicious activities (including malicious reporting of untrue allegations against a colleague);
- there has been an act of gross misconduct (e.g. treating patients whilst under the influence of drugs or alcohol);
- a breach of the criminal law (e.g. theft or assault) or professional conduct has occurred.

9.9 **Communication with staff, patients and public –** it is important that communication relating to risk management is both transparent and effective for staff and patients. The communication of risk management issues will be available through the Health Board and Board Committee papers available on the Health Board's website Click Here. The patients and the public have an important role to play in the identification and reduction of risk. Further work will be undertaken to build on the current involvement of patients and public in service development. Gaining their perspective and involvement in risk management will support the identification and reduction of risk throughout the organisation.

9.10 CTMUHB works with a number of **external partners** including Social Services and the Voluntary Sector. It is important that a clear process for communication with these partners regarding risk is implemented. Healthcare Inspectorate Wales (HIW), Welsh Risk Pool (WRP), Health and Safety Executive (HSE), South Wales Fire & Rescue Service, Internal Audit and External Audit have a role in the monitoring and evaluation of organisational risk issues. CTMUHB will continue to work

collaboratively with these agencies in the continuous improvement of risk management and risk reduction.

9.11 **Partnership Working -** Risk management does not exist in isolation and is one of the enabling systems within Governance frameworks. The risk management processes must continue to enable the organisation to identify unacceptable risks, these can then be minimised to meet high quality care for patients.

## 10. LEGISLATIVE REQUIREMENTS

10.1 The risk assessment provision of the Management of Health and Safety at Work Regulations (1999) requires employers to assess the risks created by their undertaking, so as to identify the measures they need to have in place to comply with their duties under health and safety legislation.

10.2 As such, the assessment provision of the Management of Health and Safety at Work Regulations are superimposed over all other workplace legislation including the general duties in the Health and Safety at Work Etc. Act 1974.

10.3 This Policy is the overarching document for implementing the Risk Management Strategy and is intended to meet all legal and internal requirements.

## 11. IMPLEMENTATION/POLICY COMPLIANCE

11.1 There is a requirement of all staff to comply with the provisions of this Policy and, where requested, to demonstrate such compliance. Failure to comply will be dealt with in accordance with the appropriate Workforce and Organisational Development policy.

## 12. EQUALITY IMPACT ASSESSMENT STATEMENT

12.1 This policy has been screened for relevance to Equality. No potential negative impact has been identified.

12.2 Advice and guidance should be sort from the Equality Team prior to implementing any risk management measures that could have a potential impact on equality.

## 13. TRAINING IMPLICATIONS

13.1 The effectiveness of managing risk within CTMUHB relies upon the knowledge of staff, patients and public regarding risk identification and reporting.

13.2 It is important that all staff are aware of their responsibilities regarding risk management. The identification and management of risk must be a core competency of the annual personal review and appraisal process.

13.3 A range of training and education relating to risk management is available aimed at the specific needs of staff members. Where required the education and training programmes can also be extended to our independent contractor colleagues to support their responsibilities in the management of risk and safety.

13.4 All Managers must ensure:

- that all members of staff receive sufficient training to fulfil their individual duties, to ensure compliance with this policy, and to understand the importance of identifying and controlling risks;
- that adequate risk assessment training is given to appropriate members of staff in their specific duties as defined within the Risk Management Strategy. It is essential that risk assessments are completed by competent members of staff, who have sufficient experience of the working procedures and have received the appropriate training.

## 14. REVIEW AND MONITORING ARRANGEMENTS

14.1 All Departmental Heads will regularly monitor to ensure that measures to control risks are being fully implemented and remain effective. They will arrange for managers to continually review risk assessments and risk registers, in accordance with the frequency set out in the Risk Assessment Procedure and Risk Management Strategy.

14.2 This Policy will be formally reviewed every three years or sooner should there be any service or legislative changes that require an earlier review to be undertaken.

## 15. GETTING HELP

15.1 Risk Management support and guidance is available from:

Assistant Director of Governance & Risk:**Cally.Hamblyn2@wales.nhs.uk**

Or visit:

**http://ctuhb-intranet/dir/HealthandSafety/default.aspx**

## 16. RELATED POLICIES

16.1 This policy should be read in conjunction with the following policies and procedures:

- Risk Management Strategy;
- Risk Management Procedure;
- Health & Safety Policy;
- Incident Reporting Policy;
- Being Open Policy.

## 17. REFERENCES


- Bateman, Mike. (2006) Tolley's Practical Risk Assessment Handbook. Elsevier.
- Control of Substances Hazardous to Health Regulations 2002.
- Controls Assurance and Corporate Governance Agenda.
- Corporate Manslaughter Act 2007.
- Display Screen Equipment Regulations 1992.
- Financial controls documentation.
- Health and Safety at Work Etc. Act 1974.
- Health and Safety Executive. (2006) Five Steps to Risk Assessment.
- Health and Safety Executive. Health and Safety at Work etc. Act 1974.
- Health and Safety Executive. (2000) Management of Health and Safety at Work Regulations 1999. Approved Code of Practice and guidance L21. HSE Books.
- Health and Safety Executive. (1998) Successful Health and Safety Management HSG65. HSE Books.
- Management of Health and Safety at Work Regulations 1999.
- Manual Handling Operations Regulations 1992 (as amended).
- Medicines and Healthcare products Regulatory Agency – Medical Device Alerts.
- National Patient Safety Agency. (2008) A Risk Matrix for Risk Managers.
- Noise at Work Regulations.
- Personnel Protective Equipment Regulations 1992.
- Provision and Use of Work Equipment Regulations 1998.
- Regulatory Reform Act.
- Health and Care Standards.
- Statutory duty of quality in the NHS by meeting the requirements of the Clinical Governance agenda.
- Welsh Risk Management Standards.
- Workplace (Health, Safety & Welfare Regulations) 1992.


These references are not exhaustive and may be subject to change and amendment.

# RISK ASSESSMENT PROCEDURE

| | |
|---|---|
| **Document Type:** | Non Clinical Procedure |
| **Ref:** | RM 04 |
| **Author:** | Cally Hamblyn, Assistant Director of Governance & Risk |
| **Executive Sponsor:** | Director of Corporate Governance |
| **Approved By:** | |
| **Approval / Effective Date:** | |
| **Review Date:** | |
| **Version:** | Version 7 Draft |

**Target Audience:**

| | |
|---|---|
| **People who need to know about this document in detail** | Risk Handlers, Owners and Managers. |
| **People who need to have a broad understanding of this document** | All employees of the Health Board. |
| **People who need to know that this document exists** | All employees of the Health Board. Board Members, Stakeholders. |

**Integrated Impact Assessment:**

| | |
|---|---|
| **Equality Impact Assessment Date & Outcome** | **Date:** 20.11.2020<br>**Outcome:** No potential negative impact identified. |
| **Welsh Language Standard** | No |
| **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 |

| **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 |

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

## Contents


**1. INTRODUCTION** ..... 3
**2. PURPOSE** ..... 5
**3. DEFINITIONS** ..... 6
**4. THE FIVE STEP RISK ASSESSMENT PROCESS** ..... 8
**5. STEP ONE – IDENTIFY AND ANALYSE THE RISKS** ..... 8
**6. STEP TWO – ASSESS WHO MIGHT BE HARMED AND HOW** ..... 11
**7. STEP THREE – EVALUATE AND CONTROL THE RISKS** ..... 11
**8 STEP FOUR – RECORD THE FINDINGS AND IMPLEMENT THEM** ..... 15
**9 STEP FIVE - MONITOR, REVIEW AND FEEDBACK** ..... 18
**10.0 DOCUMENTATION** ..... 19
**11.0 COMPLETED RISK ASSESSMENTS** ..... 19
**12.0 RISK REGISTER** ..... 19
**13.0 TRAINING** ..... 20
**14.0 RESPONSIBILITIES** ..... 20
**15.0 NON CONFORMANCE** ..... 20
**16.0 EQUALITY IMPACT ASSESSMENT STATEMENT** ..... 20
**17.0 RESEARCH** ..... 21
**18.0 APPENDIX 1 - RISK DOMAINS & SCORING MATRIX** ..... 22
**19.0 APPENDIX 2 – RISK IDENTIFICATION FORM** ..... 23
**20.0 APPENDIX 3 – RISK ASSESSMENT FORM** ..... 24
**21.0 APPENDIX 4 – RISK MANAGEMENT PROCESS – SERVICE TO BOARD ESCALATION** ..... 28

## 1. INTRODUCTION

1.1 Risk is present in any organisation, in its service and business activities, people, management and support systems, buildings, equipment and supplies. Healthcare is a high-risk activity and clinicians and managers should not be discouraged from taking some risks in developing more effective/innovative methods of treatment. It is important however, that such risks are taken as a result of an objective decision to do so based on reliable information and an understanding of the possible outcome. All employees should fully comply with the requirements of the Risk Assessment Procedure. If a member of staff becomes aware of a risk they must take immediate remedial action and report their concerns to their supervisor or manager.

1.2 The purpose of this Risk Assessment Procedure is to provide clear instructions on the identification of risks and the process and management of those risks, with regard to risk assessment. This will enable Cwm Taf Morgannwg University Health Board (CTMUHB) to actively monitor, manage, prioritise and develop a consistent approach to all risk assessments in order to protect the safety of patients, staff, visitors, contractors and members of the public, equipment, finances, premises and the environment. This Procedure aligns to the Risk Management Policy; Risk Management Strategy and Health and Safety Policy.

1.3 This Procedure aligns to all of the Health and Care Standards, however, specifically:

- Governance, Leadership & Accountability
- Standard 2.1 – Managing Risk and Promoting Health & Safety.

1.4 Risk assessment is an essential part of any risk management system. Risk assessment methods are used to decide on priorities and to set objectives for eliminating hazards and reducing risks. Wherever possible risks are eliminated, if they cannot be eliminated, they are minimised by the use of physical controls or, as a last resort, through systems of work and personal protective equipment.

1.5 In order to minimise risk it is vital that remedial/ mitigating action is taken immediately or as soon as reasonably practicable following the identification of the risk.

1.6 A risk is deemed acceptable when there are adequate control mechanisms in place and the risk has been managed as far as is considered to be reasonably practicable. The potential benefits should outweigh the potential harm.

1.7 The general duties of CTMUHB to its employees in section 2 of the Health and Safety at Work etc. Act 1974 implies the need for risk assessment. This duty was extended by section 3 to anybody else affected by its activities including contractors, visitors, patients and members of the public. However, the Management of Health and Safety at Work Regulations 1999 lays down the following requirements:

"Every employer shall carry out a **suitable and sufficient** assessment of the risk to the health and safety of their employees and to anyone else who may be affected by their activity, so that the necessary preventative and protective measures can be identified."

1.8 The Approved Code of Practice (ACOP) to the Regulations state:

"Suitable and sufficient is not defined in the Regulations. In practice it means the risk assessment should do the following:

The risk assessment should identify the risks arising from or in connection with work. The level of detail in a risk assessment should be proportionate to the risk. Once the risks are assessed and taken into account, insignificant risks can usually be ignored, as can risks arising from routine activities associated with life in general, unless the work activity compounds or significantly alters those risks. The level of risk arising from the work activity should determine the degree of sophistication of the risk assessment."

1.9 A suitable and sufficient risk assessment should:

- identify the significant risks;
- identify and prioritise the measures required to comply with any relevant statutory provisions;
- remain appropriate to the nature of the work and valid over a reasonable period of time.

1.10 CTMUHB, as an employer, must demonstrate a clear commitment to carrying out risk assessments. The organisation will:

- enable a consistent approach to managing risks that exist and the actions necessary to reduce them;

- produce a risk register;
- determine roles and responsibilities for the assessing and reporting of risks.

1.11 This procedural document covers both clinical and non-clinical risk assessment.

1.12 CTMUHB will work with colleagues, independent contractors and others outside the organisation to share knowledge, information, and training in making quality improvements. This will require a high level of management commitment, professional competence and adequate resources.

## 2. PURPOSE

2.1 The purpose of carrying out a risk assessment is to enable the organisation to effectively take the measures necessary for the safety and health protection of staff, patients and everyone who is on CTMUHB sites. These measures include prevention of occupational risks and prevention and/or reduction in risks to patients and users.

2.2 The law expects CTMUHB to follow the hierarchy of control (see section 7). Most risks cannot be totally eliminated and these risks will need to be managed to ensure that people and the organisation is protected as far as reasonably practicable. The risk assessment:

- can identify risk to patients' safety;
- will enable CTMUHB to identify the risks to which employees are exposed whilst they are at work;
- will identify risks to the safety of persons not in the CTMUHB's employment arising out of or in connection with any work being undertaken by the organisation;
- can be regarded as an important management decision making tool;
- can highlight the benefits of positive action taken, the consequence of no action and the costs involved;
- will identify any risks related to the premises and organisation of CTMUHB;
- will enable CTMUHB to plan, introduce and monitor preventative measures to ensure that risks are adequately controlled;
- will identify where staff need appropriate training;
- will provide information to make changes, improve facilities, and services.

2.3 It is important that risk assessments are developed where a risk has been identified or revised following an incident, when circumstances change, when new technology, research, and new regulations and procedures are introduced, and at regular intervals depending on the level of risk.

2.4 Following an incident there is a requirement to review the risk assessment and in doing so incorporate the outcome from the investigation and/or root cause analysis. The review date for the risk assessment will need to be based on any actions identified within the investigation or root cause analysis to ensure that appropriate mitigating action has been taken within the specified period.

## 3. DEFINITIONS

3.1 **Hazard -** A hazard is something which has the potential to cause harm. In the context of operational business risk, it is sometimes easier to use the term threat instead, and the word harm should be read as harm to what you are trying to achieve. In other words, if there is something which has the potential to stop you achieving your objectives, this is a hazard (or threat).

3.2 **Risk** - Risk is the likelihood that the harm will be realised e.g. the chance that somebody could be harmed by the hazard, together with an indication of how serious the harm could be. The key thing here is that for anything to be described as a risk there **MUST** be some level of uncertainty connected with it. If there is no uncertainty, then you do not have a risk – you have a problem or an issue.

Some examples of hazards and the associated risk are shown below.

| Hazard | Risk |
|---|---|
| walking on uneven floor surfaces | slips, trips or falls |
| climbing up or down steep stairs or ladders | falling down stairs or the collapse of the ladders |
| use of electrical equipment | electrical shock or burns |
| behavioural problems | assault on staff |
| medication error | wrong drug, wrong patient resulting in patient harm |

| Hazard | Risk |
|---|---|
| misdiagnosis | no treatment, wrong treatment, delayed treatment resulting in short or long term ill health or injury |
| mislabelling of specimens | delay to or incorrect treatment, tests have to be redone, increased time and cost |

3.3 **Problem / Issue** – is simply something which is happening or has happened and needs to be dealt with. These are not managed through the risk management system and are therefore not further referred to within this document.

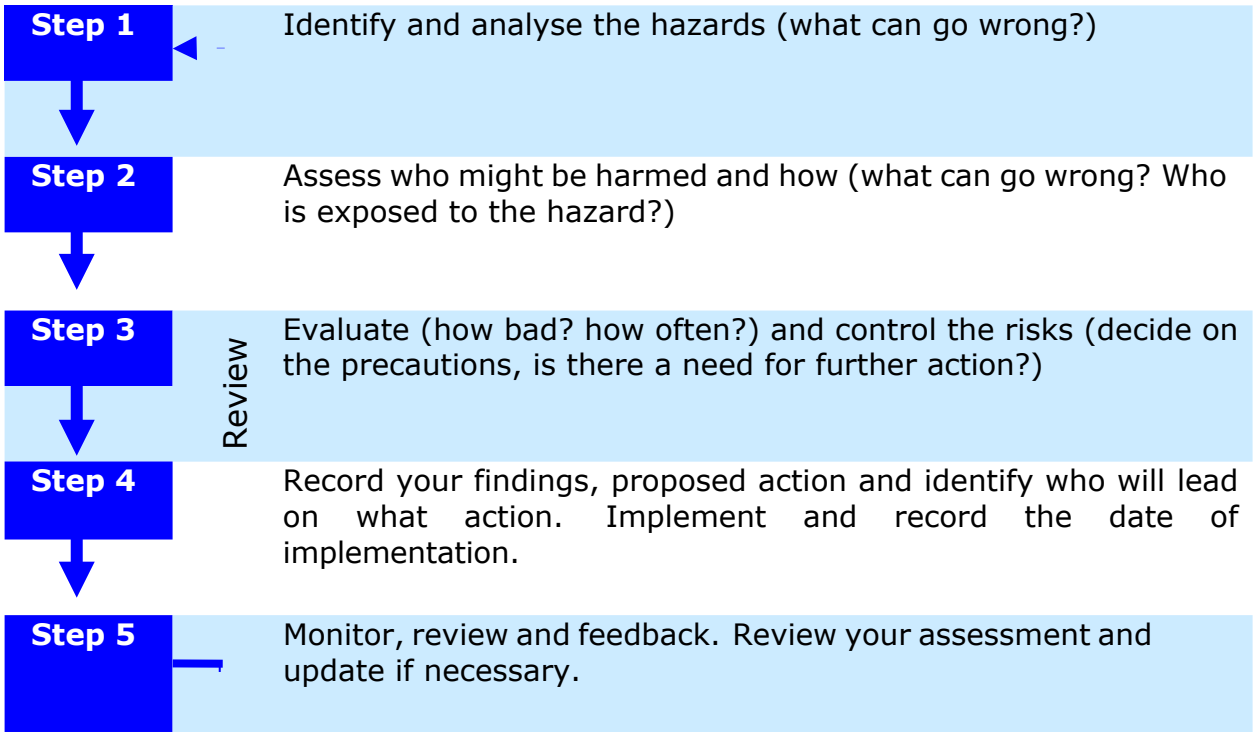
3.4 The extent of risk takes into account the number of people who might be exposed to a risk and the consideration for them. In the first example above, factors that would greatly increase the risk include holes in the floor, wet surfaces, poor lighting etc. Those risks can be effectively reduced by measures such as ensuring that the floor is in a good condition, spillages are prevented or cleared promptly, and lighting is adequate.

3.5 **Risk assessment -** A risk assessment is a careful and systematic examination of what in the work activity could cause injury, harm or loss to people, the environment or business, so that a decision can be made whether further actions need to be taken or control measures introduced in order to prevent harm or loss. Patients, employees and others have a right to be protected from harm.

3.6 The **risk rating** is calculated by multiplying the consequence (severity) score by the likelihood of occurrence score in accordance with the Risk Domain and Scoring Matrix (Appendix 1). The time spent on a risk assessment should therefore be proportionate to the nature and degree of the risk.

## 4. THE FIVE STEP RISK ASSESSMENT PROCESS

4.1 The risk assessment process can be divided into the following five steps:




## 5. STEP ONE – IDENTIFY AND ANALYSE THE RISKS

5.1 A positive, proactive and planned approach is required so that identifying risk becomes part of the work culture, a natural, normal part of managing, supervising, and decision making and undertaking your role. It is important to understand not only what is likely to go wrong but also how and why people or the organisation could be harmed or suffer loss. Concentrate on the significant risks, which could result in serious harm or affect a number of people. Risks can be identified through:

- walking around and inspecting the working area with colleagues, safety coordinators, managers or safety representatives;
- discussions with staff and users;
- checking that policies, procedures and guidelines are in use;
- carrying out audits;
- comparing previous adverse incidents, complaints, specific claims and ill health statistics and trends that have occurred within the area, the Health Board or the NHS;
- referring to manufacturer's instructions;

- examining clinical practices;
- examining professional standards or guidelines.
- Considering gaps in skill mix
- Considering any impact of workforce capacity constraints
- Risks relating to non-compliance with standards / targets /legislation/regulation
- Considering risks that may impact on stakeholder / patient experience and/or trust and confidence in the Health Board.

5.2 It is important to consider any long-term risks to health for patients (such as falls, pressure damage and hospital acquired infections), staff and others (such as high levels of noise or exposure to harmful substances, as well as safety hazards).

5.3 When the risks have been identified they then need to be analysed, and the following questions asked:

- what could go wrong?
- how could it happen?
- how severe would the effect be?
- how often are they likely to happen?
- how much are they likely to cost?

5.4 **Undertaking a Risk Assessment -** Those carrying out the assessment must:

- understand the requirements of risk assessment;
- have received risk assessment training;
- have a comprehensive knowledge of the working procedures or activities taking place in the work area;
- have the ability and authority to get all the necessary information;
- have the knowledge and skill to make correct decisions about the risks and precautions needed.

5.5 When undertaking the risk assessment, it is important to plan the approach. Consider the work practice and procedure in the workplace. This could include the clinical treatment of patients, physical, environmental, use of chemicals or general activities.

5.6 Think about the risks they could present;

- discuss with the staff and safety representatives to obtain their opinions;
- contact the Care Group Quality Governance Team and/or Central Quality & Patient Safety Team, Health, Safety and Fire team or the Assistant Director of Governance & Risk for their view and advice;
- consider manufacturer's instructions and data sheets, which will also give information on hazards;

- look at the controls that are in operation and evaluate if they are sufficient or if they can be improved on;
- consider the condition of the patients and the environment in which care is provided;
- decide on the actions, and determine accordingly what procedures and systems will be implemented to reduce or remove the risk;
- consider contingency planning, the assessment should take into account any emergency situations.

5.7 **Collaborative Session -** A collaborative session should be set up which can include a cross section of staff, as it is important to try to avoid subjectivity when evaluating risks. Therefore, where possible, a multi-disciplinary team should be used since no single person can reasonably be expected to know everything about all subjects, and it is often easier to view a subject with which one is unfamiliar in an objective way.

5.8 The importance of the team becomes apparent when setting risk priorities as different people will have different views on the relative significance of the risk for example:

- some individuals will want to give priority to issues that are required by law;
- some will pick the one which most worries staff or could have a greater impact on the patient or quality of care.
- others will decide by frequency;
- others by how disruptive the action will be;

5.9 All staff who are included should feel able to take a full share in the discussion, in accordance with the organisational values – *We will all Work together as One Team and We will Treat Everyone with Respect.* Experience from risk management workshops demonstrates that it is the people working within systems who can often identify risks and problems.

5.10 The idea is to identify service issues which present a risk to patients, stakeholders, or staff, either to their immediate safety or to the ability to manage and care for them; risks to staff, visitors or the business of CTMUHB that could cause harm, disruption or loss to the organisation.

5.11 Risks are specific to each area and specialty, it is the responsibility of the staff on each ward, department and service area to use the procedures and standards available, identify the risks present and ensure compliance in all areas.

5.12 Where risks are identified they should be listed on the Risk Identification Form (Appendix 2) which can be used to list all of the activities or tasks.

## 6. STEP TWO – ASSESS WHO MIGHT BE HARMED AND HOW

6.1 Once the risks to be assessed have been identified you need to consider who might be harmed (groups of people rather than named individuals) and how. Some individuals or groups may be more at risk than others. It is not enough to merely identify all clinical staff or all those who come into contact with patients.

6.2 The persons affected will range from those involved in the task including staff members, patients, students etc. People sharing the workplace (facilities staff etc.) must also be considered and it is important to think about how the work affects others present. In each case identify how they might be harmed, i.e. what type of injury or ill health might occur, examples could include:

- nursing staff who may suffer from a back injury due to practicing poor lifting techniques;
- visitors, other patients, nursing, clinical or facilities staff could be infected with, for example, clostridium difficile.

6.3 To help in the assessment of risk it is important that there are appropriate policies, procedures, good practice standards and guidelines in place. They must be suitable and sufficient, up-to-date and used.

## 7. STEP THREE – EVALUATE AND CONTROL THE RISKS

7.1 Consider how likely it is that each hazard could cause harm. Assess the possible consequences and examine what controls are already in place and how the work is organised. Then compare this with the good practice and see if there is more you should be doing. Identifying new controls will not in itself reduce the risk, the controls must be implemented in order to reduce the risk. See section 7.4 on the Risk Domains and Scoring Matrix to see how to evaluate and score the risks in conjunction with Appendix 1 Risk Domains and Scoring Matrix.

7.2 Can you get rid of the risk altogether? Many risks can never be eliminated and, if prevention is not reasonably practicable,

consideration must be given as to how risks can be controlled or be made less likely. After introducing effective precautions and controls there may still be a certain amount of residual risk remaining.

7.3 It is important to remember that if an incident has already occurred then the controls are not working effectively and control mechanisms will need to be reviewed, tightened, and the risk assessment updated.

7.4 **Risk Domains and Scoring Matrix** - As part of the risk assessment process the risk must be allocated a risk score which can be obtained through using the Risk Domain and Scoring Matrix in Appendix 1.

7.5 The Risk Domain and Scoring Matrix domains are:

- Safety & Wellbeing – Patients/Staff/Public
- Quality/Complaints/Assurance/Patient Outcomes
- Workforce Organisational Development/Staffing/Competence
- Statutory Duty, Regulation, Mandatory Requirements
- Adverse Publicity or Reputation
- Business Objectives or Projects
- Financial Stability & Impact of Litigation
- Service/Business Interruption
- Environmental/Estate/Infrastructure
- Health Inequalities / Equity

Risk assessment is subjective, and it is suggested that if one or more risk domains apply that the one that features as the highest risk is used for the purposes of scoring the risk.

7.6 **Risk Scoring** - In order to effectively assess a risk, it is necessary to consider two factors: Consequence (Impact) and Likelihood.

CTMUHB uses a common form of risk scoring referred to as a 5x5 risk matrix. Consequence and Likelihood are assessed on a scale of 1 to 5, and then the two scores are multiplied to arrive at the final risk score (between 1 and 25 with 1 being the lowest).

The scoring is a very subjective process and so some guidance on what different likelihoods and impacts would look like is provided as detailed in Appendix 1 Risk Domain and Scoring Matrix.

It is important to remember that these descriptors are provided only as guidance and you should not attempt to be too scientific with your assessment.

There are three different scores to be arrived at in assessing any risk and entering the scoring on the Datix Risk Management Module.

1. **Initial (Inherent) Risk Score -** This is the risk, considered without taking account of any controls. Sometimes called the raw risk score, this is important as it shows the true severity of the risk should it ever be realised.
2. **Current (Residual) Risk Score -** This is the risk, considered with any existing controls taken into account. The current risk score will almost always be lower than the initial risk, and the important point is that the greater the difference between the two scores, the greater the reliance on the control environment.
3. **Target Risk Score** - This is the risk score that the Risk Owner, having decided to treat the risk, needs to be actively working towards. The target score is usually lower than the initial score and it must be accompanied by an action plan to achieve the target (Mitigating action that will be taken to reduce the risk).

7.7 **Risk Treatment and Risk Decision Making -** There are four options when deciding how to treat a risk and this is known as the 4T approach to risk decision-making.

1. **Terminate** - This is where the activity that could lead to the risk being realised is itself terminated so that the risk can no longer occur.
2. **Transfer -** This is where a third party, usually on the payment of a premium agrees to take on the risk on your behalf. The most common form of risk transference is in insurance, whereby we pay insurance companies a premium to accept (usually a financial) risk on our behalf. This is a rare form of operational risk treatment and so anyone considering this as an option should contact the Strategic Risk Lead for advice.
3. **Tolerate -** This is where the risk has been assessed and the Risk Owner has determined that the risk is acceptable – in other words it is within our risk appetite. Once this decision has been taken, although the risk should be kept under regular review, there would not normally be any requirement for an action plan.
4. **Treat** - This is where the risk has been assessed and the Risk Owner has determined that it still presents an unacceptable level of exposure and so needs further treatment. Treatment may be in

the form of investment in resources, contingency planning or any other action that may help to reduce the risk further.

7.8 **Controls and Assurances**

A control is something which is actively working to control a risk. For a control to be valid it must be:

- Actively working at the time (i.e. not planned for some future date)
- Something which is actually within our control

The whole network of controls for a particular risk is called the risk's 'control environment.'

An assurance on the other hand is something which provides evidence that a control is effective.

7.9 Controlling the risk - There are many techniques for controlling risk, many of which require little or no financial outlay. They are:

- **physical controls**, for example where equipment, materials, drugs and dangerous or valuable items can be locked away;
- **system controls** which may involve restricting access to hazardous areas, recording attendance of staff at manual handling courses, ensuring that staff are trained and comply with set policies and procedures.

7.10 When considering the cost of a risk, it is important that one does not simply consider the direct financial impact of loss of, or damage to, property or personal injury. There may be other expenses involved, such as hiring temporary staff, or the effect of the untoward incident on staffing levels. Neither should the consequences of the event or activity throughout the rest of the organisation be overlooked, for example a fire in the kitchen not only affects provision of meals to patients and staff, but also may impact on income generation activity.

7.11 Putting controls in place need not be expensive. For example, placing a mirror on a dangerous blind corner to help prevent vehicle accidents is a low-cost precaution considering the risks. Failure to take simple precautions can cost you a lot more if an accident does happen.

7.12 **Hierarchy of Control** - The law requires you to do everything reasonably practicable to protect people from harm. Whenever possible the risk should be avoided altogether, otherwise all practical

steps must be taken to minimise identified dangers by applying the principles below:

**ERIC PD**

- **Elimination** by changing the process or activity;
- **Reduce** by substituting with something less hazardous;
- **Isolate** through enclosure or automation or prevent access to the hazard by guarding or segregation of people;
- **Control** - safe system of work that reduces the risk to an acceptable level, written procedures that are known, understood, followed and regularly updated;
- **Personal protective equipment** or clothing which must be used as a last resort when no other precautions are available;
- **Discipline** if the above are not followed this could result in the Health Board disciplinary procedures being evoked.

7.13 Risk assessments can also identify where health surveillance is required. Where there is a likelihood that a disease or condition may occur as a result of the work, health surveillance will improve the protection and the health of employees. Occupational Health and Wellbeing Department should be involved to provide advice and support.

7.14 It is important to involve colleagues in the process so that you can be sure that what you propose to do will work in practice and will not introduce any new hazards.

## 8 STEP FOUR – RECORD THE FINDINGS AND IMPLEMENT THEM

8.1 The next stage is to complete a risk assessment. The Datix Risk Management module is the system mandated for use in the Health Board for recording risk assessments. If you do not have readily available access to Datix when completing the risk assessment then the paper copy of the risk assessment form can be used for the purposes of initial assessment, **However,** the risk must be entered onto the Datix System within 5 working days.

8.2 Risks can only be added by colleagues who have received training and who are authorised to access the system. It is important that all information on the completed Risk Assessment Forms is transferred onto the Datix Risk module and not stored separately in electronic or paper form. The reason for this requirement is that the information

to inform reports and/or escalation will be extracted from Datix and therefore information must be available via the system.

8.3 Utilising Datix also allows for triangulation and theming of risk with incidents, claims and complaints and for the identification of themes to support lessons learned within the Health Board.

8.4 When completing the risk assessment it must be suitable and sufficient, but also straightforward enough for everybody to understand. You need to be able to show that:

- a thorough review was made;
- you dealt with all the obvious significant risks taking into account the number of people who could be involved;
- the precautions are reasonable;
- the solutions are realistic, sustainable and effective.
- you have considered whether the risk is one which could be wider than your area e.g. impacting all acute sites within the Health Board, and whether appropriate calibration has been applied and the risk rating accurately reflects a risk that may have a wider impact. This will ensure that a consistent approach for the organisation is applied.

8.5 When writing the risk description the following format of "If, Then, Resulting In" should be used, for example:

- **If**: the Health Board fails to recruit sufficient medical and dental staff.
- **Then**: the Health Board's ability to provide high quality care may be reduced.
- **Resulting In:** a reliance on agency staff, disrupting the continuity of care for patients and potentially effecting team communication. This may also impact patient safety and experience and staff wellbeing and experience.

Articulating the risk descriptor in this way will support those not in your specific service area with an understanding of the risk. Supporting documentation such as Safe Systems of Work, reports etc can be added to the risk record in Datix to further support the risk assessment and controls. Risks escalated to the Organisational Risk Register are also published in the public domain and therefore its important risks can be understood by the lay person.

8.6 It is essential that appropriate control measures are in place and maintained. It is therefore necessary to record all significant findings of a risk assessment.

8.7 It is important that the risk assessment is:

- implemented within each ward, department, service group, central function and/or Care Group;
- brought to the attention of staff who are affected by this;
- updated when any change occurs.

8.8 Whilst the recording of the risk assessment is an important legal requirement, it is equally as important that the mitigating actions /recommendations for improvement identified during the assessment are continually monitored and reviewed through to implementation. It should be noted that risk assessments could be requested in support of litigation challenge such as Personal Injury claims, therefore ensuring risks assessments are clear, appropriate and robust is vitally important not only for this purpose but also to ensure all colleagues involved in the activity understand the risks and control measures that need to be adhered to.

8.9 **Risk Acton Planning -** Risk action planning is no different to any other form of action planning and there are clear advantages to using the tried and tested SMART process for developing an action plan.

S - Specific
M - Measureable A
- Achievable
R - Relevant T
– Timescale

8.10 This system is adequately detailed in management training and so no further explanation is provided here, except to say that in this context 'Relevant' must mean that the action once complete (either on its own or in conjunction with other actions) will have some effect on the control environment.

8.11 Action Plans must be entered into the Datix Risk Module in the action module in order for the mitigating action to reduce the risk to be captured and provide assurance as to the measures being taken to reach the target risk score.

## 9 STEP FIVE - MONITOR, REVIEW AND FEEDBACK

9.1 It is essential to continue to reduce risks to their lowest level practicable through ongoing monitoring and review~~ing~~. 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. |

9.2 All findings must be recorded and retained and staff must be informed of the findings.

9.3 Control measures can be monitored by:

- routine inspection of control measures;
- ensuring correct use of control measures;
- ensuring full implementation of systems and policies;
- ensuring staff are fully aware of risks;
- monitoring to measure performance;
- reviewing incident statistics;
- undertaking regular environmental safety inspections, clinical audits and quality audits;
- implementing appropriate training programmes.

9.3 The Executive Leadership Group and Board Committee(s) will review and scrutinise risks graded 15 and above all those that are novel and contentious. Please refer to Appendix 4 Service to Board escalation reporting.

9.4 Local Groups within Central Support Functions or Care Groups will have a monitoring role and will periodically:

- review the risk assessment reports;

- review and monitor the risk register;
- call for a review of working practices;
- examine the training system and records.

## 10.0 DOCUMENTATION

10.1 The documentation required for reporting and how to access the Datix system for completing a risk assessment can be located on the intranet, under Risk Assessment or Click Here.

## 11.0 COMPLETED RISK ASSESSMENTS

11.1 Following completion of the risk assessment, all staff in the area must be informed of the outcome of the risk assessment and must know what their responsibilities are as a result.

11.2 Risk assessments which are specific to an individual patient must be included in their care plan and will not form part of the risk assessment database.

11.3 Once the controls have been implemented the action plan must be updated and the risk score reviewed. If new systems or controls cannot be implemented until a later date, for example new equipment purchased, the original risk score may stay the same.

11.4 For timescales in relation to the retention of risk assessments please refer to CTMUHB's Records Management Policy / Retention Schedule.

11.5 When a risk assessment is entered and/or updated on the Datix Risk Module please use the "Progress Notes" section to record any changes or updates including the rationale for amending risk scores. A record of the changes is automatically generated so that an audit trail can be made of all amendments. For risk assessments which were undertaken prior to the introduction of the risk assessment database the electronic or paper copy must be kept for the time specified.

## 12.0 RISK REGISTER

12.1 This is the final part of the process, in which once approved and agreed for escalation the risk appears on the appropriate risk register in order that it can be managed at the appropriate level. When risk assessments are entered into Datix a risk register can be generated. When a risk assessment has been reviewed the risk register will be updated. There are specific report templates which have been set up

depending on which department, ward, group or committee require the information.

12.2 Where Care Groups and Central functions consider that a risk requires escalating to the Organisational Risk Register (i.e. risks scoring 15 and above or which are novel and/or contentious) these must be escalated via the mechanism in the Datix Risk Module so that the Assistant Director of Governance & Risk is notified as the lead for co- ordinating the submission of the Organisational Risk Register to the Executive Team meetings and Board Committees as appropriate.

## 13.0 TRAINING

13.1 It is essential to ensure all staff involved in undertaking risk assessments receive the appropriate training. For available training please use the 'contact us' section on the risk intranet page: Risk Assessment - Contact Info.

## 14.0 RESPONSIBILITIES

14.1 Responsibility for ensuring that CTMUHB has a risk assessment system lies with the Chief Executive, who delegates responsibility to the Executive Lead for this area. The responsibilities of the Chief Executive, Directors, Managers and Employees are as those set out in the Risk Management Policy, Risk Management Strategy and Health and Safety Policy.

## 15.0 NON-CONFORMANCE

15.1 There is a requirement of all designated staff to comply with the provisions of this Procedure and, where requested, to demonstrate such compliance. Failure to comply will be dealt with in accordance with the appropriate People Services policy.

## 16.0 EQUALITY IMPACT ASSESSMENT STATEMENT

16.1 This Procedure has been subject to a full equality assessment and no impact has been identified.

16.2 Advice and guidance should be sort from the Equality Team prior to implementing any risk management measures that could have a potential impact on equality.

## 17.0 RESEARCH


- Bateman, Mike. *Tolley's Practical Risk Assessment Handbook*. Elsevier. 2006.
- Cardiff and Vale University Health Board. *Risk Assessment and Risk Register Procedure.* 2011.
- Health and Safety Executive. *Five Steps to Risk Assessment.* 2006.
- Health and Executive. *Health and Safety at Work etc. Act 1974.*
- Health and Safety Executive. *Management of Health and Safety at Work Regulations 1999. Approved Code of Practice and guidance* L21 HSE Books 2000.
- Health and Safety Executive. *Successful Health and Safety Management HSG65*. HSE Books. 1998.
- National Patient Safety Agency. *A Risk Matrix for Risk Managers*. 2008.
- National Patient Safety Agency. *Healthcare Risk Assessment made easy.* 2007.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

# APPENDIX 1 - RISK DOMAINS & 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.<br>No time off work.<br>Physical injury to self/others that requires no treatment or first aid.<br>Minimum psychological impact requiring no support.<br>Low vulnerability to abuse or exploitation - needs no intervention.<br>Category 1 pressure ulcer. | Minor injury or illness, requiring minor intervention.<br>Requires time off work for >3 days Increased hospital stay 1-3 days.<br>Slight physical injury to self/others that may require first aid.<br>Emotional distress requiring minimal intervention.<br>Increased vulnerability to abuse or exploitation, low level intervention.<br>Category 2 pressure ulcer. | Moderate injury/professional intervention.<br>Requires time off work 4-14 days.<br>Increased hospital stay 4-15 days.<br>RIDDOR/Agency reportable incident.<br>Impacts on a small number of patients.<br>Physical injury to self/others requiring medical treatment.<br>Psychological distress requiring formal intervention by MH professionals.<br>Vulnerability to abuse or exploitation requiring increased intervention.<br>Category 3 pressure ulcer. | Major injury leading to long-term disability.<br>Requires time off work >14 days.<br>Increased hospital stay >15 days.<br>RIDDOR Reportable.<br>Regulation 4 Specified Injuries to Workers.<br>Patient mismanagement, long-term effects.<br>Significant physical harm to self or others.<br>Significant psychological distress needing specialist intervention.<br>Vulnerability to abuse or exploitation requiring high levels of intervention.<br>Category 4 pressure ulcer. | Incident leading to death.<br>RIDDOR Reportable.<br>Multiple permanent injuries or irreversible health effects<br>An event which impacts on a large number of patients. |
| Quality/ Complaints/ Assurance/ Patient Outcomes | Peripheral element of treatment or service suboptimal.<br>Informal complaint/inquiry. | Overall treatment/service suboptimal.<br>Formal complaint (Stage 1).<br>Local resolution.<br>Single failure of internal standards.<br>Minor implications for patient safety.<br>Reduced performance. | Treatment/service has significantly reduced effectiveness.<br>Formal complaint (Stage 2). Escalation.<br>Local resolution (poss. independent review).<br>Repeated failure of internal standards.<br>Major patient safety implications. | Non-compliance with national standards with significant risk to patients.<br>Multiple complaints/independent review.<br>Low achievement of performance/delivery requirements.<br>Critical report. | Totally unacceptable level or quality of treatment/service<br>Gross failure of patient safety.<br>Inquest/ombudsman/inquiry.<br>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.<br>Unsafe staffing level (>1 day)/competence.<br>Low staff morale.<br>Poor staff attendance for mandatory/key professional training. | Uncertain delivery of key objective/ service due to lack/loss of staff.<br>Unsafe staffing level (>5 days)/competence.<br>Very low staff morale.<br>Significant numbers of staff not attending mandatory/key professional training. | Non-delivery of key objective/service due to loss of sever<br>key staff.<br>Ongoing unsafe staffing levels or competence/skill mix.<br>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.<br>Reduced performance levels if unresolved. | Single breach in statutory duty.<br>Challenging external recommendations/improvement notice. | Enforcement action. Multiple breaches in statutory duty.<br>Improvement notices.<br>Low achievement of performance/ delivery requirements. Critical report. | Multiple breaches in statutory duty.<br>Zero performance rating. Prosecution. Severely critical report. Total system change needed. |
| Adverse Publicity or Reputation | Rumours.<br>Low-level negative social media.<br>Potential for public concern. | Local media coverage - short-term reduction in public confidence/trust.<br>Short-term negative social media.<br>Public expectations not met. | Local media coverage - long-term reduction in public confidence & trust.<br>Prolonged negative social media. Reported in local media. | National media coverage <3 days, service well below reasonable public expectation.<br>Prolonged negative social media, reported in national media, long-term reduction in public confidence & trust.<br>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.<br>Total loss of public confidence/trust.<br>Escalation of scrutiny status by WG. |
| Business Objectives or Projects | Insignificant cost increase/ schedule slippage. | <5 per cent over project budget.<br>Schedule slippage. | 5–10 per cent over project budget.<br>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.<br>Schedule slippage.<br>Key objectives not met. |
| Financial Stability & Impact of Litigation | Small loss.<br>Risk of claim remote. | Loss of 0.1–0.25% of budget<br>Claim less than £10,000. | Loss of 0.25–0.5% of budget.<br>Claim(s) between £10,000 and £100,000. | Uncertain delivery of key objective. Loss of 0.5-1.0% of budget.<br>Claim(s) between £100,000 and £1 million.<br>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<br>Loss of contract/payment by results. |
| Service/ Business Interruption | Loss/interruption of >1 hour.<br>Minor disruption. | Loss/interruption of >8 hours.<br>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.<br>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 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.<br>If scored 20 or above the risk should be reviewed on a monthly basis. |

## 19.0 APPENDIX 2 – RISK IDENTIFICATION FORM

| RISK IDENTIFICATION FORM | |
|---|---|
| **Clinical Service Group / Department / Function** | |
| **Specific Location –** i.e. site, ward, department | |

**C = Consequence** **L = Likelihood** **R/S = Risk Score – C x L**

| **Task / Activity / Clinical Procedure including hazards / risks** (more than one task can be entered in this section) | **If risk score is 8 or more, then a full risk assessment is required** | | | | | |
|---|---|---|---|---|---|---|
| | **C** | **L** | **R/S** | **Comments / Justification of Score** | **Date Assessed** | **Lead Assessor(s)** |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

**This document should be reviewed** following a change in working practice or procedure; an incident; a change in legislation; when a new risk has been identified.

## 20.0 APPENDIX 3 – RISK ASSESSMENT FORM (THIS DOES NOT REPLACE THE NEED TO ADD RISKS TO DATIX)

| RISK ASSESSMENT FORM | |
|---|---|
| **SERVICE GROUP** | |
| **SPECIALITY** | |
| **SUB- SPECIALITY** | |
| **CARE GROUP / CENTRAL FUNCTION** | |
| **HOSPITAL / SITE** | |
| **LOCATION EXACT**<br>(Ward, Department etc) | |
| **LINKED TO ANY OF THE FOLLOWING** (Claim, Complaint, Incident, Inquest, Redress or Safety Alert) | |
| **RISK DOMAIN –** (See Appendix 1 Risk Domain Matrix and Scoring) | |
| **RISK TYPE** (Organisational, Clinical, Fire or Health and Safety) | |

| | |
|---|---|
| **RISK CATEGORY** (e.g. patient injury, patient handling, Security, etc) | |
| **ACTIVITY / TASK / CLINICAL PROCEDURE**<br><br>(Complete the relevant details of the activity being assessed) | |
| **DESCRIPTION OF HAZARD / RISK**<br><br>(Describe the hazard / risk and the nature of any injury or loss that might arise from it) Please use the 'If, Then, Resulting In' format. | |
| **THOSE AT RISK** | Staff ☐ Patients ☐ Visitors ☐ Young Persons / Work Experience ☐ Contractors ☐ Other ☐ (Please state) |

| **WHAT IS THE INITIAL RISK SCORE** *(This is the risk, considered without taking account of any controls. Sometimes called the raw risk score, this is important as it shows the true severity of the risk should it ever be realised)* | | | | | |
|---|---|---|---|---|---|
| **Consequence - C** | Please select | **Likelihood - L** | Please select | **Risk Score and Colour** | Please select |

| **CURRENT CONTROL MEASURES IN PLACE:**<br><br>(What is currently being done to reduce the risk of the hazard giving rise to loss or injury) |
|---|
| |

| | | | | | |
|---|---|---|---|---|---|
| **WITH THESE CURRENT CONTROL MEASURES THE LEVELS OF RISK ARE**: *(This is the risk, considered with any existing controls taken into account. The current risk score will almost always be lower than the initial risk, and the important point is that the greater the difference between the two scores, the greater the reliance on the control environment)* | | | | | |
| **Consequence - C** (table 1) | Please select | **Likelihood - L** (table 2) | Please select | **Risk Score and Colour** (table 3) | Please select |

**Mitigating Action Plan** (List further action needed to adequately control hazards / risks)

| No. | Action(s) Required | By Whom? | By When? | Cost (State actual or estimated) |
|---|---|---|---|---|
| | | | | |

| | | | | | |
|---|---|---|---|---|---|
| **WITH THE ABOVE CONTROLS, THE TARGET LEVELS OF RISK WILL BE:** *(This is the risk score that the Risk Owner, having decided to treat the risk, needs to be actively working towards. The target score is usually lower than the initial score and it must be accompanied by an action plan to achieve the target (Mitigating action that will be taken to reduce the risk).* | | | | | |
| **Consequence - C** | Please select | **Likelihood - L** | Please select | **Risk Score and Colour** | Please select |
| **Assessor(s)** | | | | | |
| **Date of Assessment** | | **Date for Review*** | | | |

* Dependent upon initial risk score

| THIS SECTION TO BE COMPLETED BY DESIGNATED MANAGER / CLINICAL LEAD | | | |
|---|---|---|---|
| **Does this risk require capital funding?** | | **Yes** ☐ **NO** ☐ | |
| **Does this risk require escalation to the next senior level?** | | **Yes** ☐ **NO** ☐ | |
| **Approval Status** *(If Assessor/Reporter Only please choose "Awaiting Review". If Manager of risk please choose "Risk Approved")* | | | |
| **Strategic Risk Owner** (a member of the Executive Director leadership Team) | | | |
| **Strategic Goal (**Improving Care, Creating Health, Inspiring People, Sustaining Our Future) | | | |
| **Is this risk to be escalated for consideration for adding to the organisational risk register (i.e. score of over 15)?** **Only to be completed by Function Heads and agreed with Strategic Risk Lead ** | | | |
| **Comments / feedback to risk assessor:** | | | |
| **Name** | | **Date** | |

## 21.0 APPENDIX 4 – RISK MANAGEMENT PROCESS – SERVICE TO BOARD ESCALATION

### Service to Board Risk Escalation in CTMUHB

This process should be read in conjunction with the Risk Assessment Procedure available here: Risk Assessment Procedure.docx

Further tools and support for undertaking risk assessments is available on the dedicated Risk page on SharePoint available here: Risk Assessment - Undertaking Risk Assessments.

Training on risk is available to book on ESR please search for course: **110 Risk Management Strategy and Risk Assessment and Training Awareness**.

A step-by-step guide for completing a risk assessment on the Datix Web Module is available here: Risk Assessment - Undertaking Risk Assessments – "DatixRiskWeb User Guide V6".

The Risk Scoring & Domain Matrix is a key reference point when scoring risks and is available in the Risk Assessment Procedure

**1. Risk Assessment**

Risk identified and a risk assessment needs to be undertaken.

A risk assessment should be completed directly into the Datix Risk Web Module or via completing a hard copy of the risk assessment form to upload to Datix Web Module following completion.

**2. Risks scored with a risk score of between 1 and 6 (Low) and 8 and 10 (Moderate)**

Any risks identified and evaluated as having a low/moderate rating, can be managed locally within the relevant area i.e., local/Directorate level risk register.

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/Directorate risk register within each service area/department.

All risks should be reviewed and updated as per the frequency captured in the Risk Assessment Procedure and Risk Scoring and Domain Matrix.

Escalation via Care Group / Central Directorate Senior Team is not required unless there is a novel or contentious matter that should have visibility or further input, or support is needed.

**Risk scored with a risk score of 12 (Moderate)**

Risks identified as having a moderate rating i.e., a score of 12 are managed at a local level but should also be escalated to Care Group / Central Directorate Senior Team for visibility and review.

Risk owners should also add a note to the "Escalation Status" in the Datix Web Module indicating where in the process the risk is i.e. escalated and to be considered by the Care Group Senior Leadership Team.

The review at the escalated level should be undertaken on at least a quarterly basis.

The forums for which these risks are monitored will be at the discretion of the Care Group / Central Directorate, although it is suggested that this is undertaken via the QSRE meetings, Health, Safety & Fire meetings or equivalent in Care Groups and Governance Meetings, at a Central/Corporate Directorate Level.

**Risk scored with a risk score of 15 and above and/or is novel and contentious**

Risks identified as having a high rating i.e. a score of 15 and above and/or is novel and contentious, will still be managed in the service/area for which they were identified, however they should be escalated immediately to a Care Group / Central Directorate level.

High level risks should be monitored at least monthly if scored 20 and above or bi-monthly if 15 and above. The forums for which these risks are monitored will be at the discretion of the Care Group / Central Directorate, although it is suggested that this is undertaken via the QSRE meetings or equivalent in Care Groups and Governance Meetings, at a Central/Corporate Directorate Level.

Once escalated, it will be for the Care Group Senior Team / Central Corporate Director to consider if the risk should also be escalated to the Organisational Risk Register, managed via the Assistant Director of Governance & Risk.

If the Care Group/Central Director consider that this risk should be escalated to the Organisational Risk Register, it will do so as follows:

- Include in highlight report / update report to the next Operational Management Board meeting which meets monthly;
- Once the Operational Management Board have reviewed the risk and support escalation the "Yes to escalate" in the Datix Web Module, the box should be ticked which will generate a notification to the Assistant Director of Governance & Risk; and
- Risk owners should also add a note to the "Escalation Status" in the Datix Web Module, indicating where in the process the risk is i.e. escalated and to be considered at Operational Management Board on (date). Once approved for escalation, the date it was escalated to the Organisational Risk Register should also be captured in this box.

The risk should continue to be reviewed by the area for which it has been identified and in addition on a bi-monthly basis updates for the Organisational Risk Register will be requested.

Once escalated to the Organisational Risk Register, these risks will be reviewed at Public Board Committees, where assurance as to the robust monitoring and review will be sought.

**De-escalation of Risks from the Organisational Risk Register**

If because of successful mitigation, a risk score can be reduced below the threshold for escalation, "Datix Web Module escalation status" should be updated, as well as the rationale for risk score changes. This demonstrates robust and proactive management.

**Endorsed by the Operational Management Board on the 2nd October 2024**

**Approved by the Executive Leadership Group on the 7th October 2024**

| Agenda Item |
| --- |
| 4.3 |

# Audit, Risk & Assurance Committee

## Organisational Risk Register

| | |
| --- | --- |
| **Dyddiad y Cyfarfod / Date of Meeting** | 22 May 2025 |
| **Statws Cyhoeddi / Publication Status** | Open/ Public<br>Not Applicable |
| **Awdur yr Adroddiad / Report Author** | Cally Hamblyn, Assistant Director of Governance & Risk |
| **Cyflwynydd yr Adroddiad / Report Presenter** | Gareth Watts, Director of Corporate Governance & Risk |
| **Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor** | Gareth Watts, Director of Corporate Governance / Board Secretary |

| | |
| --- | --- |
| **Pwrpas yr Adroddiad / Report Purpose** | For Approval |

| **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)** | | |
| --- | --- | --- |
| **Committee / Group / Individuals** | **Date** | **Outcome** |
| Service, Function and Executive Formal Review | April / May 2025 | RISKS REVIEWED |
| Operational Management Board | April / May 2025 | ENDORSED RISKS WHERE APPLICABLE FOR ELG |
| Executive Leadership Group | Via email 6-9 May 2025 | MANAGEMENT SIGN OFF RECEIVED |
| Quality, Safety & Experience Committee | 20 May 2025 | ASSIGNED RISKS REVEIWED |

| **Acronyms / Glossary of Terms** | |
| --- | --- |
| | |
| | |

## 1. Situation /Background

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

## 2. Specific Matters for Consideration

### Risk Review

2.1 Care Groups and Central leads are continuing to review and update their assigned risks considering feedback received from Members in relation to scoring, actions with associated timeframes and ensuring timely reviews.

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 2 May 2025.

### Training

2.6 Risk training, although not a core training requirement under the statutory and mandatory framework, has been added to the Electronic Staff Record (ESR) to support staff in registering for training and to support ease of reporting. This is managed by the Quality Assurance and Compliance Team. Interest in the course continues with positive uptake.

2.7 The sessions are run by the Assistant Director of Governance & Risk and Heads of Quality and Safety. The session is held virtually via Teams on a monthly basis for a duration of 1 hour and covers the following areas:

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

2.8 To date **773** members of staff trained to date since training commenced in 2021. Based on the Risk Management Awareness Training Needs Analysis all attendees completed Training Profile 2.

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

2.10 109 attendees have provided formal feedback (using the URL Code for the Evaluation Form, which was introduced in November 2023). The average rating for the course is 4.80 out of a maximum score of 5.

2.11 100% of the 109 attendees providing formal feedback found that:
- The session provided the right amount of information.
- They gained more confidence and knowledge in risk management having attended.
- They would recommend this training to a colleague.

2.12 98% of the 109 attendees providing formal feedback said they felt more confident to escalate a risk through the organisation.

2.13 Some of the recent comments from the session, received through evaluation, have been included below:
- *"Delivered well and clear".*
- *"training, well rounded, concise and very informative"*
- *"This course was extremely useful being new to risk assessments in" CTM it was the right amount of content/information and well delivered"*

## 3. Key Risks / Matters for Escalation

### 3.1 NEW RISKS

**Diagnostics, Therapies, Pharmacy and Sciences**
- Datix Risk ID 3567 - Capacity of Cellular Pathology Service – Space – new risk escalated to the Organisational Risk Register with a score of 16 in May 2025.

**Public Health Directorate**
- Datix Risk ID 6179 - High and increasing prevalence of overweight and obesity in children and adults **-** new risk escalated to the Organisational Risk Register with a score of 20 in May 2025.

### 3.2 CHANGES TO RISKS

**Risk Score Increased**

There were no risks currently escalated to the Organisational Risk Register had risk scores increased this period.

**Risk Score Decreased**

**Digital and Data Directorate**
- Datix Risk ID – 5226, Risk of damage to records and equipment due to leaking roof in the Williamstown Records Hub. Risk score de-escalated from a 20 to an 8 in May 2025. Repairs completed mid- April 2025. To date, no further leaks have been observed; however, there has not yet been sustained rain to enable

confirmation that all leaks have been stopped. The situation is being monitored on an ongoing basis.

## 3.3 CLOSED RISKS REMOVED FROM THE ORGANISATIONAL RISK REGISTER

**Finance Directorate**

- Datix Risk ID – 5765 - Failure to reduce the £19.4m recurrent deficit at the start of 24/25 down to the planned £2.1m recurrent surplus at the end of 24/25. Closed and new risk for the financial period 25/26 has been escalated to the Organisational Risk Register.

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

| Consequence | | | | | | | |
|---|---|---|---|---|---|---|---|
| | 5 | | | 3337 | 4664<br>5276<br>5932<br>6053<br>6102 | | |
| | 4 | | | 5820 | 4337<br>4417<br>5374<br>4671<br>4908<br>4885<br>6039<br>5576<br>5903<br>5753<br>5821 | 5646<br>5579<br>5761<br>5691<br>5961<br>2795<br>5793<br>5045<br>4973<br>5669<br>3567 | 4491<br>3826<br>4632<br>5417<br>6111<br>6179 |
| | 3 | | | | | | 4672<br>4691<br>5040 |
| | 2 | | | | | | |
| | 1 | | | | | | |
| CxL | | 1 | 2 | 3 | 4 | | 5 |
| | | Likelihood | | | | | |

## 3.5 EMERGING RISKS

3.5.1 **The Patient, Care and Safety Directorate** have identified potential challenges in their Legal Service Directorate which will require a detailed review of any associated risk assessments. It is anticipated that updated risks relating to this service area will follow in the next iteration of the Organisational Risk Register.

3.5.2 **The Diagnostics, Therapies, Pharmacy and Sciences Care Group** are reviewing the following risk for escalation to the Organisational Risk Register in July 2025:

- Datix Risk ID 5304 – Air Handling Unit for the Pharmacy Aseptic Production Suite – Medicines Management.

3.5.3 **The Primary, Care & Community Care Group** are assessing a risk in relation to the Welsh General Optometry Service (WGOS), with a few to escalating to the Organisational Risk Register in July 2025.

3.5.4 **Finance Directorate –** following closure of Risk ID 5765, captured in section 3.3, a new risk for the financial year 2025-2026 is being developed with a view to escalating to the Organisational Risk Register in July 2025.

## 4. Assessment

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

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

## 5. Recommendation

5.1 The Committee are asked to:

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

## 6. Next Steps

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

| | A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P | Q | R |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 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 |
| 2 | 6179 | Executive Director of Public Health | Public Health - Health Protection | Executive Director of Public Health | Creating Health & Improving Care | Quality / Complaints / Assurance / Patient Outcomes<br>Impact on the safety – Physical and/or Psychological harm | High and increasing prevalence of overweight and obesity in children and adults. | **If** there is insufficient preventative activity to reduce rates of overweight and obesity<br><br>**Then** rates of obesity will remain high in CTM .<br><br>**Resulting in** increased activity/acuity/complexity of patients resulting from obesity, poorer patient outcomes, increasing pressures on services, risk of clinical incidents and continuing financial pressures on the organisation<br><br>There is also a continued risk from a health and safety perspective for sufficient equipment and capability to move people with extreme BMIs in the event of incidents. | A range of work is currently under way in response to high levels of obesity in CTM including:<br>1)Grant funded Whole system approach to healthy weight work- building momentum to influence system wide change in our obesogenic environment<br>2)Adult Weight Management Service – the scale of this is vastly insufficient to make a difference to population level rates of obesity<br>3)Children and Young People's weight management service – current time-limited funding for Pipyn, preventative family based intervention, ongoing development work to maximise population impact, scale remains small. Proposed future development of a service in line with level 3 of the All-Wales Weight Management Pathway.<br>4)Healthy pre- and health schools programmes – working to enable educational settings to be healthy weight environments.<br><br>Current activities are insufficient for population level impact.<br><br>A new action plan will be published in the Spring/Summer 2025 for Healthy Weight: Healthy Wales, the national strategy for Obesity. This will include actions across 4 domains:<br>-healthy environments<br>-healthy settings,<br>-healthy people,<br>-leadership and enabling change.<br><br>The Food (Promotion and Presentation) (Wales) Regulations 2025 are due to come into force in 2026 and will introduce some restrictions on the promotion and placement of unhealthy food. | The Healthy Weight Steering Group is currently developing a healthy weight road map for CTMUHB, outlining actions and strategic direction over the short, medium and long term. This will be in line with Healthy Weight: Healthy Wales, and take into consideration health board actions under the new national action plan.<br><br>There is a business case in place for sustainability and increased capacity for Pipyn (level1+), and a CYP level 3 weight management service.<br>A level 3 weight management service will help improve outcomes for some our most disadvantaged children. | Quality, Safety & Experience Committee.<br><br>Strategic Development Committee. | 20 | C4xL5 | 9<br>C3xL3 | New risk escalated to the Organisational Risk Register in May 2025. | 06.05.2025 | 06.05.2025 | 30.06.2025 |
| 3 | 6111 | Executive Medical Director | Medical Directorate Function | Medical Directorate Manager | Improving Care | Patient / Staff /Public Safety<br><br>Impact on the safety – Physical and/or Psychological harm | Medical Examiner Delays | **If:** there continues to be delays in length of time for scrutiny of deaths by the Medical Examiner Service<br><br>**Then:** death certification will not be completed in a timely manner and so increasing the length of stay of the deceased<br><br>**Resulting in:** complaints from bereaved relatives due to delayed funerals, inability to view loved ones, and deterioration in condition due to delay and inability to comply with WG bereavement framework and mortuary capacity being overwhelmed | Bereavement database updated to track cases and ensure timely attendance by doctors following scrutiny. Bereavement teams to provide estimated timescales for scrutiny based on database. Daily monitoring of daily occupancy. Funeral directors to be contacted by mortuary teams. All contingency capacity HB wide activated in line with mortuary escalation action card. Use of contracted funeral director staircase if required. Use of medilink sessions to manage post mortem demand. | Plan to improve timely death certification by CTMUHB specific QR code to alert wider staff and reduce delays and education videos from MES to improve accuracy. Continue to improve on communication with families around delays and estimated timescales.<br><br>Update May 2025 - No change to risk score or mitigation on this review. | Quality, Safety & Experience Committee.<br><br>Operational Delivery Committee. | 20 | C4xL5 | 12<br>(C4xL3) | ↔ | 05.03.2025 | 06.05.2025 | 30.06.2025 |
| 4 | 6053 | Chief Operating Officer | Primary Care and Community Care Group | Care Group Service Director | Sustaining Our Future | Service / Business interruption | Failure to secure an alternative Clinical System for GP practices on Vision | **If:** a new supplier is not secured.<br><br>**Then** there will be a significant risk to the availability of a clinical system/solution to support General Practice service delivery for our GP practices yet to transfer to an alternative provide (EMS).<br><br>**Resulting in** GP service delivery and patient care being significantly impacted and further impacting on other healthcare services. | Digital Health Care Wales (DHCW) Task force with 4 workstreams set up to manage the incident:<br>Comms & engagement. The company is currently seeking a buyer, process started on Friday, December 13th. DHCW will work with the administrator on the next steps, whatever the outcome of the marketing process. The administrator has advised they are planning to maintain a full service to minimise disruption to practices. Health Boards are working together with DHCW to produce business continuity plans for both HBs and for practices. | Collaboration with DHCE and other Health Boards for Business Continuity Plans - timeframe 27.3.2025.<br><br>Securing a new Clinical System Provider - timeframe 30.06.2025.<br><br>Update May 2025 - Digital Health Care Wales (DHCW) are still in negotiations with interested / preferred buyer of the Cededim clinical system. In the meantime HOPC/DHCW and Health Board Digital Leads working on mitigation and business continuity plans. | Quality, Safety & Experience Committee.<br><br>Operational Delivery Committee. | 20 | CSxL4 | 5<br>(CSxL1) | ↔ | 15.01.2025 | 06.05.2025 | 30.06.2025 |
| 5 | 6102 | Director of Digital | Central Corporate - Digital & Data | Head of Clinical Admin Transformation | Sustaining Our Future | Patient / Staff /Public Safety<br><br>Impact on the safety – Physical and/or Psychological harm | Patient Pathways - Working in WPAS Instances. | **If:** A patient is moved between SB WPAS and CT WPAS and their pathway is closed in one before it is opened in the other.<br><br>**Then:** The pathway will not be automatically re-opened by the systems (this must be manually transacted) and the pathway will remain closed.<br><br>**Resulting in:** The incorrect ending of the patient pathway, as they will not be visible on the system, which could lead to possible patient harm/ death. | Monitor records/ processes through agreed Standard Operating Procedure's and ensure corrective actions are taken until mitigation is successful. Flagging to users/ management where examples of this not being followed are identified. | Review current business processes and Standard Operating Procedures to clarify the importance of opening the CTM record before closing the Swansea Bay University Health Board record. This process prevents delays in urgent pathway management, as highlighted by flagged dermatology cancer referrals that were discharged on WPAS but not set up on another system at the time of checking.<br><br>It is anticipated that the target score will not be achieved until CTMUHB have a fully migrated PAS systems and the whole organisation is using a singular PAS system for patient pathways.<br><br>Update May 2025 - No change to this risk until PAS migration has been completed. | Quality, Safety & Experience Committee.<br><br>Operational Delivery Committee. | 20 | CSxL4 | 5<br>(CSxL1) | ↔ | 19.02.2025 | 2.5.2025 | 30.06.2025 |
| 6 | 5932 | Executive Director of Finance<br><br>Executive Lead for Estates | Central Corporate - Estates | Assistant Director of Planning - ( Capital and Estates), Strategic and Operational Planning | Sustaining Our Future | Environmental / Estate / Infrastructure | Roof covering replacement works to resolve identified roof integrity issue and consequent risk of tiles falling internally and externally from weakened roof at POWH Phase 1. | If: the Health Board fails to act upon the recommendations of the findings of the report from the appointed Structural Engineers in relation to the roof area at the POWH.<br><br>Then: there is a risk of collapse of the roof coverings which could result in the roof coverings falling through the roof void into occupied clinical/non clinical areas and externally from the edges of Phase 1.<br>This risk increases in adverse weather with additional loading on the roof.<br><br>Resulting in: significant impact/harm to patient, staff and public safety.<br>Healthcare facilities which are not fit for purpose or sustainable for the future.<br>Service delays impacting the patient experience and service performance of the Health Board.<br>Potential legislative challenge and reputational damage.<br>Loss of confidence in the Health Board estate infrastructure across CTM. | Command structure established to manage the critical incident following identification of roof structure failings.<br><br>Immediate mitigations being considered under 4 key Cells:<br>1) Discharge Cell - Objectives: The safe but rapid discharge of patients and services from top floor phase 1 POW site and to maintain quality of care and patient safety<br><br>2) Decant Cell - Objectives are the safe but rapid decant of patients and services from top floor phase 1 POW site, to maintain quality of care and patient safety and to maintain staff safety and the deployment of the right staff to the right place.<br><br>3) Redirect Take - Objective - Reduce demand for inpatient beds on the POW site<br><br>4) Estates - focusing on ensuring decant areas are fit for purpose as well as overseeing the plans for the works on the roof.<br><br>Enabling Support Cells Established:<br>Patient Transport<br>Workforce<br>Digital<br>Facilities<br>Patient Safety<br>Communication<br><br>In addition barriers are in place around the footpaths to keep pedestrians away from the edge of Phase 1 roofs. | Update April 2025:<br>Removal of Roof Coverings at the Princess of Wales Hospital site in accordance with the recommendations in the structural engineering report of 9th October 2024. Contractor started the roof replacement programme on Monday 11th November. Phase 1 prioritised Maternity and Special Care Baby Unit, these areas are complete and were handed back 13th January, services returned to site in Feb. Contractors have replaced the old tiles above Main Theatres and Wards 9, 10, ITU and Endoscopy are almost complete so risk of falling tiles has reduced considerably with the large area of roof where the old tiles have been removed. Remaining Wards 5, 6, 7 and 8 roof works have started.<br>Full programme including Theatre FEN works and fire compartmentation above vacated wards and depts due to be completed mid August 2025. | Operational Delivery Committee<br><br>Quality, Safety & Experience Committee<br><br>Health, Safety & Fire Sub Committee | 20 | CSxL4 | 10<br>(CSxL2) | ↔ | 23.09.2024 | 06.05.2025 | 30.06.2025 |
| 7 | 4491 | Chief Operating Officer | Deputy Chief Operating Officer - Acute Services. | Deputy Chief Operating Officer - Acute Services. | Improving Care | Patient / Staff /Public Safety<br><br>Impact on the safety – Physical and/or Psychological harm | Failure to meet the demand for patient care at all points of the patient journey | **IF:** The Health Board is unable to meet the demand upon its services at all stages of the patient journey.<br><br>**Then:** the Health Board's ability to provide high quality care will be reduced.<br><br>**Resulting in:** Potential avoidable harm to patients | Controls are in place and include:<br>• Technical list management processes as follows:<br>- Specialty specific plans are in place to ensure patients requiring clinical review are assessed.<br>- All patients identified will be clinically reviewed which will include an assessment of avoidable harm which will be reported and acted upon accordingly.<br>- A process has been implemented to ensure no new sub specialty codes can be added to an unreported list, this will be refined over the coming months.<br>- All unreported lists that appear to require reporting have been added to the RTT reported lists<br>- 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.<br>• Patients prioritised on clinical need using nationally defined categories<br>• Demand and Capacity Planning being refined in the UHB to assist with longer term planning.<br>• Outsourcing is a fundamental part of the Health Board's plan going forward.<br>• The Health Board will continue to work towards improved capacity for Day Surgery and 23:59 case load.<br>• A Harm Review process is being piloted within Ophthalmology – it will be rolled out to other areas.<br>• The Health Board has taken advice from outside agencies especially the DU when the potential for improvement is found.<br>• Appropriate monitoring at ILG and Health Board levels via scheduled and formal performance meetings with additional audits undertaken when areas of concern are identified<br>Planned Care board established.<br>- The Health Board is exploring working with neighbouring HBs in order to utilise their estate for operating. | Update May 2025:<br>Planned Care -Progress being made towards the >104 week position. There has been continuous improvement against trajectories for elective demand for a range of services including Mental Health and Learning Disabilities.<br>4 mobile theatres and 2 endoscopy modular units have been opened on Royal Glamorgan Hospital site since the 10th April, to provide additional surgical and diagnostic capacity following the critical incident at POW.<br>Unscheduled Care - Stroke remains on the risk register to closely monitor the temporary centralisation of service and quality of patient journey and outcomes. Stroke Service re-design programme has been established to support development of a longer term sustainable service.<br><br>Impact on the capacity reduction and resilience across the full CTMUHB system is monitored and managed closely with continuous planning and review of clinical pathways. | Quality, Safety & Experience Committee<br><br>Operational Delivery Committee | 20 | C4xL5 | 12<br>C4 x L3 | ↔ | 13.7.2023 | 06.05.2025 | 30.06.2025 |
| 8 | 4632 | Executive Director of Therapies and Health Sciences. | Unscheduled Care Group | Head of Strategic Planning and Commissioning | Improving Care | Patient / Staff /Public Safety<br><br>Impact on the safety – Physical and/or Psychological harm | Provision of an effective and comprehensive stroke service across CTM (encompassing prevention, early intervention, acute care and rehabilitation) | **IF:** changes are not made to improve and align stroke prevention initiatives, early intervention campaigns, and acute and rehabilitation stroke care pathways across CTM<br><br>**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<br><br>**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.<br>• ToR and membership of Strategy Group updated.<br>• Close working amongst executive team to escalate and address operational and clinical issues in relation to stroke pathway<br>• Board briefing to ensure all sighted to challenges<br>• Quarterly briefings to Quality and Safety Committee<br>• Performance data regularly presented to Performance, Planning and Finance Committee<br>• Strong CTM input to regional and national Stroke Programme Boards<br>• Unified, evidence-based pathway developed for thrombolysis<br>• Preparations progressing to prepare for 24/7 thrombectomy service at Bristol and updated RCP guidance on thrombolysis and thrombectomy<br>• Designated senior operational lead for performance and improvement leadership for stroke pathway | Update May 2025 - Update added 21.4.25 - Prior to critical incident and since temporary consolidation of stroke services at RGH, there is no psychology support for stroke patients during any part of the patient pathway. A dedicated psychology support service needs to be included in planning the sustainable service model for stroke within CTM.<br>Care groups are working to ensure a workforce plan and redesign for a sustainable provision. Regular stroke oversight meetings where the risk can be closely monitored and actions taken where appropriate to manage the risk. | Quality, Safety & Experience Committee<br><br>Operational Delivery Committee | 20 | C4xL5 | 12<br>(C4 x L3) | ↔ | 11.05.2021 | 06.05.2025 | 30.06.2025 |
| 9 | 5276 | Director of Digital | Central Support Function - Digital and Data | Pathology Directorate Manager | Sustaining Our Future | Business Objectives - Operational<br>Patient safety Digital Healthcare Wales interdependencies | Failure to deliver replacement Laboratory Information Management System, LINC Programme, by summer 2025, | **IF:** the new Laboratory Information Management System (LIMS) service is not fully deployed before the contract for the current LIMS expires in June 2025.<br><br>**THEN:** operational delivery of pathology services may be severely impacted.<br><br>**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.<br><br>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 May 2025 - Phase 1 UAT has now been completed by Digital Health Care Wales (DHCW). They are working with University Health Boards to understand any issues or critical blockers from testing. Replanning options are also being currently looked at e.g. should migration be based on individual specialities/discipline rather than at an individual University Health Board level. DHCW are currently undertaking a procurement activity reviewing the use of Citrix, which is used to deploy LIMS, so activity to explore the mitigation of a potential Citrix contract termination in December is underway. | Quality, Safety & Experience Committee<br><br>Operational Delivery Committee | 20 | CSxL4 | 5<br>(CSxL1) | ↔ | 26.10.2022 | 2.5.2025 | 30.06.2025 |
| 10 | 4664<br><br>Closed session due to business sensitivities. | Director of Digital | Central Support Function - Digital & Data | Assistant Director for Data Intelligence, Compliance & Design | Creating Health | Legal / Regulatory<br><br>Statutory duty, regulatory compliance, accreditation, mandatory requirements | Detail redacted due to business sensitivities. Details of this risk are considered in closed session of the Committee. | | | | | | | | | | | |

| | A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P | Q | R |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 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 |
| 11 | 3826<br><br>Linked to 4839 and 4841 in Bridgend<br><br>Linked to 4462 | Chief Operating Officer | Unscheduled Care Group | Care Group Service Director - Unscheduled Care. | Improving Care | Patient / Staff /Public Safety<br><br>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).<br><br>**Then:** patients are therefore placed in non-clinical areas.<br><br>**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.<br><br>Filling the last resus space compromises the ability to manage an immediate life threatening emergency.<br>Clinicians taking increasing personal risk in management of clinical cases.<br>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.<br><br>Additional repose mattresses have been purchased with associated equipment.<br><br>Additional catering and supplies.<br><br>Incidents generated and attached to this risk.<br><br>Weekly report highlighting level of above risk being generated.<br>All patients are triaged, assessed and treatment started while waiting to offload.<br>- Escalation of delays to site manager and Director of Operations to support actions to allow ambulance crews to be released.<br>- Rapid test capacity in the POW hot lab has recently increased with a reduction in swab turnaround times.<br>- Expansion of the bed capacity in YS to mitigate against the loss of bed capacity in the care home sector and Maesteg community hospital.<br>- Daily site wide safety meeting to ensure flow and site safety is maintained.<br>- 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.<br>-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.<br>-Appointment of Clinical Lead and Lead Nurse for Flow appointed Feb 21<br>- 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.<br>- Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board. | Update May 2025 - The care group continue to review and monitor targets that will assist with reducing overcrowding, such as 4- and 12-hour ED performance. Care group are reflecting on MAG recommendations to align their targets and meet performance standards.<br><br>Agree date for implementation of Internal Professional Standards<br>Ongoing monitoring of UTC Pilot at PCH through established programme – extend until the end of April 2025 – seeking recurrent funding<br>Phase 3 of STAMP Programme – a further 3 workshops planned for SDEC/AMU/ACE/ED Ambulatory - 30 April/ 7th May/14th May 2025<br>Review opportunities for Phase 3 of SDEC at PCH in line with STAMP and securing additional Acute Physicians – locums whilst recruit<br>Review opportunities for 7/7 Acute Medicine with recruitment of Acute Medicine Consultants – Locum whilst recruit<br>Review opportunities to expand Frailty provision at PCH in line with STAMP with additional COTE Consultant – Locum out whilst we recruit<br>ED Patient Tracking in WPAS launch 3 sites<br><br>Urgent care continues to work at pace through their action plan and senior leadership are monitoring their performance closely, with regular operational meetings. | Quality, Safety & Experience Committee<br><br>Operational Delivery Committee | 20 | C4xL5 | 12<br>(C4xL3) | ↔ | 24.09.2019 | 6.05.2025 | 30.06.2025 |
| 12 | 5417 | Chief Operating Officer | Primary Care and Community Care Group | Care Group Service Director | Improving Care | Patient / Staff /Public Safety<br><br>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.<br><br>**Then…** the number of children waiting list for assessment and treatment will continue to increase beyond 1000 by March 2024.<br><br>**Resulting in…**<br>1. children waiting increased times for assessment/treatment who have high levels of dental caries and painful teeth requiring extraction,<br>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 form 48% to 80%. Children can only wait 8 wks form assessment to treatment therefore there is a large backlog of assessments due to limited GA lists to provide treatment. | Current theatre lists are run on Monday mornings and Friday afternoons and are likely to be cancelled due to bank holidays. This impacts the running of the service, no additional lists are available when lists are missed. There are currently 800+ patients waiting for appointments, with some already waiting for 17 months. Patients are advised to return to their General Dental Practitioner (GDP) if they experience pain, some children are being prescribed multiple courses of antibiotics to ease dental infections that can only be alleviated by tooth extraction. There is a risk these patients will require the removal of more teeth/more require GA when assessed/children will present as an urgent case in Accident and Emergency if left untreated. | Update May 2025 - Prince Charles Hospital (PCH) has confirmed a GA session will run every Friday, this will enable up to 7 patients to be seen p/w dependent on complexity.<br>Still exploring possible use of Vanguard, waiting for the theatres to be utilized by adults patients from the 10 April to understand suitability if theatres are safe for Paediatric use.<br>CDS have started to assess 30 patients p/w in readiness for the Saturday list however will pull down additional assessment clinics in the next few weeks if there is a delay in use of the Vanguard Theatres Confirmation is required as soon as possible due to children can only be assessed 9-10 weeks prior to treatment, additionally other CDS patient lists are currently being cancelled to ensure there is an appropriate cohort for treatment on the Vanguard lists. Currently waiting for secondary care staffing costs to be shared with Service Director to enable costs to be reviewed/signed off. | Quality, Safety & Experience Committee<br><br>Operational Delivery Committee | 20 | C4xL5 | 9<br>C3xL3 | ↔ | 20.04.2023 | 6.5.2025 | 30.6.2025 |
| 13 | 5903 | Chief Operating Officer | Children & Family Care Group | Care Group Service Director | Improving Care | Statutory Duty, Regulation, Mandatory Requirements. | Unfunded Continuing Care Packages / unfilled packages | **If** the budget is not allocated, to employ additional staff within Children's Continuing Care<br><br>**Then** agreed packages of care which have clearly identified an unmet need, will remain unfilled<br><br>**Resulting in** impacts of child and family wellbeing, risk to the child, risk of the unmet need continuing, children with packages for school being prevented from attending. Not meeting health boards obligation against Welsh Government Continuing Care Guidance. | Recruitment activity underway.<br>Temporary posts advertised for Health Care Support Worker - partially successful<br>Risk remains high as staff need to be recruited, inducted and trained<br>SBAR for permanent recruitment escalated to Operational Management Board - no decision to date. | Update May 2025 - Financial allocation being discussed with Care Group which is likely to reduce / remove this risk. | Quality, Safety & Experience Committee<br><br>Operational Delivery Committee | 20 | C4xL5 | 6<br>(C2xL3) | ↔ | 05.09.2024 | 06.05.2025 | 30.6.2025 |
| 14 | 3567 | Chief Operating Officer | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Care Group Service Director | Improving Care | Quality / Complaints / Assurance / Patient Outcomes | Capacity of Cellular Pathology Service - Space | **If**: there is not enough laboratory and office space for Cellular Pathology to operate the core service safely or support increasing demand, service disaggregation and future Health board changes;<br><br>**Then:** the service will be unable to work effectively and efficiently in line with Duty of Quality guidance and recognised Health board standards for IP&C, H&S etc.<br><br>**Resulting in:**<br>- Inability to meet increasing demand<br>- increase in staff stress and compromised well being due to working in suboptimal conditions.<br>- Poor cancer performance and inability to meet expected turnaround times, impacting on Health Board cancer performance<br>- poor quality patient care due to delays in diagnosis or misdiagnosis<br>- Increase in clinical incidents, complaints and potential for reputational damage.<br>- Inability to effectively disaggregate the current SLA with Swansea Bay and repatriate services from Bridgend impacting clinical services across CTM.<br>- inability to support full digital rollout and support regional reporting in line with WG strategic direction<br>- delayed development of advanced scientist dissection to support increasing reporting capacity and delivery of workforce modernisation<br>- loss of tissue leading to Serious incidents and Regulatory non-compliance with HTA and potential compromise of HTA license.<br>- financial risk of outsourcing<br>- threat to strategic regionalisation project due to the scale of the lack of capacity in CTM | SOPs are in place to standardise practice and mitigate risk of variation in practice caused by limitations of the laboratory environment.<br>Controls to reduce the use of reception/dissection as a thoroughfare including signage and demarcation belt.<br>Workflows established to maximize efficiency of limited space.<br>Block and slide filing removed from laboratory area where possible.<br>System of work including check established in dissection to minimize risk of error.<br>IPC and H&S environment inspections undertaken to assess impact of laboratory environment on clinical effectiveness and risk to patients and staff. | Mitigating Action Plan includes:<br>Engagement with estates to review small scale projects to increase laboratory space.<br>Engagement and participation in Regional Scoping group to scope options including estates to look at long term solutions. | Quality, Safety & Experience Committee<br><br>Operational Delivery Committee | 16 | C4xL4 | C3xL2<br>6 | New risk escalated to the Organisational Risk Register in May 2025. | 28.05.2019 | 06.05.2025 | 30.06.2025 |
| 15 | 5045 | Chief Operating Officer | Unscheduled Care Group | Care Group Service Director | Improving Care | Patient / Staff /Public Safety<br><br>Impact on the safety – Physical and/or Psychological harm | Access to Neurology Inpatient and Outpatient Services for CTM Residents | **If:** there is no clear direction and commissioning intentions set out in respect of neurology service provision for the residents of RTE;<br><br>**Then**: existing service pressures in respect of the consultant workforce, availability of diagnostic tests, inpatient demand, care of women on valproate medication, provision of epilepsy specialist nursing services, lack of ante natal epilepsy services and outpatient demand and waiting times will continue;<br><br>**RESULTING IN**: a risk of harm from late diagnosis; patient condition deterioration; delays starting appropriate treatments, long waiting times; medication issues and potentially sudden unexpected deaths. There is also an issue around reporting of waiting times for neurology patients. | An additional Locum Consultant working out of RGH providing inpatient and outpatient neurology services support. Plan to appoint x3 consultant neurologists within CTM as part of the Neurology Liaison Plan. | Update May 2025 - Neurology capacity pressures remain across CTM and limited access to neurophysiology testing is also an issue.<br><br>A locum consultant neurologist started in Royal Glamorgan Hospital (RGH) in December 24 and is currently providing inpatient support to RGH and 4 OP clinics per week. This is supporting reducing the OP backlog and improving inpatient support, however, as at end of March 25 there are 1782 patients waiting over 26 weeks for a first op appointment.<br>INTP bid for neurology consultant posts submitted and awaiting a decision. | Quality, Safety & Experience Committee<br><br>Operational Delivery Committee | 16 | C4xL4 | 8<br>(C4xL2) | ↔ | 09.3.2022 | 06.05.2025 | 30.6.2025 |
| 16 | 5576 | Chief Operating Officer | Primary Care and Community Care Group | Care Group Service Director | Sustaining Our Future | Workforce / Organisational Development / Staffing / Competence | Palliative Medicine Staffing | **If** the Health Board are unable to recruit to the vacant Palliative Medicine Consultant post in Ysbyty Cwm Cynon (YCC) for Merthyr/Cynon.<br><br>**Then.**. there will be a 60% gap in palliative medicine consultant cover. This is in addition to an already understaffed consultant compliment.<br><br>**Resulting In**.. a negative impact to the delivery of Specialist Palliative Care (SPC) inpatients at YCC. As well as negatively impact on capacity in the other SPC Centres in Royal Glamorgan Hospital and Princess Of Wales Hospital, as remaining Consultants will be required to cover. They are already low as a workforce establishment. Despite this the SPC Centre in YCC will not meet the required standards to retain the SPC status. | Unit is currently open with strict criteria for acceptance End of Life patients only when accepted by a consultant.<br><br>Limited cover from other SPC centres provided but this individual has now retired, and only remote cover has been secured from other SPC sites going forward.<br><br>Recruitment in specialist agencies being sought. Additional middle grade cover sought but will have limited impact as not meeting national standards | Update May 2025 - Our current Palliative Care Service is fragile as a result of vacancies within the medical workforce. A request for an immediate emergency service change and focus on redesign of Palliative, End of Life Care model was considered and supported by Executive Leadership Group. Engagement has taken place with Llais and a full communications brief and plan has been drafted for consideration before implementation is started. | Quality, Safety & Experience Committee<br><br>Operational Delivery Committee | 16 | C4xL4 | 8<br>(C4xL2) | ↔ | 11.10.2023 | 06.05.2025 | 30.6.2025 |
| 17 | 5753 | Executive Nurse Director / Deputy Chief Executive | Children & Family Care Group | Care Group Service Director | Improving Care | Workforce / Organisational Development / Staffing / Competence | Inadequate Special School Nurse Provision | **If** the Health offer towards the current Special Schools Nursing Model is not increased and Bridgend Local Education Authority (LEA) does not contribute financially to the Service Level Agreement (SLA) in Special Schools<br><br>**Then t**he Community Children's Nursing (CCN) Service are unable to meet their obligations across the five special schools in CTM and be unable to fulfil their obligation to Rhondda Cynon Taf (RCT) and Merthyr who are the only LEAs who contribute financially into the SLA<br><br>**Resulting in**, Dissatisfaction and fractured relationships within RCT and Merthyr LEA, inequity of service provision across CTM special schools, risks to the children & young people (CYP), impact on Consultant Led clinics, inability of special school nurse to deliver on School Nursing Framework in Wales part 2 - Nursing in Special Schools and Healthy Child Wales (HCW) part 2, lack of access to continual professional development and peer support for the nurses based in Special Schools, continued issues with recruitment and retention of nursing staff into Special Schools | Mitigation - reviewing SLA at pace with LA, high level meetings with EDON, Nursing Director and Directors of education. Supporting staff, sharing risk across SSN schools. During periods of absence or vacancies; access to a school nurse will not be available in person 5 days per week. However, telephone advice and support will be available. These control measures do not meet expectations of Local Authority.<br><br>Meetings have been held between Directors of education and Director and Executive Nurse. SBAR has been escalated to Care Group OMB but needs to be escalated to HB OMB (19/02/2025) Engagement between senior nurse and head teachers and support for special school nurses has been given. | Update May 2025 - Special school nursing team remains fragile, 1 LTS ongoing from September, 1 Maternity Leave unsuccessful backfill, 1 staff member just returned from LTS.<br><br>Increasing demands from schools and uncertainty of agreed roles and responsibilities heighten this fragility. Discussion scheduled for May with Chief Operating Officer (COO) and Executive Director of Nursing and Care Group. | Quality, Safety & Experience Committee<br><br>Operational Delivery Committee | 16 | C4xL4 | 8<br>(C4xL2) | ↔ | 16.04.2024 | 06.05.2025 | 30.6.2025 |

| | A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P | Q | R |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 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 |
| 18 | 4973 | Chief Operating Officer | Mental Health Care Group | Care Group Service Director | Improving Care | Patient / Staff /Public Safety<br><br>Impact on the safety – Physical and/or Psychological harm | Clinical Medical Cover within CTM Adult Mental Health Services | **If:** CTM Mental Health Service fails to implement adequate senior medical cover across adult in-patient and CMHT services<br><br>**Then:** the Health Board's ability to provide quality care, a safe environment for patients and a good standard of training for junior doctors will be reduced and potentially compromise the safety of patients and staff<br><br>**Resulting in:** sub-optimal care to patients, inability to discharge its legal duties under the Mental Health Act, due to insufficient numbers of suitably skilled and experienced Approved Clinicians. Junior doctor supervision will be reduced which may affect future recruitment, patient safety/experience compromised and staff well being will be poor. | Functional inpatient model in place with 3 consultants to cover. Redeployment out of the service and resignation has led to a further depleted workforce and cover will reduce to two consultants from January 2025 with additional middle grade support.<br>Rehabilitation service is at a critically low level with urgent closure of one service needed.<br>Redeployment from inpatients to Rehabilitation of locum has had knock on effect on inpatients.<br>Difficulty recruiting to locum posts due to introduction of rate card and need to have Welsh AC approval. Permission to go out to non-DE has been provided.<br>Weekly cover rota going out to inpatients and rehab wards to ensure all are aware of the cover arrangements.<br>Two PAs recruited to Rehab and IP in Jan/March 2025 which will free up senior time<br>The Adult Directorate is managing medical staffing through "escalated action" procedures with daily scrutiny and communication pressures and counter measures to release the Consultant body.<br>Daily reviews with Retinue on the availability of staff | Substantive jobs which are new posts are being developed and advertised.<br>Substantive and significant programme of work running alongside this in the Medical Workforce Productivity in place.<br>International recruitment drive looking to recruit two Specialty Doctors to Inpatients and Rehab in August 2025.<br><br>Update 15.4.2025 - Risk reviewed with Adult Directorate Senior Management Team, risk remains with no change at present. | Quality, Safety & Experience Committee<br><br>Operational Delivery Committee | 16 | C4xL4 | 12<br>(C4xL3) | ↔ | 06.01.2022 | 15.04.2025 | 31.05.2025 |
| 19 | 5821 | Executive Director of Strategy & Transformation | Central Corporate Directorate - Commissioning | Assistant Director of Transformation, Strategic and Operational Planning | Improving Care | Service / Business interruption | Provision of secondary care immunology services by external provider (this is a service that is not provided by CTM UHB). | If: CTM is unable to secure a new contract with an alternative commissioned provider;<br><br>Then: CTM residents will have no access to secondary care immunology provision.<br><br>Resulting in: unacceptable level of clinical risk for both routine and urgent referrals that are currently without any available referral option. Patient experience will be impacted by delays in onward referral for investigation, diagnosis and definitive treatment/management plan. This could lead to both informal and formal concerns being submitted to the health boards. | Working group in place to seek and secure service (meets monthly), although more regular communication and updates is sent in between meetings. Exploration of suitable providers within the NHS and also private providers undertaken. Short term contract being sought for urgent referrals and expected by end July 2024.<br><br>CTM UHB Referral Management Centre currently maintaining database of both urgent and routine referrals received. CTM GP's have been informed of the challenges currently experienced with immunology provision and delays can be expected. | Update 17.04.2025 - agreement with North Bristol NHS Trust extended to 30/4/25 to all North Bristol Trust to schedule all the new out patient appointments. Wash up meeting planned for May to discuss progress and whether it is something that could be repeated in 25/26 (subject to funding). Funding discussions ongoing. Welsh Government have commenced scoping exercise and has met with all University Health Board commissioning leads in March and will meet with clinical leads this month. Draft report to be submitted to Welsh Government by scoping lead in April. | Quality, Safety & Experience Committee<br><br>Operational Delivery Committee | 16<br>(Decreased from a 20 to a 16 in February 2025) | C4xL5 | 4<br>(C4xL1) | ↔ | 08.07.2024 | 17.04.2025 | 30.06.2025 |
| 20 | 2795 | Director of Digital | Central Corporate - Digital & Data | Assistant Director for Digital Delivery | Sustaining Our Future | Statutory Duty, Regulation, Mandatory Requirements | EUC: Unsupported Windows 10 Desktop Operating Systems | **IF:** Unsupported Desktop 10 Operating Systems on the network are not upgraded / replaced<br><br>**THEN:** the devices running these OS's, will remain unsupported by the vendor as well as being vulnerable to:<br><br>1. Virus infection.<br>2. Intrusion.<br>3. Denial of Service.<br>4. Support Issues.<br><br>**RESULTING IN:** A lack of vendor support for any issues, and a potential loss of data, function or service, due to the increased risk of the above points. There is also an increased risk to the rest of the network as these devices could be used as a route in, before traversing the network with malicious intent. | 1. Plan of Action to upgrade current operating systems.<br><br>2. Where equipment cannot be upgraded replacement stock available.<br><br>3. Rolling replacement programme includes replacement of remaining equipment.<br><br>4. Where operating system cannot be replaced there is Risk Assessment document from OSSMB to mitigate the risks. | Update May 2025 - Work is progressing to increase the deployment of Windows 11 and minimise our Windows 10 estate. Additional resource has been allocated to this task, a number of differing technical solutions are being tested and developed. Conversations are also taking place in differing national forums such as MJAS Service Management Board and National Service Management board discussing how we address the issues across the whole NHS system. | Operational Delivery Committee | 16 | C4xL4 | 4<br>(C4xL1) | ↔ | 11.07.2017 | 2.5.2025 | 30.06.2025 |
| 21 | 5669 | Director of Digital | Central Corporate - Digital & Data | Assistant Director for Digital Delivery | Sustaining Our Future | 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<br><br>**Then:** Some or all of the staff that use Citrix will no longer be able to do so<br><br>**Resulting in:** Staff being unable to access local and national systems<br><br>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.<br>Legacy Annual Budget - £284k<br>Interim renewal offer - £416k (based on 12 month cost)<br>Proposed Annual Cost - £1.44M<br>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 organisations. | Renewal costs will increase. Work underway with NHS Wales and Citrix to arrive at the best value licensing on an all Wales basis.<br><br>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.<br><br>A task and finish group has been started to reduce Citrix use across CTM.<br><br>Additional WG slipgage 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 current Citrix licensing agreement runs out in December 2025 - it was hoped that we would not need Citrix licenses by this date, however due to competing demands this may now not be possible. Initial conversations with DHCW and Citrix about extending our licensing arrangements are not positive. We had hoped for another tactical 1 year extension based on a smaller number of licenses however Citrix are indicating that they would only extend for 3 years with a similar cost profile regardless of number of licenses - this could work out to be approx. £1.8m for 3 years. Planning has begun to negate the need to renew for 3 years.<br><br>The T&F group are working on a number of strands:<br>Understand and minimising ~1000 Citrix users not using iGels.<br>Understand and start to roll out of iGel replacement - (2,600 PCs).<br>Understand approach to licensing Citrix delivered DHCW Apps (WLIMS, WPAS, etc).<br>Complete Procurement of temp Citrix licenses to take us up to December.<br>Continue conversation with national groups about Citrix.<br>Understand more about National Procurement Exercise for Citrix and key dates.<br>Consideration of alternative technologies to Citrix<br><br>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.<br><br>Update May 2025 - A procurement activity is in its final stages, this will give us a clearer picture of the any costs pressures associated with the renewal of the Citrix software. | Operational Delivery Committee | 16 | C4xL4 | 4<br>(C4xL1) | ↔ | 12.01.2024 | 2.5.2025 | 30.06.2025 |
| 22 | 6039 | Director of Digital | Central Corporate - Digital & Data | Assistant Director for Digital Delivery | Sustaining Our Future | Operational:<br>• Core Business<br>• Business Objectives<br>• Environmental / Estates<br>Impact<br>• Projects<br><br>Including systems and processes, Service /business interruption | Increased cost of VMWare Licensing | **IF** the proposed increase in costs for providing a virtual server infrastructure (VMWare/VXRail) is not affordable or fully funded within FY25/26 and FY26/27<br><br>**THEN** nearly every clinical service (e.g. Pathology, ICU) will be affected<br><br>**RESULTING IN** the health board being unable to access local clinical systems | Identification of funding within discretionary capital allocations and opportunities in end of year slippage - estimates to replace all 35 VXRail nodes is £3.5m (Feb 26 - 4 nodes go out of support, June 26 - 6 nodes go out of support, Jan 27 - 18 nodes. Estimate cost to replace each node is £100k). | The further mitigating action plan is that the Digital and Data Team are exploring alternative technologies with providers to ensure an effective and efficient service.<br><br>Update May 2025 - End of year funding from the All Wales Capital Programme (AWCP) enabled us to buy 5 new VXRail nodes that will replace the 4 nodes that go out of support in Feb 26. Work will commence to understand options to replace additional nodes in FY 26/27. | Operational Delivery Committee | 16 | C4xL4 | 8<br>(C4xL2) | ↔ | 09.01.2025 | 2.5.2025 | 30.06.2025 |
| 23 | 5961 | Executive Director of Finance<br><br>Executive Lead for Estates | Central Corporate - Estates | Estates Directorate | Sustaining Our Future | Environmental / Estate / Infrastructure | Remedial roof works to resolve the water ingress at POWH. | If: the Health Board fails to act upon the recommendations of the findings of the report from the appointed Structural Engineers in relation to the roof areas at the POWH<br><br>Then: water ingress will continue to be a problem.<br><br>Resulting in: significant impact/harm to patient, staff and public safety.<br>Healthcare facilities which are not fit for purpose or sustainable for the future.<br>Service delays impacting the patient experience and service performance of the Health Board.<br>Potential legislative challenge and reputational damage.<br>Loss of confidence in the Health Board estate infrastructure across CTM. | Command structure established to manage the critical incident following identification of roof structure failings.<br>Immediate mitigations to vacate 1st floor wards & depts. of Phase 1 being managed under 4 key Cells:<br>1) Discharge Cell - Objectives: The safe but rapid discharge of patients and services from top floor phase 1 POW site and to maintain quality of care and patient safety<br>2) Decant Cell - Objectives are the safe but rapid decant of patients and services from top floor phase 1 POW site, to maintain quality of care and patient safety and to maintain staff safety and the deployment of the right staff to the right place. Decant plan agreed 15th Oct.<br>3) Redirect Take - Objective - Reduce demand for inpatient beds on the POW site<br>4) Estates - focusing on ensuring decant areas are fit for purpose as well as overseeing the plans for the works on the roof.<br>Enabling Support Cells Established: Patient Transport, Workforce, Digital, Facilities, Patient Safety, Communication<br><br>In addition barriers are in place around the footpaths to keep pedestrians away from the edge of Phase 1 roofs. | Update April 2025:<br>Removal of Roof Coverings at the Princess of Wales Hospital site in accordance with the recommendations in the structural engineering report of 9th October 2024. Contractor has been appointed. Welsh Government funding £26.524m was approved Friday 8th November, contractor started the roof replacement programme on Monday 11th November. Phase 1 has prioritised Maternity and Special Care Baby Unit, roof replaced and handed over on Monday 13th January, services returned to site mid Feb.<br>Full programme including Theatre FEN works and fire compartmentation above vacated wards and depts due to be completed mid August 2025. Water ingress on the Phase 1 areas of the roof is only a risk on areas yet to be completed i.e. ITU, Endoscopy, Wards 5, 6, 7 and 8 but all are vacant and roof works progressing. | Quality, Safety & Experience Committee<br><br>Operational Delivery Committee<br><br>Health, Safety & Fire Sub Committee | 16 | C4xL4 | 8<br>(C4xL2) | ↔ | 21.10.2024 | 06.05.2025 | 30.06.2025 |
| 24 | 4885 | Director of Corporate Governance / Board Secretary | Corporate Governance | Corporate Governance | Improving Care<br><br>Sustaining our Future | Quality / Complaints / Assurance / Patient Outcomes | Failure to deliver and sustain effective Policy Management System and Process | If: the Health Board fails to maintain an effective policy management process/system to monitor, store and manage the review of policy and procedural documentation<br><br>Then: there is a risk that staff may act in a manner that is not consistent with strategic and functional expectations. Policies and procedures may not be readily accessible to support decision making and service delivery, and the Health Board may not be protected from litigation if policies and procedures are not regularly reviewed to reflect changes in standards and/or legislation.<br><br>Resulting in: Policies not being readily available for reference in decision making / emergency situations to support courses of action. Non compliance with new standards and legislative changes leading to possible legal challenge. Limited version control which could impact decision making if there are inconsistent or varying versions of a policy available. | The Policy for the Development, Review and Approval of Organisational Wide Policies is extant and sets out the process to follow.<br><br>Policy and Procedure advice and guidance is available from the Clinical Policy lead and the Assistant Director of Governance & Risk for non clinical policies.<br><br>SharePoint Intranet page acts as document library. | Update 30.4.2025 for May 2025 Org RR iteration - a revised "Policy on Policies" has been drafted to simplify the process for development and approval which will shortly be shared for consultation. New policy page on SharePoint in design stages. Baseline position on Central Directorate policy statuses is being collected so that an accurate compliance position can be captured.<br>On track with timescales outlined in the Project Initiation Document. | Quality, Safety & Experience Committee<br><br>Operational Delivery Committee | 16 | C4xL4 | 8<br>(C4xL2) | ↔ | 26.10.2021 | 30.04.2025 | 30.06.2025 |
| 25 | 5691<br><br>Closed Session due to business sensitivities | Chief Operating Officer | Facilities Directorate | Assistant Director Facilities | Sustaining Our Future | Patient / Staff /Public Safety<br><br>Impact on the safety – Physical and/or Psychological harm | Detail redacted due to business sensitivities. Details of this risk are considered in closed session of the Committee. | | | | | | | | | | | |

| | A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P | Q | R |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 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 |
| 26 | 5761 | Executive Medical Director | Medical Directorate Function | Medical Directorate Manager | Improving Care | Patient / Staff /Public Safety<br><br>Impact on the safety – Physical and/or Psychological harm | Cross Health Board Data Sharing | If: Digital services across Wales are unable to resolve an ongoing issue with the ability to share patient data in both directions across health boards/trusts<br><br>Then: Clinical staff across CTM will be unable to provide the safe and effective care to patients using transparent, available data<br><br>Resulting in: Potential harm to the patients of CTM due to the lack of clinical information available to clinicians when making clinical assessments | For CTM, this is a particular issue in Prince Charles Hospital as there is a lot of patient cross over at the boundary of Aneurin Bevan Health Board. As a health board we continue to raise this as a serious patient safety issue and will continue to press for a solution with Digital Health Care Wales. CTMUHB have asked for alternate options for a quicker solution and timescales to be aligned with these. This has been added as an agenda item for discussion at the next All Wales Medical Director meeting. | Digital Health Care Wales have been working on the ability to share data in both directions so data flows in the Health Board systems – this has been an issue for some time. ABLUHB have allocated some project resource to scope, map and plan the work needed, however, resources will need to be allocated by C&V and AB to get the work done. There was a strong commitment from Pan-South East Wales Regional Digital to work closer together and link into a wider regional programme board, this was repeated at the regional planning meeting.<br><br>Update May 2025 - No change to risk score or mitigation this period. Executive Medical Director to raise risk again at next All Wales Medical Director meeting. | Quality, Safety & Experience Committee<br><br>Operational Delivery Committee | 16 | C4xL4 | 8<br>C4xL2 | ↔ | 26.04.2024 | 01.05.2025 | 30.6.2025 |
| 27 | 5646 | Chief Operating Officer | Mental Health Care Group | Care Group Service Director | Improving Care | Patient / Staff /Public Safety<br><br>Impact on the safety – Physical and/or Psychological harm | The impact of "Right Care Right Person" (RCRP) approach. | **If:** South Wales Police (SWP) implement Right Care Right Person<br><br>**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.<br><br>**Resulting in**: Increased risks to our staff and the people who use our services. | Multi-agency planning meetings have been arranged to review policies.<br><br>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.<br><br>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. | Update 15.04.2025 - Risk reviewed<br><br>Phases 3+4 commenced 10/03/25, no significant impact yet, risk reviewed, no change at present.<br><br>The Care Group will continue to monitor and discuss scoring review at next Mental Health Learning Development Operational Management Board. | Quality, Safety & Experience Committee<br><br>Mental Health Act Monitoring Committee | 16 | C4xL4 | 12<br>(C3XL4) | ↔ | 08.12.2023 | 15.04.2025 | 31.05.2025 |
| 28 | 5579 | Executive Director of Public Health | Diagnostics, Therapies, Pharmacy and Sciences Care Group | Head of Nutrition and Dietetics, Therapies, PCH | Creating Health | Patient / Staff /Public Safety<br><br>Impact on the safety – Physical and/or Psychological harm | Rising childhood obesity rates resulting in an increase in obesity related conditions and poorer health outcomes. | **If** there is no children and young person's weight management service<br><br>**Then** the Health Board will be unable to support children and young people to manage their overweight and obesity<br><br>**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. | Non-finance dependant controls:<br>1) Level 1 service via PSPYN continues to be delivered in Merthyr (PHW funding until 26) and Taff Ely and Rhondda (Cluster funding until 26)<br>2) Written first line advice and guidance on the management of referrals available and provided to referrers and shared with families and carers<br>3)Business case developed submitted and submitted for IMTP consideration. Business case proposes a phased approach at levels 1 and 3 and was developed in collaboration with stakeholders.<br>Finance-dependant controls:<br>1)Set up service if funding identified via IMTP process. | Update May 2025 - Awaiting formal notification of IMTP investment which will reduce this risk | Quality, Safety & Experience Committee<br><br>Strategic Development Committee | 16 | C4xL4 | 8<br>C4xL2 | ↔ | 13.10.2023 | 06.05.2025 | 30.06.2025 |
| 29 | 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<br><br>**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.<br><br>**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<br><br>New operating model in respect of quality, safety and governance almost fully implemented.<br><br>New systems and processes, including escalation, implemented to assist to effectively manage cases.<br><br>The Assistant Director of Concerns & Claims, Head of Legal Services and Legal Services Manager are all carrying case loads to help mitigate this risk.<br><br>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 May 2025 - due to a number of challenges identified within the Legal Services Directorate a review is underway which includes a detailed review of any associated risks which will be supported by a recovery plan. This review is being led by the Deputy Director of Nursing. Updated risks will be captured in the next iteration of the Organisational Risk Register. | Quality, Safety & Experience Committee<br><br>Operational Delivery Committee | 16 | C4xL4 | 8 (C4xL2) | ↔ | 02.11.2021 | 06.05.2025 | 30.06.2025 |
| 30 | 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<br><br>**Then:** we will not fulfil our socio-economic duty, our Wellbeing of Future Generations objectives or our value based healthcare principles<br><br>**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.<br>• 'CTM 2030' delivery focusses on community developments, employment and local procurement where possible.<br>• CTM becoming established as an Anchor Organisation.<br>• Decarbonisation Action Plan<br>• Established a CTM Environmental Sustainability Group which will have oversight and delivery of CTM's decarbonisation agenda<br>• 'CTM 2030' seeks to ensure that services take account of the impact on the environment<br>• All-Wales approach to sustainable procurement<br>• Green CTM Staff Forum<br>• Fleet emissions reduction programme and trial of electric vehicles<br>• Tree planting initiatives<br>• Waste management – elimination of landfill for foodstuffs<br>• Use of less environmentally impactful anaesthetic gases<br>- CTM representatives attend the Welsh Government Green meeting<br>- Adaptation sub-group established and plan to be produced by March 2026<br>- DAP updated and signed off by Board March 2024<br>- Board and Committee cover papers also now include environmental impact against 5Rs.<br>- Sustainability post appointed to, started July 2024<br>- - Use of SimplyDo platform<br>- Close working with Innovation Team and wider partners to deliver a number of sustainability projects<br>- Solar panels being rolled out<br>- LED lighting fitted in POW as part of roof programme | Update 17.04.2025 - Mitigating action continues to undertake work to assess the environmental impact of projects and programmes that are not classed as "sustainability" projects/programmes.<br>Currently score remains unchanged. | Strategic Development Committee | 16 | C4xL4 | 8 (C4xL2) | ↔ | 21.2.2023 | 17.04.2025 | 30.06.2025 |
| 31 | 4337 | Director of Digital | Central Support Function - Digital & Data | Assistant Director for Digital Systems | Creating Health | Operational:<br>• Core Business<br>• Business Objectives<br>• Environmental / Estates Impact<br>• Projects<br><br>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<br><br>**Then:** The Health board will be unable to deliver safe, high quality, clinically and cost effective care to patients<br><br>**Resulting In:** Compromised safety of patients needing treatment that are reliant on clinical test results and information being available to clinicians to plan and deliver the treatment plan and the requirement for sub-optimal manual processes | **Key Controls**<br>1. SBUHB Service Level Agreement<br>2. Bridgend disaggregation and the one-CTM aggregation plan<br>3. NHS Wales Control Agreement and data sharing agreements<br>4. Numerous national service management boards and Technical oversight groups providing strategic, tactical and operation governance.<br>5. National ePR programme and systems<br><br>Gaps in Control<br>The full business case for the Bridgend / old-CT integration remains unfunded.<br>There are currently a number of CTM systems that are not compatible with Bridgend systems.<br>There is insufficient discretionary capital funding available to support delivery of the aggregation plan<br>There is no data item integration with GP systems, the ABHB Clinical Workstation or Local Authority system<br>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)<br>Strategic approach to becoming an anchor organisation to encourage SMEs not developed, resulting in challenges in proceeding with small agile developments<br>Discipline of organisation in keeping to the supported application platforms is being challenged - in particular staff are keen to exploit the opportunities presented by the MS365 platform however there are no resources available to support, train or integrate this platform within the EPR architecture | Update March 2025: Still on track for 16th May 2025. Consideration needs to be given to any service changes being made during May 2025.<br><br>Update May 2025: A successful migration dry was undertaken on 26th April, activity is underway to examine defects and issues raised, confidence grows to be able to undertake go live in May, however there are still outstanding issues with WPRS and data quality that will need to be resolved. | Operational Delivery Committee | 16 | C4 x L4 | 8<br>(C4xL2) | ↔ | 14.10.2020 | 2.5.2025 | 30.06.2025 |
| 32 | 4417<br><br>(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<br><br>Impact on the safety – Physical and/or Psychological harm<br><br>&<br>Statutory Duty / Legislation | Management of Security Doors in All Hospital Settings | Following several serious incidents following patients absconding from clinical areas, the HSE have issue an Improvement Notice on Bridgend Integrated Locality Group (see Documents) outlining the following actions:<br>In consultation with employees and involving competent persons:<br>1. Identify the units, wards and premises where in-patients may be at risk from wandering, absconding or escaping.<br>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.<br>3. Identify the measures needed to protect patients at risk<br>4. Record the significant findings.<br><br>Any lessons learned from the above should be formally shared with the other 2 Integrated Locality Groups for action.<br><br>IF: the Health Board do not comply with the notice.<br>THEN: the Health Board may be subject to prosecution by the HSE<br>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.<br><br>A document has been circulated from Estates which outlines procedures around how and where staff should be reporting failures in doors. | Update May 2025 - Princess of Wales (POW) Hospital – An allocation of funding has been approved. Security Vulnerability Risk Assessments (SVRA's) have been carried out. Technical system surveys have been carried at some of the high risk Ward areas and at adjacent areas. Stakeholders updated on the plans. The planned further work and commencement dates have been affected by the Princess of Wales Hospital roof issues in particular gaining access to the areas to be surveyed. Because of this there are several phases to the site plan in FY 2025/26 namely 1a and 1b. Phase 1a estimated costs have been provided as of 28/4/25 waiting for cost for Phase 1b. The work plan schedule for FY 2025/26 will be prioritised based on risk, the cost within budget allocated. Capital team will schedule the work once costs are in. Work will then be planned in FY 2025/26. This work will continue in FY2026/27 with plans for a Phase 2 scheme to address other sites access and CCTV site risks at Princess of Wales Hospital. | Health Safety & Fire Sub Committee | 16 | C4 x L4 | 8<br>C4xL2 | ↔ | 30.09.2020 | 06.05.2025 | 30.06.2025 |
| 33 | 4671<br><br>Closed Session due to business sensitivites | Director of Digital | Central Support Function - Digital & Data | Assistant Director for Data Intelligence, Compliance & Design | Creating Health | Operational:<br>• Core Business<br>• Business Objectives<br>• Environmental / Estates Impact<br>• Projects<br><br>Including systems and processes, Service /business interruption | Detail redacted due to business sensitivities. Details of this risk are considered in closed session of the Committee. | | | | | | | | | | | |

| | A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P | Q | R |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 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 |
| 34 | 4672 | Director of Digital | Central Support Function - Digital & Data | Assistant Director for Data Intelligence, Compliance & Design | Creating Health | Operational:<br>• Core Business<br>• Business Objectives<br>• Environmental / Estates Impact<br>• Projects<br><br>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<br><br>**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<br><br>**Resulting in:** Degradation in our delivery of the quadruple aim and strategic objectives and damage to our reputational standing with our population and partners. Further we will be prevented from driving forward our ambitions to become a digital organisation, an exemplar for R&D and Value etc. | **Operational controls:**<br>Coding key performance indicators covering productivity, demand and backlog robustly monitored<br>Digitised Patient Notes programme board monitors scanning times, adherence of contractor to terms and quality of staff in maintaining a record<br>DHCW annual coding quality audit.<br>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.<br>Natural language programming resource deployed and outputs of programme being validated.<br>Tactical - EPR programme with deployment of snomed-CT onotology server, WCP & E-forms etc.<br>**Tactical controls:**<br>Digital element of the strategic programme - Culture to digitise the EPR, our communications, how we do business<br>National Architecture Review - encompassing (NDR /CDR & Sharing arrangements)<br>Coding transformation programme .<br>**Gaps in controls**<br>Scanning time of outpatient activity to digitise the record is at 51 days cf maximum clinically safe time of 24-48 hours<br>Quality of paper record and its filing is very poor with audits identifying over 70% of paper records are not maintained to acceptable standards<br>Digital solutions not yet using snomed-CT/ structurally coded data<br>Information and Technical Standards not being followed with national body favouring document rather than data exchange<br>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)<br>Digital transcription programme unsupported & unsupported from march 23 | Update May 2025 - Continual progress is being made by the team to alleviate the pressures across the Bridgend locality, with notes moving between Unit 32 and Williamstown. There has been a delay with the repatriation of SB identified notes in Glanrhyd due to the box weights exceeding 15kg and we are awaiting sufficient workforce capacity to redistribute the boxed up notes into smaller lighter loads for transport to SB. Day forward scanning continues to maintain 48 hour KPI. | Operational Delivery Committee | 15 | C3 x L5 | 9<br>(C3xL3) | ↔ | 05.06.2021 | 2.5.2025 | 30.06.2025 |
| 35 | 5040 | Director of Digital | Central Support Function - Digital & Data | Assistant Director for Data Intelligence, Compliance & Design | Creating Health | Operational:<br>• Core Business<br>• Business Objectives<br>• Projects<br><br>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<br>**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<br>**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:<br>1. Loss of information integrity and accessibility as multiple copies of clinical records.<br>2. Failure and delay of digital system deployments (e.g. WEDS)<br>3. Possible breaches to the GDPR, safeguarding and information governance risks.<br>4. Mistrust by staff of the ICT systems and services they are using<br>5. Money being wasted | A Myrddin strategic programme group has been established, chaired by the CEO of DHCW to map out how the constraints can be overcome<br><br>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<br><br>Gaps in controls:<br><br>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 CareSC) 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 May 2025 - Digital and Data IMTP submission has now been approved. Funding has been allocated to engage a strategic partner to support and develop our digital and data strategic roadmap, and a procurement activity is underway. The MAG report has now been published and we analysing the detail. | Operational Delivery Committee | 15 | C3xL5 | 9<br>C3xL3 | ↔ | 07.02.2022 | 2.5.2025 | 30.06.2025 |
| 36 | 3337<br><br>Linked to RTE Risk 4813 and M&C 4817. Also linked to 4804. | Chief Operating Officer<br><br>Director of Primary Care and Mental Health Services | Central Support Function: Digital & Data<br><br>Mental Health Care Group | Lead Infrastructure Architect<br><br>Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services | Creating Health | Patient / Staff /Public Safety<br><br>Impact on the safety – Physical and/or Psychological harm | Lack of a Single Electronic Patient Record in Mental Health Services | **If:** Mental Health Services do not have a single integrated clinical information system that captures all patients details.<br><br>**Then:** Clinical staff may make a decision based on limited patient information available that could cause harm.<br><br>**Resulting In**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace. | Control measures updated September 2023.<br><br>1. A PID has been developed which outlines the processes, resources and timelines sought - this to be discussed in September Programme Board.<br><br>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.<br><br>3. Business case to be progressed following Board approval.<br><br>4. A new MHLD Care Group risk will be developed relating to the operational mitigations required in the interim to support safe communication and this will be held by the High Quality Clinical Record group, part of the Inpatient Improvement Programme | Update March 2025 - Update provided by the Director of Digital, confirmed that the implementation period of the Single Record Programme is Jan-July 2027. The programme board will be convened in April 2025 and the tender will be awarded by the end of 2025.<br><br>Update May 2025 - risk reviewed no change to risk score or mitigation this period. | Quality, Safety & Experience Committee<br><br>Operational Delivery Committee | 15 | C5xL3 | 6 | ↔ | 07.11.2018 | 06.5.2025 | 30.06.2025 |
| 37 | 4691<br><br>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:<br>• Core Business<br>• Business Objectives<br>• Environmental / Estates Impact<br>• Projects<br><br>Including systems and processes, Service /business interruption | New Mental Health Unit | **IF**: Mental health inpatient environments fall short of the expected design and standards.<br><br>**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.<br><br>**Resulting in**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace and extended lengths of stay. | A Quality Improvement programme in relation to inpatient care has started and a work stream in relation to Safe and Therapeutic Environments has been established with the aim of optimising the patient experience. Inaugural workshop took place on the 26th April.<br><br>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.<br><br>Annual revisiting of all patient ligature risks and completion of Statement of Needs via capital process for any ligature risks assessed as needing resolution.<br><br>All anti ligature works planned for 2022 – 2023 have now been completed.<br><br>A scoping document case is to be prepared and submitted to WG.<br><br>Inpatient Improvement Programme established April 2023 | Update 30.4.2025 - 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 & Experience Committee<br><br>Operational Delivery Committee | 15 | 15<br>(C3xL5) | 6<br>(C3xL2) | ↔ | 15.06.2021 | 30.04.2025 | 31.07.2025 |
| 38 | 5820 | Executive Director of Public Health | Public Health - Health Protection | Health Protection Team | Improving Care & Creating Health | Patient / Staff /Public Safety<br><br>Impact on the safety – Physical and/or Psychological harm | Potential inability to deliver all elements of the Health Protection Strategic priorities as a result of reduced allocation of funding. | **IF** as a result of the reduced allocation of Health Protection resource the Health Protection Team has insufficient resources to deliver a safe and sustainable service.<br><br>**THEN** there may not be sufficient resources to deliver all elements of vaccination and immunisation (which is the first line of defence against infectious disease) in accordance with the NIF. The health board response to infectious disease or environmental hazards will also be significantly hindered and work to address gaps in equity of access will be limited.<br><br>**RESULTING in** avoidable harm to patients in vulnerable groups and harm to the public as a result of insufficient health protection interventions delivered. This also poses a reputational risk as a consequence | Governance structure agreed in Health Protection.<br>Health Protection Board established.<br>Recruitment underway to Health Protection structure.<br>A series of planning workshops with partners agreed to review resources available, develop Health Protection strategy and highlight ongoing gaps | A workforce structure has been approved by ELG and work to identify gaps is ongoing which will be reviewed once recruitment is complete.<br>Work with partners is ongoing to reduce inefficiencies and develop A collaborative Health Protection (HP) plan based on all resources available to ensure priorities can be clearly defined and delivered.<br>Work with CTM finance is needed to ensure the HB allocation is maximised to support HP priorities. Welsh Government discussions are ongoing with regards to the reduced allocation<br><br>N/B - Whilst this risk is not scored at a level of 15 and above - the Executive Lead considers this risk to be of a contentious nature that should be escalated to the Board via the Organisational Risk Register.<br><br>Update February 2025 - This risk has been reviewed by the Local Public Health Team Strategic Group meeting on Tuesday 11th February 2025. As the uplift in Health Protection funding for 2025/2026 still does not bring parity to the funding across Wales and is insufficient to deliver the Health Protection strategic plan, there remains a funding gap. Work is ongoing to establish the impact of the gap and the risk consequence score will be updated accordingly as this work completes.<br><br>Update 29th April 2025 - Risk reviewed and remains unchanged, next review will be at the PH Strategic Group meeting in May. | Quality, Safety & Experience Committee<br><br>Strategic Development Committee | 12<br><br>Please see note in column J | C4xL3 | 8<br>(C4xL2) | ↔ | 01.07.2024 | 29.04.2025 | 13.05.2025 |

| Datix ID | Strategic Risk owner | Strategic Objective | Risk Domain | Risk Title | Risk Description | Controls in place | Action Plan | Assuring Committees | Rating (current) | Rating (Target) |
|---|---|---|---|---|---|---|---|---|---|---|
| 5226 | Director of Digital | Improving Care | Patient / Staff /Public Safety<br><br>Impact on the safety – Physical and/or Psychological harm | Risk of damage to records and equipment due to leaking roof in the Williamstown Records Hub | **If:** the paper records stored at Williamstown Records Hub are damaged due to the recurrent water leaks in the roof.<br><br>**Then:** then they may be damaged beyond repair.<br><br>**Resulting in:** records not being available for patient care or for legal purposes. | The Estates Directorate have arranged for checks and repairs but roof continues to leak in Library Record Store and above workstations in Library Office. Staff are vigilant and containers are placed to catch known leaks. However, new leaks can occur and unavoidable water damage could occur at any hour during wet weather. Leaks could also cause slips/falls in hard-floor areas. | Update March 2025 - As at 10.2.2025- Repairs have commenced on the southern end of the roof. However, since 6/1/25, 6 new areas of leakage have occurred. On 4 of these occasions, patient records have been water-damaged. @300 records have been affected in total so far, including maternity records which have a 25-year retention period. Work to repair the northern end of the roof is awaited with urgency. Plastic sheeting has been utilised in an attempt to protect notes but it is only possible to do this in small areas. approximately 40% of the Library remains at significant risk.<br><br>Update May 2025 - Repairs completed mid- April 2025. To date, no further leaks have been observed; however, there has not yet been sustained rain to enable confirmation that all leaks have been stopped. The situation is being monitored on an ongoing basis. The likelihood has been reduced to 2 and it is hoped to reduce this further, if no leaks occur during sustained wet weather. | Quality, Safety & Experience Committee<br><br>Operational Delivery Committee | 8<br>Risk reduced from a 20 in May 2025 | 4<br>(C4xL1) |

| De-escalation Rationale |
| --- |
| Update May 2025 - Repairs completed mid- April 2025. To date, no further leaks have been observed; however, there has not yet been sustained rain to enable confirmation that all leaks have been stopped. The situation is being monitored on an ongoing basis. The likelihood has been reduced to 2 and it is hoped to reduce this further, if no leaks occur during sustained wet weather.<br><br>Risk will continue to be monitored by the Digital Directorate Function. |

| | A | B | C | D | E | F | G | H | I | J | K |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 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 |
| 2 | 5765 | Executive Director of Finance | Finance Directorate | Financial Risk | Failure to reduce the £19.4m recurrent deficit at the start of 24/25 down to the planned £2.1m recurrent surplus at the end of 24/25 | IF: The Health Board is not able to plan and deliver recurrent expenditure run rates that align with the available recurrent funding for 2024/25.<br>THEN: The Health Board may not be able to deliver a break-even financial position for 2025/26.<br>RESULTING IN :<br>• The Health Board not being able to increase investments in services and/or reduce savings targets from current levels.<br>• Potential short term unsustainable cost reductions with associated risks and potential Welsh Government regulatory action.<br>• WG not supporting the Health Board's plan for 25/26<br>• Failure to meet the statutory financial duty to break even over a 3 year period resulting in qualification of the Annual Accounts in 25/26.<br>• Potential cash shortfalls in 25/26. | • Financial Accountability letters from CEO to Executive Leadership Group.<br>• Monthly monitoring arrangements and meetings in place with Care Groups and directorates.<br>• Regular reporting to the Executive leadership Group, the Planning, Performance & Finance Committee and the Board. | Update at end of March 2025 - Month 12 update: The forecast underlying deficit at the end of 2024/25 is £7.9m (M10: £10.7m). The deterioration in the underlying position is mainly attributed to under achievement of savings delivery. The forecast recurrent deficit also excludes any ongoing costs of the Princess of Wales Hospital critical incident, which will represent an additional non recurrent cost pressure in 25/26. Our latest estimate is that these costs will be circa £10.0m.<br><br>The main action is to develop a more project and programmatic approach to planning and delivery of efficiency savings schemes, with a focus on pipeline schemes for 25/26 as well as schemes in delivery for 24/25. | Operational Delivery Committee | May 25 | Risk can now be closed as CTMUHB have reported 2024/25 financial year and achieved a break even position overall.<br><br>Two new risks being developmed for the 2025/26 financial year and will be captured in the July Organisational Risk Register. |

| Agenda Item |
| --- |
| 5.1 |

# Audit Risk & Assurance Committee

## Losses and Special Payments 01.01.25 to 31.03.25

| | |
| --- | --- |
| **Dyddiad y Cyfarfod / Date of Meeting** | 22/05/2025 |
| **Statws Cyhoeddi / Publication Status** | Open/ Public<br>Not Applicable |
| **Awdur yr Adroddiad / Report Author** | Owen James – Head of Corporate Finance |
| **Cyflwynydd yr Adroddiad / Report Presenter** | Sally May - Executive Director of Finance & Procurement |
| **Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor** | Sally May, Executive Director of Finance |

| | |
| --- | --- |
| **Pwrpas yr Adroddiad / Report Purpose** | For Noting |

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

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

## 1. Situation /Background

1.1 This report advises the Audit, Risk & Assurance Committee on the losses and special payments made by the University Health Board (UHB) for the 3-month period from 1 January 2025 to 31 March 2025, as required by the Standing Financial Instruction.

1.2 The Health Board is liable for the first £25k of any Personal Injury or Medical Negligence claim (not including Redress cases), with amounts over this being borne by the Welsh Risk Pool (WRP) managed by the NHS Wales Shared Services Partnership (NWSSP). For any "other" cases such as Employment Matters or Voluntary Early Release (VER) for example, the full cost of the loss is borne by the UHB. Where the WRP would be liable for a reimbursement to the UHB then there will be timing differences between payments being made and any reclaim from the Risk Pool. There is a strict protocol in place for reclaiming from the WRP.

1.3 General Medical Practice Indemnity Scheme (GMPI) was introduced in recent years by the Welsh Government as a state-backed scheme within NHS Wales. Legal and Risk Services and WRP operates this scheme, and cases settled under the scheme are presented to WRP for reimbursement.

- Scrutiny of the Learning from Events Report is conducted in the same manner as cases settled under NHS Indemnity or as part of the redress scheme.

- Payments in relation to claims managed under GMPI are made by the defendant Health Board, and reimbursement by the WRP is made to the Health Board.

- No excess in relation to reimbursement of cases settled under the GMPI will apply to the Health Board and all costs incurred are fully reimbursed.

1.4 In accounting for losses on claims, liability is recognised when legal advice states that there is a probability in excess of 50% of the Health Board having to settle. The quantum of the claim, and associated plaintiff costs are therefore recognised as "expenditure" at this point, with the risk pool recovery element also being recognised. Other losses are recognised as and when they arise.

1.5 There is therefore a significant timing issue (which can be several years) between expenditure being recognised within the Health Board's accounts and cash payments being made. Write-off approval action is only required for cash payments. This report highlights:

a) Losses & special payments recoded during the period.

b) Claims that have been identified as a provision on the balance sheet as they have been deemed as probable but have yet to be paid.

c) The impact of these claims being recognised on the Health Boards in year revenue position.

## 2. Specific Matters for Consideration

2.1 Standing Financial Instructions require all losses to be reported to the Audit, Risk & Assurance Committee. This report is therefore a key element of the governance process around losses and special payments.

2.2 The number of claims, both Medical Negligence and Personal Injury, continues to result in significant levels of expenditure. These levels of expenditure are determined case by case and are based on information supplied by Welsh Legal Services.

### a) Losses and Special Payments recorded during period

2.3 The losses and special payments recorded during this period totalled £7,037k, with the majority of this comprising of payments in respect of Clinical Negligence, Redress and Personal Injury.

2.4 It is important to note that the majority of these losses would have been recorded in the revenue position when the claim was deemed as probable, this is showing the cash impact of the payments made during the period.

2.5 The total recovered from Welsh Risk Pool during the period is £3,051k, giving a net cash out position for the period of £3,986k.

2.6 The losses and special payments are available in detail on request from the Head of Corporate Finance if required and are summarised in the table below.

| | 01.01.25 - 31.03.25 £000 | Previous Periods | Total 24-25 £000 |
|---|---|---|---|
| Medical Negligence Claims | 4,057 | 3,438 | 7,495 |
| Medical Negligence Costs | 1,264 | 2,317 | 3,581 |
| Medical Negligence Defence Fees | 414 | 850 | 1,264 |
| **Medical Negligence Totals** | **5,735** | **6,605** | **12,340** |
| Redress Medical Negligence Claims | 126 | 152 | 278 |
| Redress Medical Negligence Costs | 9 | 47 | 56 |
| Redress Medical Negligence Defence Fees | 4 | 68 | 72 |
| **Redress Medical Negligence Totals** | **139** | **267** | **406** |
| GP Indemnity Claims | 0 | 66 | 66 |
| GP Indemnity Costs | 1 | 158 | 159 |
| GP Indemnity Defence Fees | 0 | 16 | 16 |
| **GP Indemnity Totals** | **1** | **240** | **241** |
| Personal Injury Claims | 221 | 77 | 298 |
| Personal Injury Costs | 26 | 145 | 171 |
| Personal Injury Defence Fees | 148 | 77 | 225 |
| **Personal Injury Totals** | **395** | **299** | **694** |
| Permanent Injury Benefit | 241 | 239 | 480 |
| **Permanent Injury Benefit Totals** | **241** | **239** | **480** |
| **Other:** | | | |
| Ex-Gratia | 11 | 80 | 91 |
| Debt Write Off | 0 | 0 | 0 |
| WRP Penalty Charge | 42 | 0 | 42 |
| Ombudsman | 2 | 1 | 3 |
| Employment Matter/Other | 471 | 0 | 471 |
| **Other Totals** | **526** | **81** | **607** |
| **TOTAL** | **7,037** | **7,731** | **14,768** |
| **Recovered from Welsh Risk Pool** | **(3,051)** | **(3,052)** | **(6,103)** |
| **Net Cash Write-Off/(Recovery)** | **3,986** | **4,679** | **8,665** |

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

APPROVE

APPROVE: The learning and case information submitted was accepted by the Committee and where reimbursement is requested it has been

approved. Where the case is a review of learning only, the matter will be reconsidered when reimbursement is requested.

DEFER

DEFER: Additional information is requested which should be gathered and supplied to the Safety & Learning Advisor and this will be presented to the next WRP Committee.
*We would like to receive this information within 1 calendar month. A maximum of six calendar months applies for the submission of additional information, from the date it was first requested. – after which the reimbursement will be permanently deferred. Details of the additional information requested is outlined in the case detail below*

DEFER UNTIL INFO REC'D

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

2.8 At its latest meeting, the WRP committee approved the payment of a further £2,243k of claims (19 claims), this was paid in March. 15 further claims reviewed by the committee were deferred, and another 14 claims were deferred until further information was received.

**b) Provision as at 31 March 2025**

2.9 A provision reflecting the estimated value of the claim will be made on the balance sheet as a claim is deemed probable. There will also be an estimate for the value recoverable from Welsh Risk Pool, leading to a net provision value on the balance sheet.

2.10 The table below shows the provision made for each type of claim and the amount recoverable from Welsh Risk Pool as at the period stated. It could be deemed the lower value the net claim provision the more efficient the health board are at recovering from Welsh Risk Pool i.e. payments have been made out and they have been recovered from Welsh Risk Pool in an efficient manner.

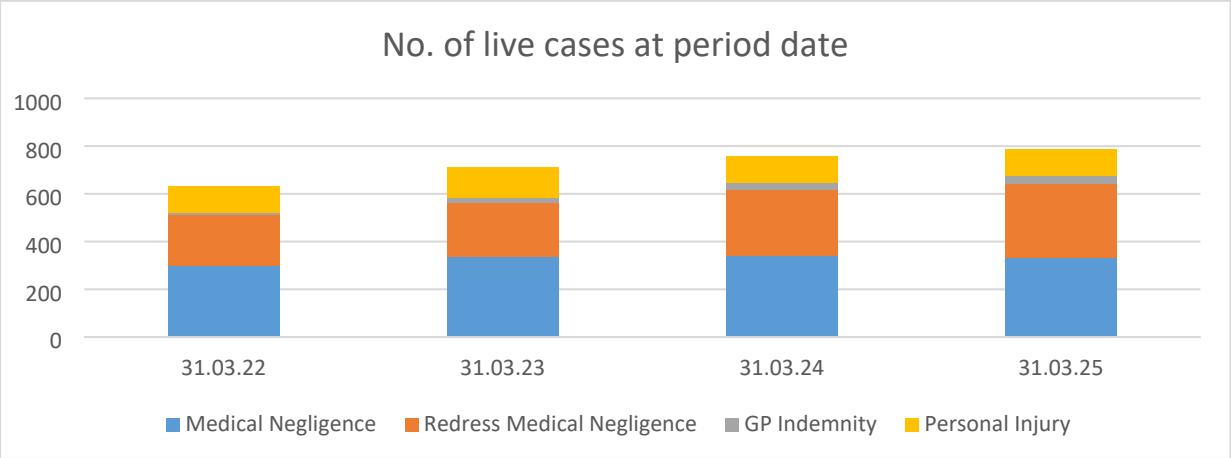
2.11 The total claims provision has increased by £44,244k since 31st March 2024, this is mainly due to an increase in value of medical negligence claims.

2.12 The net provision at the end of 31st March 2025 was £11,904k which is £2,917k higher than the previous reported period.

| | 31.03.25 | 31.03.24 | 31.03.23 | 31.03.22 |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| | Cumulative | Cumulative | Cumulative | Cumulative |
| Medical Negligence claims/costs | 136,729 | 94,478 | 72,198 | 65,127 |
| Redress Medical Negligence claims/costs | 490 | 372 | 385 | 235 |
| GP Indemnity (Note 1) | 1,670 | 612 | 0 | 0 |
| Personal Injury claims/costs | 1,734 | 917 | 701 | 611 |
| **TOTAL CLAIMS/COSTS PROVISION** | **140,623** | **96,379** | **73,284** | **65,973** |
| **Recoverable from Welsh Risk Pool** | (156,234) | (106,450) | (83,623) | (93,074) |
| **NET CLAIMS / COSTS PROVISION** | **(15,611)** | **(10,071)** | **(10,339)** | **(27,101)** |
| **Permanent Injury Benefit** | 3,707 | 3,755 | 4,077 | 6,201 |
| **NET PROVISION inc Perm Injury Ben.** | **(11,904)** | **(6,316)** | **(6,262)** | **(20,900)** |

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

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




### c) Revenue impact for the year to date

2.14 As previously highlighted, the Health Board is liable for the first £25k of any Personal Injury or Medical Negligence claim (not including Redress cases), with amounts over this being borne by the Welsh Risk

Pool (WRP). For any "other" cases such as Employment Matters or Voluntary Early Release (VER) for example, the full cost of the loss is borne by the UHB. The net impact of this value impacts the revenue account of the Health Board in the period the claim is recognised.

2.15 The table below shows the year-to-date position for each of type of claim. The "other" category mainly consists of payment of retirement gratuities, Employment Matters and voluntary early releases.

| | **Year to** |
|---|---|
| | **31.03.25** |
| | **£000** |
| Medical Negligence claims/costs | 54,589 |
| Redress Medical Negligence claims/costs | 523 |
| GP Indemnity | 1,300 |
| Personal Injury claims/costs | 1,510 |
| Recoverable from Welsh Risk Pool | (55,886) |
| **Net claim expenditure (Note 1)** | **2,036** |
| Permanent Injury Benefit | 432 |
| Other | 606 |
| **Total Net expenditure** | **3,074** |

**Note 1**: The annual budget for net claim expenditure for 2024-25 is £1,785k, actual expenditure for the year is £2,036k, therefore an overspend of £251k to March 2025. It is important to note that these costs can fluctuate during the year.

**WRP Risk Sharing Agreement**

2.16 The Audit & Risk Committee will be aware that any overspend incurred by the Welsh Risk Pool will need to be shared amongst NHS organisations and is therefore an additional financial risk to those organisations.

2.17 For 2024/25 the WRP Risk Sharing agreement value came in on budget. For 2025/26 the according to the March 2025 Shared Services Partnership Committee, the overall WRP share contribution is increasing from £30.5m to £36.1m, and the CTM share percentage is increasing from 14.76% to 15.81% an increase of £1.09m. This increase is built in to the IMTP. The table below shows the split and share anticipated share contributions to 2027/28:

| Organisation | Total RSA % | | Total RSA £000's | | | |
|---|---|---|---|---|---|---|
| | 24/25 | 25/26 | 24/25 | 25/26 | 26/27 | 27/28 |
| Aneurin Bevan | 16.78% | 18.26% | 5,115 | 6,582 | 6,887 | 7,151 |
| Swansea Bay | 15.25% | 15.28% | 4,649 | 5,510 | 5,766 | 5,986 |
| Betsi Cadwaladr | 19.22% | 19.41% | 5,857 | 6,999 | 7,323 | 7,603 |
| Cardiff & Vale | 15.86% | 15.81% | 4,835 | 5,702 | 5,966 | 6,194 |
| Cwm Taf Morgannwg | 14.76% | 15.50% | 4,499 | 5,589 | 5,847 | 6,071 |
| Hywel Dda | 9.70% | 9.57% | 2,955 | 3,451 | 3,610 | 3,749 |
| Powys | 4.13% | 2.71% | 1,257 | 977 | 1,023 | 1,062 |
| Public Health Wales | 1.14% | 0.64% | 348 | 232 | 243 | 253 |
| Velindre | 1.15% | 0.85% | 352 | 306 | 320 | 332 |
| Welsh Ambulance Service | 2.01% | 1.97% | 612 | 709 | 741 | 770 |
| Totals | 100.00% | 100.00% | 30,478 | 36,056 | 37,726 | 39,169 |

## 3. Key Risks / Matters for Escalation

Net provision increase

3.1 Note that there is an increase in the net cash write off and net provision of values owed from WRP, which reflects that the amount being paid out is higher than the value being recovered.

3.2 This is largely a timing issue, but there is a need to ensure there is timely completion of learning submitted in order from reimbursements to be approved in a timely manner, reducing value owed from WRP.

WRP penalties

3.3 The Welsh Risk Pool Committee (WRPC) met on the 28th January and reviewed the position on learning performance to consider the application of penalties to be applied to Welsh Risk Pool matters.

3.4 The WRPC agreed to undertake a review of late submitted evidence in order to try to waive penalties. Following the review, the Committee applied penalties to 5 cases at £2,500 each, totalling £12,500, this hit the budget in 2024/25. There is a risk for further penalties if deferred learning is overdue.

| WRP Reference | Penalty triggered? | Reason | Penalty applied or Waived |
|---|---|---|---|
| CLA7A5-0542/CC | Y | Overdue deferred learning | Applied |
| CLA7A5-0412/CB | Y | Overdue deferred learning | Applied |
| CLA7A5-0480/SW | Y | Overdue deferred learning | Applied |
| CLA7A5-0491/KP | Y | Overdue deferred learning | Applied |
| CLA7A5-0225/RS | Y | Overdue deferred learning | Applied |
| CLA7A5-0346/LT | Y | Overdue deferred learning | Waived |
| CLA7A5-0482/JW | Y | Overdue deferred learning | Waived |
| CLA7A5-0561/LJ | Y | Overdue deferred learning | Waived |
| CLA7A5-0686/LF | Y | Overdue deferred learning | Waived |

## 4. Assessment

| Objectives / Strategy | |
|---|---|
| **Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)** | Improving Care<br>If more than one applies please list below: |
| **Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas** | Starting Well<br>If more than one applies please list below:<br>Growing Well<br>Living Well<br>Ageing Well<br>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<br>If more than one applies please list below: |
| **Dolen i Hwyluswyr Ansawdd** *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))* | Whole-systems Perspective<br>If more than one applies please list below: |

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

| | |
|---|---|
| *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)* | The report highlights the resource impact of losses both in expenditure and cash terms. It also highlights the level of provision within the balance sheet for potential future payments |

## 5. Recommendation

5.1 The Audit & Risk Committee is requested to:

- **NOTE** the losses and special payments made for the period 1 January 2025 to 31 March 2025.
- **NOTE** the increase in the WRP sharing agreement values for 2025/26.
- **NOTE** the key risks for escalation on the increasing net provision value and the penalties imposed for overdue deferred learning.

## 6. Next Steps

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

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

| Agenda Item |
| --- |
| 5.2 |

# Audit, Risk & Assurance Committee

## Procurement & Scheme of Delegation Update

| | |
| --- | --- |
| **Dyddiad y Cyfarfod / Date of Meeting** | 22/05/2025 |
| **Statws Cyhoeddi / Publication Status** | Open/ Public<br>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 /Forum 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) Invoices on Hold & No PO No Pay summary

This report provides details of any such transactions within the period 01.02.25 to 31.03.25

### 1.2 Purchase to Pay (PSPP)

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

### 1.3 Scheme of Delegation and Financial Control Procedures

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

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

## 2. Specific Matters for Consideration

## 2.1 Procurement Matters

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

There were no engagements or contracts entered into during the period 01.02.25 to 31.03.25

**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.

In exceptional circumstances, there may be a need to secure goods/services/works from a single supplier. This may concern securing requirements from a single supplier, due to a special character of the firm, or a proprietary item or service of a special character. Such circumstances may include:

- Follow-up work where a provider has already undertaken initial work in the same area (and where the initial work was awarded from open competition;
- A technical compatibility issue which needs to be met e.g. specific equipment required, or compliance with a warranty cover clause;
- a need to retain a particular contractor for genuine business continuity issues (not just preferences); or
- When joining collaborative agreements where there is no formal agreement in place. Request for such a departure must be supported by written evidence from the Procurement Service confirming local agreements will be replaced by an all-Wales competition/National strategy.

Procurement Services must be consulted prior to any such application being submitted for approval. The Director of Finance must approve such applications up to £25,000, the Chief Executive or designated deputy, and Director of Finance, are required to approve applications exceeding £25,000. A register must be kept for monitoring purposes and all single tender actions must be reported to the Audit Committee.

**Tables A and B** below provides details of such actions during the period 01.02.25 to 31.04.25

**Table A – Single Tender Actions** 01.02.25 to 31.04.25

| STA | Revenue / Capital | Division | Contract description | Supplier | Contract Value Exc. VAT | Reason for approval | Date Returned |
|---|---|---|---|---|---|---|---|
| CTM-STA-1767 | Rev | Sterile Services | Provision of the planned preventative maintenance contract for Dekomed washer-disinfectors. | Dekomed Ltd | £29,552 | ( c ) | 03/04/25 |

Reasons for approval:

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

b) Compatibility issue

c) Genuine 1 provider

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

**Table B -** Single Tender Actions - Retrospective CTM - None for this period

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

None for this period

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

Health Boards must provide a contract summary to Welsh Government for contracts between £500,000 and £1 million prior to the contract being let. This requirement also applies to contracts that are to be let through a mini-competition under a public sector contract framework, such as National Procurement Service, NHS Supply Chain or Crown Commercial Services. There are none for this period.

## e) Free of Charge Services

Where free of charge services are made available to the Health Board, NWSSP Procurement Services must be consulted to ensure that any competition requirements are not breached, particularly in the case of pilot activity to ensure that the Health Board does not unintentionally commit itself to a single provider or longer-term commitment. Below is a summary of free of charge services that have been provided between 01.02.25 to 31.03.25

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

## f) Retrospective orders and non-receipting areas

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

| Supplier | Area | Retro Orders | Comment |
|---|---|---|---|
| Blue Arrow | 544063_LLW_DOM TOP B<br>559148_Houskeeping YCC<br>555109_PCH CATERING | 83 | Agency Staffing |
| Manpower | 555115 PCH DOMESTIC<br>555109 PCH CATERING<br>544486_YGT DOMESTIC | 14 | Agency Staffing |
| Arjo UK Ltd | 5003_Clinical Engineering (EBI | 12 | Beds |

| Top 3 Receipting Areas | Total |
|---|---|
| 533862_RGH THEATRE | 153 |
| 533170 YGT Patient Catering | 115 |
| 555180 YCC Restaurant | 70 |

## g) Consultancy Contracts

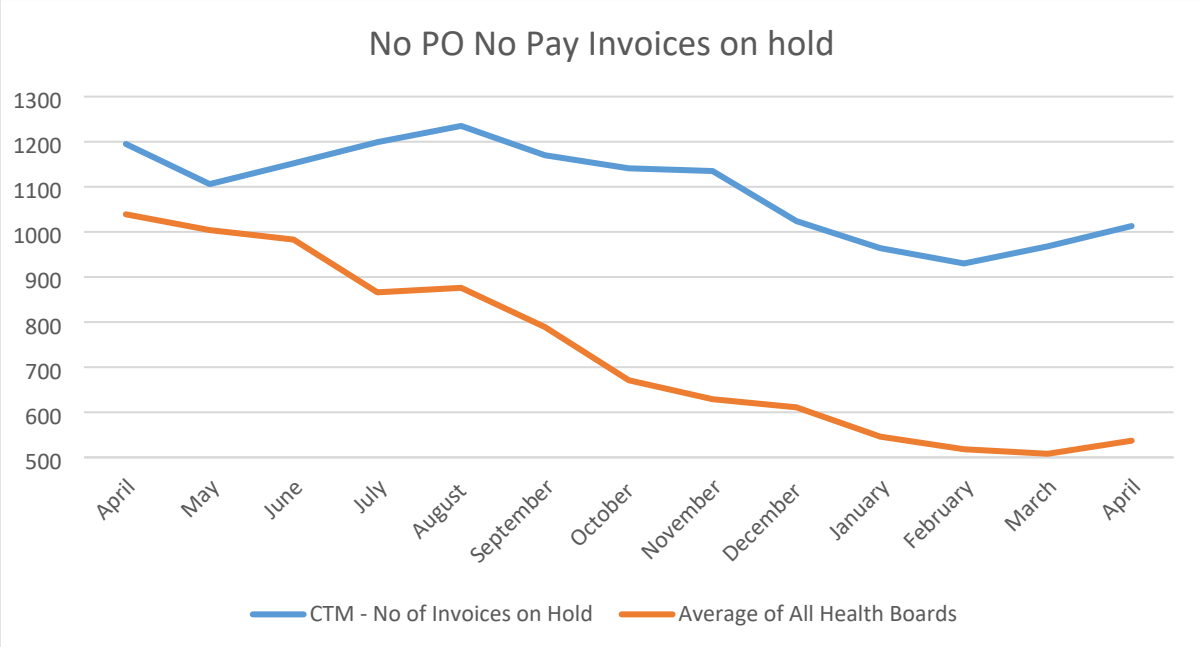
Below is a table detailing consultancy contracts that have been awarded between 01.02.25 to 31.03.25

None for this period

## h) Invoices on hold & No PO No Pay Summary

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

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




- CTM continue to have a higher number of invoices on hold due to NO PO compared to the average of all Welsh Health Boards.
- Improvements at the back end of the calendar year have seen a slight dip in recent months.
- NWSSP over April and May have put on two P2P training workshops for all requistioners and approvers, which will hopefully see an increase in compliance with invoices being submitted with a PO.
- The largest organisation with No PO No Pay holds has been in advanced discussion with the Procurement team on clearing outstanding invoices. There has recently been a clear steer on how these can be cleared, this will clear around 400 invoices on No PO No Pay holds, which will take CTM closer to the average across Wales.
- Without a PO an invoice cannot be assigned to a directorate or cost centre, therefore an assessment by directorate cannot be provided.

## 2.2 Purchase to Pay (P2P)

The PSPP figures are reported to the end of 31st March 2025.

The Health Board has met its 95% target of paying non-NHS invoices within 30 days to Month 12 2024-25 achieving 96.0% (value 94.1%). This means the Health Board achieved the target of 95% for the year.

| | 0 - 30 Days | | Total | | % | |
|---|---|---|---|---|---|---|
| | Number | Value | Number | Value | Number | Value |
| Apr-24 | 22,578 | 35,827,302 | 23,700 | 38,481,025 | 95.27% | 93.10% |
| May-24 | 20,087 | 37,485,008 | 20,890 | 41,651,491 | 96.16% | 90.00% |
| Jun-24 | 20,219 | 38,326,962 | 20,971 | 40,869,496 | 96.41% | 93.78% |
| Jul-24 | 23,972 | 39,914,765 | 24,837 | 47,066,950 | 96.52% | 84.80% |
| Aug-24 | 19,770 | 44,452,809 | 20,477 | 46,830,448 | 96.55% | 94.92% |
| Sep-24 | 21,392 | 45,067,608 | 22,146 | 47,512,201 | 96.60% | 94.85% |
| Oct-24 | 22,358 | 43,052,769 | 23,832 | 46,241,647 | 93.82% | 93.10% |
| Nov-24 | 23,278 | 42,489,691 | 24,004 | 45,068,742 | 96.98% | 94.28% |
| Dec-24 | 21,381 | 55,493,338 | 21,999 | 57,983,477 | 97.19% | 95.71% |
| Jan-25 | 22,560 | 67,499,315 | 23,954 | 70,829,243 | 94.18% | 95.30% |
| Feb-25 | 20,936 | 53,972,949 | 21,799 | 56,411,788 | 96.04% | 95.68% |
| Mar-25 | 21,988 | 77,192,889 | 22,693 | 78,466,454 | 96.89% | 98.38% |
| **YTD** | **260,519** | **580,775,404** | **271,302** | **617,412,962** | **96.03%** | **94.07%** |

The NHS invoice position continues to be challenging and shows a final position of 81.7% (number) and 97.1% (value) of invoices were paid within 30 days to Month 12 2024-25.

## 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 No matters for escalation

## 4. Assessment

| Objectives / Strategy | |
|---|---|
| **Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)** | Not Applicable<br>If more than one applies please list below: |
| **Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas** | Not Applicable<br>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<br>If more than one applies please list below: |
| **Dolen i Hwyluswyr Ansawdd** *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))* | Whole-systems Perspective<br>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<br>If more than one applies please list below: |
| **Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)** | No - Not Applicable<br>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** | Yes: ☐ | No: ☒ |

| | | |
|---|---|---|
| *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?* | Outcome for Equality (delete as appropriate):<br><br>POSITIVE/NEUTRAL<br>NEGATIVE<br><br>Outcome for Welsh Language (delete as appropriate):<br>POSITIVE/NEUTRAL<br>NEGATIVE | If no, please include rationale below:<br><br>Not applicable |
| **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 **NOTE** the position on procurement matters for the period 01.02.2025 to 31.03.2025;

**NOTE** the update regarding Purchase to Pay and achievement of PSPP target up to Month 12 of 2024/25;

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

| Agenda Item |
| --- |
| 5.3 |

# Audit, Risk & Assurance Committee

**Post Payment Verification End of Year Report 1st April 2024 – 31st March 2025**

| | |
| --- | --- |
| **Dyddiad y Cyfarfod / Date of Meeting** | 22/05/2025 |
| **Statws Cyhoeddi / Publication Status** | Open/ Public |
| **Awdur yr Adroddiad / Report Author** *If you do not wish for your name to be included in the public domain, please only include your job title* | Amanda Legge – All Wales Post Payment Verification Manager |
| **Cyflwynydd yr Adroddiad / Report Presenter** *If you do not wish for your name to be included in the public domain, please only include your job title* | Amanda Legge – All Wales Post Payment Verification Manager |
| **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 /Forum Individuals** | **Date** | **Outcome** |
| (Insert Details) | Click or tap to enter a date. | |

| **Acronyms / Glossary of Terms** | |
| --- | --- |
| PPV | Post Payment Verification |
| | |

## 1. Situation /Background

The purpose of the PPV process is to provide assurance to Health Boards that the claims for payment made by primary care contractors are appropriate and that the delivery of the service is as defined by NHS service specifications and relevant legislation.

The report details specific risks but provides the narrative for what PPV, Primary Care, Finance and Counter Fraud consider to be the best approach to support practices in improving.

The Audit, Risk & Assurance Committee is asked to note and take assurance of the contents of this report. This paper highlights PPV progress and how practices have been performing over the current Post Payment Verification (PPV) cycle. It also compares the overall performance of the Health Board against the national PPV visits.

PPV of claims from General Medical Services (GMS), General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS) are undertaken as a part of an annual plan by NHS Wales Shared Services Partnership (NWSSP).

Mid-year and end of financial year, the PPV Manager will prepare a report for Health Board Audit Committees, which should provide reasonable assurance that public monies are being appropriately claimed and that PPV continue to maintain an excellent level of PPV across all disciplines.

## 2. Specific Matters for Consideration

The following key points should be noted:

**General Medical Services (GMS):** in 2024-2025 we had 52 visits planned for Cwm Taf Morgannwg Health Board consisting of 27 routine and 25 revisits. By the 31st of March 2024, we had in progress 19 routine visits with 12 revisits. The incompletion of routine/revisits was a national issue and is not specific to any individual Health Board. With revisits, we need to check 100% of the services that have been triggered, and they take a long time to finalise and unfortunately this year we are experiencing unexpected absence in the team in a disproportionate number.

In the first 2 months of the new financial year 2025/2026 we will be completing all outstanding visits that are overdue before we begin the new visit plan.

We have also been requested by Welsh Government to undertake the additional verification of Covid and RSV vaccines and will begin these checks for the visits due in 2025/2026.

**General Ophthalmic Services (GOS):** The visit plans for GOS 2024-2025 progressed well than the last few years based on us having the ability to carry out remote access on more contractors who have transferred to electronic patient records.

We do however have to carry out elements of physical visits too, as not all contractors are electronic.

This new financial year of 2024-2025 we completed 11 visits out of 16 visits planned and have 5 more to complete and carry over into the new financial year of 2025/2026.

Moving forward into 2025/2026 we will also be verifying claims for an additional 2 services which are the WGOS 4 (Glaucoma and Medical Retina) and IPOS (Independent prescribing) 5 urgent claims.

**General Pharmacy Services (GPS):** In 2024/2025 NWSSP/PPV introduced a new service check following a successful pilot, which was the Collaborative Working Scheme. We now verify this service along with the Quality and Safety Scheme remotely. We have completed 20 visits out of 32 visits planned and have 12 more to complete.

**Additional Services:** We progressed will with our quarterly dispensing data checks and have introduced a robust service moving forward into the new financial year, which may result in future financial recoveries. The results will be added to our PPV reports once finalised.

Clinical Waste Self Assessments for GMS are going well and as planned to ensure compliance with legislation. We are hoping to incorporate these into our GOS visits this new year financial to align to the WGOS reform and the managing of clinical waste.

The PPV team also manages the Waste Management Audit programme on behalf of the Health Boards offering advice and support to GP Practices and Community Pharmacies in respect of Waste Management.
Quarterly meetings are scheduled with all Health Boards and Counter Fraud teams to regularly review the progress report and to discuss themes, recommendations, and any risks.

We are also continue investigating other avenues for savings from the provision of Clinical Waste services and produce a 'non-collection' report to all our Health Boards.

There are bi-monthly National GMS, GOS Working Group and Clinical Waste meetings with Primary Care Managers and PPV, to discuss and agree any issues

regarding the national application of the programme. These are beneficial to all parties who attend.
PPV training events continue to be delivered to our Health Boards and contractors, and we facilitate one-on-one training requirements when required, particularly for new practice staff within the Primary Care setting

## 3. Key Risks / Matters for Escalation

The reports provide the PPV overall progress of visits and narrative for what PPV, Primary Care, Finance and Counter Fraud consider the be the best approach to support practices in improving throughout the claiming process.

## 4. Assessment

| **Objectives / Strategy** | |
|---|---|
| **Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)** | Not Applicable |
| **Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas** | Not Applicable |
| **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 |
| **Dolen i Hwyluswyr Ansawdd** *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))* | Not Applicable |
| **Dolen i Feysydd Ansawdd** *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))* | Not Applicable |
| **Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)** | No - Not Applicable |

| **Impact Assessment** | | |
|---|---|---|
| **Ansawdd** | Yes: ☐ | No: ☒ |

| | | |
|---|---|---|
| *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?* | 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):<br><br>POSITIVE/NEUTRAL<br>NEGATIVE<br><br>Outcome for Welsh Language (delete as appropriate):<br>POSITIVE/NEUTRAL<br>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

It is recommended that the Audit & Risk Assurance Committee Members note the contents of this report. There are no options included in this report. The report is for Assurance.

## 6. Next Steps

Produce Mid-Year Report and enhance future financial reports.

# Audit Report - 1st April to 31st March 2025 = Cwm Taf Morgann

## To Note

Above planned numbers were sent to HB for 2024/2025 Visit Plan. Numbers may change due to a

Health Board and Counter Fraud receive copies of each visit report to act upon PPV recommendati

PPV work collaboratively with Health Board managers and Local Counter Fraud to assist with any concerns

Training/support is provided to practices after visit and throughout the year, whenever requested

**CTMuHB 2023/2024 = 18 visits were completed**
**recovery of £16,941.57**

| GMS | Visit Type | HB Annual Visits Due | No. In progress | No. Recoveries |
|---|---|---|---|---|
| | Routine | 27 | 19 | 197 |
| | Revisit | 25 | 12 | 480 |
| | **TOTAL** | **52** | **31** | **677** |

| PRACTICE | Routine or Revisit | Claim errors | % recovery | Value of recovery |
|---|---|---|---|---|
| Practice 1 | Routine | 16 | 10,13 % | £207,94 |
| Practice 1 | Revisit | 3 | 0,60 % | £90,87 |
| Practice 2 | Routine | 64 | 14,81 % | £2 391,32 |
| Practice 2 | Revisit | 31 | 67,39 % | £682,93 |
| Practice 3 | Routine | 13 | 4,04 % | £834,14 |
| Practice 3 | Revisit | 14 | 3,44 % | £420,00 |
| Practice 4 | Routine | 3 | 1,03 % | £30,09 |
| Practice 4 | Revisit | 18 | 7,00 % | £240,25 |
| Practice 5 | Routine | 32 | 9,61 % | £2 848,49 |
| Practice 5 | Revisit | 25 | 28,74 % | £2 281,80 |
| Practice 6 | Routine | 9 | 6,82 % | £130,79 |
| Practice 6 | Revisit | 178 | 11,80 % | £2 354,50 |
| Practice 7 | Routine | 13 | 3,53 % | £363,05 |
| Practice 7 | Revisit | 106 | 2,23 % | £1 063,18 |
| Practice 8 | Routine | 0 | 0,00 % | £0,00 |
| Practice 8 | Revisit | 30 | 2,65 % | £552,43 |
| Practice 9 | Routine | 8 | 3,85 % | £667,50 |
| Practice 9 | Revisit | 0 | 0,00 % | £0,00 |
| Practice 10 | Routine | 13 | 2,12 % | £378,48 |
| Practice 10 | Revisit | 9 | 4,62 % | £202,50 |
| Practice 11 | Routine | 63 | 15,56 % | £2 312,05 |
| Practice 11 | Revisit | 3 | 2,50 % | £77,52 |
| Practice 12 | Routine | 6 | 2,28 % | £94,18 |
| Practice 13 | Routine | 20 | 7,58 % | £688,30 |
| Practice 14 | Routine | In Progress | | |
| Practice 14 | Revisit | | | |
| Practice 15 | Routine | In Progress | | |
| Practice 16 | Routine | In Progress | | |
| Practice 16 | Revisit | | | |
| Practice 17 | Routine | In Progress | | |
| Practice 18 | Routine | In Progress | | |
| Practice 18 | Revisit | | | |

| Practice 19 | Routine | In Progress | | |
|---|---|---|---|---|
| **GOS** | **Visit Type** | **Annual Visits Planned** | **No. In progress** | **No. Recoveries** |
| | Routine | 16 | 11 | 39 |
| | Revisit | 0 | 0 | 0 |
| | **TOTAL** | **16** | **11** | **39** |

**Summary of themes/findings/issues**

As contractors are transistioning to electronic records, remote access and physical visits are progressing we

| PRACTICE | Routine or Revisit | Claim errors | % recovery | Value of recovery |
|---|---|---|---|---|
| Practice 1 | Routine | 3 | 2,91 % | £167,36 |
| Practice 2 | Routine | 4 | 3,88 % | £174,46 |
| Practice 3 | Routine | 3 | 2,91 % | £115,03 |
| Practice 4 | Routine | 3 | 2,91 % | £110,92 |
| Practice 5 | Routine | 0 | 0,00 % | £0,00 |
| Practice 6 | Routine | 1 | 0,97 % | £26,00 |
| Practice 7 | Routine | 2 | 1,94 % | £86,46 |
| Practice 8 | Routine | 17 | 16,50 % | £442,70 |
| Practice 9 | Routine | 0 | 0,00 % | £0,00 |
| Practice 10 | Routine | 6 | 5,83 % | £226,61 |

**Summary of themes/findings/issues**

Nothing to report at this stage

| GPS | Visit Type | Annual Visits Planned | No. In progress | No. Recoveries |
|---|---|---|---|---|
| Q&S Scheme / Collaborative Working Scheme | Routine | 32 | 20 | 0 |
| | **TOTAL** | **32** | | |

## ıwg University Health Board

| | |
|---|---|
| d hoc visits or closures/mergers | **Summary of themes/findings/issues** |
| ions | Revisits are taking longer that expected due to 10C |
| that may arise | Revisits are normally expected to have higher clain |

| **with a total of** | **ALL WALES 2023/2024 = 205 visits were completed with a recovery of £216,810.03** | | |
|---|---|---|---|
| **Value of recoveries** | **All Wales Visits Due** | **All Wales No. in progress** | **All Wales Value of Recoveries** |
| £8 634,28 | 152 | 106 | £72 058,66 |
| £10 278,03 | 241 | 88 | £111 025,24 |
| £18 912,31 | **393** | **194** | **£183 083,90** |

| Value of recoveries | All Wales visits due | All Wales No. in progress | All Wales Value of Recoveries |
|---|---|---|---|
| £1 349,54 | 126 | 99 | £16 247,97 |
| 0 | 5 | 1 | £68,70 |
| **£1 349,54** | **131** | **100** | **£16 316,67** |

ell

| Value of recoveries | All Wales visits due | All Wales No. in progress | No. Recoveries | All Wales Value of Recoveries |
|---|---|---|---|---|
| £0,00 | 238 | 179 | 0 | £0,00 |

)% check of claims
n error rates

GIG CYMRU NHS WALES | Partneriaeth Cydwasanaethau Shared Services Partnership

# Primary Care Services
# Post Payment Verification
## April 2025

## Situation

Between 2020-2023 Post Payment Verification (PPV) faced significant challenges associated with the COVID-19 pandemic and a new General Medical Services (GMS) Family Practitioner Payment System (FPPS).

The PPV service was initially reinstated towards the latter part of 2020 and through reinstatement at the end of 2020, to April 2022 we managed to complete a 3-year cycle of routine visits into a 2-year period. At this point, the revisits that were triggered in these periods were carried over in an attempt to complete them at the earliest opportunity.

As with all new systems there is a bedding in period, and with a new way for the contractors to submit evidence to support their claims posed more pressure for the PPV Team.

Moving forward into a new financial year, we have undertaken an analysis of the data to understand the position of our outstanding revisits remaining and to realign an achievable solution to provide the levels of assurance required.

## Background

Comms 23 - PPV Schedule 2022_23.pdf

Comms 26 - FPPS_PPV.pdf

Comms 22 - Supporting Evidence_

In 22-23 there were 261 visits on our GMS visit plan.

In 23-24 there were 297 visits on our GMS visit plan.

In 24-25 we had 393 GMS visits to undertake = 152 routine, and 241 revisits. On nearing the end of this financial year, we have 106 Routine visits, and 88 revisits finalised or in progress.

In 22-23 and 23-24 we undertook our routine visits which were triggering a higher-than-average number of revisits than we have seen in previous years. On closer inspection, it was noted that the data submitted by practices through the payment system was limited, resulting in a smaller pool of information available for sample verification.

Our normal process in creating a sample for a routine visit is 10% or 22 of the claims out of all the submissions, whichever is the greater. E.g. 100 claims we would check 22 as this is more than 10 and 250 claims, we would check 25.

We have recently reviewed the prompts for revisits along with looking at a plan moving into the next financial year. Due to a lower volume of claims submitted through the payment system, and the reduction of available evidence, we can give assurance that a large number of outlined visits would not have prompted a revisit in traditional circumstances.

There are approximately 40 routine visits to carry over into 25-26 which we will complete as a priority and then we will proceed with the new financial year's routine visits.

The revisits remaining that need to be undertaken, will be completed throughout the year and may include the routine visit as well. We refer to these as extended visits and has been an effective performance tool for us previously.

Alongside this, we are currently experiencing unexpected absence in the team, and we aim to adopt a practical approach going forward, focusing on what is realistically achievable while continuing to uphold a high standard of assurance.

## Recommendation

Following the review of our practices, those that prompted revisits under unusual circumstances, specifically for claims verified at 19 and under in the financial years of 22-23 and 23-24, where the claim data and evidence provided by the practices affected the standard data samples available for PPV to be able to validate, we will recommend remove the need to revisit those practices, given the assurance we have in place.

We have also analysed the history of these practices to ensure there is no patterns to take into consideration in this provision of assurance, and we can confirm that we find nothing to raise concern with moving forward with the outlined plan.

Alongside this assurance, we have other trend data available to our team, and since October 2024, we have been verifying any duplicate claims in conjunction our visits, which is proving to be valuable in supporting assurance around practice claiming. We will continue to undertake this moving forward as additional assurance to our Health Boards, Committees and the service.

| Agenda Item |
| --- |
| 6.1 |

# Audit Risk & Assurance Committee

## Local Counter Fraud Update Report

| | |
| --- | --- |
| **Dyddiad y Cyfarfod / Date of Meeting** | 22/05/2025 |
| **Statws Cyhoeddi / Publication Status** | Open/ Public<br>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** *(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)) /* | Not Applicable |
| | If more than one applies please list below: |

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

## 5. Recommendation

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

## 6. Next Steps

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

**Agenda Item 6.1**

# Cwm Taf Morgannwg University Health Board

## Audit Risk & Assurance Committee – 22nd May 2025

## Counter Fraud Progress Report

**Matthew Evans**
**Head of Local Counter Fraud Services**

## 1. INTRODUCTION

The purpose of this report is to update the Audit Risk & Assurance 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 | 48 | 5 |
| Ensuring that anti-crime measures are embedded at all levels across the organisation | | |
| Inform and Involve | 100 | 8 |
| Identifying the risks and consequences of crime against the NHS, and raising awareness of these risks amongst NHS staff, stakeholders, and the public. | | |
| Prevent and Deter | 143 | 15 |
| Discouraging those who may want to commit crimes against the NHS and ensure that such opportunities are minimised. | | |
| Hold to Account | 290 | 15 |
| Detecting and investigating crime, prosecuting those who have committed crimes and seeking redress as a result. | | |
| TOTAL | 581 | 43 |

## 4. STRATEGIC GOVERNANCE

The Counter Fraud Annual Report 2024/25 has been completed and submitted to this meeting for review. The Annual Report incorporates the Health Board's submission of compliance with NHS Counter Fraud Standards to NHS Counter Fraud Authority. The Committee's Chair has a direct sign off responsibility for this submission therefore the Annual Report presentation at this meeting allows for Committee Members to feed into that Chair approval.

## 5. INFORM AND INVOLVE

The Counter Fraud Team have issued revised literature for use in supporting counter fraud awareness within the Health Board. The Team have developed a tri-fold leaflet intended to replace an ageing information booklet. As well as stylistic updates to align to corporate branding the new leaflet contains core information around NHS fraud and signposts readers to other available means of learning and engaging with counter fraud.

## 6. PREVENT AND DETER

Work on the Health Board's matched data sets released by the National Fraud Initiative is underway. The first focus is on Payroll to Payroll matches which highlights dual employment between the Health Board and other public sector organisations. This follows identification of an allegation of dual working relating to a Health Board member of staff currently under investigation. This area of fraud risk has increased since the introduction of remote working opportunities following the Covid pandemic. A full progress report is presented as a separate item in this meeting for review.

## 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.

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

# Item 4.1 – 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 2025/26 |
|---|---|---|
| 10 | 1 | 5 |

**Case Rates**

| Referrals Received 2025/26 | Cases Under Investigation for Over 12 Months |
|---|---|
| 2 | 4 |

**Sanctions/Outcomes**

| Criminal Sanctions | Civil Sanctions (Inc. Financial Recovery) | Disciplinary Sanctions |
|---|---|---|
| 0 | 0 | 0 |

| Open Cases | | | | |
|---|---|---|---|---|
| Reference Number | Date Opened | Allegation | Case Information | Update |
| WARO/20/00 032 | 24/01/2020 | Alleged theft of petty cash/False representation of employment history and qualifications | The subject has been found guilty in relation to 9 counts faced at Crown Court. The subject received a 5 years immediate custodial sentence.<br>The subject resigned their Health Board position whilst disciplinary proceedings were underway.<br>NMC have been updated of the outcome of the criminal case and are assessing. | The NMC process is ongoing.<br>An interim suspension order for 18 months has been imposed and subsequently confirmed.<br><br>**Proceeds of Crime hearing is listed for 01.05.2025 for mention to proceed with the Confiscation Order and decide on any compensation to be awarded to the Health Board.** |

| Open Cases | | | | |
|---|---|---|---|---|
| Reference Number | Date Opened | Allegation | Case Information | Update |
| 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.<br>Digital forensics of mobile devices has been undertaken and evidence analysed.<br>An interview under caution has been undertaken and an account gained.<br>This investigaiton forms part of a wider investigative strategy with Home Office immigration and Police involvement.<br>A case file has now been submitted to CPS consideration of charges. | **CPS review ongoing.** |

| Open Cases | | | | |
|---|---|---|---|---|
| Reference Number | Date Opened | Allegation | Case Information | Update |
| 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.<br>Enquires have gathered timesheets and analysis is being undertaken. | Analysis identified shift patterns of concern in which it appears that on-call shifts have been claimed at full rate. There will be difficulty demonstrating this to the criminal standard however.<br>Since intervention mitigation has been introduced:<br>No on call work, meaning one standard rate of pay for in hospital work.<br>10 sessions per week with 2 admin.<br>Consultants now found to be generally finishing at 17:00hrs, where previously they worked until 20:00hrs.<br>A flagging system, where if a rostered doctor cannot be located, senior manager's office is contacted and the doctor is tracked down.<br>Timesheets are now being authorised by a manager instead of an admin officer. |

| Open Cases | | | | |
|---|---|---|---|---|
| Reference Number | Date Opened | Allegation | Case Information | Update |
| | | | | This locum no longer provides services to the Health Board. |
| 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.<br>Enquires have gathered timesheets and analysis is being undertaken. | Analysis identified shift patterns of concern in which it appears that on-call shifts have been claimed at full rate. There will be difficulty demonstrating this to the criminal standard however.<br>Since intervention mitigation has been introduced:<br>No on call work, meaning one standard rate of pay for in hospital work.<br>10 sessions per week with 2 admin.<br>Consultants now found to be generally finishing at 17:00hrs, where previously they worked until 20:00hrs.<br>A flagging system, where if a rostered doctor cannot be located, senior manager's office is contacted and the doctor is tracked down.<br>Timesheets are now being authorised by a manager instead of an admin officer. |

| Open Cases | | | | |
|---|---|---|---|---|
| Reference Number | Date Opened | Allegation | Case Information | Update |
| INV/24/02428 | 30/09/2024 | Overpayment of Salary | An existing staff member moved to a new post within the Health Board. Process was intended to be undertaken as an internal transfer but a new ESR record was established for new role that led to subject being paid for both assignments resulting in an overpayment from 07/01/24 to 31/07/2024 with gross value of £10,508.17 and Net £7,216.78.<br><br>An interview was arranged with the subject. Upon attendance it was clear to the interviewers that the subject did not have a clear understanding of the process and potential outcomes. The interview was postponed to allow subject to properly assess need for legal representation following advice given. | The subject has now engaged a legal representative. New date for interview has been offered via the representative who is confirming with the subject.<br><br>**Subjected attended a voluntary interview under caution.**<br><br>**Awaiting response from subject's legal representative before being able to progress further.** |

| Open Cases | | | | |
|---|---|---|---|---|
| Reference Number | Date Opened | Allegation | Case Information | Update |
| INV/24/03044 | 28/11/2024 | Manager not working their contracted hours | Referral received via the fraud and corruption reporting line. Multiple potential subject matches have been identified from information supplied as part of referral, work underway to formally identify person of interest. | Subject has now been identified and a sample of Health Roster time shift time information analysed. No evidence was established to support ongoing criminal investigation.<br>Liaison with subject's managers established existing concerns with amount of overtime being claimed. Additionally, an ongoing NMC investigation which covers a similar allegation to this fraud matter as well as other concerns.<br>**Measures put in place locally to prevent excessive overtime hours being allocated/claimed.**<br>**NMC investigation ongoing.** |

| Open Cases | | | | |
|---|---|---|---|---|
| Reference Number | Date Opened | Allegation | Case Information | Update |
| INV/24/03275 | 19/12/2024 | Community Pharmacy claiming for excessive amount of out of pocket expenses | Pharmacy in question is the highest claimer of out of pocket expenses across the Health Board by some margin. A meeting has been held with PPV and Community Pharmacy. PPV have obtained claim data and backing information which was shared with Counter Fraud. | No direct link could be established between the pharmacy and their supplier. A meeting will be to review possible next steps.<br><br>**Enquiries ongoing, data requested from Prescribing Services and Suppliers before considering further reasonable lines of enquiry.** |
| INV/25/00458 | 17/02/2025 | Overseas Patient receiving treatment on the NHS | Referral received via the fraud and corruption reporting line that an individual is residing in the Philippines and returning to the area for treatment on the NHS. | **Subject is using a family address for registration with a GP in the CTM UHB area.**<br>**Enquiries carried out with Boarder Force for dates subject had returned back to the UK to establish whether any treatment has been provided by the NHS during these periods.**<br><br>**Enquiries ongoing.** |

| Open Cases | | | | |
|---|---|---|---|---|
| Reference Number | Date Opened | Allegation | Case Information | Update |
| INV/25/00632 | 04/03/2025 | Allegation of theft of Health Board property by staff working in the Estates Department. | Allegation that the staff working out of PCH estates department have removed pipes and cables from a decommissioned area of the site and sold them for scrap. | **Meetings held with Senior Management around Health Board processes.**<br>**Enquiries ongoing to establish whether sufficient evidence available to support the allegation.** |
| INV/25/00682 | 06/03/2025 | Working elsewhere while reporting sick to the Health Board and on Bereavement leave | | |

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

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

| Closed Cases | | | |
|---|---|---|---|
| **Reference Number** | **Date Opened** | **Allegation** | **Outcome** |
| INV/24/03189 | 12/12/2024 | Allegation that individuals have claimed to be a couple for the purposes of obtaining IVF treatment but are not actually in a relationship together | **Enquiries carried out established the subjects had not received IVF treatment funded by the NHS.** |
| INV/25/00197 | 23/01/2025 | Non-declaration of criminal convictions | A meeting has been held with subject's manager who has informed that the subject was in fact convicted whilst in Health Board employment and an investigation was undertaken alongside a professional body investigation at that time.<br>**Conviction disclosed and known by Health Board with actions undertaken under disciplinary policy.** |
| INV/25/00065 | 09/01/2025 | Selling on prescription medication | **Enquiries carried out failed to establish evidence to support the fact the individual was selling their prescription medication. Safeguarding concerns highlighted to the GP Practice.** |
| INV/25/02945 | 24/01/2025 | Selling on prescription medication | **Referral issued to South Wales Police due to subject being prescribed controlled drugs which they are alleged to be selling on to known drug dealers. Safeguarding concerns highlighted to the GP practice.** |

| Closed Cases | | | |
|---|---|---|---|
| **Reference Number** | **Date Opened** | **Allegation** | **Outcome** |
| INV/25/00905 | 25/03/2025 | Working elsewhere while reporting sick to the Health Board | **Enquiries carried out established the subject was a Bank worker for the Health Board and had not carried out any shifts for some time.** |
| INV/25/00864 | 21/03/2025 | Working elsewhere while reporting sick to the Health Board | **Evidence obtained insufficient to progress with a criminal investigation, matter referred in to People Services where Initial Assessment of Facts carried out resulting in words of advice by management.** |
| INV/25/00448 | 14/02/2025 | Allegation that a Community Pharmacy are receiving fake prescriptions, not dispensing the items and claiming reimbursement from the NHS | **Enquiries carried out failed to uncover evidence on any wrongdoing on the part of the Community Pharmacy.**<br>**Meeting held with colleagues in the Health Board's Pharmacy team resulted in a visit being actioned by the Health Board where processes were reviewed and no concerns with the way the Community Pharmacy were submitting their reimbursements.** |
| INV/25/00630 | 03/03/2025 | Working elsewhere when should be attending Course paid for by the Health Board | **Enquiries carried out failed to uncover any evidence the subject was working for her private business when she was either working for the Health Board or should have been attending a course funded by the Health Board.** |

| Closed Cases | | | |
|---|---|---|---|
| **Reference Number** | **Date Opened** | **Allegation** | **Outcome** |
| | | | **Advice provided to management around the submission of a DOI** |

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

| Agenda Item |
| --- |
| 6.2 |

# Audit, Risk & Assurance Committee

## Counter Fraud Annual Report 2024/25

| | |
| --- | --- |
| **Dyddiad y Cyfarfod / Date of Meeting** | 22/05/2025 |
| **Statws Cyhoeddi / Publication Status** | Open/ Public<br>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 the counter fraud activity in 2024/25 and incorporates the Organisation's self-assessed return submitted to NHS Counter Fraud Authority to evidence compliance with standards.

## 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** *(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):<br><br>POSITIVE/NEUTRAL<br>NEGATIVE<br><br>Outcome for Welsh Language (delete as appropriate):<br>POSITIVE/NEUTRAL<br>NEGATIVE | If no, please include rationale below: |
| **Cyfreithiol / Legal** | There are no specific legal implications related to the activity outlined in this report. | |
| | | |
| **Enw da / Reputational** | There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report. | |
| | | |

## 5. Recommendation

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

## 6. Next Steps

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

# Counter Fraud Annual Report 2024/25

**May 2025**

## Table of contents


**1. Introduction ..... 1**

**2. Executive summary of organisational compliance ..... 1**

**3. Declaration of compliance against the Functional Standard Requirements at the end of March 2025 ..... 2**

**Provider Organisation Declaration** ..... 2

**4. Work carried out against the Functional Standard Requirements ..... 2**

Governance ..... 4

Counter Fraud Bribery and Corruption Practices ..... 7

**5. Appendices ..... 14**

Appendix 1 – Counter Fraud Activity ..... 14

Appendix 2 – Counter Fraud Costs ..... 14

Appendix 3 – Nominations Overview ..... 15

Appendix 4 – Case Information Overview ..... 16

Appendix 5 – CLUE Investigation Information ..... 17

Appendix 6 – Fraud Risk Based Exercises ..... 18

Appendix 7 - Sanction & Redress Overview ..... 19

## 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 2024/25 was approved by the Audit Committee in March 2024 and identified a total resource of 606 days for the year. The Counter Fraud Team delivered 584 days of counter fraud activity. The under delivery of activity days relates to a Local Counter Fraud Specialist leaving the team in February 2025. Some reserve resource was deployed to ensure the full completion of the 2024/25 Counter Fraud Work Plan however and service delivery remained largely unaffected from this short-term vacancy. The total cost for the provision of local counter fraud services for the year was £153,009.

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 2024/25 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. NHS Wales have adopted the Government Functional Standards on Counter Fraud (NHS Requirements) to replace NHS Counter Fraud Authority's (NHS CFA) 'NHS Counter Fraud Standards (Wales)'. At the conclusion of 2024/25 the Health Board is assessed as Green rated across all Standards with a Green overall rating. This is a reflection of the Health Board's support to counter fraud activity and a realisation of previous years counter fraud work to drive compliance with Standards. The 2025/26 Counter Fraud Work Plan seeks to consolidate these ratings.

## 3. Declaration of compliance against the Functional Standard Requirements at the end of March 2025

The annual report must contain the declaration 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.

# Provider Organisation Declaration

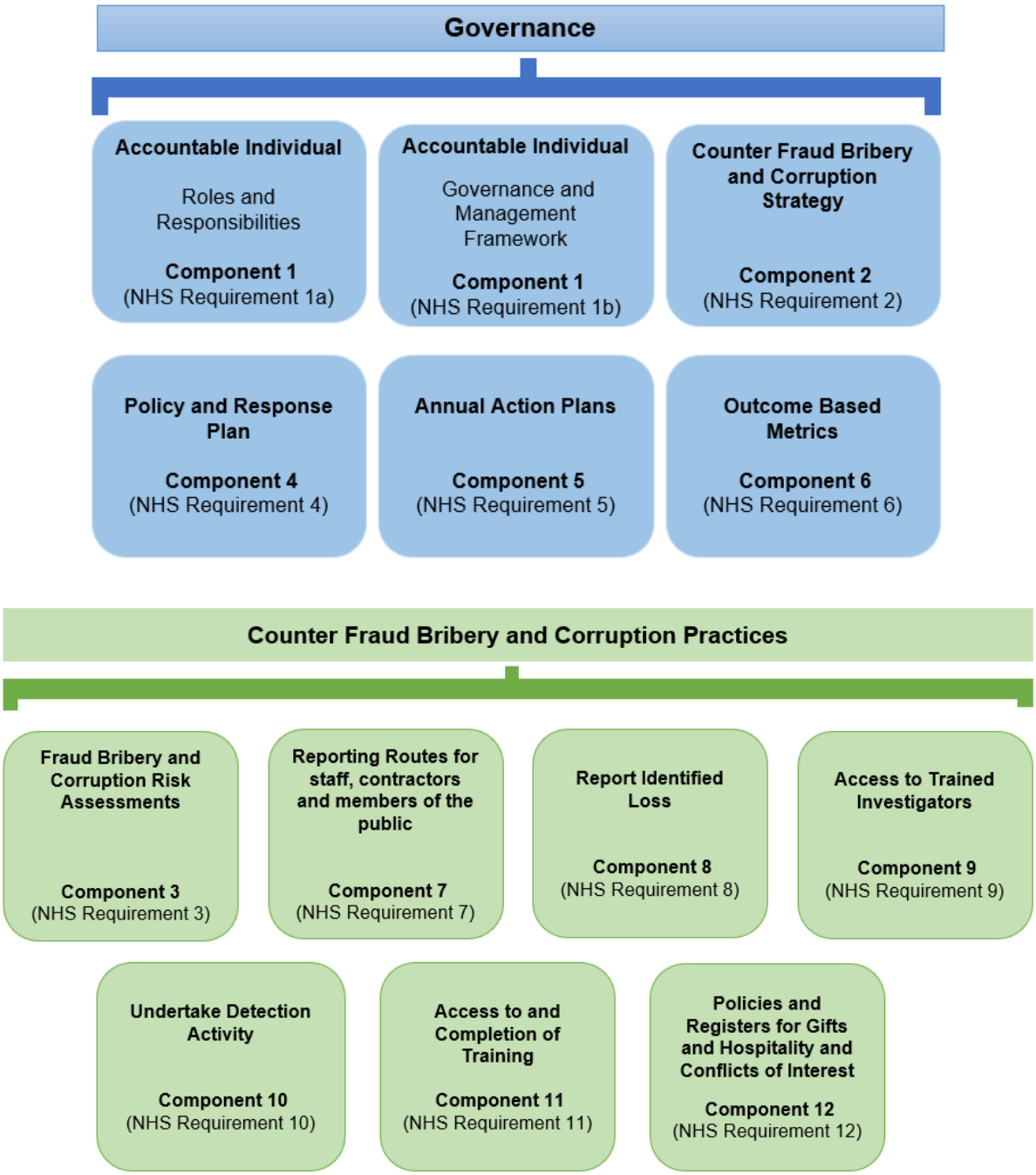
I declare that the counter fraud, bribery and corruption work carried out during 2024/25 has been self-reviewed against the Functional Standard Requirements relating fraud, bribery and corruption and Service Condition 24 of the NHS Standard Contract, and that the above rating has been achieved.

| | |
|---|---|
| **Organisation** | **Cwm Taf Morgannwg University Health Board** |
| **Accountable Board Member Signature** | **Sally May** |
| **Date** | |

## 4. Work carried out against the Functional Standard Requirements

In completing the annual report on the counter fraud, bribery and corruption work undertaken, the organisation should refer to the Functional Standard Requirements and the expected work needed to be compliant with each component.

The report should detail the work completed against each of the components relating to governance actives and counter fraud, bribery and corruption practices undertaken during the year, as set out below.



# Governance

This section of the annual report should outline 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 | | 2024 Rating | 2025 Rating | Current Position |
|---|---|---|---|---|---|
| **Component 1**<br><br>**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.<br><br>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 gaining assurance | GREEN | GREEN | The Audit Committee receives an Annual Report written in line with NHSCFA guidance using the |

| Function Standard Component | NHS Requirement | | 2024 Rating | 2025 Rating | Current Position |
|---|---|---|---|---|---|
| | | and evaluating the counter fraud work undertaken during the year. This requirement also covers the role of the Counter Fraud Champion. | | | template. This includes details of the Functional Standard Return for review.<br><br>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**<br><br>**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 aligned to the objectives of the strategy and locally identified risks. | 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 fraud, bribery and corruption strategy.<br><br>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.<br><br>The CFP&RP and work plan are agreed |

| Function Standard Component | NHS Requirement | | 2024 Rating | 2025 Rating | Current Position |
|---|---|---|---|---|---|
| | | | | | by Director of Finance and Audit Committee and progress is tracked via regular reporting and attendance at Audit Committee. |
| **Component 4**<br><br>**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.<br><br>Issues relating to bribery and fraud are also referenced within the Standards of Behaviour Policy. |
| **Component 5**<br><br>**Annual Action Plan** | **NHS Requirement 5** | This Component relates to the development and management of the organisation's annual counter fraud work plan. This plan should be informed by national and local fraud, bribery and corruption risk assessments. | GREEN | GREEN | A counter fraud work plan is developed in line with key objectives of the strategy and alignment to national standards. Resource is 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.<br><br>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 |

| Function Standard Component | NHS Requirement | | 2024 Rating | 2025 Rating | Current Position |
|---|---|---|---|---|---|
| | | | | | overall resource availability. |
| **Component 6**<br><br>**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.<br><br>Clue3 includes recording and reporting mechanisms 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 should outline 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 | | 2024 Rating | 2025 Rating | Current Position |
|---|---|---|---|---|---|
| **Component 3**<br><br>**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, 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**<br><br>**Reporting routes for staff, contractors** | **NHS Requirement 7** | This Component relates to the reporting routes in place at the organisations to report suspicions of fraud, bribery and | GREEN | GREEN | The Health Board has well documented reporting routes for any party to report incidents of fraud, bribery and corruption. Reporting routes are |

| Function Standard Component | NHS Requirement | | 2024 Rating | 2025 Rating | Current Position |
|---|---|---|---|---|---|
| **and members of the public** | | corruption and a mechanism for recording these referrals and allegations on the approved NHS fraud case management system. | | | 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 routes to Director of Finance and whistleblowing charity Protect-Public Concern at Work.<br><br>The Counter Fraud Team have regularly received contact from individuals raising concerns resulting in the commencement of 29 new investigations in 2024/25. |

| Function Standard Component | NHS Requirement | | 2024 Rating | 2025 Rating | Current Position |
|---|---|---|---|---|---|
| **Component 8**<br><br>**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.<br><br>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. |
| **Component 9**<br><br>**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 |

| Function Standard Component | NHS Requirement | | 2024 Rating | 2025 Rating | Current Position |
|---|---|---|---|---|---|
| | | | | | role on an ongoing basis.<br><br>The counter fraud accredited resource for 2024/25 was 2.6 FTE. |
| **Component 10**<br><br>**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 assessments are considered as part of this work and completed where necessary.<br><br>As a result of this information and intelligence review process the Counter Fraud Team have registered 22 local proactive exercises on the case management system in 2024/25. |

| Function Standard Component | NHS Requirement | | 2024 Rating | 2025 Rating | Current Position |
|---|---|---|---|---|---|
| **Component 11**<br><br>**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.<br><br>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 connections with staff with a more informal style. |

| Function Standard Component | NHS Requirement | | 2024 Rating | 2025 Rating | Current Position |
|---|---|---|---|---|---|
| **Component 12**<br><br>**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. |

## 5. Appendices

# Appendix 1 – Counter Fraud Activity

This section of the annual report details the total counter fraud resources used by the organisation.

| Area of activity | Days used |
|---|---|
| **Proactive work** | 304 |
| **Reactive work** | 280 |
| **Total days used** | 584 |

# Appendix 2 – Counter Fraud Costs

This section of the annual report details the total costs of the counter fraud resources used by the organisation.

| Cost of Counter Fraud, Bribery and Corruption Work | Total Costs £ |
|---|---|
| **Proactive costs** | £74,890 |
| **Reactive costs** | £64,323 |
| **Total costs** | £139,213 |

# Appendix 3 – Nominations Overview

| Role | Name of Nominated Person |
|---|---|
| **Accountable Board Member** | Sally May |
| **Audit Committee Chair** | Patsy Roseblade |
| **Counter Fraud Champion** | Gareth Watts |
| **Lead LCFS** | Matthew Evans |
| **Supporting LCFS** | Alison Williams |
| **Supporting LCFS** | Vacant |

# Appendix 4 –Case Information Overview

This section of the annual report details case investigation activity recorded on the Clue case management system.

| Case Information | Number |
|---|---|
| **Cases carried forward from previous years** | 14 |
| **Cases Opened during the period** | 29 |
| **Cases Closed or Transferred during period** | 29 |
| **Cases Ongoing** | 14 |

# Appendix 5 – CLUE 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.

| CLUE Information | Number |
|---|---|
| **Investigations opened during the most recent financial year** | 29 |
| **Investigations closed during the most recent financial year** | 29 |
| **Investigations open as at 31/03/2025** | 14 |

# Appendix 6 – Fraud 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** | 8 |
| **Number of new FRAs recorded in line with the organisations risk management policy** | 8 |

| Local Proactive Exercises | Number |
|---|---|
| **Number of LPEs conducted during the year** | 22 |
| **Number of LPEs recorded on the NHS CFA Case management system as per component 8** | 22 |
| **Number of LPEs concluded during the year** | 22 |

| 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 7 - 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 applied and recorded during this financial year** | 1 |
| **Civil applied and recorded during this financial year** | 1 |
| **Criminal applied and recorded during this financial year** | 0 |
| **Total Sanctions** | 2 |

| Redress Imposed | Total Amount £ |
|---|---|
| **Fraud identified** | £22,780 |
| **Fraud Loss Identified** | £22,780 |
| **Fraud Prevented** | £0 |
| **Fraud Recovered** | £17,794 |
| **Non-Fraud Loss** | £0 |
| **Non-Fraud Recovery** | £0 |

| Agenda Item |
| --- |
| 6.3 |

# Audit Risk & Assurance Committee

## Counter Fraud Functional Standard Return 2024/25

| | |
| --- | --- |
| **Dyddiad y Cyfarfod / Date of Meeting** | 22/05/2025 |
| **Statws Cyhoeddi / Publication Status** | Open/ Public<br>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 the counter fraud activity in 2024/25 and outlines the Organisation's self-assessed return submitted to NHS Counter Fraud Authority to evidence compliance with standards.

## 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** *(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** | Not Applicable |

| | | |
|---|---|---|
| *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))* | 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):<br><br>POSITIVE/NEUTRAL<br>NEGATIVE<br><br>Outcome for Welsh Language (delete as appropriate):<br>POSITIVE/NEUTRAL<br>NEGATIVE | If no, please include rationale below: |
| **Cyfreithiol / Legal** | There are no specific legal implications related to the activity outlined in this report. | |
| | | |
| **Enw da / Reputational** | There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report. | |
| | | |

## 5. Recommendation

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

## 6. Next Steps

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

# Counter Fraud Functional Standard Return (2024/2025)

## CWM TAF MORGANNWG UNIVERSITY LOCAL HEALTH BOARD

**Your Overall Self-Assessment Rating is: GREEN**

**Submitted By: N/A**

# Organisational information

| | |
|---|---|
| Name of the organisation | CWM TAF MORGANNWG UNIVERSITY LOCAL HEALTH BOARD |
| Annual budget of the organisation | Over £ 1 billion |
| Staff headcount at the organisation including contracted employees | 10,000 to 15,000 |
| Organisation code | 7A5 |
| Organisation/provider type | Health Board |
| For which provider organisations are you the commissioner?\|\|Co-ordinating Commissioner for this provider | WALES<br>Co-ordinating Commissioner for this provider |
| NHS England region | Wales |

# Personnel information

| | |
|---|---|
| Name of the member of the executive board or equivalent body responsible for overseeing and providing strategic management | Sally May |
| Name of the Local Counter Fraud Specialist | Matthew Evans |
| Email of the Local Counter Fraud Specialist | matthew.evans20@wales.nhs.uk |
| Name of the counter fraud supplier organisation (including in-house) | Other<br>Swansea Bay UHB |
| Counter fraud supplier type | Wales |
| Name of the Chair of the Audit Committee / equivalent body | Patsy Roseblade |
| Email of the Chair of Audit Committee / equivalent body | patsy.roseblade@wales.nhs.uk |
| Name of the Counter Fraud Champion | Gareth Watts |
| Email of the Counter Fraud Champion | gareth.watts@wales.nhs.uk |

# Costs and days information

| | |
|---|---|
| Proactive days used (Maximum 3 digits) | 304 |
| Reactive days used (Maximum 3 digits) | 280 |
| Total days used for counter fraud work | 584 |
| Cost of counter fraud staffing per financial year - Proactive | 74890.00 |
| Cost of counter fraud staffing per financial year - Reactive | 64323.00 |
| Total costs for counter fraud work | 139213.00 |

# Reactive information

| | |
|---|---|
| Number of allegations received and recorded as an investigation during the most recent financial year | 29 |
| Number of allegations received during the most recent financial year and recorded as an investigation on the case management system | 35 |
| Rationale for any discrepancy between case management system investigations received and expected | Unable to identify 35 allegations from clue records |
| Number of investigations recorded and closed during the most recent financial year | 29 |
| Number of investigations closed during the most recent financial year as recorded on the case management system | 32 |
| Rationale for any discrepancy between case management system investigations closed and expected | Unable to identify 32 closed allegations from clue records |
| Number of investigations open as at 31/03/2025 | 14 |
| Number of investigations open as at 31/03/2025 as recorded on the case management system | 19 |
| Rationale for any discrepancy between case management system investigations open as of 31/03/2025 and expected | Unable to identify 19 allegations from clue records |
| Amount of fraud losses identified and recorded during the most recent financial year | 22780.00 |
| Amount of fraud losses recovered and recorded during the most recent financial year | 17794.00 |
| Amount of fraud losses prevented from reactive work and recorded during the most recent financial year | 22780.00 |

| | |
|---|---|
| Number of criminal sanctions applied and recorded during the year | 0 |
| Number of civil sanctions applied and recorded during the year | 1 |
| Number of disciplinary sanctions applied and recorded during the year | 1 |

# Proactive information

| | |
|---|---|
| Number of proactive exercises conducted and recorded during the most recent financial year | 22 |
| Amount of fraud losses identified and recorded from proactive exercises during the most recent financial year | 0.00 |
| Amount of fraud losses prevented and recorded from proactive exercises during the most recent financial year | 0.00 |
| Amount of fraud losses recovered and recorded from proactive exercises during the most recent financial year | 0.00 |

# Engagement information

| | |
|---|---|
| Have you had an engagement visit which provided recommendations by NHSCFA to improve counter fraud work in the last two financial years | No |
| Have you actioned the recommendations | No |
| Please provide a statement outlining your progress against your recommendations | N/A |

# 1: Accountable individual

## NHS Requirement 1A:

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 accountable board member is responsible for the provision of assurance to the executive board in relation to the quality and effectiveness of all counter fraud bribery and corruption work undertaken. The accountable board member is responsible for ensuring that nominations to the NHSCFA for the accountable board member, audit committee chair and counter fraud champion are accurate and that any changes are notified to the NHSCFA at the earliest opportunity and in accordance with the nominations process. N.B. ‘Equivalent body’ may include, but is not limited to, the board of directors, the board of trustees or the governing body. Oversight of counter fraud, bribery and corruption work should not be delegated to an individual below this level of seniority in the organisation

Your Rating is: **GREEN**

Comments:

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:

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 counter fraud champion understands the threat posed and promotes awareness of fraud, bribery and corruption within the organisation. Board level evaluation of the effectiveness of counter fraud, bribery and corruption work undertaken is documented. Where recommendations have been made by NHSCFA following an engagement, it is the responsibility of the accountable board member to provide assurance to the board surrounding the progress of their implementation. The organisation reports annually on how it has met the standards set by NHSCFA in relation to counter fraud, bribery and

corruption work, and details corrective action where standards have not been met.

Your Rating is: **GREEN**

Comments:

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.

# 2: Counter fraud bribery and corruption strategy

## NHS Requirement 2:

The organisation aligns counter fraud, bribery and corruption work to the NHSCFA counter fraud, bribery and corruption strategy. This is documented in the organisational counter fraud, bribery and corruption policy, and is submitted upon request. The counter fraud work plan and resource allocation are aligned to the objectives of the strategy and locally identified risks. (The organisation may have its own counter fraud, bribery and corruption strategy, however, this must be aligned to and referenced to the NHSCFA counter fraud, bribery and corruption strategy)

Your Rating is: **GREEN**

Comments:

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 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.

# 3: Fraud bribery and corruption risk assessment

## NHS Requirement 3:

The organisation has carried 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. Risk analysis is undertaken in line with Government Counter Fraud Profession (GCFP) fraud risk assessment methodology and is recorded and managed in line with the organisation's risk management policy and included on the appropriate risk registers, and the risk assessment is submitted upon request. Measures to mitigate identified risks are included in an organisational work plan, progress is monitored at a senior level within the organisation and results are fed back to the audit committee (or equivalent body). For NHS organisations the fraud risk assessments should also consider the fraud risks within any associated sub company of the NHS organisation.

Your Rating is: **GREEN**

Comments:

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, 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.

# 4: Policy and response plan

## NHS Requirement 4:

The organisation has a counter fraud, bribery and corruption policy and response plan (the policy and plan) that follows NHSCFA's strategic guidance and has been approved by the executive body or senior management team. The plan is reviewed, evaluated and updated as required, and levels of staff awareness are measured.

Your Rating is: **GREEN**

Comments:

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.

# 5: Annual action plan

## NHS Requirement 5:

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. This includes (but is not limited to) defined objectives, milestones for the delivery of each activity and measurable areas for improvement in line with strategic aims and objectives. The plan is agreed, and progress monitored by the audit committee (or equivalent body).

Your Rating is: **GREEN**

Comments:

A counter fraud work plan is developed in line with key objectives of the strategy and alignment to national standards. Resource is 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.

# 6: Outcome-based metrics

## NHS Requirement 6:

The organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance. This should be informed by national and local risk assessment, national benchmarking and other comparable data. Proactive and reactive outcomes and progress are recorded on the approved NHS fraud case management system. Metrics should include all reported incidents of fraud, bribery and corruption, the value of identified fraud losses, the value of fraud recoveries, the value of fraud prevented, criminal sanctions and disciplinary sanctions.

Your Rating is: **GREEN**

Comments:

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 for proactive and reactive outcomes of counter fraud work which is utilised as a recording mechanism.

# 7: Reporting routes for staff, contractors and members of the public

## NHS Requirement 7:

The organisation has well established and documented reporting routes for staff, contractors and members of the public to report incidents of fraud, bribery and corruption. Reporting routes should include NHSCFA's Fraud and Corruption Reporting Line and online reporting tool. All incidents of fraud, bribery and corruption are recorded on the approved NHS fraud case management system. The incident reporting routes are publicised, reviewed, evaluated and updated as required, and levels of staff awareness are measured.

Your Rating is: **GREEN**

Comments:

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 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 2024/25.

# 8: Report identified loss

## NHS Requirement 8:

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. The case management system is used 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

Your Rating is: **GREEN**

Comments:

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.

# 9: Access to trained investigators

## NHS Requirement 9:

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 will ensure that any changes to nominations are notified to the NHSCFA at the earliest opportunity and in accordance with the nominations process. The accredited nominated person (or persons) must demonstrate continuous professional competencies and capabilities on an annual basis by examples of practical application of skills and associated training to include (but is not limited to), obtaining witness statements, conducting interviews under caution and maintaining up to date knowledge of legal and procedural requirements.

Your Rating is: **GREEN**

Comments:

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 2024/25 was 2.6 FTE.

# 10: Undertake detection activity

## NHS Requirement 10:

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. Results of this work are evaluated and where appropriate feed into improvements to prevent and deter fraud, bribery and corruption. Relevant information and intelligence may include (but is not limited to) internal and external audit reports, information on outliers, recommendations in investigation reports and NHSCFA led loss measurement exercises. The findings are acted upon promptly.

Your Rating is: **GREEN**

Comments:

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 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 22 local proactive exercises on the case management system in 2024/25.

# 11: Access to and completion of training

## NHS Requirement 11:

The organisation has 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. This should cover the role of the NHSCFA, LCFS and the requirements and national implications of Government Counter Fraud Functional Standard providing a standardised approach to counter fraud work.Content may be delivered through presentations, newsletters, leaflets, posters, intranet pages, induction materials for new staff, emails and other media, making use of the NHSCFA's fraud awareness toolkit as appropriate. The effectiveness of the awareness programme is measured.

Your Rating is: **GREEN**

Comments:

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 connections with staff with a more informal style.

# 12: Policies and registers for gifts and hospitality and COI.

## NHS Requirement 12:

The organisation has a managing conflicts of interest policy and registers that includes reference to gifts and hospitality with reference to fraud, bribery and corruption, and the requirements of the Bribery Act 2010. Staff awareness of the requirements of the policy are tested sufficiently regularly to demonstrate effectiveness of the process.

Your Rating is: **GREEN**

Comments:

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.

# ACC Declaration

I declare that the anti-fraud, bribery and corruption work carried out during the year to date has been self reviewed against the NHS CFA requirements for anti-fraud, bribery and corruption.As the Audit Committee Chair, and in line with the audit committee's responsibility for the strategic assurance and oversight of counter fraud work as described in section 5.6 of the NHS Audit Committee Handbook, I confirm that the information contained in this self review for CWM TAF MORGANNWG UNIVERSITY LOCAL HEALTH BOARD reflects the work reported to and considered by the Audit Committee.

Opportunity to comment

# DOF Declaration

I declare that the anti-fraud, bribery and corruption work carried out during the year to date has been self reviewed against the NHS CFA requirements for anti-fraud, bribery and corruption.

Opportunity to comment

# Declaration

Overall Rating

Please ensure that this functional standard return has been fully completed. If your Director of Finance and/ or audit committee chair have not authorised or reviewed the functional standard return you will not be able to submit it. Once you have submitted the functional standard return, no further changes are possible.

| Agenda Item |
| --- |
| 6.4 |

# Audit Risk & Assurance Committee

## Counter Fraud Work Plan 2025/26

| | |
| --- | --- |
| **Dyddiad y Cyfarfod / Date of Meeting** | 22/05/2025 |
| **Statws Cyhoeddi / Publication Status** | Open/ Public<br>Not Applicable |
| **Awdur yr Adroddiad / Report Author** | Matthew Evans, Head of Local Counter Fraud Services |
| **Cyflwynydd yr Adroddiad / Report Presenter** | Matthew Evans, Head of Local Counter Fraud Services |
| **Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor** | Sally May, Executive Director of Finance |

| | |
| --- | --- |
| **Pwrpas yr Adroddiad / Report Purpose** | For 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** | |
| --- | --- |
| 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 drafted for the year setting out work to meet these standards based around four strategic areas. The work plan also takes account of local risks.

## 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** *(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** | 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** *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):<br><br>POSITIVE/NEUTRAL NEGATIVE<br><br>Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE | If no, please include rationale below: |
| **Cyfreithiol / Legal** | There are no specific legal implications related to the activity outlined in this report. | |
| | | |
| **Enw da / Reputational** | There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report. | |
| | | |

## 5. Recommendation

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

## 6. Next Steps

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

# Counter Fraud Work Plan 2025/26

**Matthew Evans**
**Head of Counter Fraud Services**

**May 2025**

## 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 accredited counter fraud specialist resource role, recruitment is in progress. It is anticipated that the deliverable days of counter fraud activity will be reduced by 35 days for 2025/26. This work plan is therefore based on 581 days of day's deliverable for counter fraud activity.

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 – 291 and reactive days - 290 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<br>Review and maintain materials and media used.<br>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 risk based training for staff groups identified at higher risk of exposure to fraud. This will include known staff groups (Finance, Estates, relevant People Services staff) but also to include groups identified dynamically through risk assessment work in year. | GovS 013 component 11 | Throughout the Year |
| I&I.3 | 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.4 | 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 |

| 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.5 | 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.6 | Actively promote and encourage staff awareness and completion of the Counter Fraud E-learning package. | GovS 013 component 11 | Throughout the Year |
| 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:<br>Counter Fraud, Bribery and Corruption Policy and Response Plan;<br>Fraud, Bribery and Corruption incident reporting routes; and<br>Policy and procedures relating to Conflicts of Interests, Gifts and Hospitality and Bribery Act. | GovS 013 Components 4, 7 and 12 | 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.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.**<br><br>**The organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance.**<br><br>**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.<br>The communication of revised policies, procedures and documents as appropriate, emphasising the organisational commitment to countering fraud. | GovS 013 component 3<br>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<br>GovS 013 component 3<br>GovS 013 component 5 | 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.**<br><br>**The organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance.**<br><br>**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<br>GovS 013 component 3<br>GovS 013 component 5<br>FR01, FR02, FR03, FR04, FR05, FR06, FR21, FR26, FR61 | Throughout the Year |
| 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 |
|---|
| **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.**<br><br>**The organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance.**<br><br>**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 in response to Fraud Prevention Notice around S12 Mental Health Assessments. | FPN - M-002-25 | Q1 |
| P&D.9 | Finalise fraud risk assessment in response to Fraud Prevention Notice around Fraudulently Obtained Certificate of Sponsorship | FPN - M-004-25 | Q1 |
| P&D.10 | Finalise fraud risk assessment around identified issue of Working Elsewhere utilising new intelligence and learning from NHS Wales Counter Fraud partners | FPN – L001-23 | Q2 |
| P&D.11 | Review and update information sharing protocols currently in place. Review and refresh protocols with People Services | Service level | Q1 |
| P&D.12 | Regular meetings with the Head of Internal Audit (NWSSP Audit & Assurance) | Service level | Throughout the Year |
| P&D.13 | Record and respond to ad-hoc requests for assistance received. | Service level | Throughout the Year |
| P&D.14 | 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 |

| 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.**<br><br>**The organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance.**<br><br>**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.15 | Issue of fraud alerts to all appropriate staff. | GovS 013 component 11 | As Appropriate |
| P&D.16 | 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 |
| P&D.17 | 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.18 | Participate in thematic fraud risk evaluation exercises as instructed by the NHS Counter Fraud Authority. | GovS 013 component 10 | As Required |
| P&D.19 | 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 |

| 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.**<br><br>**The organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance.**<br><br>**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 | Membership of Local Intelligence Network and attendance at meetings. | Service level | As Required |
| P&D.21 | Develop local response to outcome findings of the National Proactive Exercise around Procurement led by NHS Counter Fraud Authority and Interanl Audit review around Procurement. | GovS 013 component 10 | Q1/Q4 |
| | **TOTAL DAYS ALLOCATED** | **143** | |

| 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.**<br><br>**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.**<br><br>**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<br>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<br>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<br>GovS 013 component 8 | As Required |

| | | | |
|---|---|---|---|
| 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** | **290** | |

| 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.**<br><br>**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.**<br><br>**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 | | | |
|---|---|---|---|
| **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.**<br><br>**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.**<br><br>**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 *ad hoc* 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<br>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** | 143 |
| C | **HOLD TO ACCOUNT** | 290 |
| D | **STRATEGIC GOVERNANCE** | 48 |
| | **TOTAL** | **581** |

| Agenda Item |
| --- |
| 6.5 |

# Audit Risk & Assurance Committee

## National Fraud Initiative Progress and Outcomes

| | |
| --- | --- |
| **Dyddiad y Cyfarfod / Date of Meeting** | 22/05/2025 |
| **Statws Cyhoeddi / Publication Status** | Open/ Public<br>Not Applicable |
| **Awdur yr Adroddiad / Report Author** | Matthew Evans, Head of Local Counter Fraud Services |
| **Cyflwynydd yr Adroddiad / Report Presenter** | Matthew Evans, Head of Local Counter Fraud Services |
| **Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor** | Sally May, Executive Director of Finance |

| | |
| --- | --- |
| **Pwrpas yr Adroddiad / Report Purpose** | For Noting |

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

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

## 1. Situation /Background

1.1 The Health Board is a mandatory participant of the National Fraud Initiative. This report sets out current progress of review of the Organisation's matched data sets.

## 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** *(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<br>If more than one applies please list below: | |
| **Impact Assessment** | | |
| **Ansawdd**<br>*Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /*<br>**Quality**<br>*Have you undertaken a Quality Impact Assessment Screening?* | Yes: ☐ | No: ☒ |
| | Outcome: | If no, please include rationale below: |
| **Cydraddoldeb a'r Gymraeg**<br>*Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /*<br>**Equality and Welsh Language**<br>*Have you undertaken an Equality and Welsh Language Impact Assessment Screening?* | Yes: ☐ | No: ☒ |
| | Outcome for Equality (delete as appropriate):<br><br>POSITIVE/NEUTRAL<br>NEGATIVE<br><br>Outcome for Welsh Language (delete as appropriate):<br>POSITIVE/NEUTRAL<br>NEGATIVE | If no, please include rationale below: |
| **Cyfreithiol / Legal** | There are no specific legal implications related to the activity outlined in this report. | |
| | | |
| **Enw da / Reputational** | There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report. | |
| | | |

## 5. Recommendation

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

## 6. Next Steps

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

# National Fraud Initiative

# Progress and Outcomes

## Matched Datasets Background

**Payroll to Payroll**

To identify individuals who may be committing employment fraud by failing to work their contracted hours because they are employed elsewhere or are taking long-term sickness absence from one employer and working for another employer at the same time.

The criteria for a match are a person having one full-time post plus at least one other post elsewhere.

**Payroll to Creditors**

The match identifies instances where an employee and creditor are linked by the same bank account (report 80) or the same address (report 81) to identify employees with interests in companies with which your organisation is trading.

This may indicate potential undeclared interests and possible procurement corruption or where a member of staff has set up a creditor with their own bank details in order to receive payments they are not entitled to.

**Duplicate Creditors by Credit Reference**

Duplicates identified in this match suggest poor creditor management as the system has permitted a creditor reference to be used more than once.

**Duplicate Creditors by Creditor Name**

To identify instances where the same supplier has been set up with more than one reference number on the system thus increasing the potential for creditors to obscure fraudulent activity.

**Duplicate Creditors by Address Detail**

To identify multiple creditors operating at the same address. These may represent simple errors, where the same creditor may have been set up twice using a slightly different spelling, for example LIMITED and LTD, or an attempt to obscure fraudulent activity.

**Duplicate Creditors by Bank Account Number**

This output shows where the same bank account details appear on more than one record. Of particular interest is where the same bank details are shown against suppliers with different names. These may indicate where a supplier has changed trading name but the standing data has not been updated to reflect this or there are links between companies with different trading names.

**Duplicate Records by Reference, Amount and Creditor Reference**

This match highlights possible duplicate payments in excess of £500 that may have arisen as a result of poor controls or fraudulent activity by suppliers and/or staff.

**Duplicate Records by Invoice Amount and Creditor Reference**

This match highlights possible duplicate payments in excess of £1,000 that may have arisen as a result of poor controls or fraudulent activity by suppliers and/or staff. There are likely to be more matches than in report 707 as this report does not require the invoice reference field to match.

**VAT Overpaid**

This report identifies instances where VAT may have been overpaid. This is based on the information provided within the NFI invoice history data submission and the output includes the level and scale of overpaid VAT. The VAT amount is compared to a calculated maximum VAT of 20%, the maximum VAT rate in the payment period covered by the NFI exercise.

**Duplicate Records by Supplier Invoice Number and Invoice Amount but Different Creditor Reference and Name**

This match highlights possible duplicate payments for the same goods/services but to creditors with different reference numbers, which may have arisen as a result of poor controls or fraudulent activity by suppliers and/or staff.

**Duplicate Records by Postcode, Invoice Date and Invoice Amount but Different Creditor Reference and Supplier Invoice Number**

This match highlights possible duplicate payments for the same goods/services but to creditors with different reference numbers, which may have arisen as a result of poor controls or fraudulent activity by suppliers and/or staff.

**Procurement - Payroll to Companies House (Director)**

To identify potential undeclared interests that have given a pecuniary advantage. To do this we have matched your payroll data to companies house information and then to your creditors data.

The reports are split between those highlighting employees who appear to be registered directors of companies that the employing body has traded with (Report 750) and those where the employees address appears to have links to the company directors or the company (Report 752).

| Report ID | Report Title | Responsible Lead | Total Matches | Status | Closed Matches | Further Enquiries | Matches Outstanding |
|---|---|---|---|---|---|---|---|
| 65 | Payroll to Payroll | Counter Fraud | 9 | Not Opened | 0 | 0 | 9 |
| 66 | Payroll to Payroll | | 143 | Opened | 129 | 14 | 0 |
| 67.1 | Payroll to Payroll - Phone Number | | 1 | Not Opened | 0 | 0 | 1 |
| 68.1 | Payroll to Payroll - Phone Number | | 3 | Opened | 1 | 0 | 2 |
| 78 | Payroll to Pensions | Pensions/Counter Fraud | 114 | Not Opened | 0 | 0 | 114 |
| 81 | Payroll to Creditors | Counter Fraud | 9 | Not Opened | 2 | 0 | 7 |
| 700 | Duplicate creditors by creditor reference | NWSSP -Accounts Payable/Finance | 1075 | Not Opened | 0 | 0 | 1075 |
| 701 | Duplicate creditors by creditor name | | 4 | Not Opened | 0 | 0 | 4 |
| 702 | Duplicate creditors by address detail | | 72 | Not Opened | 0 | 0 | 72 |
| 703 | Duplicate creditors by bank account number | | 91 | Not Opened | 0 | 0 | 91 |
| 707 | Duplicate records by reference, amount and creditor reference | | 6 | Not Opened | 0 | 0 | 6 |
| 708 | Duplicate records by amount and creditor reference | | 4245 | Not Opened | 0 | 0 | 4245 |
| 709 | VAT overpaid | | 43 | Not Opened | 0 | 0 | 43 |

| Report ID | Report Title | Responsible Lead | Total Matches | Status | Closed Matches | Further Enquiries | Matches Outstanding |
|---|---|---|---|---|---|---|---|
| 711 | Duplicate records by invoice number and amount but different creditor reference and name | | 30 | Not Opened | 0 | 0 | 30 |
| 712 | Duplicate records by postcode, invoice date and amount but different creditor reference and invoice number | | 21 | Not Opened | 0 | 0 | 21 |
| 713 | Duplicate records by postcode, invoice amount but different creditor reference and invoice number and date | | 11 | Not Opened | 0 | 0 | 11 |
| 750 | Procurement - Payroll to Companies House (Director) | Counter Fraud | 30 | Not Opened | 0 | 0 | 30 |
| 752 | Procurement - Payroll to Companies House (Director) | | 28 | Not Opened | 0 | 0 | 28 |
| 9999 | Multiple occurrence report | | 7 | Not Opened | 0 | 0 | 7 |

| Agenda Item |
|---|
| 7.1 |

# Audit, Risk & Assurance Committee

## AUDIT RECOMMENDATIONS TRACKER UPDATE REPORT

| | |
|---|---|
| **Dyddiad y Cyfarfod / Date of Meeting** | 22/05/2025 |
| **Statws Cyhoeddi / Publication Status** | Open/ Public<br>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 |

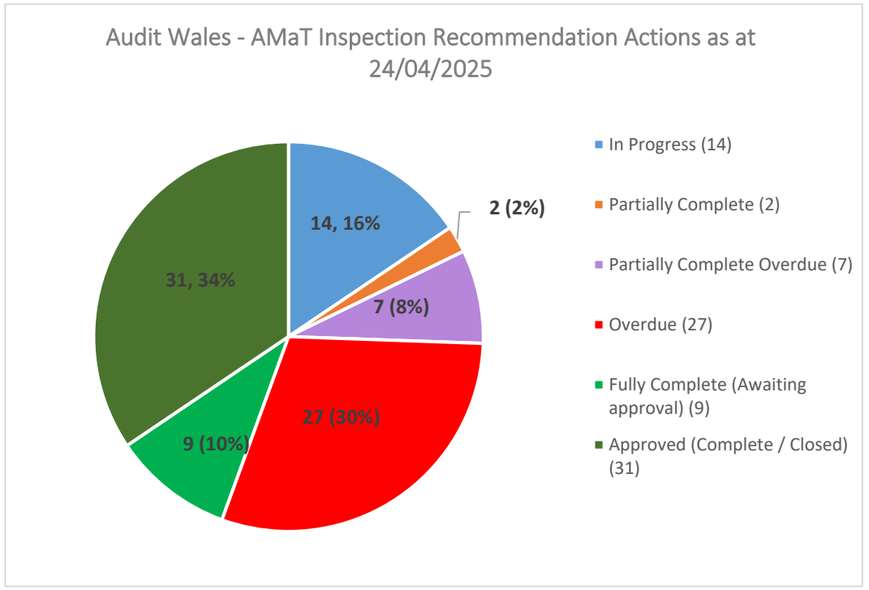
| **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)** | | |
|---|---|---|
| **Committee / Group / Individuals** | **Date** | **Outcome** |
| Executive Leadership Group | 6th May 2025 | |

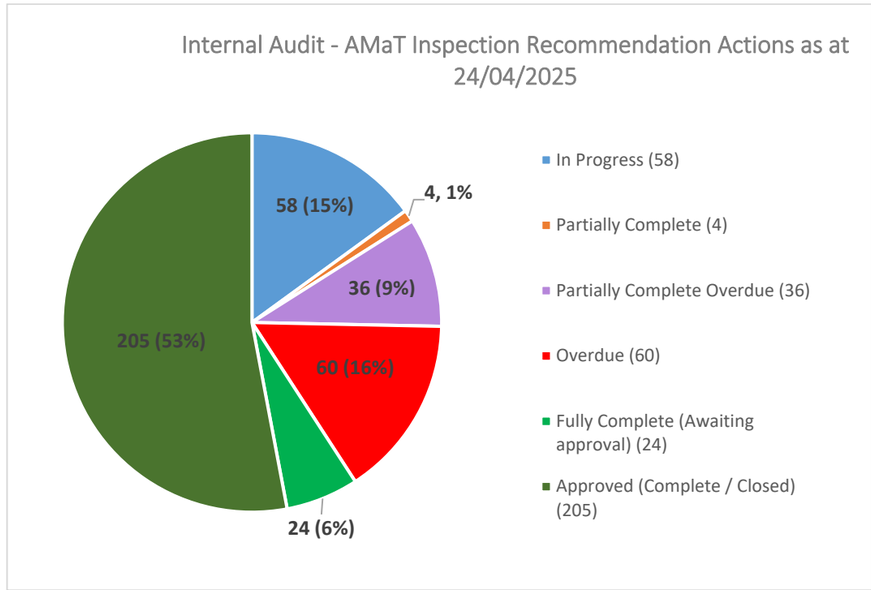
| **Acronyms / Glossary of Terms** | |
|---|---|
| AMaT | Audit Management and Tracking |
| HIW | Healthcare Inspectorate Wales |

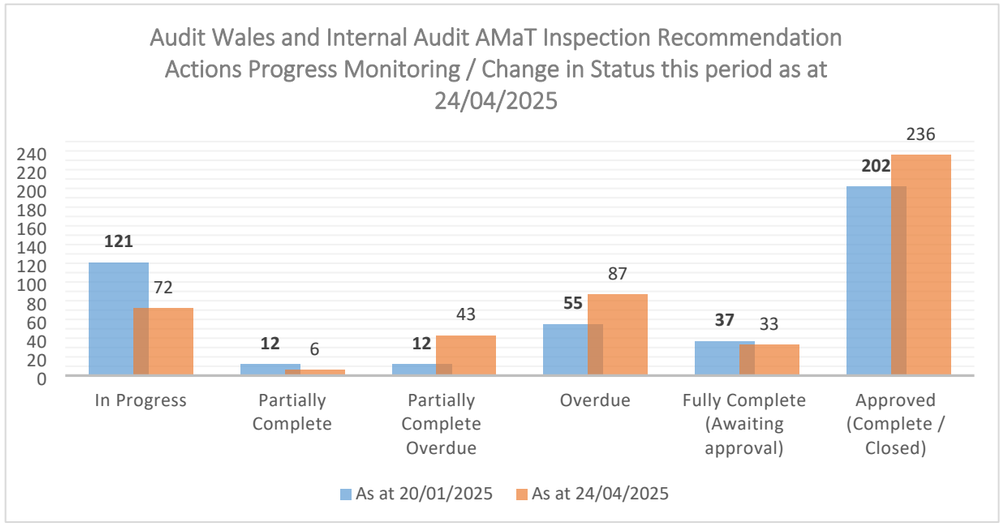
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

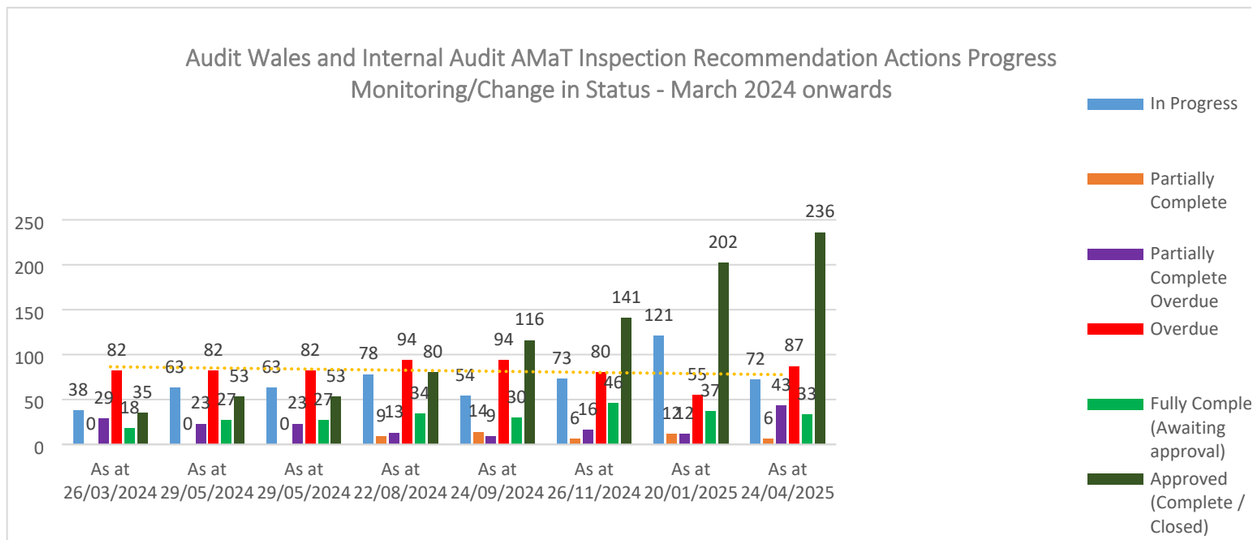
# Tracker Dashboard

## Status: Inspection Actions:

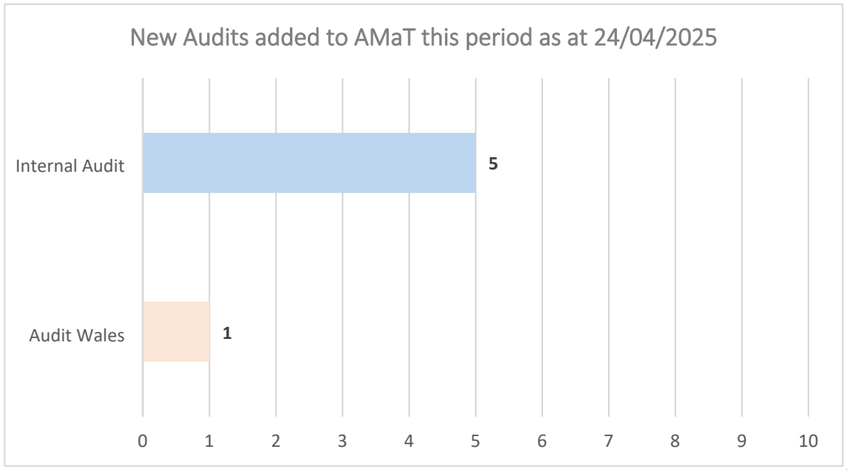


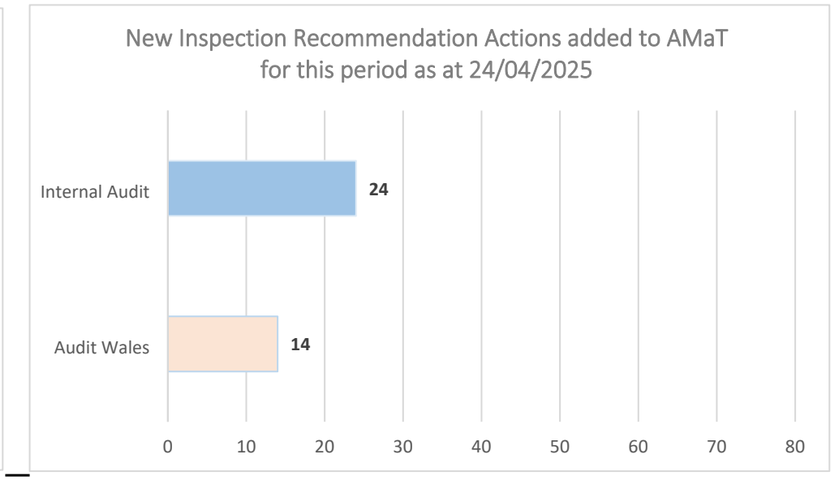



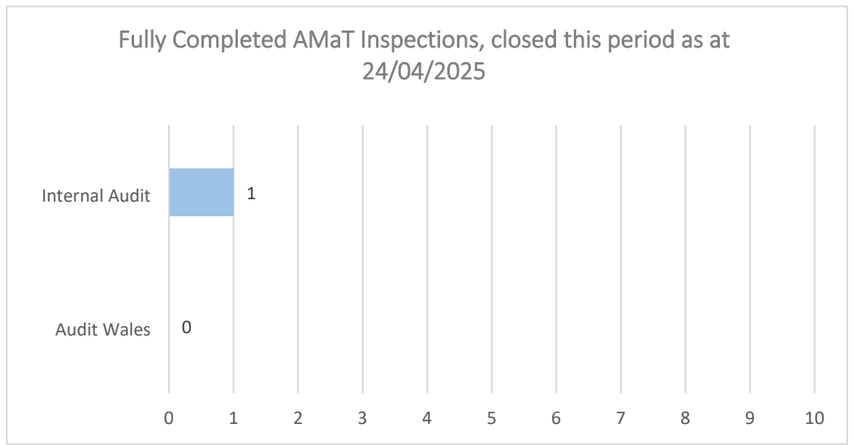



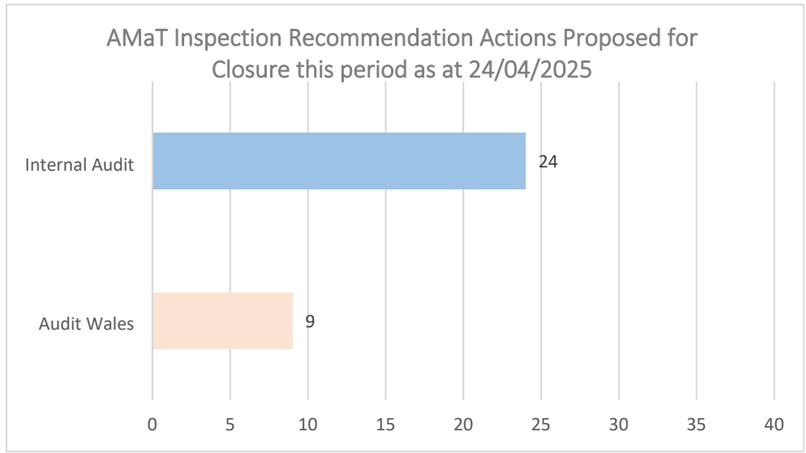
## New Inspections/Actions added to AMaT




## Closed Inspections:

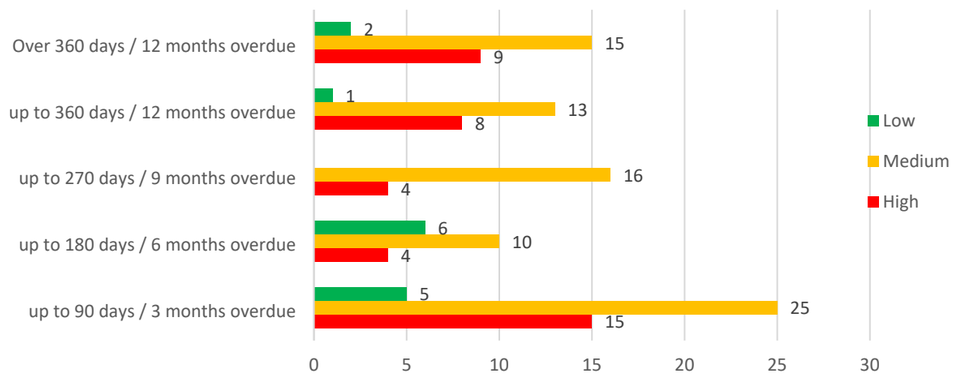


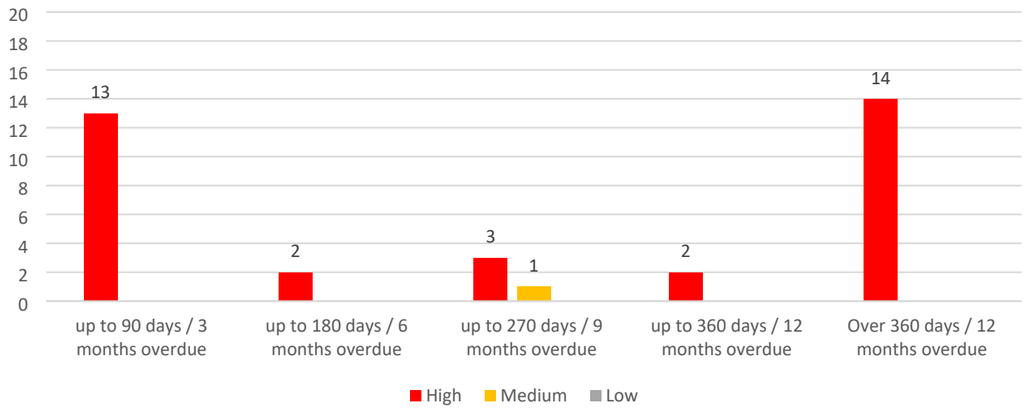
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

# Performance Dashboard

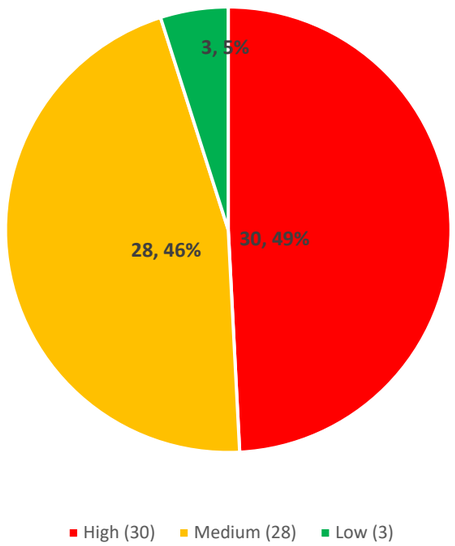
**Total Overdue Internal open Inspection Recommendation Actions (total days overdue from Original Due Date) by Action priority as at 24/04/2025**



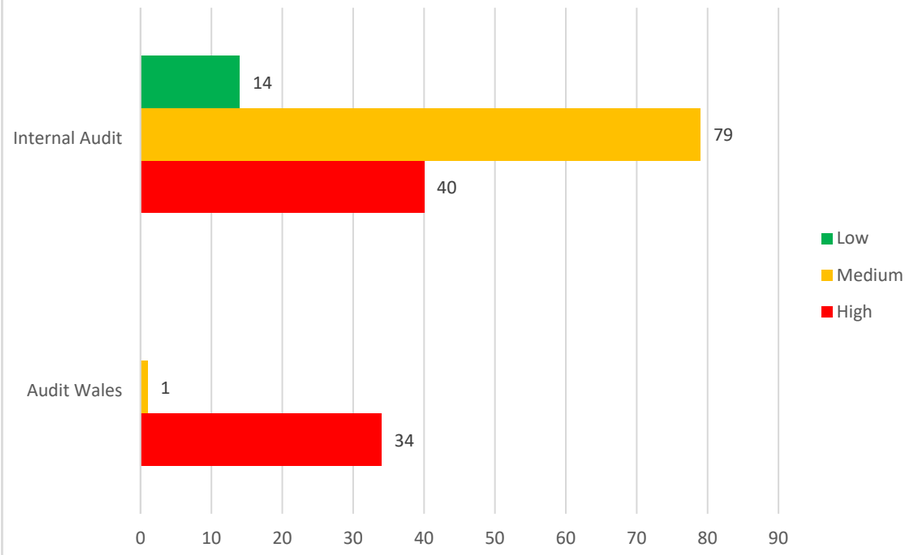

**Overdue Audit Wales open Inspection Recommendation Actions (total days overdue from Original Due Date) by action priority as at 24/04/2025**




**Limited Assurance reports only** - Overall overdue Internal Audit open Inspection Recommendation Actions (total days overdue from Original Due Date) by Action Priority as at 24/04/2025




**Overall overdue Audit Wales & Internal Audit open Inspection Recommendation Actions (total days overdue from Original Due Date) by Action priority as at 24/04/2025**



## 1. Background

1.1 The main purpose of this report is to present an update to the Audit & Risk Committee on reported progress of audit report recommendations in the revised format following transition to an automated system using the Audit Management and Tracking (AMaT) inspection module.

1.2 The scope of this report relates to both internal and external audit review recommendations. Information from HIW included for information only as this was received at the Quality, Safety & Experience Committee on the 20th May 2025.

## 2. Specific Matters for Consideration

2.1 This report has been prepared using the previously agreed format which includes all audit report recommendations. Following a session with Committee Members on the 23rd April 2025, the Quality Assurance & Compliance Team will be exploring different approaches to presenting the data, including the possibility of future reports containing the 'Overdue' actions tracker only with further analysis of the data provided in the written report. The Committee will continue to have access to the full tracker report should members wish to review.

*2.2* The number of overdue actions from Internal Audits remain stable with a slight increase from 79 to 80 medium priority. There has been a slight reduction of 4 high priority, overdue Internal Audit actions from last report with 36 overdue actions.

Additionally, in the case of Audit Wales overdue actions there has been an increase of 9 high Priority actions which now reached 34.

2.3 Month to month analysis of the data indicates that improvements are being made to meet the closure requirements of Audit actions, however it is evident in graph 4 page 3 that when you look across the yearly analysis graph, the data appears to be consistent. There is a need for increased engagement in meeting the Audit requirements to close down recommendation actions sooner. It is important to note that there is a need for continued and sustained momentum in the evaluation and addressing these high priority actions.

2.4 Work continues to cleanse the tracker and identify any recommendations which may have now become irrelevant or obsolete so that they may be closed ensuring the focus is on current, existing and ongoing governance and assurance priorities of CTM. The team continue to engage Executive colleagues and Internal Audit as well as regular meetings with the Business Managers for each Care Group in order to track the progress of ongoing Audit Recommendations.

2.5 Progress on this work continues to be reported to this Committee following appropriate Executive approval at Executive Leadership Group before closure on the system There have been **33 total completed actions** proposed for **closure** this period with a further 38 new actions added.

2.6 Internal Audit are currently undertaking a review of the audit tracker process and will report back in due course.

2.7 Also, as part of our on-going work on continuous improvement the Corporate Governance team is developing an Audit Process and Reporting Handbook. This will be shared with all colleagues on the CTM Intranet. This will provide colleagues with the knowledge they need should they be involved in an audit whether that be internal or external audit. It also sets out the roles and responsibilities including those for senior management and the Board committees. This handbook is currently at the final review stage and will be shared more widely (including with this committee) shortly.

2.8 The current position on the status of recommendation actions can be viewed in *Appendix 1,* with the most recent updates provided in red.

2.9 The Quality Assurance and Compliance team continue to offer support to Care Groups and leaders to independently update actions onto AMaT and is a step by step guide has been sent out to all involved to encourage prompt, succinct and quality updates. The system development gaps in the AMaT system continues to be a necessitate a prescribed process that must be strictly adhered to in the independent updating of AMaT to ensure the team are able to provide a robust level of assurance of the governance process supporting the production of the Audit Tracker report.

2.91 **Tracker Updates**

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

- **5 New** Internal Audit Review has been added to the Audit Recommendations Tracker including **24** new actions.
- Internal Audit Inspections have been completed and **24** are proposed for **CLOSURE**.

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

- **1 New** External Audit Review has been added to the Audit Recommendations Tracker which includes 14 new recommendations.
- **No** Audit Wales recommendations have been completed, and **9** recommendations are proposed for **CLOSURE**.

**Health Inspectorate Wales (HIW) -** Reports from Healthcare Inspectorate Wales will be included in brief for noting and observation. The HIW tracker is included at Appendix 2, however, the Committee should note that this was received by the Quality & Safety Committee at its meeting on the 21st January 2025:

- **0 New** agreed Improvement Plans added resulting in **0 New** actions.

- **508** Inspection actions **Fully Complete-Closed** and a further **5** actions were fully complete and awaiting approval. The Head of Quality Assurance and Compliance continues to work closely with Inspection leads in providing assurance of the completion of actions which is reflected in the high number of closures seen in this period.

## 3. Key Risks / Matters for Escalation

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

## 4. Assessment

| **Objectives / Strategy** | |
|---|---|
| **Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)** | Improving Care |
| | If more than one applies, please list below: |
| **Dolen i Feysydd Strategol BIP CTM /Link to CTMUHB Strategic Areas** | Not Applicable |
| | If more than one applies, please list below: |
| **Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals** *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)* | Not Applicable |
| | If more than one applies, please list below: |
| **Dolen i Hwyluswyr Ansawdd** *(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: |
| **Dolen i Feysydd Ansawdd** *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **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** *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?* | Yes: ☐ | No: ☒ |
| | Outcome: | If no, please include rationale below: |
| **Cydraddoldeb** *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?* | Yes: ☐ | No: ☒ |
| | Outcome: | If no, please include rationale below: |
| **Cyfreithiol / Legal** | Yes (Include further detail below) | |
| | There may be an adverse effect on the organisation if CTMUHB does not fully implement learning and improvements identified as part of Audit arrangements. | |
| **Enw da / Reputational** | There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report. | |
| | | |
| **Effaith Adnoddau** *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)* | There is no direct impact on resources as a result of the activity outlined in this report. | |
| | | |

## 5. RECOMMENDATION

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

| AMaT Inspection Code | Title | Type | Date of Inspection | Inspection Lead | Overall Assurance Rating | Recommendations | Actions |
|---|---|---|---|---|---|---|---|
| Audit Wales/2021/144 | Audit Wales Quality Governance Follow Up Review_Audit and Risk Committee Update – CTMUHB_August 2021 (Document reference: 123A2017) | New | 01/08/2021 | Greg Dix, Executive Director of Nursing & Deputy CEO | N/A | 7 | 7 |
| Audit Wales/2022/12 | Transformational Leadership Programme Board – Baseline Governance Review – CTM Regional Partnership Board 2021-22_August 2022 (Document reference: 2934A2022) | New | 01/08/2022 | Victoria Oxley, Acting Executive Director of Strategy & Transformation | N/A | 5 | 5 |
| Audit Wales/2023/149 | Structured Assessment 2023 – CTMUHB 2023_October 2023 (Document reference: 3920A2023) | New | 01/10/2023 | Gareth Watts, Director of Corporate Governance & Board Secretary / Linda Prosser, Executive Director of Strategy & Transformation / Stuart Morris, Director of Digital | N/A | 6 | 6 |
| Audit Wales/2023/150 | CONFIDENTIAL Audit of Accounts Report Addendum – CTMUHB 2022-23_November 2023 (Document reference: 3727A2023) | New | 01/11/2023 | Sally May, Executive Director of Finance | N/A | 9 | 9 |
| Audit Wales/2023/18 | Structured Assessment 2022 – CTMUHB 2022_February 2023 (Document reference: 3313A2023) | New | 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 | N/A | 8 | 8 |
| Audit Wales/2023/23 | Orthopaedic Services in Wales – Tackling the Waiting List Backlog Report of the Auditor General for Wales_March 2023 | New | 01/03/2023 | Gethin Hughes, Chief Operating Officer | N/A | 3 | 3 |
| Audit Wales/2024/168 | Review of Workforce Planning Arrangements – Cwm Taf Morgannwg University Health Board (Document reference: 4157A2024) | New | 01/02/2024 | Hywel Daniel, Executive Director for People | N/A | 6 | 6 |
| Audit Wales/2024/196 | Follow up review: Temporary Closure of the Ysbyty Cwm Cynon Minor Injuries Unit – Cwm Taf Morgannwg University Health Board (Document reference: 4361A2024) | New | 01/07/2024 | Greg Dix, Executive Director of Nursing & Deputy CEO | N/A | 1 | 2 |
| Audit Wales/2024/205 | CONFIDENTIAL Audit of Accounts Report Addendum - CTMUHB 2023-24_October 2024 (Document reference: 4395A2024) | New | 01/08/2024 | Sally May, Executive Director of Finance | N/A | 7 | 7 |
| Audit Wales/2024/212 | Primary Care Follow-Up Review - CTMUHB 2023-24_November 2024 (Document reference: 4606A2024) | New | 30/11/2024 | Gethin Hughes, Chief Operating Officer | N/A | 6 | 11 |
| Audit Wales/2024/213 | Review of Cost Savings Arrangements - CTMUHB 2023-24_October 2024 (Document reference: 4542A2024) | New | 31/10/2024 | Sally May, Executive Director of Finance | N/A | 8 | 8 |
| Audit Wales/2025/234 | Structured Asessment 2024_CTMUHB 2024_November 2024 (Document reference: 4579A2024) | New | 23/01/2025 | Gareth Watts, Director of Corporate Governance & Board Secretary / Sally May, Executive Director of Finance / Victoria Oxley, Acting Executive Director of Strategy & Transformation / Greg Dix, Executive Director of Nursing & Deputy CEO / Gethin Hughes, Chief Operating Officer / Philip Daniels, Executive Director for Public Health | N/A | 13 | 14 |
| Internal Audit/2020/65 | Directorate review: Acute Medicine and A&E Directorate_Final Internal Audit Report July 2020 (Review reference: CTMU-1920-23) | New | 29/07/2020 | Gethin Hughes, Chief Operating Officer | Reasonable Assurance | 2 | 2 |
| Internal Audit/2020/74 | Medical Equipment and Devices - Follow up Internal Audit Report 2019/20 January 2020 (Review reference: CTMU 1920-45b) | New | 24/01/2020 | Gethin Hughes, Chief Operating Officer | Reasonable Assurance | 1 | 1 |
| Internal Audit/2021/76 | Sunnyside Health & Wellbeing Centre_Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03) | New | 06/08/2021 | Sally May, Executive Director of Finance | Reasonable Assurance | 15 | 15 |
| Internal Audit/2022/161 | Continuing Health Care and Funded Nursing Care_Final Internal Audit Report February 2022 (Review reference: CTMUHB-2122-36) | New | 14/02/2022 | Greg Dix, Executive Director of Nursing & Deputy CEO | Reasonable Assurance | 1 | 1 |
| Internal Audit/2022/43 | Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01) | New | 29/07/2022 | Victoria Oxley, Acting Executive Director of Strategy & Transformation | Limited Assurance | 13 | 13 |
| Internal Audit/2022/67 | Radiology Service Review Final Internal Audit Report October 2022 (Review reference: CTMUHB-2223-03) | New | 24/10/2022 | Gethin Hughes, Chief Operating Officer | Reasonable Assurance | 5 | 5 |
| Internal Audit/2022/95 | Follow-up: Medical & Dental Rostering_Final Internal Audit Report June 2022 (Review reference: CTM 21/22-31) | New | 15/06/2022 | Dom Hurford, Executive Medical Director / Hywel Daniel, Executive Director for People | Reasonable Assurance | 1 | 1 |
| Internal Audit/2022/97 | Medical Records Management_Final Internal Audit Report October 2022 (Review reference: CTMU-2223-06) | New | 10/10/2022 | Stuart Morris, Director of Digital | Reasonable Assurance | 1 | 1 |
| Internal Audit/2023/100 | Welsh Risk Pool Claims_Final Internal Audit Report May 2023 (Review reference: CTMUHB-2223-24) | New | 31/05/2023 | Greg Dix, Executive Director of Nursing & Deputy CEO | Reasonable Assurance | 3 | 3 |
| Internal Audit/2023/107 | Decontamination_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-25) | New | 08/08/2023 | Greg Dix, Executive Director of Nursing & Deputy CEO | Reasonable Assurance | 5 | 5 |
| Internal Audit/2023/113 | National Incident Framework_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-05) | New | 08/08/2023 | Greg Dix, Executive Director of Nursing & Deputy CEO | Reasonable Assurance | 8 | 8 |
| Internal Audit/2023/117 | Performance Reporting – Integrated Performance Report_Internal Audit Report July 2023 (Review reference: CTMUHB-2223-15) | New | 28/07/2023 | Victoria Oxley, Acting Executive Director of Strategy & Transformation / Stuart Morris, Director of Digital | Reasonable Assurance | 2 | 2 |
| Internal Audit/2023/124 | Follow-up: Concerns_Final Internal Audit Report May 2023 (Review reference: CTM 22/23-29) | New | 31/05/2023 | Greg Dix, Executive Director of Nursing & Deputy CEO | Reasonable Assurance | 4 | 4 |
| Internal Audit/2023/146 | Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11) | New | 11/10/2023 | Gethin Hughes, Chief Operating Officer | Limited Assurance | 8 | 8 |
| Internal Audit/2023/148 | IT Infrastructure_Final Internal Audit Report October 2023 (Review reference: CTM-2324-19) | New | 09/10/2023 | Stuart Morris, Director of Digital | Reasonable Assurance | 5 | 5 |
| Internal Audit/2023/54 | Medical Variable Pay – Agency Costs_Final Internal Audit Report February 2023 (Review reference: CTMUHB-2223-12) | New | 06/02/2023 | Dom Hurford, Executive Medical Director / Hywel Daniel, Executive Director for People | Limited Assurance | 7 | 7 |
| Internal Audit/2024/162 | 4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03) | New | 06/02/2024 | Gethin Hughes, Chief Operating Officer | Limited Assurance | 15 | 15 |
| Internal Audit/2024/163 | IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18) | New | 08/02/2024 | Stuart Morris, Director of Digital | Reasonable Assurance | 11 | 12 |
| Internal Audit/2024/169 | Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06) | New | 11/04/2024 | Dom Hurford, Executive Medical Director | Reasonable Assurance | 17 | 18 |
| Internal Audit/2024/170 | Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-02) | New | 12/04/2024 | Gethin Hughes, Chief Operating Officer | Limited Assurance | 7 | 7 |
| Internal Audit/2024/171 | Decarbonisation Internal Audit Report_April 2024 (Review reference: CTMUHB-2324-13) | New | 09/04/2024 | Victoria Oxley, Acting Executive Director of Strategy & Transformation | Limited Assurance | 9 | 9 |
| Internal Audit/2024/187 | Leadership and Management Development Programme Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-01) | New | 06/06/2024 | Hywel Daniel, Executive Director for People | Reasonable Assurance | 4 | 7 |
| Internal Audit/2024/188 | Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-14) | New | 11/06/2024 | Greg Dix, Executive Director of Nursing & Deputy CEO | Reasonable Assurance | 5 | 9 |
| Internal Audit/2024/189 | Technical Resilience Final Internal Audit Report_June 2024 (Review reference: CTM-2324-20) | New | 07/06/2024 | Stuart Morris, Director of Digital | Reasonable Assurance | 6 | 6 |
| Internal Audit/2024/190 | Risk Management Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-17) | New | 03/06/2024 | Gareth Watts, Director of Corporate Governance & Board Secretary / Greg Dix, Executive Director of Nursing/Deputy Chief Executive / Gethin Hughes, Chief Operating Officer | Reasonable Assurance | 9 | 9 |
| Internal Audit/2024/192 | Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09) | New | 04/06/2024 | Gethin Hughes, Chief Operating Officer | Reasonable Assurance | 15 | 27 |
| Internal Audit/2024/199 | Intelligence Led Organisation Final Internal Audit Report_October 2024 (Review reference: CTM-2425-07_ | New | 04/10/2024 | Stuart Morris, Director of Digital | Reasonable Assurance | 7 | 8 |
| Internal Audit/2024/200 | Embedding the Quality Framework Final Internal Audit Report_September 2024 (Review reference: CTMUHB-2324-15) | New | 16/09/2024 | Greg Dix, Executive Director of Nursing & Deputy CEO | Reasonable Assurance | 7 | 8 |
| Internal Audit/2024/202 | Follow-Up: Reasonable Offer Final Internal Audit Report - October 2024 (Review Reference -CTM-2324-25) | Re-inspection | 02/10/2024 | Gethin Hughes, Chief Operating Officer | Reasonable Assurance | 4 | 4 |
| Internal Audit/2024/203 | Follow-up: Patient Pathways Final Internal Audit Report - September 2024 (Review Reference: CTM 23/24-31) | Re-inspection | 27/09/2024 | Gethin Hughes, Chief Operating Officer | Limited Assurance | 9 | 9 |
| Internal Audit/2024/211 | Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24/25-09) | New | 10/12/2024 | Dom Hurford, Executive Medical Director / Hywel Daniel, Executive Director for People | Limited Assurance | 21 | 36 |
| Internal Audit/2024/214 | Energy Management 2024/25 (Review Reference CTMUHB-SSU-2425-19) | New | 12/12/2024 | Sally May, Executive Director of Finance | Reasonable Assurance | 4 | 4 |
| Internal Audit/2024/215 | Charitable Funds 2024/25 (Review Reference CTM-2425-20) | New | 09/12/2024 | Sally May, Executive Director of Finance | Reasonable Assurance | 4 | 4 |
| Internal Audit/2025/229 | PCH Supply Chain Management_2024/025 (Review Reference CTM-SSU-2425-40) | New | 13/02/2025 | Sally May, Executive Director of Finance | Reasonable Assurance | 6 | 6 |
| Internal Audit/2025/230 | Vaccination Policy Implementation_2024/25 (Review Reference CTM-2425-22) | New | 31/01/2025 | Philip Daniels, Executive Director of Public Health | Limited Assurance | 3 | 3 |
| Internal Audit/2025/231 | Regional Integration Fund_2024/25 ( Review Reference: CTM-2425-23) | New | 15/01/2025 | Victoria Oxley, Acting Executive Director of Strategy & Transformation | Reasonable Assurance | 3 | 3 |
| Internal Audit/2025/232 | Medical Job Planning_2024/25 (Review Reference: CTM-2425-17) | New | 31/01/2025 | Dom Hurford, Executive Medical Director | Limited Assurance | 3 | 6 |
| Internal Audit/2025/233 | Follow-up: Arrangements for Managing Service Level Agreements_January 2025 (Review reference: CTM-2425-33) | Re-inspection | 29/01/2025 | Victoria Oxley, Acting Executive Director of Strategy & Transformation | Reasonable Assurance | 6 | 6 |

**Audit Recommendations Tracker**
**AMaT Actions - Status Key**

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

| Inspection Code | Date of Inspection | Inspection Title | Recommendation | AMaT Reference Number | Action | Executive / Inspection Lead | Original Due Date | Current / Revised Due Date | Action Rating | Progress Status | Comments/Updates | Risks | Barriers | Evidence |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Audit Wales/2021/144 | 01/08/2021 | Audit Wales Quality Governance Follow Up Review_Audit and Risk Committee Update – CTMUHB_August 2021 (Document reference: 1234/2017) | Audit Wales/HIW Quality Governance Follow Up Review R3.5<br>Ensure there is collective responsibility for quality and patient safety across the executive team and clearly defined roles for professional leads:<br>a- Strengthening of the role of the Medical Director and Clinical Directors in relation to quality and patient safety<br>b- Clarify the roles, responsibilities, accountability, and governance in relation to quality and patient safety within the directorates<br>c- Ensure there is sufficient capacity and support, at corporate and directorate level, dedicated to quality and patient safety | Audit Wales/2021/144/MD3/1 | Quality metrics capturing a greater breadth of HB services and functions, including population health measures, have been agreed and reviewed at the ILG performance meetings, Quality & Safety Committee and Board. The new measures will utilise, where possible, control limits, targets and trajectories. Once for Wales will support the HB to benchmark against other Hbs. | Patient Care and Safety<br><br>Executive Director of Nursing/Deputy Chief Executive<br><br>Executive Director of Therapies & Health Science | 01.10.2021 | 31.10.2024 | High | Partially complete (Overdue) | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 - An Executive Director led quality and patient safety Huddle takes place each week. Within the Huddle quality metrics capture a greater breadth of HB services and functions, including detailed discussion of quality and patient safety information: patient safety incidents, complaints and concerns and patient experience. | | | |
| Audit Wales/2022/12 | 01/08/2022 | Transformational Leadership Programme Board – Baseline Governance Review – CTM Regional Partnership Board 2021-22_August 2022 (Document reference: 2934/A2022) | Transformational Leadership Programme Board – Baseline Governance Review R4<br>Risk Management<br>Our work found areas of risk management that need to be improved, particularly in relation to regional workforce planning. The TLPB should strengthen regional risk management arrangements by improving the identification and prioritisation of shared risks and ensuring mitigating actions are robust and clearly articulated. | Audit Wales/2022/12/MD3/1 | Agreed.<br>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<br><br>Executive Director of Strategy and Transformation | 31.03.2023 | 31.03.2025 | High | Overdue | April 2025 Update - as per update below.<br><br>January 2025 update - work continues on the ICCS as set out below - which includes shared resources to manage shared risks across the region.<br><br>November 2024 Update - Bridgend, Merthyr Tydfil and Rhondda Cynon Taf County Borough Councils and Cwm Taf Morgannwg University Health Board (CTMUHB) have agreed to work together, with other Regional Partnership Board partners, to create an integrated community care system for older people and people living with frailty which is capable of meeting charging and increasing community need. The planned Integrated Community Care System (ICCS) where multidisciplinary teams will work on cluster footprints across the region. The ICCS will be based on two new community pathways – Urgent Community Response and Population Health Management, where the Urgent Response Pathway may be accessed primarily through a Navigation Hub. A new management model – comprising integrated management roles and shared resources, is seen as necessary to deliver integrated services effectively. | | | |
| Audit Wales/2022/12 | 01/08/2022 | Transformational Leadership Programme Board – Baseline Governance Review – CTM Regional Partnership Board 2021-22_August 2022 (Document reference: 2934/A2022) | Transformational Leadership Programme Board – Baseline Governance Review R6<br>Use of Resources Improving the health and social care outcomes of the region will require efficient and effective use of combined resources. Our work found that there had been some limited examples of pooled budgets and other arrangements for sharing resources. The TLPB needs to explore more innovative ways of sharing and pooling core. | Audit Wales/2022/12/MD6/1 | Agreed.<br>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<br><br>Executive Director of Strategy and Transformation | 31.03.2023 | 31.03.2025 | High | Overdue | April 2025 Update - MOU signed by statutory partners. Work has commenced on development of regional wide Section 33 agreement<br><br>January 2025 update - the MOU set out below is currently being taken through the Boards of statutory partners for sign off.<br><br>November 2024 Update - "MOU has been drafted under the provisions of Part 9 of the Social Services and Wellbeing (Wales) Act 2014.<br>• The MOU sets out the ambition of partners to develop a single Regional Partnership Agreement, which will be in place from April 2025 and reviewed annually, for delivery of services within the new community pathways set out in the ICCS. It has been agreed that a Section 33 Agreement is the appropriate vehicle for achieving this. The new RPA will supersede existing legally binding partnership agreements. | | | |
| Audit Wales/2022/12 | 01/08/2022 | Transformational Leadership Programme Board – Baseline Governance Review – CTM Regional Partnership Board 2021-22_August 2022 (Document reference: 2934/A2022) | Transformational Leadership Programme Board – Baseline Governance Review R7<br>Regional workforce planning Like many parts of the public sector, the region is experiencing significant workforce challenges. The TLPB needs to consider how it can facilitate a regional and strategic approach to addressing these challenges and to help it deliver its priorities" | Audit Wales/2022/12/MD7/1 | Agreed.<br>Regional workforce development arrangements exist through SCWDP Board workforce development group and work is underway to strengthen links with RPB and Health. | Strategy, Planning and Transformation<br><br>Executive Director of Strategy and Transformation | 31.03.2023 | 31.03.2025 | High | Overdue | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>November 2024 Update - Ongoing discussions to expand and strengthen the Social Care Workforce development group to better align with regional integrated pathways developments. | | | |
| Audit Wales/2023/149 | 01/10/2023 | Structured Assessment 2023 – CTMUHB 2023_October 2023 (Document reference: 3920A2023) | Structured Assessment 2023 R6<br>Performance Management Framework<br>The Health Board has appropriate arrangements in place to manage operational performance; however, it lacks a documented performance management framework. In order to enhance its arrangements further, the Health Board should prepare a written framework that clearly sets out roles, responsibilities, and frequency for reviewing performance at service, management, committee, and Board levels (High Priority). | Audit Wales/2023/149/MD6/1 | The Health Board has developed a working version of the Performance Framework, however it does require updating to reflect the new organisational structure and the latest Welsh Government performance framework. This activity will be undertaken before 31st December 2023 and presented to the first meeting of the Planning, Performance & Finance Committee in 2024 (currently scheduled for the 27 February 2024), for approval. | Performance<br><br>Executive Director of Strategy & Transformation (Performance Framework)<br><br>Chief Operating Officer (Operational Performance)<br><br>Director of Digital (Performance Information) | 01.02.2024 | 01.02.2024 | High | Overdue | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>November 2024 Update - The performance structure for the IMTP is set out on the reports provided to board. The formal framework document is under review.<br><br>September 2024 Update - An update against this recommendation has not been provided on this occasion. | | | |
| 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<br>The Health Board should ensure that its primary care working papers are clearly cross referenced to the relevant figures within the financial statements. The Health Board should also ensure that, where spreadsheets are the underlying evidence base, all cell values have an appropriate audit trail (typically formula based) and that manually entered figures are used sparingly, when they are the only valid option. | Audit Wales/2023/150/MD3/1 | There were changes to the staff preparing the primary care working papers at the end of the financial year, therefore some working papers provided were incorrect at the draft stage. However there was an improvement in the timeliness of providing working papers on the Audit system compared to previous years. The audit team were subsequently able to meet with the team who prepare the primary care figures and agree the figures for the final accounts. The financial accounts working 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 the relevant cells in the accounts. | Finance<br><br>Executive Director of Finance | 01.04.2024 | 01.04.2024 | High | Fully complete (Awaiting approval) | April 2025 Update - This has been implemented for the 2024/25 Financial Accounts and Trial Balance links with Primary Care notes.<br><br>January 2025 Update - An update against this recommendation has not been provided on this occasion. | | | |
| Audit Wales/2023/18 | 01/02/2023 | Structured Assessment 2022 – CTMUHB 2022_February 2023 (Document reference: 3313A2023) | Structured Assessment 2022 R1<br>Improving administrative governance arrangements<br>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:<br>a) publish the agendas of private Board and committee meetings;<br>b) publish the papers for all public Board, committee, and advisory meetings on its website in a timely manner;<br>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<br>d) update presentation cover sheets to enable authors to summarise the information sufficiently and capture the relevant risks and issues. | Audit Wales/2023/18/MD1/1 | a) In the exceptional circumstances where the Health Board is required to hold a Private Board meeting or Board Committee it will endeavour to highlight the agenda items covered on the Public Agenda for transparency.<br><br>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.<br><br>c) Cover reports will be reviewed to incorporate requirements of the WBFG Wales Act.<br><br>d) Presentation cover sheets to be reviewed to ensure authors sufficiently reflect key risks and issues. | Corporate Governance<br><br>Director of Corporate Governance/Board Secretary | 30.10.2023 | 30.09.2024 | High | Partially complete (Overdue) | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>Re-opended February 2025 as Audit Wales SA Report 2024 did not agree this action was closed so further update required in terms of 'b' and 'c'.<br><br>November 2024 Update - COMPLETE - The Board approved the new approach to Board and Committee business at its formal Board meeting in September 2024. This outlined those Committees where the papers will be made available in public and those that remain closed and the Board approved a variation to its standing orders in this regard. | | | |
| Audit Wales/2023/18 | 01/02/2023 | Structured Assessment 2022 – CTMUHB 2022_February 2023 (Document reference: 3313A2023) | Structured Assessment 2022 R3<br>Strengthening performance management arrangements<br>The Health Board has a number of longstanding performance challenges across many areas in both planned care and urgent and emergency care, resulting in it being escalated to enhanced monitoring from routine arrangements under Welsh Government's Escalation and Intervention Arrangements. The Health Board, therefore, should ensure its performance management and reporting arrangements are appropriately focused on the key challenges it faces in both planned care and urgent and emergency care, especially where performance in those areas is comparatively worse than other Health Boards in Wales. | Audit Wales/2023/18/MD3/1 | The Health Board continues to work to improve the Integrated Performance Reporting to the Board. The lay out, content and specifically the narrative throughout the report to Board is constantly being refined and updated to ensure the Board has the right information at the right time. In addition steps have been taken to ensure that the Board Committees receive the performance information relevant to their remit.<br>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.<br>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.<br><br>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<br><br>Executive Director of Strategy & Transformation (Performance Framework)<br><br>Chief Operating Officer (Operational Performance)<br><br>Director of Digital (Performance Information) | 30.09.2023 | 31.12.2023 | High | Overdue | April 2025 Update - a Board development session is scheduled for 2025 with a focus on the Integrated Performance Report.<br><br>January 2025 Update - An update against this recommendation has not been provided on this occasion. | | | |
| Audit Wales/2023/18 | 01/02/2023 | Structured Assessment 2022 – CTMUHB 2022_February 2023 (Document reference: 3313A2023) | Structured Assessment 2022 R4<br>Establishing measurable outcomes for strategy priorities<br>Whilst the Health Board has made positive progress in developing a long-term vision, strategic goals, and strategic priorities for the organisation, the new strategy (CTM 2030) lacks clear and measurable outcomes. The Health Board, therefore, should seek to articulate outcomes for each strategic priority, what success would look like, and how it will measure and report progress. In doing so, it should consider the relationship between the goals of the Population Health Strategy and the wider strategic goals and public health 'life course' approach set out in CTM 2030. | Audit Wales/2023/18/MD4/1 | We agree that this work needs to progress. The ongoing work of the Strategy Groups and the CTM 2030 steering group is to set out clearly the measurable improvements to be delivered. Most of these relate to pre-existing measures set out in the Quadruple Aims. Each lead for a "strategy chapter" are responsible for identifying the measurable outcomes for their "chapter".<br><br>In addition, work has already commenced to align the strategy group work to the goals and measures set out within the Population Health Management plan. We will continue to work to ensure that the thread between these aspects is more visible. | Strategy, Planning and Transformation<br><br>Executive Director of Strategy and Transformation (Performance Framework) | 01.09.2023 | 01.09.2023 | High | Fully complete (Awaiting approval) | April 2025 Update - This action is proposed for closure. Strategy groups have identified high level outcome measures and work is also aligned against population health outcome measures. Additional action identified in the Structured Assessment 2024 which develops this action further and is in progress.<br><br>February 2025 Update - Audit Wales indicated in their SA Report for 2024 that this action should remain in progress as it notes that while the Board receives routine updates on aspects of strategy delivery, the development of clear actions and outcomes measures for its high-level strategic objectives remains in progress. This work needs to be completed urgently to enable the Board to understand progress and clearly demonstrate delivery of CTM 2030. | | | |
| Audit Wales/2023/18 | 01/02/2023 | Structured Assessment 2022 – CTMUHB 2022_February 2023 (Document reference: 3313A2023) | Structured Assessment 2022 R5<br>We found opportunities for the Health Board to enhance its arrangements for monitoring<br>the delivery of corporate plans and strategies, and reporting progress to the Board. The Health Board, therefore, should<br>enhance its arrangements by ensuring:<br>a) plans and strategies contain clear summaries of key actions / deliverables, timescales, and measures to support<br>effective monitoring and reporting;<br>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<br>c) reports are aligned to performance reports to enable the Board to assess the extent to which the implementation of<br>key actions / deliverables is having a positive impact on Health Board performance. | Audit Wales/2023/18/MD5/1 | a) All plans and strategies will contain an executive summary setting out this information. As set out above, work is ongoing around outcome measures.<br><br>b) Executive Directors are clear on their responsibilities for delivery so we will ensure this is more visible.<br><br>c) Reports will be reviewed to ensure they provide the Board with sufficient information to assess the impact of implementation of key actions and deliverables on the Health Board's Performance. | Strategy, Planning and Transformation<br><br>Executive Director of Strategy and Transformation<br><br>Director of Digital | 30.06.2023 | 30.06.2023 | High | Partially complete (Overdue) | April 2025 Update - A future Board development session focused on the Integrated Performance Dashboard is planned for 2025 and will support delivery of these actions.<br><br>February 2025 Update - Re-opened as in the Audit Wales 2024 Structured Assessment Report Audit Wales colleagues did not consider this item to be closed - See detail of report - paras 83-85. Review comments and consider if closed.<br><br>November 2024 Update - By way of follow up to the October 2023 update, parts a, b and c of this action are considered completed and this action is therefore proposed for closure. | | | |
| Audit Wales/2023/18 | 01/02/2023 | Structured Assessment 2022 – CTMUHB 2022_February 2023 (Document reference: 3313A2023) | Structured Assessment 2022 R7<br>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:<br>a) review the delegated upper financial limit for the Chief Executive;<br>b) ensure there is a clear process in place for the Board to review and approve capital programmes and projects; and<br>c) ensure out-of-date financial control procedures are removed from its website and replaced with the current versions - NOT COMPLETED | Audit Wales/2023/18/MD7/1 | a) The Health Board will undertake a review of the Chief Executives upper financial limit. This will form part of the review of the Health Board's Standing Financial Instructions being led by the Head of Corporate Finance.<br><br>b) Capital approvals are managed through the Executive Capital Management Group (ECMG) which meets monthly and approves all new schemes and adjustments to approved capital schemes. ECMG is Chaired by the Director of Finance and the Director of Strategy and Transformation and Chief Operating Officer are also members. Since the removal of the Capital Programme Board the reporting for the capital programme and all business cases are reported through Planning, Performance and Finance Board Committee prior to being reported at the Board. It is proposed that quarterly capital reporting is reinstated through Planning, Performance & Finance (PPF) Committee and to the Board to cover updates on the capital programme and major projects. Business case over £1M will be brought through the PPF and Board Agenda prior to approval to Welsh Government dependent on project progression and Board Agendas.<br><br>c) A review of all the outdated Financial Control Procedures is underway. | Finance<br><br>Executive Director of Finance | 31.12.2023 | 31.12.2024 | High | Partially complete (Overdue) | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>November 2024 Update - A number of PCPs have been reviewed and approved by Audit & Risk Committee, including recently Medical Variable Pay and Charitable Funds. All other outstanding PCPs are currently updated and out for review with applicable officers. These will require formal review by finance and other relevant staff before being taken to December's Audit & Risk Committe. We anticipate the majority will be updated by end of year, but there may be a small number that require further review. | | | |
| 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<br>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:<br><br>a) ensure they maintain oversight and scrutiny of implementation of the Getting It Right First Time recommendations as part of their governance arrangements; and<br><br>b) ensure that clear action plans are in place to address the things that get in the way of improvement. | Audit Wales/2023/23/MD2/1 | The Health Board will undertake the following in order to maintain oversight and scrutiny and ensure action plans are in place:<br>• 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.<br>• The GIRFT implementation will be included in the reconfiguration programme and updated through the Improving Care Board<br>• Increase the capture of PREMs and PROMS data, digitally captured via MyMobility and through the HB website wherever possible. RGH does not have a system for PROMS or PREMS. Old CTM PCH only had funding and support from Clinical Audit and no funding or support was agreed by the HB. Would need a commitment to roll out MyMobility HB wide.<br>• 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.<br>• 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.<br>• Introduce a FLS service to prevent repeat fractures –timing will depend upon funding.<br>• Actively consider the provision of a seven day service including Therapies service to ensure earlier discharges and increased throughput.<br>• Consider seven day Theatre working when possible (longer term aim).<br>• Increase clinician engagement<br>• Updated GIRFT action plan to be created with new CD and monitored through the reconfiguration programme.<br>• Weekly Orthopaedic Reconfiguration Group ongoing. All key stakeholders are fully involved. | Planned Care<br><br>Chief Operating Officer | 01.05.2023 | 01.05.2023 | High | Overdue | April 2025 Update - Progress against this action is being made within the Care Group.<br><br>January 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>November 2024 Update - Running 'Perfect Month', Reduced LOS for Elective to 1.03 days, Running 4 cases on all day list. Condensed trauma take. Will review before changing permanently. | | | |
| 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<br>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:<br><br>a) ensure that local CMATS are appropriately staffed, and at a minimum, reflect previous Welsh Government guidance; and<br>b) ensure that where First Contact Practitioners (FCP) exist, there are clear pathways between FCPs and CMATS to reduce duplication and minimise waits. | Audit Wales/2023/23/MD3/1 | The Health Board will undertake the following in order to ensure the recommendations are achieved:<br><br>• 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.<br><br>• In PCH, CMATS is undertaken via digital referrals (started April 22). Referrals are received centrally and then pooled out within sub specialties, Nurse led, Consultant led and AHPs<br>• A full workforce and demand and capacity analysis is being undertaken through the regional and local reconfiguration work<br><br>• 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<br><br>Chief Operating Officer | 01.01.2024 | 01.01.2024 | High | Overdue | April 2025 Update - Progress against this action is being made within the Care Group.<br><br>January 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>November 2024 Update - Based on these recommendations and feedback from local stakeholders we have integrated the CMATS service into core services to give greater sustainability and clear pathways for both referrers and patients - with all orthopaedic referrals now being triaged lectronically (since October 2022 for old CTM) by a multidisciplinary team which has resulted in reduced time to triage, increased redirection to AHPs (principle of only do what you can only do) and increase in advance and guidance utilised alongside the launch of health pathways. Please note the MCAS service remains under an SLA with SBUHB thus the picture for Bridgend is different. Clinicians working within the primary care settings are still working at advanced practice level until 31st March 2025 as per current funding arrangement. Each cluster is currently deciding whether they'd like to continue with their FCP provision into the new financial year. | | | |
| 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<br>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:<br>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;<br><br>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<br>c) put arrangements in place to monitor people waiting, provide communication, support and advice when needed, and report openly and honestly, through their existing governance arrangements, the extent to which people are coming to harm whilst waiting for orthopaedic treatment. | Audit Wales/2023/23/MD4/1 | The Health Board will undertake the following in order to ensure the recommendations are achieved:<br><br>• 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.<br><br>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.<br><br>• 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.<br><br>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.<br><br>• Single Clinical Director Leadership required to establish performance structure and review of current services.<br><br>• Weekly performance reviews that monitor waiting list volumes and actions being taken to address and recover the position<br><br>• Action plan development with singe CD for performance and governance structure across CTMUHB. | Planned Care<br><br>Chief Operating Officer | 01.04.2024 | 01.04.2024 | High | Overdue | April 2025 Update - Progress against this action is being made within the Care Group<br><br>January 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>November 2024 Update - CTMUHB is making significant progress in embedding VBHC principles in healthcare delivery. Collection and use of PROMs is key to delivering value based care to inform decision making. Significant progress has been made to secure a new digital PROMs platform which was launched July 2024. Need to establish a baseline chuatsu of PROM collection across the Health Board. This will inform on further discussion on Care group priority areas and implementation plans. | | | |
| Audit Wales/2024/168 | 01/02/2024 | Review of Workforce Planning Arrangements – Cwm Taf Morgannwg University Health Board (Document reference: 4157A2024) | To address the absence of clear workforce plans, the Health Board should prepare sustainable and balanced short-, medium-, and long-term workforce plans with measurable goals and clear timelines aligned to the CTM2030 Strategy. As part of this, the Health Board should ensure that its intent to reconfigure services focusing more on prevention, population health, and digitally enabled health services is appropriately built into long term service workforce design and transformation plans. | Audit Wales/2024/168/MD1/1 | Work has begun on the development of the CTM SWP, approach underpinned by the KPMG action plan, next steps are: -<br>• 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.<br><br>Build into the plans:-<br>• Agreed priorities aligned to the Acute Clinical Services Plan<br>• To agree SWP actions for Llantrisant Health Park<br>• Identify opportunities from regional working and other programmes e.g. Accelerated Cluster Working, Six Goals, HEIW workforce Plans | People<br><br>Executive Director for People | 01.03.2025 | 01.03.2025 | High | Overdue | April 2025 Update - Awaiting priorities for ACSP to start to map the workforce demands/supply. UHP workforce requirements will be submitted for the Outline Business Case this month. Regional working plans are currently in their infancy. Work around establishment reporting and risks will inform this work. Expected to have progressed further by next meeting with UHP plans to be developed by September 2025.<br><br>January 2025 Update - Some scenario plans are being developed for the nursing workforce and potentially for some areas for the ACSP. Progress continues but this action is dependant on a number of other factors such as service modelling, which may delay completion at the target date. More will be known at the end of January 2025. | | | |

| Inspection Code | Date of Inspection | Inspection Title | Recommendation | AMaT Reference Number | Action | Executive / Inspection Lead | Original Due Date | Current / Revised Due Date | Action Rating | Progress Status | Comments/Updates | Risks | Barriers | Evidence |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Audit Wales/2024/168 | 01/02/2024 | Review of Workforce Planning Arrangements – Cwm Taf Morgannwg University Health Board (Document reference: 415742024) | The Health Board should assess and agree its funded workforce establishment for 2024-25 and then introduce arrangements to update this annually. | Audit Wales/2024/168/MI01/1 | • Annual budget setting with Care Groups in place with alignment to Heads of People.<br>• Establishment Control options appraisal underway to consider and agree preferred option to progress. | People<br><br>Executive Director for People | 01.05.2024 | 31.03.2025 | High | Partially complete (Overdue) | April 2025 Update - SIP has been automated against Ledger for Medical and Dental staff group with plans in place to finalise for approval and implementation end of May 2025. A timeline for extending to other staff groups to be agreed before the next update.<br><br>January 2025 Update - delays with some of the data has meant that the timelines have slipped. Expected completion of the data testing is early February 2025. Request to change the completion date to 31 March 2025.<br><br>November 2024 Update - Alignment of finance and workforce data is being finalised for discussions to test the feeds in December 2024.<br><br>September 2024 Update - Work continues as set out in the July update. Some delays have been incurred due to data errors and system challenges. However, engagement with key stakeholders across People, Finance and medical colleagues has been positive to enable the work once the data and system challenges are addressed. At this point, we are still aiming for the November deadline. | In the absence of an agreed establishment control across ESR, Financial Ledger and Care Group/Services we do not have an organisational understanding of our true vacancies and the issues/impact associate to develop associated plans to inform appropriate workforce decisions to fill any gaps in the most efficient, cost effective way to support high quality patient care. This is the fundamental requirement to understanding our workforce activity and spend. | Capacity and timescales to undertake the work with key stakeholders. | |
| Audit Wales/2024/168 | 01/02/2024 | Review of Workforce Planning Arrangements – Cwm Taf Morgannwg University Health Board (Document reference: 415742024) | The Health Board should review its operational workforce planning capacity and capability and then ensure it is sufficient to support their operational workforce planning requirements within the new Care Group model. | Audit Wales/2024/168/MI03/1 | • Develop SWP skills within People Directorate to promote into the organisation.<br>• Working with Care Groups and Heads of People, assess current SWP capacity and capability.<br>• Explore opportunities to embed SWP methodology in CTM Leadership Development programmes.<br>• Develop workforce planning materials and toolkits to support workforce planning delivery. | People<br><br>Executive Director for People | 01.09.2024 | 31.03.2025 | High | Overdue | April 2025 Update - Due to IMTP priorities this action is still in progress and will be reviewed alongside HSW's, training videos, materials and toolkits to adopt for CTM. This action is also be reviewed alongside the ACSP, Regional Working priorities and the current workforce efficiencies programme. It is reliant on the establishment control work with M&D data being the initial focus by end of May 2025. This action can progress in July 2025 but will need to factor in other work that contributes to this action being completed, so this is likely to extend this further to October 2025.<br><br>January 2025 Update - The assessment has been paused for POW, business continuity and Christmas. This will also align to the new Leadership training so completion dates have slipped. Request to change the completion date to 31 March 2025. Materials and tools are in development. | The absence of clear organisational knowledge and expertise to quantify and address the capacity and capability for medium to longer term workforce planning to meet CTM goals. | To establish the organisational and priorities alongside the capacity of leaders/managers to consider longer term workforce planning alongside operational workforce challenges and delivery plans. | |
| Audit Wales/2024/168 | 01/02/2024 | Review of Workforce Planning Arrangements – Cwm Taf Morgannwg University Health Board (Document reference: 415742024) | To help determine the extent that the action it is taking to mitigate workforce risks is having an impact, the Health Board should set trajectories and timescales to meet their target risk ratings and more clearly assess the impact of the actions that it is taking. | Audit Wales/2024/168/MI04/1 | • Develop a workforce baseline assessment based on risk linked to the UHB risk register to identify key workforce priority areas.<br>• Agree actions, targets and trajectories for improvement with outcome measures.<br>• Agree reporting arrangements and monitor progress (including escalations and improvements) through quarterly reviews of the risk register and at Inspiring People Board to assess any impact of the SWP actions on managing risks. | People<br><br>Executive Director for People | 01.10.2024 | 30.04.2025 | High | Partially complete | April 2025 Update - Baseline data via establishment control/reporting is underway to identify vacancies which should be completed for M&D staff group in May 2025. The IMTP CG returns, identified fragile services which will be aligned to the workforce risks on the risk register to inform key priority areas. Anticipated priority areas will align to the workforce efficiency programme which is underway, to establish workforce solutions. Further update on actions will be informed by this work in readiness for the next meeting.<br><br>January 2025 Update - The assessment has started and is linked to the BAF. Priorities, actions, targets and trajectories to be agreed and reporting arrangements. A request to extend the action to 30 April 2025.<br><br>November 2024 Update - The assessment is in development using the work of the BAF and risk register to inform the workforce risks. This is taking longer due to a number of challenges around data and capacity but is hoped to be in draft by February 2025. | | | |
| Audit Wales/2024/168 | 01/02/2024 | Review of Workforce Planning Arrangements – Cwm Taf Morgannwg University Health Board (Document reference: 415742024) | The Health Board needs to reinforce arrangements to both oversee progress and then assess the impact of the recommendations set out in the recent strategic workforce planning review via its People and Culture Committee. | Audit Wales/2024/168/MI05/1 | • Assessment of progress and impact of recommendations to be on the agenda for PCC June 2024.<br>• Regular progress updates to the relevant Board Committee. | People<br><br>Executive Director for People | 01.06.2024 | 01.06.2024 | High | Partially complete (Overdue) | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - This action was completed at PCC in June and regular updates provided. This is complete but needs to be an agenda item for the SDC / relevant committee for quarterly updates.<br><br>November 2024 Update - Workforce Planning updates have taken place at PCC and updates will be provided to the new replacement Group and relevant Committees. This is on target.<br><br>September 2024 Update - An significant SWP update was provided to PCC on 7 August 2024. A progress update will be reported at the next PCC in November 2024. | | | |
| Audit Wales/2024/168 | 01/02/2024 | Review of Workforce Planning Arrangements – Cwm Taf Morgannwg University Health Board (Document reference: 415742024) | To inform the development of its medium-term plans for workforce redesign and service transformation, the Health Board should use its workforce benchmarking to adopt best workforce practice and workforce models, ensuring similar system conditions, demographics, and population characteristics. | Audit Wales/2024/168/MI06/1 | • Development of a horizon scan to support strategic workforce planning and to inform potential changes and/or impact to people/population/services which include:<br>– Census analysis<br>– Population Needs Assessments<br>– Evidenced based practice<br>– Use the benchmarking data and information e.g. HEIW People analytics tools and dashboards/NHS England and wider sources<br>– Case studies and lessons learned<br>– Changes to Policies/Standards, education and training<br>– New roles, advanced and extended practice<br>– Labour market changes and generational changes | People<br><br>Executive Director for People | 01.10.2024 | 31.03.2025 | Medium | Partially complete (Overdue) | April 2025 Update - Due to gaps in the team this work has not progressed to completion by end of March as intended. Look to extend to June 2025 when new resources in place.<br><br>January 2025 Update - The horizon scan draft is nearly completed. New information has been shared by HEIW which will mean the horizon scan will need updating. Request to change the completion date to 31 March 2025. | | | |
| Audit Wales/2024/196 | 01/07/2024 | Follow up review: Temporary Closure of the Ysbyty Cwm Cynon Minor Injuries Unit – Cwm Taf Morgannwg University Health Board (Document reference: 4381A2024) | R4. Enhancing Quality and Safety Committee oversight - Our work has found that despite the full initial disclosure to the Quality and Safety Committee in September 2021, there was no further reporting on any assessment of potential harm, and lessons learned. The Health Board, therefore, should provide an update report to the committee outlining the lessons learned, and confirmation of any outcomes from the work to assess harm. | Audit Wales/2024/196/MI01/1 | As part of an overall appraisal in the quality, safety, and patient experience within emergency care services across the HB, the USCG is preparing a report/presentation for the Quality and Safety Committee this financial year. | Patient Care and Safety<br><br>Executive Director of Nursing/Deputy Chief Executive | 31.03.2023 | 31.01.2025 | High | Overdue | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - An update against this recommendation has not been provided on this occasion. | | | |
| Audit Wales/2024/196 | 01/07/2024 | Follow up review: Temporary Closure of the Ysbyty Cwm Cynon Minor Injuries Unit – Cwm Taf Morgannwg University Health Board (Document reference: 4381A2024) | R4. Enhancing Quality and Safety Committee oversight - Our work has found that despite the full initial disclosure to the Quality and Safety Committee in September 2021, there was no further reporting on any assessment of potential harm, and lessons learned. The Health Board, therefore, should provide an update report to the committee outlining the lessons learned, and confirmation of any outcomes from the work to assess harm. | Audit Wales/2024/196/MI01/2 | Furthermore, as part of the ongoing service delivery reviews within the newly established care group model, the USCG will seek to provide a report to the Quality and Safety Committee in full on the Minor Injury Service provision across the HB early in 2023/24. | Patient Care and Safety<br><br>Executive Director of Nursing/Deputy Chief Executive | 31.05.2023 | 31.01.2025 | High | Overdue | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>November 2024 Update - An update against this recommendation has not been provided on this occasion.<br><br>September 2024 Update - A spotlight report on MIU services was provided earlier in the year. Further updates will be included in early 2025. A full review of the MIU service provision across the HB will include an update on some of the future plans relating to Maesteg Hospital. This report will be available for Quality & Safety Committee in early 2025. | | | |
| Audit Wales/2024/205 | 01/08/2024 | CONFIDENTIAL Audit of Accounts Report Addendum - CTMUHB 2023-24_October 2024 (Document reference: 439SA2024) | Matter arising 1 - While we accepted the use of the additional narrative for the 2023-24 remuneration report, from 2024-25 the Health Board should report the gross total remuneration within the relevant tabulated figures. | Audit Wales/2024/205/MI01/1 | Adjusted figures will be used for the 2024/25 accounts. | Finance<br><br>Executive Director of Finance | 30.04.2025 | 30.04.2025 | High | In progress | April 2025 Update - No update as this will be implemented on completion of 2024/25 accounts in April, which are currently being prepared.<br><br>January 2025 - Update - No update as this will be implemented on completion of 2024/25 accounts in April.<br><br>November 2024 Update - No update as this will be implemented on completion of 2024/25 accounts in April. | | | |
| Audit Wales/2024/205 | 01/08/2024 | CONFIDENTIAL Audit of Accounts Report Addendum - CTMUHB 2023-24_October 2024 (Document reference: 439SA2024) | Matter arising 2 - The Health Board should ensure that all its pension calculations reflect the Greenbury guidance (which provides templated calculation examples). | Audit Wales/2024/205/MI02/1 | This will be actioned in full in the 2024/25 accounts. | Finance<br><br>Executive Director of Finance | 30.04.2025 | 30.04.2025 | High | In progress | April 2025 Update - No update as this will be implemented on completion of 2024/25 accounts in April, which are currently being prepared.<br><br>January 2025 - Update - No update as this will be implemented on completion of 2024/25 accounts in April.<br><br>November 2024 Update - No update as this will be implemented on completion of 2024/25 accounts in April. | | | |
| Audit Wales/2024/205 | 01/08/2024 | CONFIDENTIAL Audit of Accounts Report Addendum - CTMUHB 2023-24_October 2024 (Document reference: 439SA2024) | Matter arising 3 - The Health Board should review the procedure for preparing the operating leases note at the financial year-end, and make improvements where required. As part of the review, the Health Board should ensure that management review and sign-off are part of the process. | Audit Wales/2024/205/MI03/1 | Due to illness there was an interim arrangement for completing note, the procedure will be improved for future accounts. | Finance<br><br>Executive Director of Finance | 30.04.2025 | 30.04.2025 | High | In progress | April 2025 - Update - No update as this will be implemented on completion of 2024/25 accounts in April, which are currently being prepared.<br><br>January 2025 - Update - No update as this will be implemented on completion of 2024/25 accounts in April.<br><br>November 2024 Update - No update as this will be implemented on completion of 2024/25 accounts in April. | | | |
| Audit Wales/2024/205 | 01/08/2024 | CONFIDENTIAL Audit of Accounts Report Addendum - CTMUHB 2023-24_October 2024 (Document reference: 439SA2024) | Matter arising 4 - The Joint Commissioning Committee should put in place a robust process to ensure that:<br>• all the necessary declarations of interests (DoIs) from its senior officers and members are received soon after the financial year-end;<br>• the DoIs are evaluated by officers to establish where an individual has control and / significant influence over a declared organisation;<br>• thereafter and where necessary, officers undertake the relevant checks to the financial ledger to identify all relevant income, expenditure, payables and receivables to be disclosed; and<br>• that all the above is clearly documented for the purpose of officers preparing the accounts and to enable our audit. | Audit Wales/2024/205/MI04/1 | As part of the ongoing governance review for the new organisation, revision work on the DOI process for 2024-2025 financial year has already commenced. The new template, in the agreed format, is being used to ensure that there is clear documentation. This will ensure that the assessment of control or significant interest is complete and that the process will be robust. This will be a joint exercise between finance and governance colleagues to ensure a more comprehensive assessment and to make the financial ledger checks more integrated in the process. As part of the review of governance processes for the new organisation, both new lay members and existing members are being circularised mid year to ensure that all information requirements will be familiar in time for the year end exercise and that it will be fully complete. Regarding the end of year exercise, forms will be given to ICC members following the last ICC meeting of the financial year at the end of March, after one week members and their PA's will be followed up and again after one further week, which will continue in that manner until all forms have been returned. | Finance<br><br>Executive Director of Finance | 17.10.2024 | 17.10.2024 | High | Overdue | April 2025 Update – The ICC Foundation Annual Plan 2025-2026 was approved by the Joint Committee on 18 March 2025. On 20 March 2025 all ICC members and the JCC Senior Leadership Team (SLT) were sent Declaration of Interest (DOI) forms and a request was made for all forms to be completed by 4 April 2025. All forms from JCC members and the JCC SLT team were returned by 4 April 2025. There are currently two outstanding forms from two JCC attendees who attended meetings as deputies for HB CEOs during 2024/2025. Following investigation one deputy has left NHS Wales and one is currently on annual leaves and they will complete their form on their return to work. The DOI forms have been reviewed and all declarations have been cross-referenced with HB registers of interest and the master spreadsheet held by the ICC has been updated. The spreadsheet has been passed to Finance colleagues in readiness for Finance to undertake their quality checks against the JCC ledger. Once the finance team have completed their checks the Committee Secretary will undertake a final review before submitting to Audit Wales. The above process is on track to be completed by the necessary deadlines.<br><br>January 2025 Update - No update as this will be implemented on completion of 2024/25 accounts in April.<br><br>November 2024 Update - No update as this will be implemented on completion of 2024/25 accounts in April. | | | |
| Audit Wales/2024/205 | 01/08/2024 | CONFIDENTIAL Audit of Accounts Report Addendum - CTMUHB 2023-24_October 2024 (Document reference: 439SA2024) | Matter arising 6 - The Health Board should review its current data admin accounts and remove any access from staff who do not need it. This action should include the removal of any duplicate accounts. Also, the Health Board should regularly review (i.e. monthly) its privileged access accounts so that access is maintained only for the appropriate personnel. | Audit Wales/2024/205/MI06/1 | All privileged network access accounts are presently being subject to review by the corporate End User Computer Team. Progress on this task will be tracked at the fortnightly EUC NSC/per review meeting and assured at the Monthly Cyber Security and Availability board. As the reviews identifies issues any accounts, changes will be enforced. An automated process for this cycle is being explored. | Finance<br><br>Executive Director of Finance | 29.11.2024 | 29.11.2024 | High | Overdue | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>November 2024 Update - No update yet, implementation end of this month. | | | |
| Audit Wales/2024/205 | 01/08/2024 | CONFIDENTIAL Audit of Accounts Report Addendum - CTMUHB 2023-24_October 2024 (Document reference: 439SA2024) | Matter arising 7 - The Health Board should migrate its RAM financial server system to up-to-date and fully supported infrastructure. | Audit Wales/2024/205/MI07/1 | Plans have been made by the server team to migrate nearly all 2012 SQL servers onto supported operating infrastructure and operating systems. The date for the migration is pending awaiting confirmation from Finance system admin and the supplier. | Finance<br><br>Executive Director of Finance | 29.11.2024 | 29.11.2024 | High | Overdue | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>November 2024 Update - No update yet, implementation end of this month. | | | |
| Audit Wales/2024/212 | 30/11/2024 | Primary Care Follow-Up Review - CTMUHB 2023-24_November 2024 (Document reference: 460BA2024) | R1 - 2024 New Recommendation - The Health Board should support Board members to form a strategic view on the overall effectiveness and efficiency of primary care services and whether the organisation's actions in this area are improving the sustainability of services in the longer-term by improving the coverage of primary care matters in its routine Annual Report. | Audit Wales/2024/212/MI01/1 | A Primary Care Dashboard will be finalised by end of January 2025. | Primary Care & Community<br><br>Chief Operating Officer | 31.01.2025 | 31.01.2025 | High | Overdue | April 2025 Update - Progress is being made in building dashboard, bringing directorate reports into the dashboard. Delivery delayed due to vacancy with care group medical director. Post has been advertised, but unsuccessful on this occasion and is not in the process of being advertised.<br><br>January 2025 - The Dashboard is in progress and the first draft of the Dashboard is due to be considered in the February Operational Management Board (January Board cancelled due to exceptional circumstances).<br><br>Action added December 2024. | | | |
| Audit Wales/2024/212 | 30/11/2024 | Primary Care Follow-Up Review - CTMUHB 2023-24_November 2024 (Document reference: 460BA2024) | R1 - 2024 New Recommendation - The Health Board should support Board members to form a strategic view on the overall effectiveness and efficiency of primary care services and whether the organisation's actions in this area are improving the sustainability of services in the longer-term by improving the coverage of primary care matters in its routine Annual Report. | Audit Wales/2024/212/MI01/2 | The requirement to expand the coverage of primary care matters in CTMUHB Annual Report for 2024-2025 and beyond has been captured in the forward planning for the Annual Report development. | Primary Care & Community<br><br>Chief Operating Officer | 30.09.2025 | 30.09.2025 | High | Partially complete | April 2025 Update - Primary care services will be included in the 24/25 annual report , providing an overview of the service area in 24/25 , highlighting any plans for 25/26. Primary care have featured at the Operational Delivery Committee in January 2025, sharing an overview with the Committee. A business cycle will be proposed to ensure primary care feature regularly through the year at committee, where they can report effectiveness and efficiency of primary care services contributing to relieve pressures on the acute sites and improving patient care, such as development of the enhanced community care service. This will remain open until the annual report is published.<br><br>February 2025 Update - This requirement has been added to the Annual Report submission requests for 2024-2025. The Annual Report will not be finalised until the end of June 2025 so this action will remain open until the Annual Report is published. | | | |
| Audit Wales/2024/212 | 30/11/2024 | Primary Care Follow-Up Review - CTMUHB 2023-24_November 2024 (Document reference: 460BA2024) | R2 - 2018 Open Recommendation - While the Health Board recognises that it needs to shift resources from secondary to primary and community settings, it cannot demonstrate that this shift is happening. The Health Board should:<br>a) calculate a baseline position for its current investment and resource use in primary and community care; and<br>b) review and report, at least annually, its investment in primary and community care, to assess progress since the baseline position and to monitor the extent to which it is succeeding in shifting resources towards primary and community care. | Audit Wales/2024/212/MI03/1 | R2a - A baseline position can be obtained based on the current budget and resource allocation for the Primary Care and Community Care Group. | Primary Care & Community<br><br>Chief Operating Officer | 31.01.2025 | 31.01.2025 | High | Overdue | April 2025 Update - IMTP submission has been complete and will has been shared at Board. This has set out the primary care position and the service plans, including resource allocation.<br><br>January 2025 Update - The current baseline of investment and resources is available through the Budget position. The 2025/28 IMTP plan is in the process of being finalised and as part of this work a baseline of spend and activity and resultant shift in activity and resources required to delivery the objectives. This is anticipated to be completed February/March for the IMTP submission to WG.<br><br>Action added December 2024 | | | |
| Audit Wales/2024/212 | 30/11/2024 | Primary Care Follow-Up Review - CTMUHB 2023-24_November 2024 (Document reference: 460BA2024) | R2 - 2018 Open Recommendation - While the Health Board recognises that it needs to shift resources from secondary to primary and community settings, it cannot demonstrate that this shift is happening. The Health Board should:<br>a) calculate a baseline position for its current investment and resource use in primary and community care; and<br>b) review and report, at least annually, its investment in primary and community care, to assess progress since the baseline position and to monitor the extent to which it is succeeding in shifting resources towards primary and community care. | Audit Wales/2024/212/MI03/2 | R2b - This review and report will form part of the Primary Care and Community Transformation Plan and will be aligned to the Acute Clinical Services Plan (ACSP). The aim is to facilitate both the shift in services but also the resource from secondary care into Primary Care and Community Services. | Primary Care & Community<br><br>Chief Operating Officer | 31.03.2025 | 31.03.2025 | High | Overdue | April 2025 Update - IMTP (including cluster plans) has been developed and shared at Board. Priorities that have been identified are aligned to ACSP, the 2030 strategy and ministerial prioritise.<br><br>January 2025 Update - The 2025/28 IMTP plan is in the process of being finalised and as part of this work a baseline of spend and activity and resultant shift in activity and resources required to delivery the objectives. This is anticipated to be completed February/March for the IMTP submission to WG.<br><br>Action added December 2024. | | | |
| Audit Wales/2024/212 | 30/11/2024 | Primary Care Follow-Up Review - CTMUHB 2023-24_November 2024 (Document reference: 460BA2024) | R3 - 2018 Open Recommendation - The Health Board's workforce planning is inhibited by having limited data about the number and skills of staff working in primary care, particularly community dentistry, optometry, and pharmacy. The Health Board should develop and implement an action plan for ensuring it has regular, comprehensive, standardised information on the number and skills of staff, from all professions working in all primary care settings. | Audit Wales/2024/212/MI04/1 | R3 - The Health Board has a Primary Care Academy in place and workforce planning will be an essential remit for this. This will be an objective for 2025/26 onwards. | Primary Care & Community<br><br>Chief Operating Officer | 31.07.2025 | 31.07.2025 | High | In progress | April 2025 Update - delayed due to the absence of clinical lead. Temporary replacement has been secured.<br><br>January 2025 Update - This will be a key objective of Academy. The target date for the completion of the initial baseline will be end of Quarter 1 of 2025.<br><br>Action added December 2024. | | | |
| Audit Wales/2024/212 | 30/11/2024 | Primary Care Follow-Up Review - CTMUHB 2023-24_November 2024 (Document reference: 460BA2024) | R4 - 2018 Open Recommendation - Whilst the Health Board is taking steps towards implementing some new ways of working, more progress is required to evaluate the effectiveness of these new models and to mainstream their funding. The Health Board should:<br>a) work with the clusters to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models;<br>b) centrally collate evaluations of new ways of working and share the learning by publicising the key messages across all clusters;<br>c) work with the public to promote successful new ways of working<br>d) evaluate the effectiveness of the Health Board's new primary care communications officer role and share the learning with all health boards in Wales. | Audit Wales/2024/212/MI05/1 | R4a - An evaluation template has been introduced for clusters to use to demonstrate outcomes and support continued investment implemented. | Primary Care & Community<br><br>Chief Operating Officer | 31.03.2025 | 31.03.2025 | High | Overdue | April 2025 Update - January 2025 update is ongoing.<br><br>January 2025 Update - Framework for evaluations of cluster initiatives has been produced and is in the process of being shared with clusters. The governance structure for clusters has been reviewed and clarification on the reporting and approval process shared with clusters and at Joint Partnership Boards. All cluster initiatives will be reviewed internally by the Primary Care team and will be approved by the Joint Partnership Boards, to be implemented in February 2025.<br><br>Action added December 2024 | | | |
| Audit Wales/2024/212 | 30/11/2024 | Primary Care Follow-Up Review - CTMUHB 2023-24_November 2024 (Document reference: 460BA2024) | R4 - 2018 Open Recommendation - Whilst the Health Board is taking steps towards implementing some new ways of working, more progress is required to evaluate the effectiveness of these new models and to mainstream their funding. The Health Board should:<br>a) work with the clusters to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models;<br>b) centrally collate evaluations of new ways of working and share the learning by publicising the key messages across all clusters;<br>c) work with the public to promote successful new ways of working<br>d) evaluate the effectiveness of the Health Board's new primary care communications officer role and share the learning with all health boards in Wales. | Audit Wales/2024/212/MI05/2 | R4b - The clusters structure now sit under the GMS Directorate and all evaluations will report into one management and governance structure. Quarterly, these will be reported into the Primary Care and Transformation Board to inform wider strategic developments. The collaborative and cluster meetings are all in place and taken the opportunity to share learning of schemes. | Primary Care & Community<br><br>Chief Operating Officer | 31.03.2026 | 31.03.2026 | High | Fully complete (Awaiting approval) | April 2025 Update - Would request consideration for closure, with the structure established and a primary care transformation programme active.<br><br>January 2025 Update - a) & b) Cluster structure and reporting has been revised and brought under Primary Care GMS Directorate from a governance perspective. Meetings with Cluster Leads has been reinstated in order to enable clusters to listen and share learning from evaluations of current initiatives and to share new ones planned. Public Health representation is key member of the collaborative team assessing and discussing effectiveness. d)The primary care communications officer role has not been continued but instead has been incorporated into the corporate communications team. Relying on one post/person brought limitations but the corporate team is able to provide more capacity to provide a breadth of cover for sharing new ways of working.<br><br>Action added December 2024. | | | |
| Audit Wales/2024/212 | 30/11/2024 | Primary Care Follow-Up Review - CTMUHB 2023-24_November 2024 (Document reference: 460BA2024) | R4 - 2018 Open Recommendation - Whilst the Health Board is taking steps towards implementing some new ways of working, more progress is required to evaluate the effectiveness of these new models and to mainstream their funding. The Health Board should:<br>a) work with the clusters to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models;<br>b) centrally collate evaluations of new ways of working and share the learning by publicising the key messages across all clusters;<br>c) work with the public to promote successful new ways of working<br>d) evaluate the effectiveness of the Health Board's new primary care communications officer role and share the learning with all health boards in Wales. | Audit Wales/2024/212/MI05/3 | R4c - There is an active plan with the Health Board's Communications Team to promote the new ways of working and roles within the primary care model for Wales. Practices also work with the public to promote and discuss their cluster initiatives with their patient participation groups (PPG) as well as advertise services and offer feedback through their websites. | Primary Care & Community<br><br>Chief Operating Officer | 31.12.2024 | 31.12.2024 | High | Fully complete (Awaiting approval) | April 2025 Update - The below update is also still relevant and we would request the action as complete with evidence available to share, as per below:<br><br>January 2025 - Evidence can be provided where the corporate team has shared with the public new ways of working and new initiatives. Also evidence can be provided where GP practices have also worked with their PPG and shared on their own social media sites details of new initiatives and new roles.<br><br>Action added December 2024. | | | |
| Audit Wales/2024/212 | 30/11/2024 | Primary Care Follow-Up Review - CTMUHB 2023-24_November 2024 (Document reference: 460BA2024) | R4 - 2018 Open Recommendation - Whilst the Health Board is taking steps towards implementing some new ways of working, more progress is required to evaluate the effectiveness of these new models and to mainstream their funding. The Health Board should:<br>a) work with the clusters to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models;<br>b) centrally collate evaluations of new ways of working and share the learning by publicising the key messages across all clusters;<br>c) work with the public to promote successful new ways of working<br>d) evaluate the effectiveness of the Health Board's new primary care communications officer role and share the learning with all health boards in Wales. | Audit Wales/2024/212/MI05/4 | R4d - The Primary Care Communications Officer role is no longer in place and a decision has been taken to take a more holistic approach across the Primary Care to take opportunities of differing priorities during the year. | Primary Care & Community<br><br>Chief Operating Officer | 31.03.2025 | 31.03.2025 | High | Overdue | April 2025 Update - Strengthening the cluster leadership has been undertaken through the primary care transformation programme. This is an active programme with support of National Association of Primary Care.<br><br>January 2025 Update - a) & b) Cluster structure and reporting has been revised and brought under Primary Care GMS Directorate from a governance perspective. Meetings with Cluster Leads has been reinstated in order to enable clusters to listen and share learning from evaluations of current initiatives and to share new ones planned. Public Health representation is key member of the collaborative team assessing and discussing effectiveness. d)The primary care communications officer role has not been continued but instead has been incorporated into the corporate communications team. Relying on one post/person brought limitations but the corporate team is able to provide more capacity to provide a breadth of cover for sharing new ways of working.<br><br>Action added December 2024. | | | |
| Audit Wales/2024/212 | 30/11/2024 | Primary Care Follow-Up Review - CTMUHB 2023-24_November 2024 (Document reference: 460BA2024) | R5 - 2018 Open Recommendation - We found variation in the maturity of primary care clusters, and scope to improve cluster membership and leadership. The Health Board should:<br>a) review the relative maturity of clusters, to develop and implement a plan to strengthen its support for clusters where necessary. | Audit Wales/2024/212/MI06/1 | R5a - Each IPB will have a role to review and develop the clusters maturity and to report into Primary Care and Community Transformation Board. | Primary Care & Community<br><br>Chief Operating Officer | 31.03.2025 | 31.03.2025 | High | Overdue | April 2025 Update - This remains in progress and has now been incorporated into the primary care transformation programme.<br><br>January 2025 Update - A plan to address this recommendation is in the process of being drafted and will be shared at the next IPBs in Q4 of 2024/25.<br><br>Action added December 2024. | | | |
| Audit Wales/2024/213 | 31/10/2024 | Review of Cost Savings Arrangements - CTMUHB 2023-24_October 2024 (Document reference: 454SA2024) | R1 - The Health Board should assess operational savings delivery potential and risks within each Care Group and Clinical Service Group on an ongoing basis. | Audit Wales/2024/213/MI01/1 | The IMTP process for 2025/28 will utilise an assessment of operational savings delivery potential to inform savings targets for each Care Group | Finance<br><br>Executive Director of Finance | 31.03.2025 | 31.03.2025 | High | Fully complete (Awaiting approval) | April 2025 Update - 2025-28 IMTP submitted on 31-Mar-25. An assessment of operational savings delivery potential has informed savings targets.<br><br>January 2025 Update - The IMTP Steering Group has developed the savings requirements based on assessment of organisational requirements and capabilities. The IMTP and the delivery of improvement is supported by at Productivity Improvement and Transformation (PIT) programme which seeks to ensure efficiency and effectiveness. This programme supplies key data to inform appraisal of operational capabilities and potential for further improvement.<br><br>The process of developing financial plans is tested against service plans and workforce plans to ensure plans are aligned and deliverable and the process is iterative to ensure that all interfaces between care groups and corporate divisions are considered.<br><br>Action Added to AMaT December 2024 | | | |
| Audit Wales/2024/213 | 31/10/2024 | Review of Cost Savings Arrangements - CTMUHB 2023-24_October 2024 (Document reference: 454SA2024) | R2 - The Health Board should ensure that its service transformation plans more explicitly set out how they will help the organisation achieve financial sustainability in terms of the savings that will be generated and the timescale for achieving them | Audit Wales/2024/213/MI02/1 | R2 - The IMTP process for 2025/28 includes an intention to ensure that at least the first stage of the ACSP public engagement is undertaken, in order to arrive at a set of options for further public consideration. In parallel, there are a range of emergency services changes that are being evaluated for performance, quality and financial sustainability opportunities. This will contribute to the development of a three-year plan, including a realistic assessment of impact on cost savings. | Finance<br><br>Executive Director of Strategy and Transformation | 31.03.2025 | 31.03.2025 | High | Overdue | April 2025 Update - The IMTP has been approved by the board and submitted to Welsh Government. The next phase of the ACSP is in development.<br><br>January 2025 Update - The IMTP for 2025-2028 is in development and modelling of the impact of changes on service delivery/ performance and cost will be undertaken as part of the development process.<br><br>Action added December 2024. | | | |

| Inspection Code | Date of inspection | Inspection Title | Recommendation | AMaT Reference Number | Action | Executive / Inspection Lead | Original Due Date | Current / Revised Due Date | Action Rating | Progress Status | Comments/Updates | Risks | Barriers | Evidence |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Audit Wales/2024/213 | 31/10/2024 | Review of Cost Savings Arrangements - CTMUHB 2023-24_October 2024 (Document reference: 454AA2024) | R3 - The Health Board should make improvements to how it uses data and intelligence to inform its savings identifications and selections arrangements by:<br>R3.1 Extending its use of data and intelligence across a wider range of services.<br>R3.2 Rapidly progressing work on its local data repository to facilitate the systematic capture of benchmarking data. | Audit Wales/2024/213/MI03/1 | Plan to make improvements in how we use data and intelligence to underpin savings identification and selection to be incorporated into our IMTP planning process | Finance<br><br>Director of Digital<br><br>Executive Director of Strategy and Transformation | 31.03.2025 | 31.03.2025 | High | Overdue | April 2025 Update - Additional resources and capabilities have been identified to support the ACSP and Primary Care & Mental Health. These resources will be recruited to during Quarter 1 2025/2026.<br><br>January 2025 Update - Work ongoing to assess and identify the capabilities required within the data team to meet this objective<br><br>Action added December 2024 | | | |
| Audit Wales/2024/213 | 31/10/2024 | Review of Cost Savings Arrangements - CTMUHB 2023-24_October 2024 (Document reference: 454AA2024) | R5 - Plans for service transformation (5 years plus) need to be developed as the Care Groups continue to mature and increasingly focus on public health, prevention, community-based care and regional working | Audit Wales/2024/213/MI05/1 | R5 - Plans for service transformation will continue to underpin our IMTP and strategy development. This will be reflected in our 2025-28 IMTP | Finance<br><br>Executive Director of Finance | 31.03.2025 | 31.03.2025 | High | Fully complete (Awaiting approval) | April 2025 Update - The IMTP for 2025-2028 has been completed. This sets out our transformation programme for the next three years. The plan has been approved by the board and submitted to Welsh Government. Public Health, community services transformation and regional working are all key components.<br><br>January 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>Action added December 2024 | | | |
| Audit Wales/2024/213 | 31/10/2024 | Review of Cost Savings Arrangements - CTMUHB 2023-24_October 2024 (Document reference: 454AA2024) | R4 - Where "invest to save" opportunities are identified and taken forward through the Value and Sustainability Programme the Health Board should confirm that it is able to provide sufficient upfront funding to support them and able to demonstrate a clear return on investment. | Audit Wales/2024/213/MI07/1 | R4 - Invest to Save opportunities will continue to be supported by clear cases setting out the proposed return on investment in year and recurrently. Any proposals where there is insufficient return in year to maintain cost neutrality will be managed as an investment proposal through our established IMTP processes | Finance<br><br>Executive Director of Strategy and Transformation<br><br>Chief Operating Officer | 31.03.2025 | 31.03.2025 | High | Fully complete (Awaiting approval) | April 2025 Update - Invest to Save opportunities will continue to be supported by clear cases setting out the proposed return on investment in year and recurrently. Any proposals where there is insufficient return in year to maintain cost neutrality will be managed as an investment proposal through our established IMTP processes.<br><br>January 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>Action added December 2024 | | | |
| Audit Wales/2024/213 | 31/10/2024 | Review of Cost Savings Arrangements - CTMUHB 2023-24_October 2024 (Document reference: 454AA2024) | R7 - The Health Board should ensure that there is sufficient skills, capacity and capability across its corporate and operational teams to effectively deliver its longer-term service transformation. | Audit Wales/2024/213/MI08/1 | We will consider the sufficiency of skills, capacity and capability in developing our IMTP and future strategy. Plan to be reflected in our 2025-28 IMTP | Finance<br><br>Executive Director of Strategy and Transformation<br><br>Chief Operating Officer<br><br>Executive Director of People | 31.03.2025 | 31.03.2025 | High | Overdue | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>Action added December 2024. | | | |
| Audit Wales/2024/213 | 31/10/2024 | Review of Cost Savings Arrangements - CTMUHB 2023-24_October 2024 (Document reference: 454AA2024) | R8 - The Health Board should identify the key lessons from its approach to identifying and delivering savings during 2023-24 and apply the learning to its future approach. | Audit Wales/2024/213/MI09/1 | R8 - We will consider the key lessons in developing our IMTP and future strategy. Lessons learned to be reflected in our 2025-28 IMTP | Finance<br><br>Executive Director of Strategy and Transformation | 31.03.2025 | 31.03.2025 | High | Overdue | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - An update against this recommendation has not been provided on this occasion. | | | |
| Audit Wales/2025/234 | 21/01/2025 | Structured Assessment 2024_CTMUHB 2024_November 2024 (Document reference: 457BA2024) | R1 - The Health Board Should Strengthen arrangements for monitoring, reviewing and updating Health Board policies and routinely report progress to the relevant Committee of the Board | Audit Wales/2025/234/MI01/1 | R1 - A detailed Project Initiation Document for a review of Non-Clinical Policy Management process has been developed.<br>The project objectives are:<br>1. To establish a baseline compliance position for Non-Clinical Written Control Documents.<br>2. To ensure that Non-Clinical Written Control Documents are appropriately defined i.e. policy, procedure, guideline etc.<br>3. To explore an automated approach for the management of Written Control Documents to support monitoring, review prompts, version control and document storage.<br>4. To review the policy pages on the internal and external websites to ensure ease of access for users when searching for documents.<br>5. To review the "Policy on Policies" and develop a simplified document supported with clear process maps.<br><br>Progress on the Project will be monitored via the Executive Leadership Group.<br><br>Once completed this will generate improved monitoring through the appropriate Board Committees. | Corporate Governance<br><br>Director of Corporate Governance/Board Secretary | 31.12.2025 | 31.12.2025 | High | In progress | April 2025 Update - An update against this recommendation has not been provided on this occasion. | | | |
| Audit Wales/2025/234 | 21/01/2025 | Structured Assessment 2024_CTMUHB 2024_November 2024 (Document reference: 457BA2024) | R2 - The Health Board should introduce arrangements for identifying and monitoring actions arising from its listening and learning stories. | Audit Wales/2025/234/MI02/1 | R2 - Any actions from Listening & Learning stories shared at Board & Committee meetings should be identified, monitored and completed prior to the Listening & Learning story being shared presented however, monitoring of any actions following the presentation of Listening & Learning stories at Board & Committee will be presented through the Care Groups QSRE groups and/ or the Patient Experience forum. The governance process for any actions arising from the presentation of these stories is currently being worked through. As this will be a new revised arrangement, with the work being in its infancy, a full review of the required governance arrangements will be undertaken for assurance. The Health Board will ensure that staff stories to inform Board members on Staff Experiences are included within the library of Listening & Learning stories being built up for wider sharing, this work will be monitored through the Patient experience Forum. | Patient Care and Safety<br><br>Executive Director of Nursing/Deputy Chief Executive | 31.03.2025 | 31.03.2025 | High | Overdue | April 2025 Update - An update against this recommendation has not been provided on this occasion. | | | |
| Audit Wales/2025/234 | 21/01/2025 | Structured Assessment 2024_CTMUHB 2024_November 2024 (Document reference: 457BA2024) | R3 The Health Board should strengthen the Board Assurance Framework (BAF) by clearly reporting the impact of actions that the Health Board is taking to mitigate its strategic risks. | Audit Wales/2025/234/MI03/1 | R3 - In order to clearly articulate the impact of actions an additional section will be added to the mitigating action of the Board Assurance Framework to clearly capture the impact. | Corporate Governance<br><br>Director of Corporate Governance/Board Secretary | 31.03.2025 | 31.03.2025 | High | Fully complete (Awaiting approval) | April 2025 Update - Complete. The Board Assurance Framework now includes the impact and indicators of success for each mitigation action identified against the strategic risks. | | | |
| Audit Wales/2025/234 | 21/01/2025 | Structured Assessment 2024_CTMUHB 2024_November 2024 (Document reference: 457BA2024) | R4 -The Health Board should strengthen its Integrated Performance Dashboard by clearly articulating whether actions to improve underperformance are achieving their intended impact. | Audit Wales/2025/234/MI04/1 | R4 - The performance report narrative will be stripped back to focus on remedial action and their impact, then updates on impact. | Chief Operating Officer<br><br>Executive Director of Strategy and Transformation | 31.03.2025 | 31.03.2025 | High | Overdue | April 2025 Update - a Board development session is planned for 2025 which will focus on the Integrated Performance Dashboard. | | | |
| Audit Wales/2025/234 | 21/01/2025 | Structured Assessment 2024_CTMUHB 2024_November 2024 (Document reference: 457BA2024) | R5.1 - The Health Board should strengthen its reporting on the Duty of Quality and Candour by: R5.1 ensuring that future annual reports are clearer around the challenges it is experiencing in embedding the requirements; | Audit Wales/2025/234/MI05/1 | R5.1 - Future Annual Reports will include details in respect of the health board reporting mechanisms and in particular include clear narrative around the challenges experienced in embedding the requirements. | Patient Care and Safety<br><br>Executive Director of Nursing/Deputy Chief Executive | 31.05.2025 | 31.05.2025 | High | In progress | April 2025 Update - An update against this recommendation has not been provided on this occasion. | | | |
| Audit Wales/2025/234 | 21/01/2025 | Structured Assessment 2024_CTMUHB 2024_November 2024 (Document reference: 457BA2024) | R5.2 including appropriate milestones and targets to help the reader understand when it is aiming to achieve priorities. | Audit Wales/2025/234/MI06/1 | R5.2 - Appropriate milestones will be included following the clarification of the required targets to help the reader understand the aim of the priorities. | Patient Care and Safety<br><br>Executive Director of Nursing/Deputy Chief Executive | 31.05.2025 | 31.05.2025 | High | In progress | April 2025 Update - An update against this recommendation has not been provided on this occasion. | | | |
| Audit Wales/2025/234 | 21/01/2025 | Structured Assessment 2024_CTMUHB 2024_November 2024 (Document reference: 457BA2024) | R6.1 - The Health Board should ensure that it rapidly completes its work to strengthen the audit recommendations tracker | Audit Wales/2025/234/MI07/1 | R6.1 The process for updating audit recommendations will fully transition to the automated system, AMaT, by the end of March 2025. There remain system improvements and automated report improvements that the Quality Assurance & Compliance Team are linked in with the software provider on to take forward, however it is anticipated this activity may not be completed until the end of July 2025.<br>Audit Handbook also being developed to support colleagues with their understanding of the audit process and various stages that require compliance - due to be completed by the 28 February 2025. | Corporate Governance<br><br>Director of Corporate Governance/Board Secretary | 31.07.2025 | 31.07.2025 | High | In progress | April 2025 Update - An update against this recommendation has not been provided on this occasion. | | | |
| Audit Wales/2025/234 | 21/01/2025 | Structured Assessment 2024_CTMUHB 2024_November 2024 (Document reference: 457BA2024) | R6.2 - The Health Board should strengthen ownership and accountability for delivery of audit recommendations. | Audit Wales/2025/234/MI08/1 | R6.2 The following processes have been implemented to strengthen ownership and accountability of audit recommendations to support the proactive management and closure of actions:<br>• Regular meetings established with Business Managers to discuss progress against recommendation actions.<br>• Performance is reported to the Executive Leadership Group in terms of compliance with timescales for returning management responses and action completion dates.<br>• Director of Corporate Governance / Board Secretary is reviewing the audit tracker and meeting with Executive Leads to ensure all actions remain current and accurate and will liaise with audit colleagues should there be any challenge to continued applicability.<br>• The Corporate Governance Dashboard received at the weekly Executive Leadership Groups has specific items on Audit reviews to flag where any management responses have been issued and identifies any areas of concern.<br>• Performance dashboard now included in the Audit Tracker report to the Audit & Risk Committee that identifies the areas of concern and limited progress. This report is also received at the Executive Leadership Group. | Corporate Governance<br><br>Director of Corporate Governance/Board Secretary | 31.03.2025 | 31.03.2025 | High | Fully complete (Awaiting approval) | March 2025 Update - Complete. This is now implemented as business as usual activity so it is suggested that this recommendation is complete as it will be ongoing action. Improvement will be monitored via the Audit, Risk & Assurance Committee and through future Structured Assessment reviews. | | | |
| Audit Wales/2025/234 | 21/01/2025 | Structured Assessment 2024_CTMUHB 2024_November 2024 (Document reference: 457BA2024) | R7 - The Health Board should set out how each individual well-being objective aligns to the national well-being objectives and well-being objectives of its partners. | Audit Wales/2025/234/MI09/1 | R7 - The wellbeing objectives are currently embedded throughout the CTM 2030 strategy as cross cutting themes in each programme. However we acknowledge that it would be beneficial to clearly set these out separately.<br><br>In order to demonstrate how the wellbeing objectives map across to the national objectives and those of our partners, a task and finish group will be established in March to develop this work. A report will be produced that sets out our wellbeing objectives and our progress against them, from which we can monitor progress annually. This will be reflected in a written output which will allows stakeholders to access current information. | Executive Director for Public Health<br><br>Executive Director of Strategy and Transformation | 31.12.2025 | 31.12.2025 | High | In progress | April 2025 Update - An update against this recommendation has not been provided on this occasion. | | | |
| Audit Wales/2025/234 | 21/01/2025 | Structured Assessment 2024_CTMUHB 2024_November 2024 (Document reference: 457BA2024) | R8 - The Health Board should develop and report on population outcome measures to demonstrate the impact of its strategy delivery. | Audit Wales/2025/234/MI10/1 | R8 - As part of the work overseen by the Creating Health Programme Board, the development of a data dashboard to monitor and report on population outcome measures is underway. To make this meaningful however, both strategic and operational data sets will need to be developed using data from a number of different internal and external resources.<br><br>In addition to this, CTMUHB are working with the PSB to develop a data dashboard with Data Cymru and close collaboration with Swansea and NPT PSBs. Once developed, this will provide an up to date dataset across the well-being themes with around 150 indicators.<br><br>Due date to be confirmed - Initial meeting with PHW and CTMUHB to discuss the options around accessing the required data is planned for 10/01/25. After this a draft timeline for options and system development can be produced. Timelines for PSB dataset to be confirmed. | Executive Director for Public Health | 31.07.2025 | 31.07.2025 | High | In progress | April 2025 Update (22/04/24) - Action being reviewed and update to follow. | | | |
| Audit Wales/2025/234 | 21/01/2025 | Structured Assessment 2024_CTMUHB 2024_November 2024 (Document reference: 457BA2024) | R9 - The Health Board should strengthen Board and committee corporate strategy and plan reporting by clearly articulating where delivery is off-track, mitigating actions, and revised delivery timescales. | Audit Wales/2025/234/MI11/1 | R9.1 - There are three components to CTM 2030 - Building Healthier Communities – this reports in to the new Strategic Development Committee (SDC) and activities will be clearly set out with timelines and outputs (many of the outcomes of this work is expressed in decades)<br>- Integrated community and primary care – a specific plan that will report to Operational Deliver Committee (ODC) with clear timelines and performance metrics. | Chief Operating Officer<br><br>Executive Director of Strategy and Transformation | 30.04.2025 | 30.04.2025 | High | In progress | April 2025 Update - SDC has been established and Building Healthier Communities has started to report via the Committee. | | | |
| Audit Wales/2025/234 | 21/01/2025 | Structured Assessment 2024_CTMUHB 2024_November 2024 (Document reference: 457BA2024) | R9 - The Health Board should strengthen Board and committee corporate strategy and plan reporting by clearly articulating where delivery is off-track, mitigating actions, and revised delivery timescales. | Audit Wales/2025/234/MI11/2 | R9.2 - Acute Clinical Services Plan – the detail of this will be developed over the next 18 months through a process of systematic public engagement. | Executive Director of Strategy and Transformation | 30.09.2025 | 30.09.2025 | High | In progress | April 2025 Update - Programme Director has been recruited and programme governance, including delivery plan will be developed over 2025. | | | |
| Audit Wales/2025/234 | 21/01/2025 | Structured Assessment 2024_CTMUHB 2024_November 2024 (Document reference: 457BA2024) | R10.1 - The Health Board Should: monitor and manage any immediate quality and performance risks that may arise as a result of limited or no investment in services as it seeks to achieve financial balance in the short-term; | Audit Wales/2025/234/MI12/1 | R10.1 - The Quality Governance Team will review the Quality Impact Assessment (QIA), learning from its recent use in the response to the POWH Critical Incident, to ensure that any improvements are addressed and that QIA's are routinely completed where there is a risk to quality and performance where investment in services is impacted. Consideration will also be given to how such instances routinely escalate through the appropriate stages of the Quality Governance Framework. | Patient Care and Safety<br><br>Executive Director of Nursing/Deputy Chief Executive | 30.06.2025 | 30.06.2025 | High | In progress | April 2025 Update - An update against this recommendation has not been provided on this occasion. | | | |
| Audit Wales/2025/234 | 21/01/2025 | Structured Assessment 2024_CTMUHB 2024_November 2024 (Document reference: 457BA2024) | R10.2 - develop a long-term financial plan, beyond its 2024-27 Integrated Medium-Term Plan, aligned to its organisational strategy in order to achieve financial sustainability. | Audit Wales/2025/234/MI13/1 | R10.2 - The health Board recognises the need to develop a long-term plan, aligned to our organisational strategy, and underpinned by a long-term financial model.<br><br>Developing the long-term financial plan cannot be done in isolation and needs to be properly aligned to other aspects. | Finance<br><br>Executive Director of Finance | 30.09.2026 | 30.08.2026 | High | In progress | April 2025 Update - An update against this recommendation has not been provided on this occasion. | | | |

| Inspection Code | Date of Inspection | Overall Assurance Rating | Inspection Title | Recommendation | AMaT Reference Number | Action | Executive / Inspection Lead | Original Due Date | Current / Revised Due Date | Action Rating | Progress Status | Comments/Updates |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Internal Audit/2020/65 | 29/07/2020 | Reasonable Assurance | 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<br>An inventory of non-capital assets should be developed for each department within the directorate, detailing their assets, which fit under the definition of inventory as detailed within the Financial Control Procedure. | Internal Audit/2020/65/MD1/2 | It is accepted that this area needs attention and this will need to be prioritised by the CSG general managers during 2020-21 once supporting staffing structures are in place. | Unscheduled Care<br><br>Chief Operating Officer | 01.04.2021 | 31.07.2024 | High | Overdue | April 2025 Update- a new structure as been established and continue to work through actions to to align to existing model. It is queried if the action would be best considered for review to align to the new model and structure, to better ensure that appropriate oversight of the recommendation.<br><br>January 2025 - A new structure was established in 2023, moving away from the ILG model and replacing with a care group model. Now that the care group have been fully established, the Directorate manager has reviewed the recommendation with the view to adopt a process to ensure inventories are managed and reviewed across the sites. |
| Internal Audit/2020/65 | 29/07/2020 | Reasonable Assurance | 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<br>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.<br>2. Where there are common policies across a number of departments, to avoid duplication and possible inconsistencies, consideration should be given to having a set of directorate wide policies with one copy saved and clear information on the lead area for the policy including who is responsible for reviewing and updating the policy." | Internal Audit/2020/65/MD2/1 | The review of policies and procedures needs to be undertaken on each acute site and it is acknowledged that this is an area of concern with focussed attention needed over the next 6 months. There also needs to be clear guidance from the ILG on the process for the approval of policies and procedures in the new operating model. | Unscheduled Care<br><br>Chief Operating Officer | 01.12.2020 | 30.04.2024 | Medium | Overdue | April 2025 Update - A new structure as been established and continue to work through actions to to align to existing model. It is queried if the action would be best considered for review to align to the new model and structure, to better ensure that appropriate oversight of the recommendation.<br><br>January 2025 - Corporate services are conducting an internal review of the management of non clinical policies and procedures across the HB. The care group will feed into the review and take from that any learning or practices that can be adopted. A review of policies and procedures will form part of this review across 25/26, where the care group will have completed a full inventory of policies and procedures held by the care group, utilising this to support a process of review. ILG is no longer the structure and are now referred to as Unscheduled Care Group. |
| Internal Audit/2020/74 | 24/01/2020 | Reasonable Assurance | 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<br>While we understand that currently, the department does not have the resources to undertake a reconciliation of equipment that has been loaned to wards, consideration should be given to undertaking periodic checks between the equipment available in the library and the equipment recorded as being on loan on the system. | Internal Audit/2020/74/MD1/1 | 1. Band 2 Equipment library Job Description is now matched – to be uploaded and advertised on TRAC to appoint staff. This will then enable periodic checks between the equipment available in the library and the equipment recorded as being on loan on the system to be undertaken.<br>2. Continued use of partial RF-ID system to be utilised with confirmation that data connection to RAM 5000 can be completed.<br>3. SCN to be submitted to Capital for increased RF-ID system coverage for RGH (£244.8K), early indication from Capital is that a more detailed business case will be required as roll out to other sites is also required. | Diagnostics, Therapies, Pharmacies and Specialties (Clinical Engineering)<br><br>Care Group<br><br>Chief Operating Officer | 01.04.2020 | 31.01.2024 | Medium | Partially complete (Overdue) | April 2025 Update (08/04/2025) - New linux Server and apps installed on hand held scanner in March 2025 following various ICT access issues resolved. Data migrated and undergoing tests by Clin Eng prior to confirming switch off of K2 windows and full go live and re-launch of platform to staff. Await Power BI team to respond regarding dashboard template provided as part of web application. Further background API work can proceed following data/app checks are completed and confirmed all working correctly).<br><br>January 2025 Update (15/01/2025) - Supplier developed draft plan for final migration work and server switch over to be agreed with CE/ICT and ensure ICT available for any problems to be resolved when on site. A planned date at end of January/ beginning February to allow this to be sorted as handheld scanner apps will also be updated for new server when on site. This date will be sorted within next few days. |
| Internal Audit/2021/76 | 06/08/2021 | Reasonable Assurance | Sunnyside Health & Wellbeing Centre_Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03) | Sunnyside Health & Wellbeing Centre 18<br>Management should obtain signed lease agreements with relevant parties at the earliest opportunity. | Internal Audit/2021/76/MD1/1 | The Primary Care lead will continue to work with NWSSP Specialist Estates Services to ensure that the lease is signed off as soon as possible. | Capital and Estates<br><br>Executive Director of Finance | 01.01.2022 | 30.06.2024 | Medium | Fully complete (Awaiting approval) | April 2025 Update - Agreement for Lease agreed and signed.<br><br>December 2024 Update - Updated drawings provided as requested, with GP for final review |
| Internal Audit/2021/76 | 06/08/2021 | Reasonable Assurance | Sunnyside Health & Wellbeing Centre_Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03) | Sunnyside Health & Wellbeing Centre 20<br>Objectives at the business case should be measurable. | Internal Audit/2021/76/MD1/3 | 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<br><br>Executive Director of Finance | 01.01.2022 | 29.02.2024 | Medium | Partially complete (Overdue) | April 2025 Update - discussed at Project Board, circulated to members. Awaiting feedback and follow up discussion.<br><br>December 2024 Update - No further update, as per November update next meeting in January 2025. |
| Internal Audit/2021/76 | 06/08/2021 | Reasonable Assurance | Sunnyside Health & Wellbeing Centre_Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03) | Sunnyside Health & Wellbeing Centre 21<br>Management should review and confirm project objectives based on only measurable outcomes within a Benefits Realisation Plan. | Internal Audit/2021/76/MD1/4 | 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<br><br>Executive Director of Finance | 01.01.2022 | 29.02.2024 | Medium | Partially complete (Overdue) | April 2025 Update - discussed at Project Board, circulated to members. Awaiting feedback and follow up discussion.<br><br>December 2024 Update - No further update, as per November update next meeting January 2025. |
| Internal Audit/2022/161 | 14/02/2022 | Reasonable Assurance | Continuing Health Care and Funded Nursing Care_Final Internal Audit Report February 2022 (Review reference: CTMUHB-2122-36) | CHC and FNC 1.3<br>The CHC Financial Control Procedure should be reviewed by the finance team in conjunction with the CHC team and updated to reflect current processes and set up within the Health Board. | Internal Audit/2022/161/MD1/1 | The Finance Team will review the Financial Control Procedure (FCP) in line with any changes identified in the new CHC Framework. The updated FCP will be an agenda item at the Audit Committee and a further review date agreed. As part of an internal review of CHC we have identified the need for a policy to outline the principles of CHC commissioning and the financial control procedure can be incorporated. | Patient Care & Safety<br><br>Executive Director of Nursing/Deputy Chief Executive | 01.05.2022 | 30.04.2024 | Medium | Overdue | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - An update against this recommendation has not been provided on this occasion. |
| Internal Audit/2022/43 | 29/07/2022 | Limited Assurance | 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<br>The Health Board should ensure appropriate contractual arrangements are in place for the Cost Adviser. | Internal Audit/2022/43/MD4/1 | Agreed | Capital and Estates<br><br>Executive Director of Strategy & Transformation | 01.08.2022 | 31.01.2025 | Medium | Fully complete (Awaiting approval) | April 2025 Update - Contract with J&N signed by all parties. |
| Internal Audit/2022/67 | 24/10/2022 | Reasonable Assurance | Radiology Service Review Final Internal Audit Report October 2022 (Review reference: CTMUHB-2223-03) | Radiology Service Review 12.1<br>A detailed workforce plan should be developed by the CSG in conjunction with their Workforce Business Partner that incorporates both the current workforce situation, plus longer-term plans in relation to areas such as known retirements. | Internal Audit/2022/67/MD2/1 | The Service Group now sits in the Diagnostic and Therapies Care Group since September 2022 and the Care Group Director and Medical Director will work with the teams to advise of the workforce plan required for the IMTP/Annual Plan for 2023/24. On receipt of this advice the Service Group will work with the Workforce Business Partners to articulate the current workforce issues and medium and longer term plans. | Diagnostics, Therapies, Pharmacies & Specialities<br><br>Chief Operating Officer | 30.11.2022 | 31.12.2023 | High | Partially complete (Overdue) | April 2025 Update - No change. Business Case still not approved at Executive level. Insourcing EOI not signed off at Executive level.<br><br>January 2025 Update - Still awaiting confirmation for approval at Executive level for CT staffing. The workforce detailed in this paper underpins the Radiology workforce plans. Short term workforce planning meeting (07/01/25) - scoping of Insourcing contract with procurement.<br><br>November 2024 Update - Still awaiting confirmation for approval at exec level for CT staffing. The workforce detailed in this paper underpins the Radiology workforce plans.<br><br>September 2024 Update - NOUS and CT paper partially approved. The staffing element of the CT BC is critical for workforce planning. The team await confirmation of approval at Exec level. |
| Internal Audit/2022/95 | 15/06/2022 | Reasonable Assurance | 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<br>The draft Medics Rostering Policy should be further reviewed to remove any legacy references to the Nursing Rostering Policy. Feedback should then sought from the appropriate groups and approval obtained from the appropriate committee ahead of making the policy available to all relevant staff. | Internal Audit/2022/95/MD1/1 | The draft has been reviewed substantially and is now complete. The policy has been submitted to the Medical Workforce Sustainability Group (MWSG) for review. This will be set as an agenda item for the next meeting and then progress through the formal Health Board route to ratification. | People<br><br>Executive Medical Director<br><br>Executive Director for People | 01.11.2022 | 30.04.2024 | Medium | Partially complete (Overdue) | April 2025 Update - Policy drafted and comments from LNC have been sought to incorporate into the document. Expected to complete May 2025.<br><br>January 2025 Update - Policy to be reviewed at March 2025 LNC Committee meeting (11 March 2025). Request to change the due date to 30 April 2025. |
| Internal Audit/2022/97 | 10/10/2022 | Reasonable Assurance | Medical Records Management_Final Internal Audit Report October 2022 (Review reference: CTMU-2223-06) | Medical Records Management 1.1<br>The responsibilities of the Health Records departments across the Health Board should be standardised.<br>Linked to this the procedures operating within each site should be standardised as much as possible, given the limitations imposed by digitisation. | Internal Audit/2022/97/MD1/1 | Accept<br>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<br><br>Director of Digital | 01.07.2024 | 01.09.2025 | Medium | In progress | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - An update against this recommendation has not been provided on this occasion. |
| Internal Audit/2023/100 | 31/05/2023 | Reasonable Assurance | Welsh Risk Pool Claims_Final Internal Audit Report May 2023 (Review reference: CTMUHB-2223-24) | Welsh Risk Pool 1.1<br>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.<br>1.1b Regular monitoring oN the 'stages' within Datix should be carried out to ensure compliance and that no 'blanks' are being reported. | Internal Audit/2023/100/MD2/1 | 1.1a Staff will be reminded of importance in next meeting in respect of closure.<br>A check list will be developed to support staff in the completion of Datix at all stages of process. This information will included in the Standard Operating Procedures for the closing of records. A refresher training session will be provided to the Claims Team in relation to Datix Cymru by the Business Intelligence Team.<br>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.<br>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<br><br>Executive Director of Nursing/Deputy Chief Executive | 01.06.2023 | 31.12.2024 | Medium | Partially complete (Overdue) | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - 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 | Reasonable Assurance | Welsh Risk Pool Claims_Final Internal Audit Report May 2023 (Review reference: CTMUHB-2223-24) | Welsh Risk Pool 2.2<br>Management should ensure that staff are aware of accurately recording date information within Datix to allow the calculation of target dates and monitoring. | Internal Audit/2023/100/MD4/1 | Staff will be reminded of the importance of accurately recording date information on Datix Cymru and ensuring it is reflected on documents submitted to WRP. The recording of LFER information will be included in the audit and data validation programme described in action 1.1b. | Patient Care & Safety<br><br>Executive Director of Nursing/Deputy Chief Executive | 01.06.2023 | 31.03.2025 | Medium | Partially complete (Overdue) | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - unfortunately, due to operational demands, and staff unavailability, the Redress Dashboard is yet to be completed. Anticipated time scale for completion is now 31 March 2025. |
| Internal Audit/2023/107 | 08/08/2023 | Reasonable Assurance | Decontamination_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-25) | Decontamination 3.0<br>Arrangements be put in place to ensure that there is a dedicated Microbiologist (Decontamination) in place for Princess of Wales site as soon as practically possible. | Internal Audit/2023/107/MD4/1 | 3a Escalation to the Deputy Medical Director and escalated to the last IP&C Committee meeting (11/07/23).<br>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<br><br>Executive Director of Nursing/Deputy Chief Executive | 01.10.2023 | 01.10.2023 | Medium | Overdue | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - An update against this recommendation has not been provided on this occasion. |
| Internal Audit/2023/107 | 08/08/2023 | Reasonable Assurance | Decontamination_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-25) | Decontamination 5.0<br>A schedule/programme of independent decontamination audits be implemented to evaluate and assess the decontamination facilities/arrangements across the Health Board. The outcome of these audits be summarised into a report for presentation to the Decontamination Committee so that appropriate actions can be taken. | Internal Audit/2023/107/MD5/1 | 5a Decontamination audit tools are currently being developed. Three audit tools will be taken to the next Decontamination Committee meeting for approval. Decontamination audit programme to commence.<br>5b Audit program to review decontamination facilities/arrangements across the Health Board to inform all appropriate future governance. | Patient Care & Safety<br><br>Executive Director of Nursing/Deputy Chief Executive | 01.06.2024 | 01.06.2024 | Medium | Overdue | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - An update against this recommendation has not been provided on this occasion. |
| Internal Audit/2023/113 | 08/08/2023 | Reasonable Assurance | National Incident Framework_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-05) | National Incident Framework 2.1<br>The draft training needs analysis should be finalised and staff in Care Groups should be requested to identify who needs to attend incident management training and RCA training. As part of the process of identifying staff training needs, consideration should be given to if refresher training on Datix is required. | Internal Audit/2023/113/MD4/1 | A training strategy to be developed which outlines all levels of training in relation to Incident and Concerns Management for different staff groups across the Health Board. This will include a reference to Datix Cymru requirements.<br>Following approval of the Strategy, a training need analysis will be undertaken and a training Programme established. | Patient Care & Safety<br><br>Executive Director of Nursing/Deputy Chief Executive | 01.11.2023 | 28.02.2025 | Medium | Partially complete (Overdue) | March 2025 Update - As part of the revision of the Putting Things Right regulations, a Stakeholder reference Group was established. Once the revised documentation has been agreed, an All Wales Implementation Group is to be established which will develop a training and education package for roll out across all organisations. The package will outline the varying levels of training and those staff that require training. Whilst no firm date for launch has been identified, it is anticipated that this training package will be available at the latter part 2025.<br><br>January 2025 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 2025. |
| Internal Audit/2023/117 | 28/07/2023 | Reasonable Assurance | Performance Reporting – Integrated Performance Report_Internal Audit Report July 2023 (Review reference: CTMUHB-2223-15) | Performance Reporting Integrated Performance Report 2.1<br>The Standard Operating Procedure for preparing the performance report should be enhanced to fully set out the process for preparing the report. It should include more comprehensive information on how it is determined, which performance measures are to be reported on, how data should be checked for accuracy and completeness and a detailed monthly timetable for production that allows sufficient time for Executive review. | Internal Audit/2023/117/MD2/1 | A review of the Standard Operating Procedure will be undertaken to ensure it comprehensively covers the activities required. | Performance<br><br>Executive Director of Strategy & Transformation<br><br>Director of Digital | 01.01.2024 | 30.06.2024 | High | Overdue | April 2025 Update - A draft performance report framework has been created which has been considered by the current Executive Director of Strategy. This will be taken forward by the new Director once they are in post, with progress expect by the end of Q1. Once the performance report framework has been confirmed the SOP for creating the report can be progressed.<br><br>January 2025 Update - An update against this recommendation has not been provided on this occasion. |
| Internal Audit/2023/117 | 28/07/2023 | Reasonable Assurance | Performance Reporting – Integrated Performance Report_Internal Audit Report July 2023 (Review reference: CTMUHB-2223-15) | Performance Reporting Integrated Performance Report 1.1<br>The draft performance management framework should be reviewed to ensure:<br>• There is alignment to the most up to date Welsh Government Performance Framework, ensuring<br>all metrics and measures outlined are accurate and there is link the IMTP trajectories required by WG<br>• Greater clarity is provided on how the framework will be applied in practice, including how reporting against metrics will take place.<br>• Listed metrics can be clearly linked to source requirements e.g. WG quadruple aims, other<br>national indicators, internal indicators.<br>• The roles and responsibilities of all Health Board Committees is set out including how those roles<br>relate to one another.<br>• Reference is made to the revised operating model and therefore reporting structure within the<br>Health Board.<br>Following the completion of the review, the framework should be appropriately approved and made<br>available to relevant staff. | Internal Audit/2023/117/MD3/1 | The Health Board needs to formalise a Performance Framework. This review will consider the points listed above. | Performance<br><br>Executive Director of Strategy & Transformation<br><br>Director of Digital | 01.01.2023 | 31.12.2024 | Medium | Overdue | April 2025 Update - A draft performance report framework has been created which has been considered by the current Executive Director of Strategy. This will be taken forward by the new Director once they are in post, with progress expect by the end of Q1<br><br>January 2025 Update - An update against this recommendation has not been provided on this occasion. |
| Internal Audit/2023/124 | 31/05/2023 | Reasonable Assurance | Follow-up: Concerns_Final Internal Audit Report May 2023 (Review reference: CTM 22/23-29) | Concerns Follow Up Review 3.1<br>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<br>may have previously completed training on previous policies and processes.<br>3.1b A training programme should be put in place to deliver the identified concerns training requirement.<br>3.1c A decision should be made on the best method for capturing concerns training attendance, that allows management the ability to review and monitor attendance going forward. | Internal Audit/2023/124/MD3/1 | 3.1a Training Needs Analysis to be developed and sent to all Care Groups to identify staff which require training<br>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<br>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<br><br>Executive Director of Nursing/Deputy Chief Executive | 01.10.2023 | 31.10.2024 | Medium | Partially complete (Overdue) | March 2025 Update - As part of the revision of the Putting Things Right regulations, a Stakeholder reference Group was established. Once the revised documentation has been agreed, an All Wales Implementation Group is to be established which will develop a training and education package for roll out across all organisations. The package will outline the varying levels of training and those staff that require training. Whilst no firm date for launch has been identified, it is anticipated that this training package will be available at the latter part 2025.<br><br>January 2025 Update - An update against this recommendation has not been provided on this occasion. |
| Internal Audit/2023/146 | 11/10/2023 | Limited Assurance | Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11) | Interventions Not Normally Undertaken 1.1<br>Key staff, especially those listed as the target audience at the start of the INNU policy, should be made aware of the revised policy and its contents. Where necessary, training should be carried out to ensure staff understand the policy and the application of it. | Internal Audit/2023/146/MD1/1 | CTMUHB Policy updated and circulated through service groups. Training will be carried out where required across service groups. | Planned Care<br><br>Chief Operating Officer | 01.09.2023 | 01.09.2023 | High | Overdue | April 2025 Update - Progress against this action is being made within the Care Group.<br><br>January 2025 Update - INNU is an area that is being picked up at a national level. CTM are waiting for the outcome of this to inform local policies, procedures and guidance. |
| Internal Audit/2023/146 | 11/10/2023 | Limited Assurance | Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11) | Interventions Not Normally Undertaken 1.2<br>A Standard Operation Procedure in relation to INNUs should be developed to provide guidance on consistent application of the INNU policy. | Internal Audit/2023/146/MD2/1 | Standard Operating Procedure to be developed as part of the working group and provided to all service groups. | Planned Care<br><br>Chief Operating Officer | 01.01.2024 | 01.01.2024 | High | Overdue | April 2025 Update -progress against this action is being made within the Care Group.<br><br>January 2025 Update - INNU is an area that is being picked up at a national level. CTM are waiting for the outcome of this to inform local policies, procedures and guidance. |
| Internal Audit/2023/146 | 11/10/2023 | Limited Assurance | Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11) | Interventions not Normally Undertaken 2.0<br>For those patients where it is deemed that an INNU intervention is necessary, a record, such as a checklist should be retained on their patient file demonstrating that the criteria set out in the INNU policy or within WHSSC guidance has been met.<br>Consideration should be given to the need for an independent check to be made and/or approval to be granted, if it is believed the patient meets the INNU criteria, prior to adding them to a waiting list. | Internal Audit/2023/146/MD3/1 | Individual patient funding request panel to be re-established to receive INNU. Intervention requests necessary. Application and outcome to be documented and WPAS to be updated. | Planned Care<br><br>Chief Operating Officer | 01.01.2024 | 01.01.2024 | High | Overdue | April 2025 Update - progress against this action is being made within the Care Group.<br><br>January 2025 Update - INNU is an area that is being picked up at a national level. CTM are waiting for the outcome of this to inform local policies, procedures and guidance. |
| Internal Audit/2023/146 | 11/10/2023 | Limited Assurance | Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11) | Interventions not Normally Undertaken 5.1<br>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 appropriate mechanism should be in place for addressing any matters identified, so that corrective action can be promptly taken. | Internal Audit/2023/146/MD4/1 | With the establishment of the recording and monitoring mechanism. Monthly reports will be produced with trends and anomalies highlighted. Any matters that require addressing will be via the Care Group with the service performance meeting structures. | Planned Care<br><br>Chief Operating Officer | 01.03.2024 | 01.03.2024 | High | Overdue | April 2025 Update - progress against this action is being made within the Care Group.<br><br>January 2025 Update - INNU is an area that is being picked up at a national level. CTM are waiting for the outcome of this to inform local policies, procedures and guidance. |
| Internal Audit/2023/146 | 11/10/2023 | Limited Assurance | Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11) | Interventions not Normally Undertaken 1.3<br>The policy, and an associated SOP, should provide greater clarity on whether the IPFR process can be used for those interventions that are listed as 'Do Not Do' and the relevant process to follow. | Internal Audit/2023/146/MD5/1 | Application of the above actions | Planned Care<br><br>Chief Operating Officer | 01.01.2024 | 01.01.2024 | Medium | Overdue | April 2025 Update - Progress is being made against this action within the Care Group.<br><br>January 2025 Update - INNU is an area that is being picked up at a national level. CTM are waiting for the outcome of this to inform local policies, procedures and guidance.<br><br>. |

| Inspection Code | Date of Inspection | Overall Assurance Rating | Inspection Title | Recommendation | AMaT Reference Number | Action | Executive / Inspection Lead | Original Due Date | Current / Revised Due Date | Action Rating | Progress Status | Comments/Updates |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Internal Audit/2023/146 | 11/10/2023 | Limited Assurance | Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11) | Interventions Not Normally Undertaken 4.0<br>A mechanism should be put in place that will allow the Health Board to monitor if activity has taken place against interventions that are classed as DNDs where no clinical code currently exists and the level of activity against the INNU interventions where no clinical code is recorded. | Internal Audit/2023/146/MD6/1 | Data work stream established to look at the recording of INNU's across CTMUHB. An agreed coding and monitoring mechanism to be agreed and implemented. | Planned Care<br><br>Chief Operating Officer | 01.03.2024 | 01.03.2024 | Medium | Overdue | April 2025 Update - progress against this action is being made within the Care Group.<br><br>January 2025 Update - INNU is an area that is being picked up at a national level. CTM are waiting for the outcome of this to inform local policies, procedures and guidance. |
| Internal Audit/2023/146 | 11/10/2023 | Limited Assurance | Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11) | Interventions Not Normally Undertaken 5.2<br>Consideration should be given to the need to periodically report compliance / non-compliance at a relevant level within the Health Board. | Internal Audit/2023/146/MD7/1 | Daily report to be added to the performance runs with formal monthly reporting via Planning Performance and Finance. | Planned Care<br><br>Chief Operating Officer | 01.03.2024 | 01.03.2024 | Medium | Overdue | April 2025 Update - progress against this action is being made within the Care Group.<br><br>January 2025 Update - INNU is an area that is being picked up at a national level. CTM are waiting for the outcome of this to inform local policies, procedures and guidance. |
| Internal Audit/2023/146 | 11/10/2023 | Limited Assurance | Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11) | Interventions not Normally Undertaken 3.0<br>The importance of capturing accurate information on patient records should be reiterated to all staff, with the use of alternative names ceasing. | Internal Audit/2023/146/MD8/1 | Review and update of waiting list 'holding names' to be undertaken | Planned Care<br><br>Chief Operating Officer | 01.03.2024 | 01.03.2024 | Low | Overdue | April 2025 Update - progress against this action is being made within the Care Group.<br><br>January 2025 Update - INNU is an area that is being picked up at a national level. CTM are waiting for the outcome of this to inform local policies, procedures and guidance.<br><br>November 2024 Update - INNU is an area that is being picked up at a national level. CTM are waiting for the outcome of this to inform local policies, procedures and guidance.<br><br>September 2024 Update - An update against this recommendation has not been provided on this occasion. |
| Internal Audit/2023/148 | 09/10/2023 | Reasonable Assurance | IT Infrastructure_Final Internal Audit Report October 2023 (Review reference: CTM-2324-19) | IT Infrastructure 2.1<br>Older, out of support devices should be removed from use. | Internal Audit/2023/148/MD1/1 | Continue to prioritise and review aged assets with a view to replacement, balanced with limited funding sources. Manage and maintain the related risk within the Departmental risk register. | Digital & Data<br><br>Director of Digital | 30.06.2024 | 30.01.2025 | Medium | Fully complete (Awaiting approval) | April 2025 Update - In 2024/25, the Digital team directly managed and processed c£9.2m of capital, comprised of £2.8m of discretionary capital and £6.4m of AWCP/DPIF capital.<br><br>Discretionary capital focussed on rolling replacement, statements of need (i.e. staff equipment, both general plus ringfenced investment in therapies, community and mental health), WNCR, continued delivery of the Infrastructure Review, Bridgend specific investments to enable disaggregation, Jayex patient calling system refresh, devices in readiness for the BadgerNet maternity system, and investment in a server access security authentication system (DuoMFA) and replacement/supplementary web filtering and access system (iBoss.)<br><br>The AWCP/DPIF funding enabled the formal commencement of the HEPMA in line with the original programme of work (digital medicine management portfolio, including significant investment in devices and also network improvements by replacing wireless LAN controllers and small site legacy core switches), ARMIS and ISE security appliance/software to identify and securely manage devices accessing the network, end user devices patch management solution, VxRail server upgrades to support NDR and the production environment, cyber vault expansion, network improvements (start of NEXUS switches replacement), significant investment in replacement user devices (including laptops purchased during COVID, legacy Windows 10 devices, and Ipel thin client devices), and additional devices to support the implementation of the mental health system.<br><br>We recommend that this audit action be closed. The target date for the action was set to 'ongoing' in the original audit. As recognised in Risks 585 and 4671, there are insufficient re-occurring funds to maintain an effective rolling replacement programme. We continue to prioritise and review aged assets with a view to replacement, balanced with limited funding sources using funding from discretionary capital and AWCP/DPIF capital.<br><br>January 2025 Update - We were successful in a recent bis to WG for slippage funding and have been allocated £1.9m in WG end of year slippage money. This will help in several key areas; however, we still struggle to meet our technical debt challenges without sustainable funding. |
| Internal Audit/2023/148 | 09/10/2023 | Reasonable Assurance | IT Infrastructure_Final Internal Audit Report October 2023 (Review reference: CTM-2324-19) | IT Infrastructure 3.1<br>Documentation should be produced that sets out the processes for:<br>- Managing and configuring Solarwinds; and<br>- Handling of alerts. | Internal Audit/2023/148/MD2/1 | The individual has now left. Management of the SolarWinds platform is now shared across the infrastructure team, although there is no lead and documentation produced is of limited value. Develop the skills and documentation within the team to maximise the use and value of the system for monitoring purposes. Recruit Additional staff in line with the Infrastructure Review resource plan." | Digital & Data<br><br>Director of Digital | 30.06.2024 | 30.03.2025 | Medium | Overdue | April 2025 Update - The process of recruiting additional staff is continuing. A review of our tooling is also going to commence in April, this review all of the differing management software we have and assigned technical owners.<br><br>January 2025 Update - Unfortunately no progress has been made on the activity, we have recently lost a member of the team and we are in the process of recruiting additional staff to help with capacity |
| Internal Audit/2023/148 | 09/10/2023 | Reasonable Assurance | IT Infrastructure_Final Internal Audit Report October 2023 (Review reference: CTM-2324-19) | IT Infrastructure 1.1a<br>Work to complete the register / CMDB should be progressed. Asset information for the Bridgend area should be included and kept up to date. | Internal Audit/2023/148/MD4/1 | The Asset manager has been extended to March 2024. They will continue to gather and maintain records of these assets. Service Management tooling and the related CMDB are not in place and a system for this requires investment. A case will be developed to support with the specification, costs and resources required for this. | Digital & Data<br><br>Director of Digital | 31.03.2024 | 31.07.2025 | Low | In progress | April 2025 Update - Armis software has now been purchased and is in the process of being implemented.<br><br>January 2025 Update - We have been allocated funding for the Armis software in the recent Digital capital slippage bid and are currently in the process of procuring the software. Revised due date of July 2025 requested |
| Internal Audit/2023/54 | 06/02/2023 | Limited Assurance | Medical Variable Pay – Agency Costs_Final Internal Audit Report February 2023 (Review reference: CTMUHB-2223-12) | Medical Variable Pay 5.1<br>Following the implementation of any actions arising from the Medical Productivity Board, the future reporting and monitoring requirements, in relation to medical variable pay, should be agreed and the FCP updated accordingly. | Internal Audit/2023/54/MD3/1 | 5.1 Finance currently provide comprehensive reports to the Care Groups detailing medical spend. This reporting will continue to happen and any additional requirements recommended by the Medical Productivity Board (MPB) will be added to this financial dataset.<br>The FCP will be updated to reflect the recommendations from the MPB as soon as they are communicated. | Medical Directorate and People<br><br>Executive Medical Director<br><br>Executive Director for People | 01.06.2023 | 31.03.2025 | High | Partially complete (Overdue) | April 2025 Update - The FCP has been updated and will be aligned to the workforce efficiency programme and will be ready for submission in end of May 2025.<br><br>January 2025 Update - These actions are now being captured and monitored in the actions for the 2024. Request to change the date of completion to 31/3/2025.<br><br>November 2024 Update - A meeting is scheduled to take place on 25/11/2024 to discuss this action.<br><br>Reopened October 2024 following the Internal Audit on MVP Agency Costs September 2024 where Internal Audit considered this action to be only partially completed and added the following commentary: "Whilst it has been confirmed that the relevant financial information is being appropriately disseminated, there remains an outstanding requirement to incorporate details of financial monitoring procedures into the revised FCP. We consider this matter arising partially implemented, with the residual aspect in relation to updating the FCP reported under Matter Arising 1." To close this action please indicate which section of the new FCP addresses these points.<br><br>December 2023 Update - Completed as process now in place for Care Groups to oversee. This is process going forwards.<br><br>October 2023 Update - Care Groups given monthly spend broken down into DE rates, ADH and locum agency spend. Divided into specialities and Doctor grades so target areas can be then addressed in Medical Productivity Group. Will need to include once rate card is implemented on number of breaches of the rate card and where specific problems are. |
| Internal Audit/2023/54 | 06/02/2023 | Limited Assurance | Medical Variable Pay – Agency Costs_Final Internal Audit Report February 2023 (Review reference: CTMUHB-2223-12) | 4.1 It should be ensured that suitable processes are in place and adhered to for engaging agency staff on a longer-term basis, or for extending any placements thus making them longer term. Prior to authorising longer-term placements, it should be confirmed that recent efforts to recruit into the post have been made and that plans for future recruitment attempts are in place, to prevent ongoing reliance on the agency locum.<br>Where there is a need to extend existing placements, it should be ensured that a review of the current post holder and any alternative agency staff is carried out to ensure the Health Board is achieving value for money and the best fit person is used. | Internal Audit/2023/54/MD7/1 | 4.1 - The recommendations of this action will be included in the FCP and SOP. Setting out a clear process for extending agency workers placements, that ensure the recommended considerations are taken and recorded, before offering an extension.<br><br>Training will be provided to all areas on how and when this process is to be used, to ensure the Health Board gets the correct balance between value for money and the correct person for the role. | Medical Directorate and People<br><br>Executive Medical Director<br><br>Executive Director for People | 31.08.2023 | 31.03.2025 | High | Partially complete (Overdue) | April 2025 Update - FCP and SOP have been updated but need to align to the workforce efficiency programme. It is expected this should be completed by end of May 2025.<br><br>January 2025 Update: This action will be addressed in review of the FCP/SOP along with the new 2024 audit recommendations. We request that the date is changed to 31 March 2025.<br><br>November 2024 Update - A meeting is scheduled to take place on 25/11/2024 to discuss this action. Likely to be rules and plans for looking at data and improvements.<br><br>Re-opened October 2024 - This action has been entered on AMaT as the Internal Audit MVP Agency Costs for September 2024 concluded that this item was only partially completed. Internal Audit commented: "The FCP and SOP have not been updated to provide clarity on extending agency worker placements. However, our review of booking data identified that longer-term placements, which represent a minority of engagements, were subject to regular re-approval via the Retinue system. We saw evidence that management have worked to substantively recruit longer term agency staff in some cases. Details of individual longer-term placements are reported to the Audit & Risk committee, and reasons are provided to explain their necessity. Whilst the FCP and SOP have not been updated, work has been carried out by the Health Board to reduce the numbers of longer-term placements. We consider this matter arising partially implemented, with the residual aspect in relation to updating the FCP reported under Matter Arising 1." To close this action please indicate which section of the new FCP addresses these points. |
| Internal Audit/2024/162 | 06/02/2024 | Limited Assurance | 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.<br><br>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.<br><br>Managers across all sites need to be involved in the process of creating SOP. | Internal Audit/2024/162/MD1/1 | Develop standardised approach to application of 4 hour clinical exception to include a pan CTM SOP for application of WG guidance. | Unscheduled Care<br><br>Chief Operating Officer | 01.06.2024 | 01.06.2024 | High | Partially Complete (Overdue) | April 2025 Update - Since April 2024 the WPAS team has worked closely with the 3 EDs across the sites to review and standardise all of the codes and drop down options available in WPAS to enable standardised breach reporting and as preparation for the merger of POW WPAS over to CTM and to ensure comparable data is available moving forward. This work has now been completed.<br><br>The existing training SOPs are in the process of being updated – Date for completion 30th April 2025. Roll out training programme 1st May 2025 to align with the WPAS POW merger.<br><br>January 2025 Update - 4 Hour Action Card<br>The 4 hour action card has been reviewed and updated following engagement with management, lead clinicians and senior nurses. The drafts have been sent to the site teams for sign off. Following successful testing on the 12th December, a standardised SOP will now be drafted and training provided by the operational and WPAS teams on both the PCH and RGH sites - Action by end Jan 25<br><br>November 2024 Update - An update against this recommendation has not been provided on this occasion.<br><br>September 2024 Update - An update against this recommendation has not been provided on this occasion. |
| Internal Audit/2024/162 | 06/02/2024 | Limited Assurance | 4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03) | 1.2 A review of the breach reason codes should be carried out to establish a consistent set of codes to be used across all sites. This will allow the Health Board the ability to consistently monitor reasons for patients spending longer than 4 hours in ED and help inform decision making. | Internal Audit/2024/162/MD2/1 | Develop a standardised set of codes to be used across all sites. | Unscheduled Care<br><br>Chief Operating Officer | 01.06.2024 | 01.06.2024 | Medium | Partially Complete (Overdue) | April 2025 Update - Since April 2024 the WPAS team has worked closely with the 3 EDs across the sites to review and standardise all of the codes and drop down options available in WPAS to enable standardised breach reporting and as preparation for the merger of POW WPAS over to CTM and to ensure comparable data is available moving forward. This work has now been completed.<br><br>The existing training SOPs are in the process of being updated – Date for completion 30th April 2025. Roll out training programme 1st May 2025 to align with the WPAS POW merger on 4th May 2025.<br><br>January 2025 Update- Since April 2024 the WPAS team has worked closely with the 3 EDs across the sites to review and standardise all of the codes and drop down options available in WPAS in preparation for the merger of POW WPAS over to CTM and to ensure comparable data is available moving forward. |
| Internal Audit/2024/162 | 06/02/2024 | Limited Assurance | 4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03) | 2.1Staff should be reminded of the importance of consistently and fully completing CAS cards with all required information. Management should gain an understanding from staff why the summary table as seen on the front of PoW CAS cards is not being completed and determine if it's used could be beneficial for all sites. | Internal Audit/2024/162/MD3/1 | Communicate through safety briefings the importance of fully completing CAS Cards and review implementation of summary table across all sites. | Unscheduled Care<br><br>Chief Operating Officer | 01.06.2024 | 01.06.2024 | High | Overdue | April 2025 Update - Progress is monitored through the Care Groups action plan.<br><br>January 2025 Update - ED lead nurses have confirmed that they undertake a triage audit of the cas cards. Care Group Manager has requested that they all move to a quarterly audit which should also include a review of the receptionist section of the card - Agreed 6th December and PCH audit template circulated - Action care group manager to confirm roll out |
| Internal Audit/2024/162 | 06/02/2024 | Limited Assurance | 4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03) | 2.2 The CAS cards at each site should be reviewed with a view to creating a standardised CAS card that explicitly sets out the key information that should be recorded. | Internal Audit/2024/162/MD4/1 | Develop standardised CAS card for all sites in conjunction with Clinical Director and Lead Nurse. | Unscheduled Care<br><br>Chief Operating Officer | 01.06.2024 | 01.06.2024 | Medium | Overdue | April 2025 Update - A new casualty "CAS" card has been developed and is to be implemented across all sites by May 2025. Key date and time information will be recorded on the cards. However, the updated tracker process means this information, as well as the breach reason codes, will also be directly recorded in the WPAS. As such, the CAS cards are no longer the primary source for capturing time and reason codes.<br><br>January 2025 Update - Standardised CAS cards completed and can be provided as evidence. Start date to be confirmed.<br><br>November 2024 Update - An update against this recommendation has not been provided on this occasion.<br><br>September 2024 Update - An update against this recommendation has not been provided on this occasion. |
| Internal Audit/2024/162 | 06/02/2024 | Limited Assurance | 4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03) | 3.1 Acknowledging that two versions of WPAS are in use by the Health Board, were possible a consistent approach to WPAS training should be in place for staff across the sites to ensure data capture is consistent. Once a SOP has been agreed, standard training on the application of the breach exemption and breach reason codes should be provided to relevant staff, along with an overview of the rationale for capturing information. | Internal Audit/2024/162/MD5/1 | Ensure standardised approach to training across all ED's, monitor through Directorate Performance Meetings. | Unscheduled Care<br><br>Chief Operating Officer | 01.06.2024 | 01.06.2024 | High | Partially Complete (Overdue) | April 2025 Update - Since April 2024 the WPAS team has worked closely with the 3 EDs across the sites to review and standardise all of the codes and drop down options available in WPAS to enable standardised breach reporting and as preparation for the merger of POW WPAS over to CTM and to ensure comparable data is available moving forward. This work has now been completed.<br><br>The existing training SOPs are in the process of being updated – Date for completion 30th April 2025. Roll out training programme 1st May 2025 to align with the WPAS POW merger<br><br>January 2025 Update - review and standardisation for breach exemption codes and reasons is in progress as part of the automated validation tool. Following successful testing on the POW site an SOP will be developed and training will be undertaken on both the PCH and RGH sites.<br><br>November 2024 Update - An update against this recommendation has not been provided on this occasion.<br><br>September 2024 Update - An update against this recommendation has not been provided on this occasion. |
| Internal Audit/2024/162 | 06/02/2024 | Limited Assurance | 4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03) | 4.1The importance of clearly and consistently capturing key date and time information on the CAS cards should be reiterated to staff and additional training provided where necessary. The importance of accurately transferring data from the CAS cards to WPAS should be reiterated to staff and additional training provided where necessary. | Internal Audit/2024/162/MD6/1 | Ensure standardised approach to training across all ED', monitor through Directorate Performance Meetings. | Unscheduled Care<br><br>Chief Operating Officer | 01.06.2024 | 01.06.2024 | High | Partially Complete (Overdue) | April 2025 Update - Since April 2024 the WPAS team has worked closely with the 3 EDs across the sites to review and standardise all of the codes and drop down options available in WPAS to enable standardised breach reporting and as preparation for the merger of POW WPAS over to CTM and to ensure comparable data is available moving forward. This work has now been completed.<br><br>The existing training SOPs are in the process of being updated – Date for completion 30th April 2025. Roll out training programme 1st May 2025 to align with the WPAS POW merger<br><br>January 2025 Update - Monthly emails have commenced to ED reception team to ensure it is reiterated to staff the importance of accurate and complete data capture- band 7 operational managers. CAS card available. Plans to recruit patient flow co-coordinator to support real time data capture on WPAS. |
| Internal Audit/2024/162 | 06/02/2024 | Limited Assurance | 4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03) | 4.2The criteria for determining the treatment complete time should be reviewed with a view to having a consistent definition in place across all sites. Similarly, the approach to applying breach exemption codes, specifically relating the time in the patient's journey when they are applied, should be reviewed to ensure consistency. The agreed approaches should be captured in a SOP. | Internal Audit/2024/162/MD7/1 | • Undertake review of treatment complete time and implement consistent definition on all sites.<br>• Ensure breach exemption codes applied consistently, develop SOP and monitor through Directorate Performance Meetings. | Unscheduled Care<br><br>Chief Operating Officer | 01.06.2024 | 01.06.2024 | Medium | Overdue | April 2025 Update - The new sample card and standardisation of drop downs undertaken will ensure accurate data capture moving forward with a standardise approach and understanding of the data requirement / meaning being in place across CTM.<br><br>The definitions on when and how this should be captured will be written into the updated SOP and will be discussed with staff during the training roll out. Target date 14th May<br><br>January 2025 Update - The new sample card will ensure accurate data capture moving forward with a standardise approach and understanding of the data requirement / meaning being in place across CTM - Action by End Jan 25 |

| Inspection Code | Date of Inspection | Overall Assurance Rating | Inspection Title | Recommendation | AMaT Reference Number | Action | Executive / Inspection Lead | Original Due Date | Current / Revised Due Date | Action Rating | Progress Status | Comments/Updates |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Internal Audit/2024/162 | 06/02/2024 | Limited Assurance | 4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03) | 5.1A record should be maintained of the adjustments made including who originally input the data and the error that was rectified. The data should be used to identify staff training requirements. | Internal Audit/2024/162/MD8/1 | Implement a standardised approach to capturing any changes to records, monitor through Directorate Performance reviews | Unscheduled Care<br><br>Chief Operating Officer | 01.06.2024 | 01.06.2024 | Medium | Overdue | April 2025 Update - Following implementation of the standardised patient tracking and breach recording, monthly audit meetings will be arranged and will feed into existing Directorate Performance review meetings. Data to be presented in the monthly performance meetings as part of the core data set. WPAS will be able to provide audit information that enable us to see who made changes to the breach reasons etc. Information to run monthly reports where subsequent changes have been made to breach codes give us an audit of who made changes to the records. Longer term, Informatics will develop the power BI breach app to have a built in checking system to flag user issues – App launch date TBC<br><br>January 2025 Update - Following implementation of the standardised patient tracking and breach recording, monthly audit meetings will be arranged and will feed into existing Directorate Performance review meetings - Action end January 25 |
| Internal Audit/2024/162 | 06/02/2024 | Limited Assurance | 4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03) | 5.2Further work should be undertaken to ensure that those cases adjusted as part of the retrospective validation process are being correctly captured and reported. Consideration should be given to maintaining a record of the WPAS entries that have been adjusted in order to allow spot checks to be performed to confirm the adjustment was correctly captured on the system. | Internal Audit/2024/162/MD9/1 | Undertake regular "snapshot" audits to ensure validation is correctly captured and monitor through Directorate Performance reviews. | Unscheduled Care<br><br>Chief Operating Officer | 01.06.2024 | 01.06.2024 | High | Overdue | April 2025 Update - Following implementation of the standardised patient tracking and breach recording, monthly audit meetings will be arranged and will feed into existing Directorate Performance review meetings. Data to be presented in the monthly performance meetings as part of the core data set. WPAS will be able to provide audit information that enable us to see who made changes to the breach reasons etc. Information to run monthly reports where subsequent changes have been made to breach codes give us an audit of who made changes to the records. Longer term, Informatics will develop the power BI breach app to have a built in checking system to flag user issues – App launch date TBC<br><br>January 2025 Update - PFC should review overnight cards to check that the record has been appropriately updated and roll back when appropriate - Include in SOP DNW would be an example of this |
| Internal Audit/2024/162 | 06/02/2024 | Limited Assurance | 4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03) | 5.3A review of the validation approaches currently in place across the sites should be carried out. It should be clear what the objective of validation work is, and a standard approach applied across site to ensure consistency in reporting. | Internal Audit/2024/162/MD10/1 | Review validation approaches across all ED's and implement a standardised approach to reporting. | Unscheduled Care<br><br>Chief Operating Officer | 01.06.2024 | 01.06.2024 | Medium | Overdue | April 2025 Update - WPAS team to run weekly report from system to identify where an adjustment(s) have been to a patients breach outcome. Plan to make automatically available the ED power BI app. Informatics to run monthly reports as part of the submission to WG. Standardised SOP to be develop for each site that includes breach data validation process.<br><br>January 2025 Update - Plans to produce a spreadsheet and share with Senior Nurses on all 3 sites to ensure that any adjustments made to the original entry on WPAS is captured and used to identify staff training requirements. Look at original findings to know what criteria needs to be added into the database. |
| Internal Audit/2024/162 | 06/02/2024 | Limited Assurance | 4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03) | 5.4A data cleansing exercise should be carried out on the POW outstanding cases spreadsheet. Given the age of some of the entries, it should be determined if validation is worthwhile. | Internal Audit/2024/162/MD11/1 | Undertake review of outstanding cases at POW and determine if validation is required | Unscheduled Care<br><br>Chief Operating Officer | 01.06.2024 | 01.06.2024 | Low | Fully Complete (Awaiting approval) | April 2025 Update - Management has undertaken a data cleansing exercise at Princess of Wales (PoW) to allow validation activity to focus on recent cases.<br><br>January 2025 Update - Discussions have been held to support this action and review, agreed in the meeting on the 3rd Dec that given that WG or CTM will have a requirement to use past breach data, the HB should consider not working through the backlog but ensure monthly compliance going forward.<br><br>Discussed in the pan CTM ED Senior Team meeting on the 4th December where is was agreed by the Senior Team that they also support the request not to validate the backlog. |
| Internal Audit/2024/162 | 06/02/2024 | Limited Assurance | 4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03) | 6.1 Weekly senior management team meetings at POW should be reinstated as a forum for discussing ED performance matters including performance against the 4-hour target. | Internal Audit/2024/162/MD12/1 | Re-instate weekly SM meetings at POW. | Unscheduled Care<br><br>Chief Operating Officer | 01.06.2024 | 01.06.2024 | Medium | Fully Complete (Awaiting approval) | April 2025 Update - Weekly meetings for the Senior Management Team at PoW have been re-established. These meetings have been replicated at Royal Glamorgan Hospital (RGH) and Prince Charles Hospital (PCH), with both the Deputy Clinical Service Group Manager and the Directorate Manager for Emergency and Acute Medicine in attendance. Key action plans are in place, with senior management actively monitoring the 4-hour performance during the meetings.<br><br>January 2025 Update - POW, RGH and PCH weekly ED Senior Team site based and pan CTM meetings in place. |
| Internal Audit/2024/162 | 06/02/2024 | Limited Assurance | 4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03) | 6.2 Agendas and action logs of all key groups and committees should be retained to support the discussions and decisions made during the meeting and to ensure actions are captured and followed up at subsequent meetings. | Internal Audit/2024/162/MD13/1 | Ensure agenda and action logs are retained. | Unscheduled Care<br><br>Chief Operating Officer | 01.06.2024 | 01.06.2024 | Medium | Fully Complete (Awaiting approval) | April 2025 Update - Key action plans are in place, with senior management actively monitoring the 4-hour performance during the meetings.<br><br>January 2025 Update - A dedicated pan CTM ED folder has been created that can be accessed by the ED teams across the sites to ensure all documentation and records are easily accessible.<br><br>Site based, Digital Project Group, site based and pan CTM action plans have been developed with updates and further action discussed and updated in the weekly meeting.<br><br>Agenda in place for pan CTM meetings.<br><br>Clinical Advisory Group commenced 7th January 2025 to support implementation of WECDS<br><br>November 2024 Update - An update against this recommendation has not been provided on this occasion.<br><br>September 2024 Update - An update against this recommendation has not been provided on this occasion. |
| Internal Audit/2024/162 | 06/02/2024 | Limited Assurance | 4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03) | 6.3 Consideration should be given to incorporating site specific data as part of the slide deck taken to the USC Care Group performance meetings to allow more enhanced monitoring and discussion of issues per site. | Internal Audit/2024/162/MD14/1 | Site specific slide deck in place, ensure used to underpin discussions. | Unscheduled Care<br><br>Chief Operating Officer | 01.06.2024 | 01.06.2024 | Medium | Fully Complete (Awaiting approval) | April 2025 Update - Care Group report to Oversight and Assurance and have adopted consistent data reporting slide decks to inform discussions. This has been adopted monthly.<br><br>January 2025 Update - Weekly performance slide are sent out via the informatics team and are circulated to the teams across the sites. ED Performance has also been added to the agenda for site based and the pan CTM senior team meetings.<br><br>Again the patient tracker function on WPAS will allow ED and the site to see at a glance where the barriers to flow. Once in place engagement sessions with site teams<br><br>The band 7 operational managers going forward, will play an active role in the daily review, escalation and reporting of ED waiting times, delays, reason for delay from December 2024.<br><br>This information will provide the deep dive narrative around issues that impact on ED weekly performance. This will enable the ED team to engage with the wider Site Flow teams, WAST, Diagnostics, Speciality teams and Primary Care colleagues to work towards a collaborative approach to improve ED performance |
| Internal Audit/2024/162 | 06/02/2024 | Limited Assurance | 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'.<br><br>Analysis of the breach reason codes, should be undertaken with the aim of better understanding the causes of patients exceeding the 4-hour target. | Internal Audit/2024/162/MD15/1 | Develop a more detailed report to include analysis of breach codes. | Unscheduled Care<br><br>Chief Operating Officer | 01.06.2024 | 01.06.2024 | Medium | Overdue | April 2025 Update - Plan to recruit Patient Flow Coordinators to support real time data capture on WPAS. Until recruited on each site, the patient pathway information will be updated by PFCs (PCH x 2 WTE, RGH 1 WTE) consultants and NIC. Implementation date for patient tracking on WPAS as above – 14th May 2025. Snap shot audits to be undertaken against breach outcomes and patient notes during May – Action for Band 7 Ops Managers weekly commencing after roll out. Longer term, plan to introduce as part of the data set in the ED power BI app – Action ED clinical lead, Informatics and Directorate.<br><br>January 2025 Update - Meeting arranged early December to work through the Informatics team, Clinical Lead and Directorate to undertaken an analysis of the breach codes as part of the automated validation pilot.<br><br>Following the roll out of patient tracking across the sites, this information will be available live on the ED Dashboard App that is currently in development - Action Information to confirm completion date |
| Internal Audit/2024/163 | 08/02/2024 | Reasonable Assurance | IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18) | 1.1Management should ensure that the service catalogue is complete with all required information, and that it is regularly reviewed and updated. | Internal Audit/2024/163/MD1/1 | Ensure the Service Catalogue is updated to reflect all of the critical systems in place and complete the additional fields including identifying if the system is locally managed or run by a supplier, and also identify where the system is hosted. | Digital & Data<br><br>Director of Digital | 01.07.2024 | 30.09.2025 | Medium | In progress | April 2025 Update - A supplier management workstream has been started with the new Head of Digital Service Management, resource and support is being identified, expected completion now September 2025.<br><br>January 2025 Update - A local review has been carried out of the server/hosting, networking and EUC components of our infrastructure. These were all reviewed against the CIS benchmarks and any follow up actions/risks are being logged. A view of national systems needs to be developed. |
| Internal Audit/2024/163 | 08/02/2024 | Reasonable Assurance | IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18) | 1.1Management should ensure that the service catalogue is complete with all required information, and that it is regularly reviewed and updated. | Internal Audit/2024/163/MD1/2 | Further refine and review the Service Catalogue and extend it to include dependencies of local, national and cloud infrastructure. E.g. The majority of systems are accessed via CTM Managed end user devices so the review should ensure that these common components (such as Citrix, Wireless, LAN and WAN) are reviewed for their resilience and recover ability. | Digital & Data<br><br>Director of Digital | 01.07.2024 | 30.09.2025 | Medium | In progress | April 2025 Update - A supplier management workstream has been started with the new Head of Digital Service Management, resource and support is being identified, expected completion now September 2025.<br><br>January 2025 Update - A local review has been carried out of the server/hosting, networking and EUC components of our infrastructure. These were all reviewed against the CIS benchmarks and any follow up actions/risks are being logged. A view of national systems needs to be developed. |
| Internal Audit/2024/163 | 08/02/2024 | Reasonable Assurance | IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18) | 2.1Management should ensure that knowledge management is progressed through the creation and development of ITIL aligned processes and procedures. | Internal Audit/2024/163/MD2/1 | Creation of a Digital Service Management Function. Create a Digital Service Management function as part of current structural review of Digital Delivery. Appoint into the vacant Head of IT Service Management role. Then assess current maturity of ITIL aligned processes and procedures and prioritise development. | Digital & Data<br><br>Director of Digital | 01.10.2024 | 31.07.2025 | Medium | In progress | April 2025 Update - We are looking to undertake an ITIL maturity assesment in Q2 FY 25-26, and will work with Procurement to find a third party consultancy to assist us in the process.<br><br>January 2025 Update - We have a start date for the new Head of Datacentre and Cloud for the 3rd March - this should then free up the Head of Digital Service Management to progress Service Management activities - we will then look to undertake an ITIL Maturity assessment in the new FY once end of year activities have been completed |
| Internal Audit/2024/163 | 08/02/2024 | Reasonable Assurance | IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18) | 3.1 Management should establish a defined relationship management framework to align expectations, improve communication and manage risk, and develop relationship metrics to assess their quality, value and impact. | Internal Audit/2024/163/MD3/1 | Once a Digital Service Management function has been created (Action 2.1) develop a framework and approach to internal service relationship. This action is predicated on the development of our service catalogue (Action 1.1) as well as an approach to business relationship management (BRM) that will need to span the Digital Delivery, Digital Systems and Digital Intelligence, Compliance & Design. | Digital & Data<br><br>Director of Digital | 01.01.2025 | 31.07.2025 | Medium | In progress | April 2025 Update - We are looking to undertake an ITIL maturity assesment in Q2 FY 25-26, and will work with Procurement to find a third party consultancy to assist us in the process.<br><br>January 2025 Update - We have a start date for the new Head of Datacentre and Cloud for the 3rd March - this should then free up the Head of Digital Service Management to progress Service Management activities - we will then look to undertake an ITIL Maturity assessment in the new FY once end of year activities have been completed, that activity alongside the improvements to the Service Catalogue will enable us to progress this activity. Request to revise due date to July 2025. |
| Internal Audit/2024/163 | 08/02/2024 | Reasonable Assurance | IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18) | 4.1Management should implement and maintain a single, central register of suppliers and contracts to allow visibility and control over contract data, costs, documentation, action plans and supplier performance data. | Internal Audit/2024/163/MD4/1 | Once a Digital Service Management function has been created (Action 2.1) develop a single, central register of suppliers and contracts. This will need co- ordination with our internal Business Admin team, Finance and Procurement. | Digital & Data<br><br>Director of Digital | 01.10.2024 | 31.07.2025 | Medium | In progress | April 2025 Update - Meetings are already in place between the Digital Business Admin team and with Procurement and Finance, thinking and conversations are taking place to improve the way we identify unknown contracts<br><br>January 2025 Update - We have a start date for the new Head of Datacentre and Cloud for the 3rd March - this should then free up the Head of Digital Service Management to progress Service Management activities - we will then look to undertake an ITIL Maturity assessment in the new FY once end of year activities have been completed. However thinking has already started on the approach. We are also waiting for a new Head of Procurement to be appointed in the coming months. |
| Internal Audit/2024/163 | 08/02/2024 | Reasonable Assurance | IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18) | 4.2Management should ensure that an appropriate framework for effective supplier and contract management is developed which allows for clear, planned, and regular activity e.g., measuring and policing supplier performance and active management of contract key dates and milestones. | Internal Audit/2024/163/MD5/1 | Creationof a tiered frameworkcategorising high, medium andlow value/importancesuppliers and contracts, and the appropriate level of governance and level of management given to each category. | Digital & Data<br><br>Director of Digital | 01.10.2024 | 31.07.2025 | High | In progress | April 2025 Update - We are looking to undertake an ITIL maturity assesment in Q2 FY 25-26, and will work with Procurement to find a third party consultancy to assist us in the process.<br><br>January 2025 Update - We have a start date for the new Head of Datacentre and Cloud for the 3rd March - this should then free up the Head of Digital Service Management to progress Service Management activities - we will then look to undertake an ITIL Maturity assessment in the new FY once end of year activities have been completed - this reliant on progress of action Internal Audit/2024/163/MD4/1 |
| Internal Audit/2024/163 | 08/02/2024 | Reasonable Assurance | IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18) | 4.3 Management should ensure that efficient contract control measures are developed and employed with appropriate oversight, to ensure that suppliers maintain performance and invoices are issued correctly. | Internal Audit/2024/163/MD6/1 | This action is closely tied to action 4.2 and the appropriate controls will need to be placed with supplier and contract management framework. | Digital & Data<br><br>Director of Digital | 01.10.2024 | 31.07.2025 | High | In progress | April 2025 Update - We are looking to undertake an ITIL maturity assesment in Q2 FY 25-26, and will work with Procurement to find a third party consultancy to assist us in the process.<br><br>January 2025 Update - We have a start date for the new Head of Datacentre and Cloud for the 3rd March - this should then free up the Head of Digital Service Management to progress Service Management activities - we will then look to undertake an ITIL Maturity assessment in the new FY once end of year activities have been completed. Progress on this action reliant on Internal Audit/2024/163/MD4/1 |
| Internal Audit/2024/163 | 08/02/2024 | Reasonable Assurance | IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18) | 5.1 Management should ensure that the pre-defined call functionality is expanded to all applicable services, to have a consistent approach to logging calls and more accurate metrics. | Internal Audit/2024/163/MD7/1 | This action is dependent on the selection, procurement, and implementation of a new ITSM tool. There is an expectation that ServicePoint is being deprecated by DHCW with the next 12 months. A bid for a new ITSM tool will be placed in the IMTP for 24-25. | Digital & Data<br><br>Director of Digital | 01.04.2025 | 30.04.2026 | Low | In progress | April 2025 Update - We have added the need for a replacement to ServicePoint at CTM in the IMTP for 25/26. We are also undertaking a review of the tooling we use to manage IT services. We are also actively looking for opportunities to identify funding. DHCW are in the process of developing requirements to purchase a replacement to ServicePoint, but will stated that they will keep ServicePoint available for the FY 25-26. Recommend new completion date of April 26 to work through options and implementation.<br><br>January 2025 Update - Conversations have started with DHCW about their approach to replacing ServicePoint, they are developing an approach and we are waiting for them to progress.<br><br>November 2024 Update - The Critical incident (CI) at PoW has disrupted this action. Whilst the Head of Digital Service Management is now in place, they are still covering a number of activities from their old role whilst we recruit and onboard a new Head of Datacentres and Cloud.<br><br>September 2024 Update - We have now successfully appointed a new Head of Digital Service Management, we will be looking to transfer over responsibilities from mid-October 2024. |
| Internal Audit/2024/163 | 08/02/2024 | Reasonable Assurance | IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18) | 5.2 Management should ensure that where available, the pre-defined call functionality is used to allow for the accurate recording of details, such as call type and priority. | Internal Audit/2024/163/MD8/1 | This action is dependent on the selection, procurement, and implementation of a new ITSM tool. There is an expectation that ServicePoint is being deprecated by DHCW with the next 12 months. A bid for a new ITSM tool will be placed in the IMTP for 24-25 | Digital & Data<br><br>Director of Digital | 01.04.2025 | 30.04.2026 | Low | In progress | April 2025 Update - We have added the need for a replacement to ServicePoint at CTM in the IMTP for 25/26. We are also undertaking a review of the tooling we use to manage IT services. We are also actively looking for opportunities to identify funding. DHCW are in the process of developing requirements to purchase a replacement to ServicePoint, but will stated that they will keep ServicePoint available for the FY 25-26. Recommend new completion date of April 26 to work through options and implementation.<br><br>January 2025 Update - Conversations have started with DHCW about their approach to replacing ServicePoint, they are developing an approach and we are waiting for them to progress. |

| Inspection Code | Date of Inspection | Overall Assurance Rating | Inspection Title | Recommendation | AMaT Reference Number | Action | Executive / Inspection Lead | Original Due Date | Current / Revised Due Date | Action Rating | Progress Status | Comments/Updates |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Internal Audit/2024/163 | 08/02/2024 | Reasonable Assurance | IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18) | 5.3Management should ensure that requests such as staff termination forms are accurately logged. | Internal Audit/2024/163/MD9/1 | This action is dependent on the selection, procurement, and implementation of a new ITSM tool. There is an expectation that ServicePoint is being deprecated by DHCW with the next 12 months. A bid for a new ITSM tool will be placed in the IMTP for 24-25 | Digital & Data<br><br>Director of Digital | 01.04.2025 | 30.04.2026 | Low | In progress | April 2025 Update - We have added the need for a replacement to ServicePoint at CTM in the IMTP for 25/26. We are also undertaking a review of the tooling we use to manage IT services. We are also actively looking for opportunities to identify funding. DHCW are in the process of developing requirements to purchase a replacement to ServicePoint, but will stated that they will keep ServicePoint available for the FY 25-26. Recommend new completion date of April 26 to work through options and implementation.<br><br>January 2025 Update - Conversations have started with DHCW about their approach to replacing ServicePoint, they are developing an approach and we are waiting for them to progress. |
| Internal Audit/2024/163 | 08/02/2024 | Reasonable Assurance | IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18) | 5.4 Management should ensure that the classifications data held within ServicePoint is reviewed and cleansed of duplications and are configured for all applicable services. | Internal Audit/2024/163/MD10/1 | This action is dependent on the selection, procurement, and implementation of a new ITSM tool. There is an expectation that ServicePoint is being deprecated by DHCW with the next 12 months. A bid for a new ITSM tool will be placed in the IMTP for 24-25 | Digital & Data<br><br>Director of Digital | 01.04.2025 | 30.04.2026 | Low | In progress | April 2025 Update - We have added the need for a replacement to ServicePoint at CTM in the IMTP for 25/26. We are also undertaking a review of the tooling we use to manage IT services. We are also actively looking for opportunities to identify funding. DHCW are in the process of developing requirements to purchase a replacement to ServicePoint, but will stated that they will keep ServicePoint available for the FY 25-26. Recommend new completion date of April 26 to work through options and implementation.<br><br>January 2025 Update - Conversations have started with DHCW about their approach to replacing ServicePoint, they are developing an approach and we are waiting for them to progress. |
| Internal Audit/2024/163 | 08/02/2024 | Reasonable Assurance | IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18) | 6.1Management should ensure that a defined problem management process and procedure is finalised, published, and adopted. | Internal Audit/2024/163/MD11/1 | Once a Digital Service Management function has been created (Action 2.1) complete process and procedures for Problem Management. | Digital & Data<br><br>Director of Digital | 01.01.2025 | 31.07.2025 | Medium | In progress | April 2025 Update - We are looking to undertake an ITIL maturity assessment in Q2 FY 25-26, and will work with Procurement to find a third party consultancy to assist us in the process. This is also linked to the need for ITSM tooling.<br><br>January 2025 Update - We have a start date for the new Head of Datacentre and Cloud for the 3rd March 2025 - this should then free up the Head of Digital Service Management to progress Service Management activities - we will then look to undertake an ITIL Maturity assessment in the new FY once end of year activities have been completed. Due to delays, request to revise due date to July 2025. |
| Internal Audit/2024/169 | 11/04/2024 | Reasonable Assurance | Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06) | 6.3 Consideration should be given to reviewing and monitoring the use of controlled drugs distribution across the site. This will support in reviewing patterns, themes, or periodic changes a period. | Internal Audit/2024/169/MD16/1 | Consideration will be given to reviewing and monitoring the use of controlled drugs distribution across the site. This will support in reviewing patterns, themes, or periodic changes a period. | Diagnostics, Therapies, Pharmacies and Specialities<br><br>Medical Director | 01.05.2024 | 30.09.2025 | Low | Partially complete | April 2025 Update - still being reviewed by digital pharmacy team. Suggest update of deadline to September 2025.<br><br>January 2025 update- being reviewed by digital pharmacy team. no specific update but the due date will need to be reviewed - Suggest September 2025 |
| Internal Audit/2024/169 | 11/04/2024 | Reasonable Assurance | Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06) | 7.1 A central electronic record should be retained of those staff that have undertaken Controlled Drugs training and refresher training. Consideration should be given to using ESR for this purpose. | Internal Audit/2024/169/MD17/1 | A central electronic record is retained for staff trained since 2020, however consideration will be given to using ESR for this purpose. | Diagnostics, Therapies, Pharmacies and Specialities<br><br>Medical Director | 01.09.2024 | 01.09.2025 | Medium | In progress | April 2025 Update - No progress made. ESR team still state that it may take some time for this action to be completed. Medicines Management Nurse chasing for an update of progress.<br><br>January 2025 Update - An update against this recommendation has not been provided on this occasion. |
| Internal Audit/2024/170 | 12/04/2024 | Limited Assurance | Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-02) | 1.1a A policy that outlines the Health Board's approach and responsibilities for GI pathways including demand management should be put in place.<br><br>1.1b A review of the draft 'Single CTM Colorectal USC Pathway GP Referral Triage' SOP should be carried out, with a view to creating a single SOP that describes the step-by-step process that should be followed to ensure consistency in service delivery across all sites. It should be ensured that the SOP clearly sets out the excepted process to be followed for areas such as GP and internal referrals, the triage and triage process and timeframes for undertaking the various stages in the process. The draft SOP should be agreed at an appropriate level within the Health Board. Where there are variations in service delivery, such as the Nurse Led Rapid Access One Stop Colorectal Clinic based at PCH, then a separate SOP should be formalised for use. | Internal Audit/2024/170/MD1/1 | A CTM Standardised LGI SOP to be developed, reviewed and agreed. | Planned Care<br><br>Chief Operating Officer | 30.06.2024 | 31.05.2025 | High | In progress | April 2025 Update - A new lead has been in post and taken the lead on the actions and are working through the actions, in contact and discussed with auditor during the last quarter. An update was also shared at Welsh Governments IQPD.<br><br>January 2025 Update - Draft SOP to be ratified in the March Surgical Business Meeting. Revised due date of May 2025 from June 2024. |
| Internal Audit/2024/170 | 12/04/2024 | Limited Assurance | Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-02) | 1.2 Specific guidance should be developed and made available in relation to:<br>• GPs outlining the processes relating to general or non-USC GI referrals.<br>• Internal hospital departments in respect of processes to be undertaken for internal GI referrals. | Internal Audit/2024/170/MD2/1 | Following completion of the LGI SOP - this will include flow/process charts and referral criteria to support internal and external referral process. | Planned Care<br><br>Chief Operating Officer | 30.06.2024 | 31.05.2025 | Medium | In progress | April 2025 Update - A new lead has been in post and taken the lead on the actions and are working through the actions, in contact and discussed with auditor during the last quarter. An update was also shared at Welsh Governments IQPD.<br><br>January 2025 Update - T&F group set up to develop the SOP. Revised due date of May 2025 from June 2024. |
| Internal Audit/2024/170 | 12/04/2024 | Limited Assurance | Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-02) | 2. Work should continue to explore the feasibility of integrating the WPRS and WCP/WPAS at PCH and RGH sites and negate the need for the current process of printing referrals from one system for scanning into another system.<br><br>Management should remind staff that referral and triage documentation for cases should be complete, and records saved within WCP/WPAS. | Internal Audit/2024/170/MD3/1 | 1. Need confirmation for go live date for LGI/Surgery.<br>2. Set up meeting with Records and Digital Team | Planned Care<br><br>Chief Operating Officer | 30.04.2024 | 31.05.2025 | Medium | In progress | April 2025 Update - A new lead has been in post and taken the lead on the actions and are working through the actions, in contact and discussed with auditor during the last quarter. An update was also shared at Welsh Governments IQPD.<br><br>January 2025 Update - Work is ongoing to merge WPAS within CTM and is expected to be completed in May 2025. Electronic vetting is now live for RGH site and work is in progress to align pathways to bring PCH into electronic vetting. Revised due date of May 2025 from June 2024. |
| Internal Audit/2024/170 | 12/04/2024 | Limited Assurance | Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-02) | 3.1 Processes should be implemented to ensure that referrals are efficiently and effectively triaged by clinicians within the shortest reasonable timescale after receipt, to minimise delay risks that could lead to patient harm. This should include the process to be followed where there is the known absence of a clinician.<br><br>Where there appears to be service areas where triage is not being carried out as timely as others, then a review should be undertaken to understand the cause of this and identify ways of improving service delivery. | Internal Audit/2024/170/MD4/1 | 1. Complete and roll out new CTM LGI SOP.<br>2. Produce referral and vetting process in line with SOP. | Planned Care<br><br>Chief Operating Officer | 30.09.2024 | 31.05.2025 | Medium | In progress | April 2025 Update - A new lead has been in post and taken the lead on the actions and are working through the actions, in contact and discussed with auditor during the last quarter. An update was also shared at Welsh Governments IQPD.<br><br>January 2025 Update - Referrals are vetted twice a day by colorectal consultants at the RGH site. Revised due date of May 2025 from September 2024.<br><br>November 2024 Update - An update against this recommendation has not been provided on this occasion.<br><br>September 2024 Update - An update against this recommendation has not been provided on this occasion. |
| Internal Audit/2024/170 | 12/04/2024 | Limited Assurance | Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-02) | 3.2 Management should review of the paper-based triage process used in a number of service areas to establish if the electronic processes used elsewhere can be rolled out. The use of fully electronic files will negate the need for printing and rescanning of records, meaning files can be traced and accessed, with an electronic record of decision making retained.<br><br>Where paper triage forms continue to be used, forms should be revised to require the triage clinicians printed name in addition to their signature. Clinicians should be reminded of the importance of signing triage forms once complete to provide a complete record of the decision-making process. | Internal Audit/2024/170/MD5/1 | 1. Understand go live date for E-Refs for LGI/Surgery.<br>2. link in with Records/Digital team. | Planned Care<br><br>Chief Operating Officer | 30.09.2024 | 31.05.2025 | Medium | In progress | April 2025 Update - A new lead has been in post and taken the lead on the actions and are working through the actions, in contact and discussed with auditor during the last quarter. An update was also shared at Welsh Governments IQPD.<br><br>January 2025 Update - LGI/Surgery now have a full electronic pathway. Revised due date of May 2025 from September 2024. |
| Internal Audit/2024/170 | 12/04/2024 | Limited Assurance | Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-02) | 4. Periodic 'peer review' quality assurance exercises should be undertaken by clinicians to ensure consistency in approach to patient referral triage and triage. The review should consider patients that were added to pathways and patients where their case was considered to be an 'inappropriate referral'. | Internal Audit/2024/170/MD6/1 | 1. To become part of the GI Directorate agenda - date of first meeting to be confirmed.<br>2. Replicate endoscopy peer review in line with JAG guidelines. | Planned Care<br><br>Chief Operating Officer | 30.06.2024 | 31.05.2025 | High | In progress | April 2025 Update - A new lead has been in post and taken the lead on the actions and are working through the actions, in contact and discussed with auditor during the last quarter. An update was also shared at Welsh Governments IQPD.<br><br>January 2025 Update - Gastroenterology/Endoscopy team to use the afternoon of audit days to hold this meeting, similar to Surgical colleagues. Peer review of referrals to be a standing agenda point as part of this. Revised due date of May 2025 from June 2024. |
| Internal Audit/2024/170 | 12/04/2024 | Limited Assurance | Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-02) | 5. There should be a consistent approach to reviewing and monitoring referral and demand activity across the Gastroenterology and Colorectal GI services. This could be supported further by the use of the Medical Records reports that outline delayed and unvetted referrals.<br><br>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.<br><br>Consideration should be given to other ways in which the data currently collected can be used to identify potential issues in processes and inform decision making to improve service delivery. | Internal Audit/2024/170/MD7/1 | 1. Imbed new CTM leadership structure.<br>2. Continue to work with our informatics teams to build purpose dashboards that support D&C and monitoring of productivity and efficiencies. | Planned Care<br><br>Chief Operating Officer | 31.12.2024 | 31.05.2025 | Medium | In progress | April 2025 Update - A new lead has been in post and taken the lead on the actions and are working through the actions, in contact and discussed with auditor during the last quarter. An update was also shared at Welsh Governments IQPD.<br><br>January 2025 Update - Dashboards are still being worked on, D&C conversations with colleagues ongoing in regards to drill down data. Productivity and efficiencies monitored via SIG KPI data for Gastroenterology. Revised due date of May 2025 from June 2024. |
| Internal Audit/2024/171 | 09/04/2024 | Limited Assurance | Decarbonisation Internal Audit Report_April 2024 (Review reference: CTMUHB-2324-13) | 1.1 The terms of reference for the Environmental Sustainability Group should be reviewed in line with the frequency set out in them to ensure they remain current in relation to membership details and reporting arrangements. The review should ensure that there are named representatives for each of the Executive leads with decarbonisation responsibilities. | Internal Audit/2024/171/MD1/1 | This recommendation is accepted and the terms of reference for the Environmental Sustainability Group will be updated to reflect this. | Strategy, Planning and Transformation<br><br>Executive Director of Strategy and Transformation | 01.07.2024 | 31.07.2024 | Medium | Fully complete (Awaiting approval) | April 2025 Update - Complete.<br><br>January 2025 Update - Terms of reference will be approved in ESG in January |
| Internal Audit/2024/171 | 09/04/2024 | Limited Assurance | Decarbonisation Internal Audit Report_April 2024 (Review reference: CTMUHB-2324-13) | 4.1 To aid the Health Board in identifying the commitment required to meet the WG 2030 Decarbonisation target, an assessment of those initiatives that can be quantified should take place and a costed plan developed and approved in line with organisational governance. Initiatives that cannot be quantified should be recorded as unquantifiable, but with a brief assessment to identify if the investment could be significant or not. | Internal Audit/2024/171/MD5/1 | Action will be undertaken to cost appropriate elements of the plan as resources and available information allows. However budgetary constraints are such that it is unlikely that all elements will be affordable and as for 4.2 we will stay in close dialogue with Welsh Government regarding priorities. | Strategy, Planning and Transformation<br><br>Executive Director of Strategy and Transformation | 01.03.2025 | 31.03.2025 | High | Partially complete (Overdue) | April 2025 Update - A costed plan is under development with staff supporting its creation.<br><br>January 2025 Update - Work is underway to gather data on the investment and fiscal requirements for the activities within the DAP. Information will be reported to ESB in the January meeting. It is anticipated that a fully costed plan will be available by the end of April 2025 |
| Internal Audit/2024/171 | 09/04/2024 | Limited Assurance | Decarbonisation Internal Audit Report_April 2024 (Review reference: CTMUHB-2324-13) | 4.2 For those initiatives that can be quantified, a long-term model for the funding required to support the decarbonisation programme should be developed. | Internal Audit/2024/171/MD6/1 | This recommendation needs to be undertaken in partnership with Welsh Government (through Directors of Planning/Directors of Finance channels) as the UHB works within its revenue and capital resource limits. For example, a key component of the UHB's capital planning is maximising access to funds available from Estates Funding Advisory Board for decarbonisation (which provided £0.9m in 23/24).<br><br>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. | Strategy, Planning and Transformation<br><br>Executive Director of Strategy and Transformation | 01.03.2026 | 31.03.2026 | High | In progress | April 2025 Update - Work is underway to obtain capital funding to increase estates efficiency. Further works will be delivered over the course of this FY.<br><br>January 2025 Update - Information is being gather as part of the long term investment requirements and will be reported to ESG in January |
| Internal Audit/2024/171 | 09/04/2024 | Limited Assurance | Decarbonisation Internal Audit Report_April 2024 (Review reference: CTMUHB-2324-13) | 5. Carbon impact assessments should form part of the decisions made and actions taken by the Health Board, especially in larger scale transformational projects. | Internal Audit/2024/171/MD7/1 | This recommendation is accepted by the Health Board. Work on this recommendation will commence following the recruitment of the Sustainability Manager as this will create additional capacity needed to better understand how this can be enacted systematically across the health board.<br><br>Environmental Sustainability Group meetings<br>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.<br><br>Board and Committee reporting<br>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.<br><br>The report that we saw used the Welsh Government monitoring return format, so did not include narrative for the reader to gain an overarching view of the position of the Health Board against its targets. Whilst the cover report referred to 'varying degrees of success' and the risks to achievement of the target, there did not appear to be reporting against the Health Board's overall carbon reduction target of 16% by 2025. | Strategy, Planning and Transformation<br><br>Executive Director of Strategy and Transformation | 01.03.2025 | 31.03.2025 | Medium | Overdue | April 2025 Update - In progress - More work is required to ensure decarbonisation and climate adaptation forms part of decision making.<br><br>January 2025 update - Work has been delivered to include decarbonisation as part of processes. Governance has been updated at corporate level with strong links to decarbonisation. |
| Internal Audit/2024/187 | 06/06/2024 | Reasonable Assurance | Leadership and Management Development Programme Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-01) | 1.2 Performance indicators such as the sign-up rate, conversion rate (the number that have registered that go on to start the programme) and the completion rate should be developed for the programmes, and these should be appropriately reported. | Internal Audit/2024/187/MD2/1 | These performance indicators were developed for the programmes, although inaccuracies in the data are recognised (as per 2.1a).<br>Actions:<br>• Develop new programme dashboards with HEIW, using functionality in Gwella. | People<br><br>Executive Director for People | 30.11.2024 | 31.03.2025 | Medium | Fully complete (Awaiting approval) | April 2025 Update - Gwella dashboards are now available (via HEIW), displaying CTM staff engagement with CTM's Leadership Hub.<br><br>Programme performance measurement (for the Inspire programme) is undertaken by the L&D team using the locally developed participant tracker. This is reviewed on a weekly basis, with any gaps in programme participation and engagement escalated to SLT to drive programme engagement.<br><br>Due to Inspire being a controlled cohort of set participants, performance indicators around sign-up and conversion rates are no longer relevant.<br><br>January 2025 Update - All metrics designed and reporting functionality built into programmes. To supplement HEIW Gwella reporting dashboard, participant tracker developed to monitor programme engagement. Data to be reported following Module 1 March 2025. |
| Internal Audit/2024/187 | 06/06/2024 | Reasonable Assurance | Leadership and Management Development Programme Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-01) | 1.2 Performance indicators such as the sign-up rate, conversion rate (the number that have registered that go on to start the programme) and the completion rate should be developed for the programmes, and these should be appropriately reported. | Internal Audit/2024/187/MD2/2 | These performance indicators were developed for the programmes, although inaccuracies in the data are recognised (as per 2.1a).<br>Actions:<br>• Report dashboards and programme performance indicators to People and Culture committee. | People<br><br>Executive Director for People | 31.12.2024 | 31.03.2025 | Medium | Fully complete (Awaiting approval) | April 2025 Update - People & Culture committee no longer in place, but a leadership development update was provided to the final committee in December 2025.<br><br>A further update (to include programme performance indicators) is due to be presented at Operational Management Board, May 2025.<br><br>More broadly, programme performance is reported on a weekly basis, with any gaps in programme participation and engagement escalated to SLT to drive programme engagement. |

| Inspection Code | Date of Inspection | Overall Assurance Rating | Inspection Title | Recommendation | AMaT Reference Number | Action | Executive / Inspection Lead | Original Due Date | Current / Revised Due Date | Action Rating | Progress Status | Comments/Updates |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Internal Audit/2024/187 | 06/06/2024 | Reasonable Assurance | Leadership and Management Development Programme Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-01) | 2.1a The content of the Leadership Management section of the L&D Monthly Analysis Report should be reviewed to ensure:<br>• Data is accurate.<br>• Information is comprehensive enough to enable readers to clearly understand the number of registrations, active learners and completions for each level of the programme.<br>• Reporting covers all the evaluation criteria that have been set out plus and any future performance indicators that may be set for the programme.<br><br>2.1b The Leadership and Management Programmes Evaluation & Impact Report should be prepared on a more frequent basis and presented at the People & Culture Committee to allow greater oversight. | Internal Audit/2024/187/MD3/1 | 2.1a • As per 1.2, develop new programme dashboards with HEIW, using functionality in Gwella. Ensure inclusion of evaluation data from 2.1b. | People<br><br>Executive Director for People | 30.11.2024 | 30.11.2024 | High | Fully complete (Awaiting approval) | April 2025 Update - Gwella dashboards are now available (via HEIW), displaying CTM staff engagement with CTM's Leadership Hub. Evaluation data for Inspire is being collected via MS Forms, and will be reported on once the dataset is big enough and represents coverage across a meaningful portion of the programme.<br><br>However, reporting on leadership development activity in the L&D Monthly Analysis Report is on hold, due to Inspire being a controlled and set cohort of participants (Inspire programme reporting is picked up via the participant tracker referenced elsewhere in this audit).<br><br>Once the wider leadership development offer has been reviewed (Ignite/ Aspire) and expanded, dashboards will again become relevant to drive engagement across the Care Groups. This is a key priority for the L&D team in 2025/26, but until that point, means any monthly reporting via the L&D Monthly Analysis Report will not be taking place. As a result, we propose that this action is complete, but dashboards will be developed once the organisational leadership development offer is in place.<br><br>January 2025 Update - New dashboards and an evaluation framework have been designed. These have not been shared due to the programme having not yet started. Following the launch, dashboards and evaluation reports will be compiled and shared. At an appropriate time and once the dataset is big enough, updates and accompanying reports will be shared with the relevant committee. |
| Internal Audit/2024/187 | 06/06/2024 | Reasonable Assurance | Leadership and Management Development Programme Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-01) | 2.1a The content of the Leadership Management section of the L&D Monthly Analysis Report should be reviewed to ensure:<br>• Data is accurate.<br>• Information is comprehensive enough to enable readers to clearly understand the number of registrations, active learners and completions for each level of the programme.<br>• Reporting covers all the evaluation criteria that have been set out plus and any future performance indicators that may be set for the programme.<br><br>2.1b The Leadership and Management Programmes Evaluation & Impact Report should be prepared on a more frequent basis and presented at the People & Culture Committee to allow greater oversight. | Internal Audit/2024/187/MD3/2 | 2.1b • In-line with the relaunch of Inspire, apply HEIW's Kirkpatrick Bronze evaluation framework.<br><br>This will supersede and replace any previous evaluation methods/ reporting, and will be reported to Inspiring People Board and People and Culture Committee. | People<br><br>Executive Director for People | 30.09.2024 | 30.09.2024 | High | Partially complete (Overdue) | April 2025 Update - Evaluation data for Inspire is being collected via MS Forms and participant tracker, and will be reported on once the dataset is big enough and represents coverage across a meaningful portion of the programme. An interim Evaluation & Impact Report will be written and presented at the midway point of Inspire (currently scheduled for Sep./ Oct. 2025).<br><br>January 2025 Update - New dashboards and an evaluation framework have been designed. These have not been shared due to the programme not having starting yet. Following the launch, dashboards and evaluation reports will be compiled and shared. At appropriate time and once dataset big enough, update and accompanying report will be shared with the relevant committee. |
| Internal Audit/2024/188 | 11/06/2024 | Reasonable Assurance | Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-14) | 1.1a Management should remind staff of the importance of ensuring that complete and accurate data is input to Datix (see also MA 5 relating to Standard Operating Procedures).<br><br>1.1b Regular monitoring should be carried out to ensure compliance. | Internal Audit/2024/188/MD1/1 | 1.1a Staff have been reminded of the importance of completing Datix. The SOP will be updated to provide guidance to ensure accurate data is recorded. An audit is being developed with support from the BI team to easily identify and monitor accurate data recording. | Patient Care & Safety<br><br>Executive Director of Nursing, Midwifery & Patient Care | 30.09.2024 | 31.03.2025 | Medium | Overdue | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - Unfortunately, due to operational demands, and staff unavailability, the Redress Dashboard is yet to be completed. Anticipated time scale for completion is now 31 March 2025. |
| Internal Audit/2024/188 | 11/06/2024 | Reasonable Assurance | Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-14) | 1.1a Management should remind staff of the importance of ensuring that complete and accurate data is input to Datix (see also MA 5 relating to Standard Operating Procedures).<br><br>1.1b Regular monitoring should be carried out to ensure compliance. | Internal Audit/2024/188/MD1/2 | 1.1b Regular monitoring is currently carried as part of the payment approval process. To support regular monitoring, a regular opened and closed cases audit is being developed with support from the BI team. | Patient Care & Safety<br><br>Executive Director of Nursing, Midwifery & Patient Care | 30.09.2024 | 31.03.2025 | Medium | Overdue | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - Unfortunately, due to operational demands, and staff unavailability, the Dashboard for regular monitoring of open and closed cases is yet to be completed. Anticipated time scale for completion is now 31 March 2025. |
| Internal Audit/2024/188 | 11/06/2024 | Reasonable Assurance | Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-14) | 3.1 Management should continue to remind staff of the importance of working towards the timeframes specified by WRP and should continue to monitor to ensure compliance with this requirement. | Internal Audit/2024/188/MD3/1 | Management have implemented weekly Business meetings for the Quality & Safety and Legal Teams, where reporting in respect of LFERs is undertaken to ensure timeframes are met.<br><br>LFERs are reviewed weekly in the Executive Director Led Patient Safety Meeting.<br><br>A CMR due report is run monthly by management to ensure CMRs are submitted in a timely manner. A regular opened cases audit is being developed with support from the BI team to facilitate a more thorough check on when a CMR should be triggered. | Patient Care & Safety<br><br>Executive Director of Nursing, Midwifery & Patient Care | 30.09.2024 | 30.09.2025 | Medium | In progress | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - work is ongoing to complete this action on 30/09/2025 |
| Internal Audit/2024/188 | 11/06/2024 | Reasonable Assurance | Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-14) | 5.1a The final payment section within the SOP should be reviewed and updated with clear guidance on what constitutes final payment and the process to follow should and invoice be disputed.<br><br>5.1b Management should liaise with the Once for Wales task and finish group to determine the outcome of their work on defining the key stages within Datix. The SOPs should be updated accordingly, including the 'closure' section with clear guidance on what the stages are for closed cases in Datix.<br><br>5.1c It should be ensured the authorisation details in the SOPs align to the information contained on the various forms.<br><br>5.1d All SOPs should be finalised and made available to staff. | Internal Audit/2024/188/MD5/1 | 5.1a The relevant section of the Standard Operating Procedure (SOP) will be reviewed to ensure that it clearly outlines what constitutes final payment and the process that should be followed if an invoice is disputed. Training will be provided once the SOP has been updated. This action will need to be aligned with the all-Wales approach and completion will be dependent on this. | Patient Care & Safety<br><br>Executive Director of Nursing, Midwifery & Patient Care | 30.09.2024 | 30.09.2024 | Medium | Overdue | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - Following being updated, the SOP to be finalised and approved. Training undertaken in September 2024 for Claims Investigations Officers. |
| Internal Audit/2024/188 | 11/06/2024 | Reasonable Assurance | Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-14) | 5.1a The final payment section within the SOP should be reviewed and updated with clear guidance on what constitutes final payment and the process to follow should and invoice be disputed.<br><br>5.1b Management should liaise with the Once for Wales task and finish group to determine the outcome of their work on defining the key stages within Datix. The SOPs should be updated accordingly, including the 'closure' section with clear guidance on what the stages are for closed cases in Datix.<br><br>5.1c It should be ensured the authorisation details in the SOPs align to the information contained on the various forms.<br><br>5.1d All SOPs should be finalised and made available to staff. | Internal Audit/2024/188/MD5/2 | 5.1b Management will attend or delegate staff to the WRP's Task and finish group to ensure the key stages are clearly defined. The SOP will be updated once the work has been finalised. | Patient Care & Safety<br><br>Executive Director of Nursing, Midwifery & Patient Care | 31.08.2024 | 31.08.2024 | Medium | Overdue | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - Action remains open. Team to contact WRP Task & Finish Group. |
| Internal Audit/2024/188 | 11/06/2024 | Reasonable Assurance | Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-14) | 5.1a The final payment section within the SOP should be reviewed and updated with clear guidance on what constitutes final payment and the process to follow should and invoice be disputed.<br><br>5.1b Management should liaise with the Once for Wales task and finish group to determine the outcome of their work on defining the key stages within Datix. The SOPs should be updated accordingly, including the 'closure' section with clear guidance on what the stages are for closed cases in Datix.<br><br>5.1c It should be ensured the authorisation details in the SOPs align to the information contained on the various forms.<br><br>5.1d All SOPs should be finalised and made available to staff. | Internal Audit/2024/188/MD5/3 | 5.1c The SOP will be reviewed and updated to ensure authorisation details align to the information contained in the CMRs. Staff will be informed of the updates at the Legal Services team meeting. | Patient Care & Safety<br><br>Executive Director of Nursing, Midwifery & Patient Care | 30.09.2024 | 30.09.2024 | Medium | Overdue | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - Due to operational pressures and restructuring of staff - action continues on this recommendation. |
| Internal Audit/2024/188 | 11/06/2024 | Reasonable Assurance | Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-14) | 5.1a The final payment section within the SOP should be reviewed and updated with clear guidance on what constitutes final payment and the process to follow should and invoice be disputed.<br><br>5.1b Management should liaise with the Once for Wales task and finish group to determine the outcome of their work on defining the key stages within Datix. The SOPs should be updated accordingly, including the 'closure' section with clear guidance on what the stages are for closed cases in Datix.<br><br>5.1c It should be ensured the authorisation details in the SOPs align to the information contained on the various forms.<br><br>5.1d All SOPs should be finalised and made available to staff. | Internal Audit/2024/188/MD5/4 | 5.1d SOPs are available to staff in and accessible in the local drive. Finalisation is dependent of ongoing work and updates on from the all-Wales Task and Finish Group and updates to the DCIQ system. | Patient Care & Safety<br><br>Executive Director of Nursing, Midwifery & Patient Care | 31.08.2024 | 31.08.2024 | Medium | Overdue | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - Action remains open. Team to contact WRP Task & Finish Group. |
| Internal Audit/2024/189 | 07/06/2024 | Reasonable Assurance | Technical Resilience Final Internal Audit Report_June 2024 (Review reference: CTM-2324-20) | 1. Consideration should be given to enabling SRM in order to better facilitate DR to alternate sites.<br><br>5.1d All SOPs should be finalised and made available to staff. | Internal Audit/2024/189/MD1/1 | A review into the use of VSRM will be carried out. Although an automated DR would be optimal, there are a number of scenarios where it would be preferred to have manual intervention into this type of response. This is in part due to some of the other work that would be required to ensure systems were accessible at the DR site such as network addressing. | Digital & Data<br><br>Director of Digital | 30.09.2024 | 03.03.2025 | Low | Fully complete (Awaiting approval) | April 2025 Update - Plans and Business Documentation has been developed covering the steps that need to be taken to invoke a response to a DR incident. This is deemed appropriate to the scenarios we have reviewed and recommend the action is closed.<br><br>January 2025 Update - Deli have confirmed that RecoverPoint still has a development roadmap, a process has begun to update all of the VMWare environments so that the new version of RecoverPoint can be used.<br><br>November 2024 Update - Recoverpoint is a fit for purpose solution for VMWare replication and we have validated replicas. In order to have full automated site recovery, dependent networking capabilities need to be in place, such as stretched layer 2 networks. Discussions are developing with both Cisco and PSBA on this.<br><br>September 2024 Update - Further discussion with Cisco lined up for late September. Meeting also kick off held in September with BT/PSBA team around the LANWAN strategy for the Health Board in light of increased reliance on the PSBA and Cloud services. |
| Internal Audit/2024/189 | 07/06/2024 | Reasonable Assurance | Technical Resilience Final Internal Audit Report_June 2024 (Review reference: CTM-2324-20) | 2.1 The Health Board should consider increasing alternate site capacity to enable full service delivery. | Internal Audit/2024/189/MD2/1 | Prior to increasing capacity, CTM should complete the system criticality mapping, and therefore have a structure and precedence for systems to be brought back (while noting that certain key infrastructure components need to be present as a foundation – such as DHCP, File, Print and Citrix).<br><br>Capacity relates to storage in this matter, and by not restoring legacy archive data, the storage requirements may reduce. | Digital & Data<br><br>Director of Digital | 30.09.2024 | 31.10.2025 | Medium | In progress | April 2025 Update - Using year end capital the recover capacity has been expanded. Further work to continue to complete the criticality mapping. Action due date be revised to October 2025 due to operational pressures.<br><br>January 2025 Update - A workshop has been arranged for 28th January 2025 to develop plans and processes around recovery capacity and capabilities. |
| Internal Audit/2024/189 | 07/06/2024 | Reasonable Assurance | Technical Resilience Final Internal Audit Report_June 2024 (Review reference: CTM-2324-20) | 3.1 Once the DR site has been provisioned the resilience position should be tested to ensure it operates as anticipated. Going forward resilience should be subject to regular testing, failing over between rooms and across sites to ensure it still operates. | Internal Audit/2024/189/MD3/1 | A schedule for end-to-end failover testing will be produced and implemented. This should include a full prioritised recovery of systems and validation by system managers/end users. An ongoing log will be maintained. | Digital & Data<br><br>Director of Digital | 31.12.2024 | 31.05.2025 | Medium | In progress | April 2025 Update - Awaiting finalisation of the cyber vault installed before testing. Operational pressures have affected the timescales - new target date of 31st May 2025.<br><br>January 2025 Update - A workshop has been arranged for 28th January 2025 to develop plans and processes around recovery capacity and capabilities. Operational pressures have affected the timescales - new target date of 31st March 2025. |
| Internal Audit/2024/189 | 07/06/2024 | Reasonable Assurance | Technical Resilience Final Internal Audit Report_June 2024 (Review reference: CTM-2324-20) | 4.1 The DR plan should be updated to reflect the new environment. The plan should consider the main types of failure such as IT, power, communications and cover the network infrastructure.<br>• The DR plan should include processes to follow in order to restore services in the event of varying degrees of failure such as:<br>• Failure of site provision of failover instructions, restore priorities;<br>• Failure of rack provision of failover and restore instructions;<br>• Failover of VM restore and restore from backup; and<br>• Failure of system – VM restore / backup restore. | Internal Audit/2024/189/MD4/1 | The UHB will establish a prioritised plan, incorporating step by step procedures for the restoration of services following a major incident, under 4 separate scenarios, incorporating the fault domain failures as relevant (site, rack, VM, system):<br>- Cyber impacting affecting CTM network and services<br>- Environment impact affecting CTM network and services (e.g. utility loss, flood or fire)<br>- Loss of DHCW services<br>- Loss of WAN &/or Cloud services (external to NHS Wales hosted services which we access via DHCW, PSBA & internet) | Digital & Data<br><br>Director of Digital | 30.09.2024 | 31.05.2025 | Medium | In progress | April 2025 Update - Plans have been updated and is under peer review, once peer review is complete action can be closed. Expected / revised due date 31st May 2025.<br><br>January 2025 Update - A workshop has been arranged for 28th January 2025 to develop plans and processes around recovery capacity and capabilities. Operational pressures have affected the timescales - new target date of 31st March 2025. |
| Internal Audit/2024/189 | 07/06/2024 | Reasonable Assurance | Technical Resilience Final Internal Audit Report_June 2024 (Review reference: CTM-2324-20) | 5.1 An assessment of the need for individual service DR plans should be undertaken. Following that detailed DR documentation should be in place, either within the Server DR document, or within individual DR documents for each service which sets out the architecture, and processes to follow in order to restore the service.<br><br>The DR documentation should explicitly include information on the resilience tier and RTO/RPO and this should be communicated to service leads. | Internal Audit/2024/189/MD5/1 | The criticality of systems will be prioritised based on criticality. The exercise to document DR plans for all critical systems as defined by NIS regulations will continue with progress overseen by the Cyber Security Assurance Board.<br><br>The DR documentation will include information on the resilience tier and RTO/RPO and will be communicated to system managers. | Digital & Data<br><br>Director of Digital | 30.12.2024 | 31.05.2025 | Medium | In progress | April 2025 Update - Plans have been updated and is under peer review, once peer review is complete action can be closed. Expected / revised due date 31st May 2025.<br><br>January 2025 Update - A workshop has been arranged for 28th January 2025 to develop plans and processes around recovery capacity and capabilities. Operational pressures have affected the timescales - new target date of 31st March 2025. |
| Internal Audit/2024/189 | 07/06/2024 | Reasonable Assurance | Technical Resilience Final Internal Audit Report_June 2024 (Review reference: CTM-2324-20) | 6.1 The services to be restored to alternate sites should be formally defined and a prioritised order for recovery set out. This should be based on a formal assessment of service criticality and risk. | Internal Audit/2024/189/MD6/1 | This links to the work being carried out for the NIS Regulations. This will be complete in line with MAs 2,5. | Digital & Data<br><br>Director of Digital | 30.12.2024 | 31.05.2025 | High | In progress | April 2025 Update - Plans have been updated and is under peer review, once peer review is complete action can be closed. Expected / revised due date 31st May 2025.<br><br>January 2025 Update - A workshop has been arranged for 28th January 2025 to develop plans and processes around recovery capacity and capabilities. Operational pressures have affected the timescales - new target date of 31st March 2025. |
| Internal Audit/2024/190 | 03/06/2024 | Reasonable Assurance | Risk Management Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-17) | 4.4<br>Quality and Safety Corporate Directorate<br>The terms of reference for the Quality and Safety Business Team Meeting should finalised as soon as possible, so as to formalise the responsibility in relation to risk register monitoring and the process for escalation or risks.<br><br>It should be ensured that department risk register is routinely discussed at the Quality and Safety Business Team Meeting with onward reporting and escalation to the Quality and Safety Improvement Meeting where necessary.<br><br>Minutes or action logs from each meeting should be retained to allow clarity on what was discussed and actions that need acting upon. | Internal Audit/2024/190/MD9/1 | The terms of reference for the Quality and Safety Business Team Meeting to be finalised incorporating the monitoring of risk as a routine item. Minutes and decision log reflect action taken. | Patient Care & Safety<br><br>Executive Director for Nursing/Deputy CEO<br><br>Director of Governance | 31.07.2024 | 30.04.2025 | Medium | Partially complete | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - This action was not fulfilled in so much as the approval process of the ToR was not completed; this was due to a review of the meetings and the aims and objectives of the same with a revised way of working and meeting structure. This is still work in progress and we are planning to have a fully revised meeting structure in place to start the new financial year April 2025. Revised due date of 30th April 2025. |
| Internal Audit/2024/192 | 04/06/2024 | Reasonable Assurance | Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09) | 10.1 Care should be taken to ensure data is accurately transferred from the worked roster to the Health Roster system on a weekly basis. | Internal Audit/2024/192/MD12/2 | A spot check audit of 2 separate weeks of Health Roster will be undertaken by the Senior Nurse which will compare paper roster and the Health Roster system for accuracy. This will be reported at the Directorate QSRE meeting. | Care Group<br><br>Chief Operating Officer | 31.08.2024 | 31.08.2024 | Medium | Overdue | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - An update against this recommendation has not been provided on this occasion. |
| Internal Audit/2024/192 | 04/06/2024 | Reasonable Assurance | Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09) | 11.1 Consultant job plans should be reviewed and agreed on an annual basis, with planning discussions commencing in enough time to get the plan signed off ahead of the job plan start period. | Internal Audit/2024/192/MD13/1 | All substantive inpatient consultant psychiatrists have had their job-planning meeting and all plans have been mutually agreed. The plans are in the process of being inputted to the Allocate system for formal sign off. | Care Group<br><br>Chief Operating Officer | 30.06.2024 | 30.06.2024 | High | Overdue | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - An update against this recommendation has not been provided on this occasion. |
| Internal Audit/2024/199 | 04/10/2024 | Reasonable Assurance | Intelligence Led Organisation Final Internal Audit Report_October 2024 (Review reference: CTM-2425-07_ | 1.1 The data and AI programme should be reviewed and if necessarily refreshed following the publication of the revised Ministerial Statement of Intent. | Internal Audit/2024/199/MD1/1 | The UHB will seek to contribute to the refresh of the Ministerial Statement of Intent on data and AI and the strategic and tactical refresh of the accompanying work programme.<br><br>We will ensure that the data strategy is refreshed at the appropriate time. | Director of Digital<br><br>Digital & Data | 31.12.2024 | 31.12.2024 | Medium | Overdue | April 2025 Update - The UHB contributed to the Ministerial Statement of Intent, the publication of which is awaited. The UHB is now represented on the AI Commission by the Director of Public Health. A substantial programme for data has been agreed for 2025/26 by the Board as part of the IMTP, with considerable supporting investment.<br><br>The UHB has drafted a proposal for assuring AI initiatives which will be considered by the IG Group and subsequently by the Exec Leadership Group in May 2025, with a number of AI developments being supported in the interim.<br><br>AI strategic environment continues to evolve with UK government publishing AI tactical plan implying (without granularity) how they envisage AI's application in health. WG have initiated procedures to develop a Welsh approach to which we are contributing.<br><br>January 2025 Update - Work programme for data developed for consideration within the IMTP development process, aligns to organisational and national priorities. It will require additional investment, not necessarily directly into any one service or department, if design principles are agreed and adhered to.<br>AI strategic environment continues to evolve with UK government publishing AI tactical plan implying (without granularity) how they envisage AI's application in health. We anticipate WG strategic direction on this. In the interim we are seeking to safely enable the use of AI within the UHB to support delivery of our CTM 2030 objectives. |

| Inspection Code | Date of Inspection | Overall Assurance Rating | Inspection Title | Recommendation | AMaT Reference Number | Action | Executive / Inspection Lead | Original Due Date | Current / Revised Due Date | Action Rating | Progress Status | Comments/Updates |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Internal Audit/2024/199 | 04/10/2024 | Reasonable Assurance | Intelligence Led Organisation Final Internal Audit Report_October 2024 (Review reference: CTM-2425-07_ | 1.1 The data and AI programme should be reviewed and if necessarily refreshed following the publication of the revised Ministerial Statement of Intent. | Internal Audit/2024/199/MD1/2 | It is the intention of the UHB to develop a strategic position and plan for AI over the course of the next 6 months. | Director of Digital<br><br>Digital & Data | 30.04.2025 | 30.04.2025 | Medium | In progress | April 2025 Update - The UHB has drafted a proposal for assuring AI initiatives which will be considered by the IG Group and subsequently by the Exec Leadership Group in May 2025, with a number of AI developments being supported in the interim<br><br>January 2025 Update - Work programme for data developed for consideration within the IMTP development process, aligns to organisational and national priorities. It will require additional investment, not necessarily directly into any one service or department, if design principles are agreed and adhered to.<br>AI strategic environment continues to evolve with UK government publishing AI tactical plan implying (without granularity) how they envisage AI's application in health. We anticipate WG strategic direction on this. In the interim we are seeking to safely enable the use of AI within the UHB to support delivery of our CTM 2030 objectives.<br><br>November 2024 Update - The UHB is presently contributing to the phase 4 NDR business case which is a key driver for delivery of the data programme for the next 3 years. This is pertinent as WG provides funding for the UHB's data function via the NDR programme and in agreeing to the NDR business case, the UHB will be required to contribute to delivery of these strategic objectives. If the case is agreed, the data programme will be revised accordingly. In regards to AI, there remains an intention to develop an AI strategy and to continue to benefit from the its use. An AI policy has been drafted for wider consideration and processes incorporating training materials have been established to enable staff to benefit from web based generative AI applications (e.g. chatgpt). |
| Internal Audit/2024/199 | 04/10/2024 | Reasonable Assurance | Intelligence Led Organisation Final Internal Audit Report_October 2024 (Review reference: CTM-2425-07_ | 1.2 The Data and AI programme should be refreshed in the event that the Digital Strategy is updated. This should include an organisational wide perspective, noting that the Central Data / Information Team are the professional leads and the organisational aims to improve information use. | Internal Audit/2024/199/MD2/1 | In a rapidly developing environment the UHB will endeavour to ensure that our strategic and tactical approach to digital, data and AI, the EHR, patient portal, and other areas align through regular consideration and refresh of our strategic, tactical and operational decision making. | Director of Digital<br><br>Digital & Data | 30.04.2025 | 30.04.2025 | Medium | In progress | April 2025 Update - AI strategic environment continues to evolve with UK government publishing AI tactical plan implying (without granularity) how they envisage AI's application in health. WG have initiated procedures to develop a Welsh approach to which we are contributing.<br><br>January 2025 Update - Work programme for data developed for consideration within the IMTP development process, aligns to organisational and national priorities. It will require additional investment, not necessarily directly into any one service or department, if design principles are agreed and adhered to.<br>AI strategic environment continues to evolve with UK government publishing AI tactical plan implying (without granularity) how they envisage AI's application in health. We anticipate WG strategic direction on this. In the interim we are seeking to safely enable the use of AI within the UHB to support delivery of our CTM 2030 objectives. |
| Internal Audit/2024/199 | 04/10/2024 | Reasonable Assurance | Intelligence Led Organisation Final Internal Audit Report_October 2024 (Review reference: CTM-2425-07_ | 3.1 A Data Quality Policy, or statement of intent should be developed that makes clear what good quality data looks like and its characteristic's along with clear expectations and responsibilities of staff. | Internal Audit/2024/199/MD4/1 | The UHB will develop and implement a data quality policy, recognising that we anticipate the real improvements to be made when the data becomes available to the staff members who initially made the record and staff members who would use the records to meet the requirements. This availability is dependent upon the open architecture and NDR programmes moving into rapid delivery phases. | Director of Digital<br><br>Digital & Data | 31.01.2025 | 31.01.2025 | Medium | Overdue | April 2025 Update - The data quality policy has been re-drafted to incorporate not only 'data' in the conventional sense, but also to the algorithms, tools, and workflows that led to that data, noting this is a requirement when considering the quality of data in development and adoption of AI materials. It is due to be considered by the IG group in May.<br><br>January 2025 Update - Further review has identified that if the policy extends to not only to 'data' in the conventional sense, but also to the algorithms, tools, and workflows that led to that data there is a requirement to consider quality in development and adoption of AI materials. ABMB have kindly shared their approach in this area, which on review appears eminently sensible. The policy will thus be amended to incorporate this and then be subject to the scrutiny and assurance process for policy adoption. |
| Internal Audit/2024/199 | 04/10/2024 | Reasonable Assurance | Intelligence Led Organisation Final Internal Audit Report_October 2024 (Review reference: CTM-2425-07_ | 4.1 Consideration should be given to using the IAR process to fully identify data pools and expanding the information held within the IAR. | Internal Audit/2024/199/MD5/1 | The UHB will establish a data catalogue in line with Welsh standards as part of a commissioned and funded element of the National Data Resource programme. | Director of Digital<br><br>Digital & Data | 31.03.2027 | 31.03.2027 | Medium | In progress | April 2025 Update - Considerable work was undertaken during March to spec out a work plan for the establishment of an all Wales data catalogue, via the NDR programme. The UHB is contributing to this.<br><br>January 2025 Update - No further update – NDR phase 4 BC not yet agreed by WG |
| Internal Audit/2024/199 | 04/10/2024 | Reasonable Assurance | Intelligence Led Organisation Final Internal Audit Report_October 2024 (Review reference: CTM-2425-07_ | 5.1 A Data Governance Framework for the organisation should be defined that sets out the requirements and responsibilities for the dentification, aggregation, recording and use of data. This should include requirements for the presentation of information products that comply with good practice. | Internal Audit/2024/199/MD6/1 | A data governance framework complimentary to the data quality policy, and incorporating the numerous mandated requirements placed on the UHB will be developed and implemented. | Director of Digital<br><br>Digital & Data | 31.01.2025 | 31.01.2025 | Medium | Overdue | April 2025 Update - A data governance framework complimentary to the data quality policy, and incorporating the numerous mandated requirements placed on the UHB, which is applicable for the development and adoption of AI has been drafted and will be considered by members of the IG group in May 2025.<br><br>January 2025 Update- As above – there is a requirement to incorporate a data governance framework that is applicable for the development and adoption of AI. This requires further work. |
| Internal Audit/2024/199 | 04/10/2024 | Reasonable Assurance | Intelligence Led Organisation Final Internal Audit Report_October 2024 (Review reference: CTM-2425-07_ | 6.1 Training materials on data and its users should be provided, with targeted training provided to key staff tiers. | Internal Audit/2024/199/MD7/1 | The organisation will explore core competency training that is presently available across NHS and public sector Wales with the intention of incorporating this into the personal development approach of the organisation. | Director of Digital<br><br>Digital & Data | 31.03.2025 | 31.03.2025 | Medium | Overdue | April 2025 Update - In this year's IMTP we are enhancing our data capabilities with additional roles to provide support and education on the use of data. It is hoped that these will be in place by the end of Q2.<br><br>January 2025 Update - No update |
| Internal Audit/2024/200 | 16/09/2024 | Reasonable Assurance | Embedding the Quality Framework Final Internal Audit Report_September 2024 (Review reference: CTMUHB-2324-15) | 1.1 Management within Children & Families care group should review and update the terms of reference for their QPSE meetings. | Internal Audit/2024/200/MD1/1 | We acknowledge the importance of having clear and up-to-date ToRs for our QPSE meetings. We agree that a review and update of these terms of reference is required, to ensure they align with current priorities and best practices of the Children's and Families Care Group. A thorough review of the existing QPSE meeting ToRs will be conducted. Any outdated elements or areas that require enhancement will be made to the ToRs. The ToRs will be reviewed on an annual basis. | Patient Care & Safety<br><br>Executive Director of Nursing, Midwifery & Patient Care | 31.12.2024 | 31.12.2024 | Low | Overdue | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - Work has been undertaken within the Children & Families Care Group. These have now been standardised in the QSRE slides in alignment with USC & Planned care. The business intelligence team are now providing the data which means this is up to date. CYP presented an example of which during the December QSRE, these are also provided from the maternity HoMs as well.<br><br>The terms of reference were updated accordingly in August 2024, the quorcy was reviewed as it was identified that there were too many people in attendance. Finance representation has been reviewed and an invite dependent on the agenda items will be shared with the finance lead as a co-opted member of the group. |
| Internal Audit/2024/200 | 16/09/2024 | Reasonable Assurance | Embedding the Quality Framework Final Internal Audit Report_September 2024 (Review reference: CTMUHB-2324-15) | 1.2a - The quorcy arrangements for the QPSE meetings should be reviewed and made clearer. A review of attendees at the Children & Families QPSE meetings should take place to make efficient use of time, whilst also adhering to any quorcy requirements.<br><br>1.2b - Where the Head of Quality and Patient Safety is unable to attend care group QPSE meetings, a representative should attend on their behalf. The ToRs should be updated to provide clarity on the need for representatives to attend meetings, if key members are unable to attend.<br><br>1.2c - It should be determined if finance colleagues are required to be in attendance at QPSE meetings. If it is felt they are not required to attend, the ToRs should be updated. However, if it is determined that finance representation is a requirement, care group management should remind their finance representatives of this requirement. | Internal Audit/2024/200/MD2/1 | We will conduct a thorough review of the existing ToRs and make the following updates:<br><br>1.2a - Clarify the quorcy requirements, specifically defining how many representatives are needed from each service group/area for the meeting to be considered quorate.<br><br>1.2b - Update the list of required attendees and specify the need for deputies (especially in relation to the Head of Q&S and deputy) to attend in their absence.<br><br>1.2c - The QPSE Group will review whether finance colleagues are required to be in attendance at the QPSE meetings. If it is determined that finance representation is a requirement, the QPSE Chair will:<br>• Remind finance representatives of the requirement to attend,<br>• Emphasise the importance of their participation,<br>• Ensure finance colleagues understand their role within the QPSE meetings. | Patient Care & Safety<br><br>Executive Director of Nursing, Midwifery & Patient Care | 30.11.2024 | 28.02.2025 | Medium | Overdue | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update -<br>12.a The quorcy arrangements for each of the QPSE meetings is to undergo a final review to ensure all QPSE meetings are quorate and make efficient use of time.<br>1.2b - Where the Head of Quality and Patient Safety is unable to attend care group QPSE meetings, a representative now attends on their behalf. Each of the QPSE ToRs are being reviewed to provide clarity on the need for representatives to attend meetings, if key members are unable to attend.<br>1.2c - Discussions are ongoing in relation to requirement for finance colleagues to attend QPSE meetings.<br>Final completion of the 3 recommendations will be completed by 28 February 2025. |
| Internal Audit/2024/200 | 16/09/2024 | Reasonable Assurance | Embedding the Quality Framework Final Internal Audit Report_September 2024 (Review reference: CTMUHB-2324-15) | 2.1 Management should ensure that care groups use the standard slide template provided by the framework. This includes incorporating sections for risk registers, key governance issues, and shared learning. | Internal Audit/2024/200/MD3/1 | We acknowledge the importance of consistency and comprehensive reporting in our governance framework. The Corporate Quality & Safety team will review all Care Group QPSE slide templates and/or other methods of reporting, to ensure structures for reporting are consistent and in-line with the standard slide deck template within the Quality and Safety framework.<br><br>The Corporate Quality & Safety Team will review compliance of the slide templates on a bi-annual basis. | Patient Care & Safety<br><br>Executive Director of Nursing, Midwifery & Patient Care | 31.10.2024 | 31.10.2024 | Medium | Overdue | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 update - The Corporate Quality & Safety team will review all Care Group QPSE slide templates and/or other methods of reporting, to ensure structures for reporting are consistent and in-line with the standard slide deck template within the Quality and Safety framework bi-annually: March and September each year.<br><br>The Corporate Quality & Safety Team will review compliance of the slide templates on a bi-annual basis. |
| Internal Audit/2024/200 | 16/09/2024 | Reasonable Assurance | Embedding the Quality Framework Final Internal Audit Report_September 2024 (Review reference: CTMUHB-2324-15) | 2.2 Some CSGs included additional information in their slide deck presentations, such as data on Learning from Event Reports (LFERs), PDR & mandatory training compliance rates and other performance data. If care group management consider this additional information to be beneficial, then consideration should be given to standardising this practice across CSGs and care groups. The slide deck template could be<br>updated to include these sections, ensuring departments present this information in a consistent way. | Internal Audit/2024/200/MD4/1 | The Corporate Quality & Safety Team will conduct a review of the additional information currently being included by some CSGs. This review will assess the value and relevance of any additional information and whether, for consistency, this should be included within the standard slide-deck (or other method of structure for reporting). | Patient Care & Safety<br><br>Executive Director of Nursing, Midwifery & Patient Care | 31.12.2024 | 28.02.2025 | Low | Overdue | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 update - Slide Decks have been reviewed and approval of final template will be agreed by 28 February 2025.<br><br>November 2024 Update - An update against this recommendation has not been provided on this occasion.<br><br>New inspection action added October 2024 |
| Internal Audit/2024/200 | 16/09/2024 | Reasonable Assurance | Embedding the Quality Framework Final Internal Audit Report_September 2024 (Review reference: CTMUHB-2324-15) | 3.1 Management should ensure that all Care Groups have a documented assurance framework in place, setting out the assurance activities and structure of the CSGs and Care Group as a whole. | Internal Audit/2024/200/MD5/1 | The Corporate Quality & Safety Team will:<br>• conduct a detailed assessment of existing assurance frameworks within each Care Group to identify gaps and areas for improvement;<br>• Develop a standardised assurance framework template that outlines key assurance activities and structures. This will include guidelines on documentation, reporting, and compliance requirements;<br>• Establish a bi-annual monitoring and evaluation process to regularly review the effectiveness of the assurance frameworks. This will include periodic audits and feedback mechanisms to ensure continuous improvement. | Patient Care & Safety<br><br>Executive Director of Nursing, Midwifery & Patient Care | 30.11.2024 | 28.02.2025 | Medium | Overdue | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 update - The Corporate Quality & Safety Teams are currently undertaking a review of existing assurance frameworks within each Care Group to identify gaps and areas for improvement. A standard assurance framework template is to be agreed by 28 February 2025 and will be monitored bi-annually: March and September each year. |
| Internal Audit/2024/200 | 16/09/2024 | Reasonable Assurance | Embedding the Quality Framework Final Internal Audit Report_September 2024 (Review reference: CTMUHB-2324-15) | 4.1 The annual quality work plans developed by the pathology departments should be updated to include SMART objectives. The approach used by pathology should then be shared wider within the care group and to other care groups as a template for the development of annual quality plans as required by the Quality framework. Progress in implemented the care group level plans should be monitored via the care group QPSE meetings. | Internal Audit/2024/200/MD6/1 | The Pathology Department will update their Annual Quality Work Plan to include SMART objectives. Once the Pathology Department Annual Quality Work Plan has been updated, the revised plans will be shared at Care Group QPSE meetings. | Patient Care & Safety<br><br>Executive Director of Nursing, Midwifery & Patient Care | 15.10.2024 | 15.10.2024 | High | Overdue | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - Discussions continue with Pathology Department. Action Quality Work Plans to be agreed for other QPSEs thereafter. |
| Internal Audit/2024/200 | 16/09/2024 | Reasonable Assurance | Embedding the Quality Framework Final Internal Audit Report_September 2024 (Review reference: CTMUHB-2324-15) | 4.1 The annual quality work plans developed by the pathology departments should be updated to include SMART objectives. The approach used by pathology should then be shared wider within the care group and to other care groups as a template for the development of annual quality plans as required by the Quality framework. Progress in implemented the care group level plans should be monitored via the care group QPSE meetings. | Internal Audit/2024/200/MD6/2 | Templates and guidelines will be distributed to each Care Group QPSE group, who will complete an Annual Quality Work Plan (using SMART objectives). Each Care Group will ensure their QPSE Annual Quality Work Plan aligns with the Health Board's Annual Quality Work Plan.<br><br>Care Groups will:<br>• Ensure the QPSE Annual Quality Work Plan aligns with the Health Board's overarching Work Plan.<br>• Add quality work plan updates as a standing agenda item at QPSE meetings;<br>• Provide quarterly progress reports on SMART objectives;<br>• Establish a process to escalate any objectives that are off-track;<br>• Conduct an annual review of completed objectives and any lessons learned.<br><br>* Although we would normally undertake this work immediately, due to the nature of the action a realistic timescale will be 31 December 2024. | Patient Care & Safety<br><br>Executive Director of Nursing, Midwifery & Patient Care | 31.12.2024 | 31.12.2024 | High | Overdue | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - Discussions continue with Pathology Department. Action Quality Work Plans to be agreed for other QPSEs thereafter. |
| Internal Audit/2024/200 | 16/09/2024 | Reasonable Assurance | Embedding the Quality Framework Final Internal Audit Report_September 2024 (Review reference: CTMUHB-2324-15) | 5.1 Management should review the reporting timeliness for Children & Families to ensure that the data presented is as current as possible to enable more accurate and timely data for decision making. | Internal Audit/2024/200/MD7/1 | The Children & Families Care Group will review of the current reporting processes to identify any delays in the reporting timeliness of data, to ensure it is as current as possible. | Patient Care & Safety<br><br>Executive Director of Nursing, Midwifery & Patient Care | 31.12.2024 | 28.02.2025 | Low | Overdue | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - this action is ongoing and it is anticipated to be complete at 28 February 2025. |
| Internal Audit/2024/202 | 02/10/2024 | Reasonable Assurance | Follow-Up: Reasonable Offer Final Internal Audit Report - October 2024 (Review Reference -CTM-2324-25) | 1.1 The review and refresh of the Waiting List Management Standard Operating Procedure should be concluded and be presented to Operational Management Board (OMB) and the Executive Leadership Group (ELG) for final approval. | Internal Audit/2024/202/MD1/1 | 1.1 To be added to the agenda for Operational Management Board (OMB) following the review and refresh of the Waiting List Management Standard Operating Procedure should be concluded and be presented to OMB and the Executive Leadership Group (ELG) for final approval. | Planned Care<br><br>Chief Operating Officer | 30.11.2024 | 30.11.2024 | Low | Overdue | April 2025 Update - This action is currently in progress.<br><br>January 2025 Update - An update against this recommendation has not been provided on this occasion. |
| Internal Audit/2024/202 | 02/10/2024 | Reasonable Assurance | Follow-Up: Reasonable Offer Final Internal Audit Report - October 2024 (Review Reference -CTM-2324-25) | 2.1 Following completion of changes to the operating model and the merge to one WPAS system, the Health Board should perform a training needs assessment of staff responsible for booking appointments, including the application of the Waiting List Management SOP/RTT rules, specifically in relation to reasonable offers and the required audit trail within WPAS. | Internal Audit/2024/202/MD2/1 | 2.1 An additional training needs assessment and compliance sign off will take place post WPAS merge in May 2025. | Planned Care<br><br>Chief Operating Officer | 31.08.2025 | 31.08.2025 | Medium | In progress | April 2025 Update - This action is currently in progress.<br><br>January 2025 Update - An update against this recommendation has not been provided on this occasion. |
| Internal Audit/2024/202 | 02/10/2024 | Reasonable Assurance | Follow-Up: Reasonable Offer Final Internal Audit Report - October 2024 (Review Reference -CTM-2324-25) | 3.1 Management should pursue their original management response of generating WPAS compliance reports as a mechanism to identify staff training requirements. | Internal Audit/2024/202/MD3/1 | 3.1 Following OCP phase 3, an additional audit of the 'all users with WPAS compliance' report to take place and training arranged for identified staff. Directorates will review and identify where they need training.<br>Monthly Monitoring to enable staff training requirements. | Planned Care<br><br>Chief Operating Officer | 31.01.2025 | 31.01.2025 | Low | Overdue | April 2025 Update - This action is in progress in the Care Group.<br><br>January 2025 Update - An update against this recommendation has not been provided on this occasion. |

| Inspection Code | Date of Inspection | Overall Assurance Rating | Inspection Title | Recommendation | AMaT Reference Number | Action | Executive / Inspection Lead | Original Due Date | Current / Revised Due Date | Action Rating | Progress Status | Comments/Updates |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Internal Audit/2024/202 | 02/10/2024 | Reasonable Assurance | Follow-Up: Reasonable Offer Final Internal Audit Report - October 2024 (Review Reference -CTM-2324-25) | 4.1 Post-restructure, a full review of the approach to data validation should be undertaken to ensure compliance with the Waiting List Management SOP and RTT rules. The outcome of this work should be used to identify trends in errors to allow training to be targeted on certain aspects of the process or to certain teams / specialities. | Internal Audit/2024/202/MD4/1 | 4.1 Planned Care to undertake a review of the validation process across CTMUHB. Outcome of review to be shared with the Improving Care Board. | Planned Care<br><br>Chief Operating Officer | 31.01.2025 | 31.01.2025 | Medium | Overdue | April 2025 Update - This action is in progress in the Care Group.<br><br>January 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>November 2024 Update - An update against this recommendation has not been provided on this occasion.<br><br>New Inspection added October 2024. |
| Internal Audit/2024/203 | 27/09/2024 | Limited Assurance | Follow-up: Patient Pathways Final Internal Audit Report - September 2024 (Review Reference: CTM 23/24-31) | 1.1a To minimise the number of patients on the 'outpatients not booked' reports, following outpatient appointments, WPAS should be accurately updated in a timely manner. Each speciality should be clear who is responsible for performing this role and ensure relevant staff are aware of their responsibilities. | Internal Audit/2024/203/MD1/1 | 1.1a Directorates working with admin staff & records department to ensure they are taking back to source and to identify if any training requirements. | Planned Care<br><br>Chief Operating Officer | 31.01.2025 | 30.06.2025 | High | In progress | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - Progress being made on actions, with delay as operational focus on Critical Incident. Revised due date is June 2025 from 31.10.2024. |
| Internal Audit/2024/203 | 27/09/2024 | Limited Assurance | Follow-up: Patient Pathways Final Internal Audit Report - September 2024 (Review Reference: CTM 23/24-31) | 1.1b Each speciality should set out who is responsible for actioning 'outcomes not booked' reports. Staff should be made aware of their responsibilities. | Internal Audit/2024/203/MD2/1 | 1.1b Distribution lists updated to reflect new Directorate structures, will need further updating once vacancies filled. Draft produced and to be sent to PAS team. | Planned Care<br><br>Chief Operating Officer | 31.10.2025 | 30.06.2025 | High | In progress | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - Progress being made on actions, with delay as operational focus on Critical Incident. Revised due date is June 2025 from 31.10.2024. |
| Internal Audit/2024/203 | 27/09/2024 | Limited Assurance | Follow-up: Patient Pathways Final Internal Audit Report - September 2024 (Review Reference: CTM 23/24-31) | 1.1c As reports are received each week, speciality managers should ensure they analyse the data to identify trends such as those staff or departments that are continually failing to input outcome data and those staff or department that are facility to rectify errors. Where necessary appropriate action should be taken including the provision of additional training on the WPAS and holding staff to account if they are failing to perform tasks they are responsible for. | Internal Audit/2024/203/MD3/1 | 1.1c Directorate ops teams continue to validate 'outcomes not booked', next steps to take back to source and work with admin, secretaries and medical records to ensure processes are followed. Any training needs will be highlight to WPAS team for support. | Planned Care<br><br>Chief Operating Officer | 30.11.2024 | 30.06.2025 | High | In progress | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - Progress being made on actions, with delay as operational focus on Critical Incident. Requires a CTMUHB focus on validation. A task and finish is being established for validation of pathways across all specialities. Revised due date is June 2025 from 31.10.2024. |
| Internal Audit/2024/203 | 27/09/2024 | Limited Assurance | Follow-up: Patient Pathways Final Internal Audit Report - September 2024 (Review Reference: CTM 23/24-31) | 1.2 The wording used in the emails sent by the WPAS team could be further strengthened to ensure those receiving the reports are clear on the implications for patients if the reports are not acted upon and corrective action taken. | Internal Audit/2024/203/MD4/1 | 1.2 Directorate Managers and Services Managers (new structure) will be included in reporting emails to ensure the correct message is disseminated to the ops teams. | Planned Care<br><br>Chief Operating Officer | 30.11.2024 | 30.11.2024 | Low | Overdue | April 2025 Update - Progress being made on actions as per below<br><br>January 2025 Progress being made on actions, with delay as operational focus on Critical Incident |
| Internal Audit/2024/203 | 27/09/2024 | Limited Assurance | Follow-up: Patient Pathways Final Internal Audit Report - September 2024 (Review Reference: CTM 23/24-31) | 2.1a Each speciality should set out who is responsible for actioning 'closed pathway' reports when they are received each month. Staff should be made aware of their responsibilities | Internal Audit/2024/203/MD5/1 | 2.1a Directorate and Directorate Support Managers receive data and actions to be set at local Directorate performance meetings. To be rolled out across all Directorates. Updates are recorded and discussed at weekly Planned Care Weekly Performance Meeting – chaired by Director of Ops. | Planned Care<br><br>Chief Operating Officer | 30.11.2024 | 30.06.2025 | High | In progress | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - All distribution and reporting tools updated. Focus in the weekly RTT meetings on validation. Revised due date is June 2025 from 31.10.2024. |
| Internal Audit/2024/203 | 27/09/2024 | Limited Assurance | Follow-up: Patient Pathways Final Internal Audit Report - September 2024 (Review Reference: CTM 23/24-31) | 2.1b To minimise the number of patients incorrectly on closed pathways, as reports are received each month, speciality managers should ensure they analyse the data to identify those departments with high numbers of brought forward cases, and trends such as those staff or departments that are continually failing capture information correctly. Appropriate action should be taken, including the provision of additional training on the WPAS and holding staff to account if they are failing to perform tasks they are responsible for. | Internal Audit/2024/203/MD6/1 | 2.1b Distribution lists updated to reflect new Directorate structures, will need further updating once vacancies filled. Draft produced and to be sent to PAS team. Directorate ops teams continue to validate 'outcomes not booked', next steps to take back to source and work with admin, secretaries and medical records to ensure processes are followed. Any training needs will be highlight to WPAS team for support. | Planned Care<br><br>Chief Operating Officer | 31.10.2025 | 30.06.2025 | High | In progress | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - All distribution and reporting tools updated. Focus in the weekly RTT meetings on validation. Requires a CTMUHB focus on validation. A task and finish is being established for validation of pathways across all specialities. Revised due date is June 2025 from 31.10.2024.<br><br>November 2024 Update - An update against this recommendation has not been provided on this occasion.<br><br>New Inspection action added October 2024. |
| Internal Audit/2024/203 | 27/09/2024 | Limited Assurance | Follow-up: Patient Pathways Final Internal Audit Report - September 2024 (Review Reference: CTM 23/24-31) | 2.2a The wording used in the emails sent by the WPAS team could be further strengthened to ensure those receiving the reports are clear on the implications for patients if the reports are not acted upon and corrective action taken. | Internal Audit/2024/203/MD7/1 | 2.2a - Directorate Managers and Services Managers (new structure) will be included in reporting emails to ensure the correct message is disseminated to the ops teams. | Planned Care<br><br>Chief Operating Officer | 30.11.2024 | 30.06.2025 | Low | In progress | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - All distribution and reporting tools updated. Focus in the weekly RTT meetings on validation. Revised due date is June 2025 from 31.10.2024. |
| Internal Audit/2024/203 | 27/09/2024 | Limited Assurance | Follow-up: Patient Pathways Final Internal Audit Report - September 2024 (Review Reference: CTM 23/24-31) | 2.2b Consideration should be given to issuing separate 'closed pathways' reports to each speciality, as opposed to one generic report that has to be filtered. | Internal Audit/2024/203/MD8/1 | 2.2b - New updated distribution lists will ensure correct services and teams are receiving relevant report for their areas/specialties | Planned Care<br><br>Chief Operating Officer | 31.10.2025 | 30.06.2025 | Low | In progress | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - All distribution and reporting tools updated. Focus in the weekly RTT meetings on validation. Revised due date is June 2025 from 31.10.2024. |
| Internal Audit/2024/203 | 27/09/2024 | Limited Assurance | Follow-up: Patient Pathways Final Internal Audit Report - September 2024 (Review Reference: CTM 23/24-31) | 3. Those medical secretaries that do not yet have access to QL reporting tool should request access and if necessary, training, in order to be sure monitoring of patients awaiting diagnostic test results can be done in a consistent way across the Health Board, with no restrictions, such as those created by using 'watch lists'. | Internal Audit/2024/203/MD9/1 | 3. To be discussed and action set with new structure Directorate Managers and ops teams. | Planned Care<br><br>Chief Operating Officer | 30.11.2024 | 30.06.2025 | Medium | In progress | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - Ongoing with development of 'watch lists' additional training supported by WPAS team for individuals and teams. However, audit and trends needs to be monitored. Revised due date is June 2025 from 31.10.2024. |
| Internal Audit/2024/211 | 10/12/2024 | Limited Assurance | Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24/25-09) | 1.1 An updated Standard Operating Procedure (SOP) should be developed, setting out a consistent approach to the application of the Financial Control Procedure.<br><br>The SOP should incorporate all relevant information from recently issued guidance on WLI usage and rate cards. Where appropriate it should include the flow charts developed by Retinue. Management should also ensure that the findings of this report are used to identifying other areas where clear processes need to be defined, such as:<br><br>• Timeframe for entering shifts into Patchwork (e.g. within one week of the shift being worked) and timeframes for approval for payment.<br>• Situations when the creation of shifts retrospectively is acceptable and how the Retinue out of hours service should be used to minimise the need for creating retrospective shift on the system.<br>• When WLI / sessional shifts can be created, and the grade of staff they can be used for.<br>• Definitions of the 'reason' codes and guidance of when they can be used. | Internal Audit/2024/211/MD1/1 | The FCP will be updated to reflect the changes in the audit. | People<br><br>Executive Medical Director<br><br>Executive Director for People | 31.01.2025 | 28.02.2025 | High | Partially complete (Overdue) | April 2025 Update - The FCP has been drafted for comment but will need to be aligned to the workforce efficiencies programme work which commenced 1 April 2025. This will be reviewed and updated by end of May 2025.<br><br>January 2025 Update - the FCP has been updated to reflect the audit but will need to go to key stakeholders for approval. Request to extend the deadline to 28/2/25. |
| Internal Audit/2024/211 | 10/12/2024 | Limited Assurance | Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24/25-09) | 1.1 An updated Standard Operating Procedure (SOP) should be developed, setting out a consistent approach to the application of the Financial Control Procedure.<br><br>The SOP should incorporate all relevant information from recently issued guidance on WLI usage and rate cards. Where appropriate it should include the flow charts developed by Retinue. Management should also ensure that the findings of this report are used to identifying other areas where clear processes need to be defined, such as:<br><br>• Timeframe for entering shifts into Patchwork (e.g. within one week of the shift being worked) and timeframes for approval for payment.<br>• Situations when the creation of shifts retrospectively is acceptable and how the Retinue out of hours service should be used to minimise the need for creating retrospective shift on the system.<br>• When WLI / sessional shifts can be created, and the grade of staff they can be used for.<br>• Definitions of the 'reason' codes and guidance of when they can be used. | Internal Audit/2024/211/MD1/2 | The SOP will be finalised to include the points raised in the audit and will align to the FCP. | People<br><br>Executive Medical Director<br><br>Executive Director for People | 28.02.2025 | 28.02.2025 | High | Partially complete (Overdue) | April 2025 Update - the SOP is drafted. Before submitting for approval it will need to be updated to reflect the changes to the FCP in light of the workforce efficiencies programme. This should be updated by end of May 2025.<br><br>January 2025 Update - this action remains on target. The SOP is being updated to reflect the points in the FCP so that they align and support the process in practice. |
| Internal Audit/2024/211 | 10/12/2024 | Limited Assurance | Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24/25-09) | 1.1 An updated Standard Operating Procedure (SOP) should be developed, setting out a consistent approach to the application of the Financial Control Procedure.<br><br>The SOP should incorporate all relevant information from recently issued guidance on WLI usage and rate cards. Where appropriate it should include the flow charts developed by Retinue. Management should also ensure that the findings of this report are used to identifying other areas where clear processes need to be defined, such as:<br><br>• Timeframe for entering shifts into Patchwork (e.g. within one week of the shift being worked) and timeframes for approval for payment.<br>• Situations when the creation of shifts retrospectively is acceptable and how the Retinue out of hours service should be used to minimise the need for creating retrospective shift on the system.<br>• When WLI / sessional shifts can be created, and the grade of staff they can be used for.<br>• Definitions of the 'reason' codes and guidance of when they can be used. | Internal Audit/2024/211/MD1/3 | Controls will be reviewed with Retinue to align to the FCP and SOP. | People<br><br>Executive Medical Director<br><br>Executive Director for People | 28.02.2025 | 28.02.2025 | High | Partially complete (Overdue) | April 2025 Update - The SOP is updated and does include the points above. The SOP will need to reflect the workforce efficiency programme work so may need further amending before approvals. Expected completion end of May 2025.<br><br>January 2025 Update: this action remains on target. Working with Retinue to ensure processes are in place to support the actions which will be incorporated into the SOP. |
| Internal Audit/2024/211 | 10/12/2024 | Limited Assurance | Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24/25-09) | 1.1 An updated Standard Operating Procedure (SOP) should be developed, setting out a consistent approach to the application of the Financial Control Procedure.<br><br>The SOP should incorporate all relevant information from recently issued guidance on WLI usage and rate cards. Where appropriate it should include the flow charts developed by Retinue. Management should also ensure that the findings of this report are used to identifying other areas where clear processes need to be defined, such as:<br><br>• Timeframe for entering shifts into Patchwork (e.g. within one week of the shift being worked) and timeframes for approval for payment.<br>• Situations when the creation of shifts retrospectively is acceptable and how the Retinue out of hours service should be used to minimise the need for creating retrospective shift on the system.<br>• When WLI / sessional shifts can be created, and the grade of staff they can be used for.<br>• Definitions of the 'reason' codes and guidance of when they can be used. | Internal Audit/2024/211/MD1/4 | Reporting and monitoring of retrospective shifts, WLIs usage and reason codes will be discussed at MWPP: PEG | People<br><br>Executive Medical Director<br><br>Executive Director for People | 31.03.2025 | 31.03.2025 | High | Fully complete (Awaiting approval) | April 2025 Update - reporting and monitoring of retrospective shifts, WLI usage and reason codes is available in the MWPP:PEG data slides.<br><br>January 2025 Update - this action remains on target. Working with the COO's team on WLI process and with Retinue to ensure processes in place to support the actions. These will be incorporated into the SOP and develop data outputs to report to MWPP:PEG. |
| Internal Audit/2024/211 | 10/12/2024 | Limited Assurance | Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24/25-09) | 1.2 Once an SOP has been developed:<br>• It should be made accessible to staff via the intranet pages and consideration given to having links to it within the Patchwork app.<br>• Staff should be made aware of its existence.<br>• Consideration given to running training events or overview sessions for key areas to be discussed and allow staff to raise queries. | Internal Audit/2024/211/MD2/1 | Once the FCP and SOP are agreed, both will be made accessible to all and training will be organised. | People<br><br>Executive Medical Director<br><br>Executive Director for People | 31.03.2025 | 31.03.2025 | Medium | Partially complete (Overdue) | April 2025 Update - in accordance with the previous actions, the FCP and SOP are partially complete subject to including any changes as a result of the workforce efficiency programme work. Accessibility and training will be organised once both documents are approved for implementation.<br><br>January 2025 Update - As the completion date for the SOP is being extended to 31/3/2025, this action will also need to be extended. Request to change the completion date 31 May 2025. |
| Internal Audit/2024/211 | 10/12/2024 | Limited Assurance | Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24/25-09) | 2.1 Management should minimise the use of direct bookings within the Patchwork app and encourage managers and rota coordinators to book shifts via the worker application route. To do this:<br><br>• Rota coordinators and managers should be reminded of the various booking approaches and the circumstances when each can or should be used. The importance of an open and transparent process should also be reiterated. Where necessary refresher training on use of the system should be provided.<br><br>• Guidance documentation (a SOP) should contain information on the various booking approaches and the circumstances when each can or should be used. | Internal Audit/2024/211/MD3/1 | A reminder on the appropriate booking approaches and when to be used will be shared with rota co-ordinators and managers. | People<br><br>Executive Medical Director<br><br>Executive Director for People | 28.02.2025 | 28.02.2025 | Medium | Partially complete (Overdue) | April 2025 Update - The appropriate booking approaches and when to be used will be included in the FCP and SOP, which should be available end of May 2025 to align to the workforce efficiency programme.<br><br>January 2025 Update - this action remains on target to agree booking processes with rota co-ordinators and managers, which will be incorporated into the SOP. |
| Internal Audit/2024/211 | 10/12/2024 | Limited Assurance | Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24/25-09) | 2.1 Management should minimise the use of direct bookings within the Patchwork app and encourage managers and rota coordinators to book shifts via the worker application route. To do this:<br><br>• Rota coordinators and managers should be reminded of the various booking approaches and the circumstances when each can or should be used. The importance of an open and transparent process should also be reiterated. Where necessary refresher training on use of the system should be provided.<br><br>• Guidance documentation (a SOP) should contain information on the various booking approaches and the circumstances when each can or should be used. | Internal Audit/2024/211/MD3/2 | The SOP will confirm the appropriate booking approaches and when they should be used. | People<br><br>Executive Medical Director<br><br>Executive Director for People | 28.02.2025 | 28.02.2025 | Medium | Partially complete (Overdue) | April 2025 Update - This will be covered in the SOP once aligned to the workforce efficiency programme. It is expected to be ready for submission at the end of May 2025.<br><br>January 2025 Update - this is on target for completion. The SOP will include details of the booking processes and when they should be used. |
| Internal Audit/2024/211 | 10/12/2024 | Limited Assurance | Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24/25-09) | 2.2 Management should implement regular monitoring of booking practices, generating reports to track the use of direct bookings versus the worker system application. Deviations from the established process should be flagged and addressed promptly. | Internal Audit/2024/211/MD4/1 | Monitoring of booking practices will be undertaken monthly and reported to MWPP: PEG. | People<br><br>Executive Medical Director<br><br>Executive Director for People | 31.03.2025 | 31.03.2025 | Medium | Partially complete (Overdue) | April 2025 Update - Drafts of these reports are currently produced and shared in the weekly operational meeting. The Retinue team are working on automating these for all CG's. Bank/Job planning close to completion but we are still working on the agency data with Retinue.<br><br>January 2025 Update - This is on target. Data to support the rules around booking processes will be submitted on a monthly basis to MWPP:PEG. |
| Internal Audit/2024/211 | 10/12/2024 | Limited Assurance | Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24/25-09) | 2.2 Management should implement regular monitoring of booking practices, generating reports to track the use of direct bookings versus the worker system application. Deviations from the established process should be flagged and addressed promptly. | Internal Audit/2024/211/MD4/2 | Accountability for identifying and reporting deviations will be clarified to address promptly. | People<br><br>Executive Medical Director<br><br>Executive Director for People | 31.03.2025 | 31.03.2025 | Medium | Partially complete (Overdue) | April 2025 Update - Drafts of these reports are currently produced and shared in the weekly operational meeting. The Retinue team are working on automating these for all CG's. Bank/Job planning close to completion but we are still working on the agency data with Retinue.<br><br>January 2025 Update - This is on target. Data to support the rules around booking processes will be submitted on a monthly basis to MWPP:PEG. |
| Internal Audit/2024/211 | 10/12/2024 | Limited Assurance | Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24/25-09) | 3. The tiered rate escalation approval system within Patchwork should be reviewed to ensure:<br>• Limits are set up that align to the revised FCP.<br>• Authorisers are set up in groups that align to their approval level, with no authorisers being able to approve at both below 10% escalated rates and above escalated rates. Rate approvers should also not be the same staff who can authorise timesheets for payment.<br>• Only current and relevant staff are set up with authorisation access. Periodic reviews of rate authorisers and their access should take place to ensure appropriateness. | Internal Audit/2024/211/MD5/3 | A review of authorisers will be undertaken and updated within the Retinue and Patchwork systems. | People<br><br>Executive Medical Director<br><br>Executive Director for People | 28.02.2025 | 28.02.2025 | High | Partially complete (Overdue) | April 2025 Update - Authoriser's lists have been supplied to Retinue Team and the software developer is currently working on this. Date of completion to be confirmed.<br><br>January 2025 Update - This is on target. Authoriser's have been chased up to confirm we have an accurate and up to date list of approvers at the right level. |
| Internal Audit/2024/211 | 10/12/2024 | Limited Assurance | Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24/25-09) | 4. Management should undertake monthly reviews of Patchwork data to identify shift bookings that are considered excessive, such as greater than 12 hours.<br><br>A further analysis by care group and directorate would help to target areas where long shifts are being recorded. Appropriate action should be taken to ensure:<br><br>• Patient safety and staff wellbeing are not being compromised.<br>• Ensuring that higher equivalent hourly rates are not paid by paying for longer shifts.<br>• Staff are reminded to properly code shifts to ensure correct rates are paid and accurate information is captured in the system.<br><br>Where excessive shift lengths continue, the Health Board could liaise with Patchwork to establish if controls can be included in the system that requires additional authorisation for shifts above a certain length. | Internal Audit/2024/211/MD6/1 | The SOP will confirm the approach to working long shifts and the appropriate reason codes | People<br><br>Executive Medical Director<br><br>Executive Director for People | 28.02.2025 | 28.02.2025 | High | Partially complete (Overdue) | April 2025 Update - The SOP includes the approach to working long shifts and the appropriate reason codes. We are just waiting to align any changes due to the workforce efficiencies work.<br><br>January 2025 Update - this action remains on target and will be incorporated into the SOP. |

| Inspection Code | Date of Inspection | Overall Assurance Rating | Inspection Title | Recommendation | AMaT Reference Number | Action | Executive / Inspection Lead | Original Due Date | Current / Revised Due Date | Action Rating | Progress Status | Comments/Updates |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Internal Audit/2024/211 | 10/12/2024 | Limited Assurance | Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24/25-09) | 4. Management should undertake monthly reviews of Patchwork data to identify shift bookings that are considered excessive, such as greater than 12 hours.<br><br>A further analysis by care group and directorate would help to target areas where long shifts are being recorded. Appropriate action should be taken to ensure:<br><br>• Patient safety and staff wellbeing are not being compromised.<br>• Ensuring that higher equivalent hourly rates are not paid by paying for longer shifts.<br>• Staff are reminded to properly code shifts to ensure correct rates are paid and accurate information is captured in the system.<br><br>Where excessive shift lengths continue, the Health Board could liaise with Patchwork to establish if controls can be included in the system that requires additional authorisation for shifts above a certain length. | Internal Audit/2024/211/MD6/2 | A process to periodically review of long shifts by CG will be initiated. | People<br><br>Executive Medical Director<br><br>Executive Director for People | 28.02.2025 | 28.02.2025 | High | Partially complete (Overdue) | April 2025 Update - Reports in draft stages. Once the parameters are agreed, this will be available to all CG's. Reports to be reviewed in weekly operational meeting before cascade to CG's. Date for completion being finalised and reviewed for next month's meeting.<br><br>January 2025 Update - This is on target to outline the approach to long shifts. |
| Internal Audit/2024/211 | 10/12/2024 | Limited Assurance | Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24/25-09) | 4. Management should undertake monthly reviews of Patchwork data to identify shift bookings that are considered excessive, such as greater than 12 hours.<br><br>A further analysis by care group and directorate would help to target areas where long shifts are being recorded. Appropriate action should be taken to ensure:<br><br>• Patient safety and staff wellbeing are not being compromised.<br>• Ensuring that higher equivalent hourly rates are not paid by paying for longer shifts.<br>• Staff are reminded to properly code shifts to ensure correct rates are paid and accurate information is captured in the system.<br><br>Where excessive shift lengths continue, the Health Board could liaise with Patchwork to establish if controls can be included in the system that requires additional authorisation for shifts above a certain length. | Internal Audit/2024/211/MD6/3 | Control options will be discussed with Retinue (Patchwork) regarding long shifts to establish what is possible | People<br><br>Executive Medical Director<br><br>Executive Director for People | 28.02.2025 | 28.02.2025 | High | Partially complete (Overdue) | April 2025 Update - Liaised with Retinue as the service provider to establish with Patchwork (software) if this is possible should there be extended long shifts. This will link to coding as the long shifts may be associated with on call being mis-coded. This will be reviewed in readiness for the next update to confirm if this is still an issue or completed as new coding is established.<br><br>January 2025 Update - This is on target to confirm the use/approach to long shifts and when appropriate to use. |
| Internal Audit/2024/211 | 10/12/2024 | Limited Assurance | Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24/25-09) | 4. Management should undertake monthly reviews of Patchwork data to identify shift bookings that are considered excessive, such as greater than 12 hours.<br><br>A further analysis by care group and directorate would help to target areas where long shifts are being recorded. Appropriate action should be taken to ensure:<br><br>• Patient safety and staff wellbeing are not being compromised.<br>• Ensuring that higher equivalent hourly rates are not paid by paying for longer shifts.<br>• Staff are reminded to properly code shifts to ensure correct rates are paid and accurate information is captured in the system.<br><br>Where excessive shift lengths continue, the Health Board could liaise with Patchwork to establish if controls can be included in the system that requires additional authorisation for shifts above a certain length. | Internal Audit/2024/211/MD6/4 | Monitoring long shifts will reported at MWPP: PEG | People<br><br>Executive Medical Director<br><br>Executive Director for People | 31.03.2025 | 31.03.2025 | High | Fully complete (Awaiting approval) | April 2025 Update - The reporting of long shifts are being reported to MWPP:PEG. This action will align to appropriate coding to ensure long shifts cease or are appropriately coded if they are for on call.<br><br>January 2025 Update: this action remains on target for the monitoring of long shifts and to develop the process to share with MWPP:PEG. |
| Internal Audit/2024/211 | 10/12/2024 | Limited Assurance | Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24/25-09) | 5.1 Evaluate the existing reason codes to ensure they all remain relevant and accurately reflect the needs of the organisation. Simplifying and standardising the reasons could streamline the process and improve clarity in data reporting. | Internal Audit/2024/211/MD7/1 | The mandated fixed codes will be reviewed and streamlined. | People<br><br>Executive Medical Director<br><br>Executive Director for People | 28.02.2025 | 28.02.2025 | Medium | Fully complete (Awaiting approval) | April 2025 Update - Updated reason codes have been agreed with Finance and Retinue. These have been implemented for Bank and Agency.<br><br>January 2025 Update - This is on target. To review reason codes to streamline the list for use which will improve reporting. |
| Internal Audit/2024/211 | 10/12/2024 | Limited Assurance | Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24/25-09) | 5.2 In order to ensure accurate data is captured and available for future analysis, management should include the reason codes, and a description of when they should be used, within the user guidance. Staff should be reminded of the importance of selecting the correct reason code for a shift. This will enhance the accuracy of data collection and reporting, aiding in more effective decision-making. | Internal Audit/2024/211/MD8/1 | The SOP will include the reason codes and when they should be used. | People<br><br>Executive Medical Director<br><br>Executive Director for People | 28.02.2025 | 28.02.2025 | Medium | Partially complete (Overdue) | April 2025 Update - The SOP has been drafted but will need to be aligned to the workforce efficiency programme before final sign off. The reason codes have been recently agreed and the SOP will be updated to reflect the new coding by end of May 2025.<br><br>January 2025 Update - This is on target. The SOP will include the reason codes to be utilised. |
| Internal Audit/2024/211 | 10/12/2024 | Limited Assurance | Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24/25-09) | 5.2 In order to ensure accurate data is captured and available for future analysis, management should include the reason codes, and a description of when they should be used, within the user guidance. Staff should be reminded of the importance of selecting the correct reason code for a shift. This will enhance the accuracy of data collection and reporting, aiding in more effective decision-making. | Internal Audit/2024/211/MD8/2 | The reason codes used and volumes will be reported to MWPP: PEG. | People<br><br>Executive Medical Director<br><br>Executive Director for People | 31.03.2025 | 31.03.2025 | Medium | Fully complete (Awaiting approval) | April 2025 Update - The reason codes are reported to MWPP:PEG however, the new codes took effect from the end of April 2025 so it is expected that the first month of reporting under the new coding system is May 2025 but it is likely to be June 2025 before we see a shift in the data.<br><br>January 2025 Update - This is on target. The reason codes utilisation will be submitted on a monthly basis to MWPP:PEG. |
| Internal Audit/2024/211 | 10/12/2024 | Limited Assurance | Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24/25-09) | 5.3 Management should produce and analyse periodic reports on the level of use of reason codes for hourly shifts. Particular attention should be paid to those departments that regularly book shifts using the 'establishment vacancies' code to determine what work has been taken to tackle vacancy issues. | Internal Audit/2024/211/MD9/1 | Quarterly audits will be undertaken by CGs to review reason codes and the volumes of each. | People<br><br>Executive Medical Director<br><br>Executive Director for People | 30.04.2025 | 30.04.2025 | Medium | In progress | April 2025 Update - New codes have been generated by the SWP Team and Retinue for April 2025.<br><br>January 2025 Update - This is on target. |
| Internal Audit/2024/211 | 10/12/2024 | Limited Assurance | Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24/25-09) | 6.1 Management should analyse and monitor retrospective shifts created by care groups to address the root cause of retrospective shifts in each area, especially those entered more than two days after being worked, or where an inappropriate reason code has been used. | Internal Audit/2024/211/MD10/1 | The SOP will confirm the approval control process and appropriate use of retrospective shifts within the Retinue and Patchwork systems. | People<br><br>Executive Medical Director<br><br>Executive Director for People | 28.02.2025 | 28.02.2025 | High | Partially complete (Overdue) | April 2025 Update - the SOP will need to be aligned to the workforce efficiency programme. The approval control process and appropriate use of retrospective shifts within the Retinue and Patchwork is included in the SOP. It is anticipated this will be completed by end of May 2025.<br><br>January 2025 Update - This is on target. The SOP will include the use of and approach to retrospective shifts and when it is appropriate. |
| Internal Audit/2024/211 | 10/12/2024 | Limited Assurance | Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24/25-09) | 6.1 Management should analyse and monitor retrospective shifts created by care groups to address the root cause of retrospective shifts in each area, especially those entered more than two days after being worked, or where an inappropriate reason code has been used. | Internal Audit/2024/211/MD10/2 | Monitoring and analysis of the use of retrospective shifts to be discussed with CGs. | People<br><br>Executive Medical Director<br><br>Executive Director for People | 28.02.2025 | 28.02.2025 | High | Overdue | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - This is on target. Monitoring of retrospective shifts with CGs in underway. |
| Internal Audit/2024/211 | 10/12/2024 | Limited Assurance | Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24/25-09) | 6.2 To reduce the occurrence of retrospective shifts, clearer guidance should be in place for:<br><br>• When retrospective shifts are acceptable, how higher rates should be authorised, the correct use of reason codes and the maximum timeframes for creating the shift in Patchwork after the shift has been worked. Consideration should be given to requiring additional approval where there are significant delays in creating the shift.<br>• Using the Retinue out of hours service to book urgent or outside of normal working hours shifts that cannot be processed in advance by the manager or on duty executive. | Internal Audit/2024/211/MD11/1 | This is covered in 6.1. Controls for retrospective approvals will be confirmed. | People<br><br>Executive Medical Director<br><br>Executive Director for People | 31.01.2025 | 31.01.2025 | Medium | Overdue | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - Communication of the use of retrospective shifts to CGs is in progress and aimed to be concluded by 31/1/25. |
| Internal Audit/2024/211 | 10/12/2024 | Limited Assurance | Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24/25-09) | 6.2 To reduce the occurrence of retrospective shifts, clearer guidance should be in place for:<br><br>• When retrospective shifts are acceptable, how higher rates should be authorised, the correct use of reason codes and the maximum timeframes for creating the shift in Patchwork after the shift has been worked. Consideration should be given to requiring additional approval where there are significant delays in creating the shift.<br>• Using the Retinue out of hours service to book urgent or outside of normal working hours shifts that cannot be processed in advance by the manager or on duty executive. | Internal Audit/2024/211/MD11/2 | This is covered in 6.1. To be analysed and trends will be shared at MWPP: PEG | People<br><br>Executive Medical Director<br><br>Executive Director for People | 31.03.2025 | 31.03.2025 | Medium | Overdue | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - This is on target. Data to support discussions is in development. |
| Internal Audit/2024/211 | 10/12/2024 | Limited Assurance | Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24/25-09) | 7.3 Implement a monthly review of shifts where breaks were removed, focusing on shifts longer than six hours. This will help identify patterns of non-compliance and address issues proactively. | Internal Audit/2024/211/MD14/1 | To work with Retinue to develop reporting for monitoring at MWPP: PEG. | People<br><br>Executive Medical Director<br><br>Executive Director for People | 31.03.2025 | 31.03.2025 | Medium | Overdue | April 2025 Update - Working with Retinue to produce reports for MWPP:PEG. Completion date to be confirmed but an update will be shared for the next audit meeting.<br><br>January 2025 Update - Work is underway with Retinue to develop reporting for monitoring at MWPP:PEG. |
| Internal Audit/2024/211 | 10/12/2024 | Limited Assurance | Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24/25-09) | 8.1 Clear guidance should be available to staff emphasising the importance of timely and accurate timesheet submissions by the employee (and not the rota co-ordinator) and the consequences of non-compliance. Guidance should include instructions on how to submit electronic timesheets and the timeframe they should be submitted in. Where necessary, training on the use of the Patchwork app should be provided<br>to shift workers. | Internal Audit/2024/211/MD15/1 | A review of the timesheet process will be undertaken with Retinue and Patchwork to ensure the correct authorisation process is followed in accordance with the SOP. | People<br><br>Executive Medical Director<br><br>Executive Director for People | 31.01.2025 | 31.01.2025 | Medium | Partially complete (Overdue) | April 2025 Update - The timesheet process is in place with Retinue and Patchwork. However, issues were identified with the two-step approval process which Retinue are addressing to ensure the correct authorisation process is followed. This is expected to be completed in May 2025 and is incorporated in the SOP.<br><br>January 2025 Update - The timesheet process has been undertaken and is updated into the SOP. Expected to be completed by 31/1/25. |
| Internal Audit/2024/211 | 10/12/2024 | Limited Assurance | Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24/25-09) | 9.1 Clear procedures should be in place in relation to WLIs and made available to staff that includes information on a standardised process for creating sessional shifts within the system i.e. consistency between either hourly rates or total costs and ensuring shift duration is accurately recorded.<br><br>Consideration should be given to providing training for rota coordinators, managers, and relevant staff to ensure they are fully aware of the guidelines and understand the correct usage of sessional shifts. | Internal Audit/2024/211/MD16/1 | The SOP will set out the approach for WLIs. | People<br><br>Executive Medical Director<br><br>Executive Director for People | 28.02.2025 | 28.02.2025 | High | Partially complete (Overdue) | April 2025 Update - The SOP does include the process for WLIs. The SOP will be aligned to the workforce efficiency programme and should be ready for submission by end of May 2025.<br><br>January 2025 Update - This is on target to confirm the approach for WLIs in the SOP. |
| Internal Audit/2024/211 | 10/12/2024 | Limited Assurance | Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24/25-09) | 9.1 Clear procedures should be in place in relation to WLIs and made available to staff that includes information on a standardised process for creating sessional shifts within the system i.e. consistency between either hourly rates or total costs and ensuring shift duration is accurately recorded.<br><br>Consideration should be given to providing training for rota coordinators, managers, and relevant staff to ensure they are fully aware of the guidelines and understand the correct usage of sessional shifts. | Internal Audit/2024/211/MD16/2 | Reporting and monitoring will be shared at MWPP: PEG. | People<br><br>Executive Medical Director<br><br>Executive Director for People | 31.03.2025 | 31.03.2025 | High | Overdue | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - This is on target to prepare reports to share with MWPP:PEG |
| Internal Audit/2024/211 | 10/12/2024 | Limited Assurance | Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24/25-09) | 9.2 To aid consistency and monitoring of costs, management should determine if the free-text box for recording sessional shift costs is appropriate, or if a fix rate should be captured in the system. This will also allow appropriate escalation within the system, should anyone request rates above those agreed. | Internal Audit/2024/211/MD17/1 | Free text option will be reviewed with Retinue and Patchwork systems in line with the FCP and SOP to ensure application of WLIs are applied correctly. | People<br><br>Executive Medical Director<br><br>Executive Director for People | 31.01.2025 | 31.01.2025 | High | Fully complete (Awaiting approval) | April 2025 Update - Free text box has been removed as part of the revised WLI process which has been implemented in April 2025. The process will be included in the SOP to be agreed in May 2025.<br><br>January 2025 Update - This is on target. To remove the free text box to ensure appropriate escalation for WLIs. Discussions took place with Retinue in December 2024 to action. |
| Internal Audit/2024/211 | 10/12/2024 | Limited Assurance | Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24/25-09) | 9.3 Management should liaise with Retinue to identify if a control can be built into the process that only allows the 'waiting list' reason code to be selected for WLI sessions. Where this is not possible, management should remind staff of the need for accurate coding and ongoing monitoring should take place to identify non-compliance. | Internal Audit/2024/211/MD18/1 | To discuss with Retinue what controls can be built into the (Retinue and Patchwork) systems. | People<br><br>Executive Medical Director<br><br>Executive Director for People | 31.03.2025 | 31.03.2025 | Medium | Fully complete (Awaiting approval) | April 2025 Update - The new WLI process is now implemented and this action has now been addressed and is completed.<br><br>January 2025 Update - This is on target. Discussions took place with Retinue in December 2024 for action. |
| Internal Audit/2024/211 | 10/12/2024 | Limited Assurance | Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24/25-09) | 9.4 Management should remind staff that WLI sessions should only be used for consultants in line with the Welsh contract. Ongoing monitoring should take place to identify non-compliance. | Internal Audit/2024/211/MD19/1 | Management will be reminded of the use of WLIs | People<br><br>Executive Medical Director<br><br>Executive Director for People | 28.02.2025 | 28.02.2025 | Medium | Overdue | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - This is on target, in conjunction with the COO's office and SWP Team. |
| Internal Audit/2024/211 | 10/12/2024 | Limited Assurance | Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24/25-09) | 9.5 Monitoring of shifts coded as sessional should take place to ensure they reconcile back to COO agreed WLI activity. | Internal Audit/2024/211/MD20/1 | Monitoring of shifts coded to ensure they reconcile back to COO agreed WLI activity. | People<br><br>Executive Medical Director<br><br>Executive Director for People | 31.01.2025 | 31.01.2025 | Medium | Overdue | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>January 2025 Update - Monitoring of WLIs as coded as sessional is underway. |
| Internal Audit/2024/211 | 10/12/2024 | Limited Assurance | Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24/25-09) | 10. Given the wealth of data that is available in the Patchwork app, the Health Board should liaise with Retinue to determine a suite of reports that can be routinely received and analysed to identify noncompliance with the FCP.<br><br>The reports should be used to enhance the current monitoring at the PEG meeting, and to allow scrutiny in a wider range of matters. | Internal Audit/2024/211/MD21/1 | A review of CG access to Retinue and Patchwork will be undertaken/ | People<br><br>Executive Medical Director<br><br>Executive Director for People | 28.02.2025 | 28.02.2025 | High | Partially complete (Overdue) | April 2025 Update - A revised list of users was issued to Retinue for amending on the system. Completion date to be confirmed and will be updated for the next meeting.<br>Once complete training for all users will be organised.<br><br>January 2025 Update - This is on target. Work is underway to ensure the right access is available to CGs at the right levels. |
| Internal Audit/2024/211 | 10/12/2024 | Limited Assurance | Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24/25-09) | 10. Given the wealth of data that is available in the Patchwork app, the Health Board should liaise with Retinue to determine a suite of reports that can be routinely received and analysed to identify noncompliance with the FCP.<br><br>The reports should be used to enhance the current monitoring at the PEG meeting, and to allow scrutiny in a wider range of matters. | Internal Audit/2024/211/MD21/2 | A review of Retinue (Patchwork) reporting will be undertaken to support the FCP and SOP. | People<br><br>Executive Medical Director<br><br>Executive Director for People | 31.03.2025 | 31.03.2025 | High | Partially complete (Overdue) | April 2025 Update - Work is underway with Retinue as the provider and for Patchwork to ensure correct reporting. Issues with data timelines currently a challenge and use of insights data platform demonstrated. We should be able to update in line for next meeting on progress.<br><br>January 2025 Update -This work is underway. Discussions took place with Retinue in December 2024, for action to determine what reports would support the UHB with data monitoring at PEG. |
| Internal Audit/2024/214 | 12/12/2024 | Reasonable Assurance | Energy Management 2024/25 (Review Reference CTMUHB-SSU-2425-19) | 1. BMS<br>The UHB has been proactive in looking to better understand the limitations of their existing BMS. An independent review was carried out in June 2022 by an independent firm of Consulting Engineers detailed several recommendations and areas for improvement (some outside the scope of any refit funding).<br><br>These included:<br>• Observations in respect of the ability of the UHB to react to alarms on the system at the Princess of Wales Hospital.<br>• The report goes on to recommend that the UHB could address this and other legacy BMS oversight issues with the appointment of at "least 1 Whole Time Equivalent (WTE) Health Board wide BMS manager" along with "two off BMS Technicians to ensure that all equipment is correctly serviced".<br><br>Noting the revenue implications of this especially in the current financial climate the report author suggests that if the "team were only able to achieve a conservative 3% reduction on every site in utilities, at the current predicted energy spend of £15M, this would represent a £450K annual saving. The findings of the report would benefit from a wider exposure within the UHB. In so doing ensuring that any decisions made may address not only those themes that can be addressed by refit monies, but also changes that can be made in the short-term utilising existing BMS architecture. This should highlight any limitations and agreed mitigating arrangements. | Internal Audit/2024/214/MD1/1 | Findings of the report have been shared with the Environmental Steering Group<br><br>Actions to employ additional BMS staff previously reported at the Green Group and the Environmental Steering Group and been included in the UHB's Decarbonisation Action Plan (DAP) and included in the Environmental Management Plan Objectives and Targets.<br><br>The UHB is working towards a standardised BMS system across the UHB, as per the recommendations of the BMS study completed by CTM Estates.<br><br>Veolia have included audits of the BMS system as part of the ReFit High Level Assessment.<br><br>Veolia are currently conducting a high-level assessment of BMS systems across the Estates, which will feed into an investment grade proposal for BMS repairs and upgrades as identified.<br><br>Specialist contractors are employed across the Estate to maintain the standards of BMS systems operation and control.<br><br>CTM Estates will share the findings of the BMS report again with the Environmental Steering Group and the Green Group. | Capital and Estates<br><br>Executive Director of Finance | 31.03.2025 | 31.03.2025 | Medium | Overdue | April 2025 Update - CTM have been awarded £588k over two years for the delivery of BMS upgrades and optimisation over 2025-26 and 2026-27 financial years. A Capital Projects Officer has been assigned to oversee the delivery of the projects. |
| Internal Audit/2024/214 | 12/12/2024 | Reasonable Assurance | Energy Management 2024/25 (Review Reference CTMUHB-SSU-2425-19) | 2. Site walk arounds<br>During the site visits it was observed that there were several stand-alone fans in offices, resulting in energy inefficiencies.<br><br>Conducting the twice-yearly site walk-arounds as recommended by HTM07-02 Encode offer management first hand observation of where energy is being used and presenting an opportunity to raise the profile of energy awareness with Health Board colleagues. Alternatively, the rationale/ risks for derogating from the HTM should be reported and approved by an appropriate forum. | Internal Audit/2024/214/MD2/1 | CTM Estates will raise the proposal for twice-yearly site walkarounds at the next Environmental Steering Group meeting. Decision by the group to implement or derogate from the recommendation to be recorded in minutes and action plan. | Capital and Estates<br><br>Executive Director of Finance | 31.03.2025 | 31.03.2025 | Medium | Overdue | April 2025 Update - Proposal for twice-yearly site walkarounds is included in the 10-04-2025 Estates report to the Environmental Steering Group, requesting a decision from the group to implement or derogate from the recommendation to be recorded in minutes and action plan. |
| Internal Audit/2024/214 | 12/12/2024 | Reasonable Assurance | Energy Management 2024/25 (Review Reference CTMUHB-SSU-2425-19) | 3. Benchmarking<br>The UHB submitted energy data annually via the national NHS Wales Estates & Facilities Performance Management System (EFPMS) system – this requirement was recently changed to all sites over 500m².<br><br>NWSSP: Specialist Estates Services (SES) advise that, whilst benchmarking dashboards haven't been published in recent years, raw EFPMS data has been shared with all NHS Wales organisations, which would facilitate internal data review and benchmarking against other Health Boards. | Internal Audit/2024/214/MD3/1 | The UHB has all Wales benchmarking information from NWSSP for previous years and CTM properties perform well above benchmark in these reports.<br><br>A CTMUHB Benchmarking exercise for properties above 500m2 is scheduled for Q4 of 2024-25 once the data has been provided to CTM by NWSSP-SES | Capital and Estates<br><br>Executive Director of Finance | 31.03.2025 | 31.03.2025 | Medium | Overdue | April 2025 Update - All Wales benchmarking dashboards have been received from NWSSP-Special Estates Services. CTMUHB have met with NWSSP-SES to agree a benchmarking exercise at site level to compare All-Wales data. NWSSP-SES have agreed to conduct the benchmarking exercise and are scheduling resources to complete the exercise on our behalf. A meeting has been scheduled with Pavithra Murugan (Senior Data Analyst) on 5th August 2025. Pavithra is unavailable until that date.<br><br>January 2025 Update - All Wales Estates and Facilities Performance Review data has recently been made available from the 2023-24 submissions for all NHS organisations across Wales. Emails have been sent to NWSSP-Specialist Estates Services for access to the data and access to the Microsoft BI benchmarking tool. A meeting to review the data and begin the benchmarking exercise is scheduled for 31st January 2025. |

| Inspection Code | Date of Inspection | Overall Assurance Rating | Inspection Title | Recommendation | AMaT Reference Number | Action | Executive / Inspection Lead | Original Due Date | Current / Revised Due Date | Action Rating | Progress Status | Comments/Updates |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Internal Audit/2024/214 | 12/12/2024 | Reasonable Assurance | Energy Management 2024/25 (Review Reference CTM/UHB-SSU-2425-19) | 4. Energy Risk Reporting<br>It was recognised that risks pertinent to energy management measures were captured as part of the decarbonisation governance process. Additionally, there was narrative provided within the Health Board's risk register recognising energy related issues that were contributing to an assessed high-risk rating in respect of the UHB estate.<br><br>However, several energy management related risks had been noted and discussed that may warrant formal assessment, including:<br><br>1. The new All-Wales energy contract, which continued to cause disruption to process and available data – potentially impacting billing;<br>2. Energy cost going forward; and<br>3. The Decarbonisation Strategy action to remove all Combined Heat and Power (CHP) units by 2030. Whilst this aims to reduce carbon emissions, electricity costs are significantly higher than gas, which is expected to increase the UHB's grid consumption and associated cost.<br><br>All financial and non-financial risks should be recorded within the directorate risk register – to include proposed mitigating action. | Internal Audit/2024/214/MD4/1 | Energy compliance risks are fed through to the Environmental Steering Group.<br><br>Energy finance risks are fed through to the Finance Department and included in the Estates IMTP Intermediate Medium-Term Plan.<br><br>1. Risks associated with the All-Wales energy contract are reported through the Estates IMTP.<br>2. Energy cost risks "going forward" will continue to be recorded through the Estates IMTP.<br>3. Loss of CHP plant by 2030 will be recorded through the Estates long term financial plan.<br><br>Risks associated with lifecycle and condition of energy related plant and equipment such as CHP and biomass boilers, is and will continue to be reported through the directorate risk register. | Capital and Estates<br><br>Executive Director of Finance | 31.03.2025 | 31.03.2025 | Medium | Overdue | April 2025 Update - Energy Support Officer Rhian Giddy has been appointed on 31st March 2025, part of her duties will be to compile the risk register from the submitted energy feedback forms. Any risks that require escalation will be reported to the relevant group. I.e. ISO 14001 Environmental Management System group. No risks to be reported at this stage.<br><br>January 2025 Update - Risk management form has been added to the Energy Compliance Group agenda for the feed back of energy related risks to the group. Risks when received will be formulated into an Energy Risk Register. Any risks that require escalation will be reported to the relevant group. I.e. ISO 14001 Environmental Management System group.<br>Energy accruals and budgets are reviewed on a monthly basis and reported in the form of a spreadsheet from the Carbon and Energy Manager to the Head of Finance for Estates, which reports on energy related finance risks.<br><br>NWSSP-Procurement provide utility cost forecasts for upcoming financial years, which are communicated directly to Directors of Finance across Wales via the Wales Energy Group (WEG), and to Energy and Finance leads via the Wales Operational Energy Group (WEOG). |
| Internal Audit/2024/215 | 09/12/2024 | Reasonable Assurance | Charitable Funds 2024/25 (Review Reference CTM-2425-20) | 1. Procedures and guidance<br>Whilst the FCP has recently been updated some minor errors and discrepancies remain between the procedure and its appendices and the supplementary requisitioning and finance guidance documents. We note:<br><br>• Section 2 - Creation of Charitable Funds - there is inconsistency regarding the approver details and the form Appendix A.<br>• Section 9 - Investments & Administration Costs - sets out responsibilities regarding charitable funds investments, which refers to providing updates to the ARC regarding the investment portfolio including, consideration of ethical issues arising from the investments and the approval of changes to the investment policy. We believe this may be a legacy requirement prior to the establishment of the CFC.<br>• Appendix B and C – Donation receipt form and Gift Aid form – both use the previous name of the Health Board. However, we note a revised form is used that is a combination of receipt acknowledgement and gift aid declaration, which negates the need for Appendix B and C.<br>• There is ambiguity around the need for a Statement of Need (SON) for purchasing medical equipment. The FCP states a SON may need to be considered, whereas the Oracle requisition process document requires a SON.<br>• The requisition process document has links to training information and forms, but the links no longer work. The document refers to the CEO authorising orders above £50k, whereas this is the responsibility of the CFC.<br>• The Finance Guide contains an out of date (2018) list of funds.<br><br>We also note that the supplementary guidance documents are held in different parts of the intranet, as opposed to having all guidance in one place. In addition, at the time of our fieldwork the FCP from 2016 was the version available on the intranet. | Internal Audit/2024/215/MD1/1 | The FCP and supplementary guidance will be reviewed to ensure accuracy and consistency. All guidance will be available to staff via a single section of the intranet. | Finance<br><br>Executive Director of Finance | 28.02.2025 | 28.02.2025 | Medium | Partially complete (Overdue) | April 2025 Update - The new hierarchy is now ready to be implemented and training is to take place with the fund holders. This will include the use of forms, procedures and guidance. This is due to be completed through the summer period.<br><br>January 2025 Update - The FCP and SoD has recently been updated and we are currently implementing the new hierarchy structure. Once this is in place we will review and update the FCP again to reflect the comments in the above recommendation. |
| Internal Audit/2024/215 | 09/12/2024 | Reasonable Assurance | Charitable Funds 2024/25 (Review Reference CTM-2425-20) | 3. Investment Policy / Strategy<br>In accordance with the FCP, the Health Board should have an agreed investment policy to act as a guide for making investments, considering the level of returns expected, and the level of risk to be tolerated. The terms of reference of the CFC refer to the committee having oversight of investments in accordance with the investment strategy.<br><br>We saw limited investment strategy information included in the charitable funds update reports presented at the CFC meetings. It is unclear if this information is considered to be the Health Board's policy / strategy, or if a more comprehensive document exists. Whilst there is some information included, for example the approach should reserves exceed the investment by a certain amount, key information about the type of funds to be used (e.g. ethical), the level of expected returns and the risk to be tolerated is not included.<br><br>The paragraphs also state the strategy will be reviewed annually, with particular regard to risk and return, but we can not see where this has taken place. The information contained in these paragraphs again refers to the ARC's role in approving suitable investments, which we cannot evidence and believe is no longer not part of their remit. | Internal Audit/2024/215/MD3/1 | A clearly defined investment policy / strategy will be developed and approved at the relevant committee.<br><br>The policy / strategy will be reviewed and approved on an annual basis, with particular regard to risk and return.<br><br>Monitoring of investment activity, to ensure it is in line with the agreed investment policy / strategy, will take place at the relevant committee. | Finance<br><br>Executive Director of Finance | 31.07.2025 | 31.07.2025 | Medium | In progress | April 2025 Update - There has been no Charitable Fund Committee since last update, investment policy will be taken to next available meeting.<br><br>January 2025 Update - The investment policy is currently being reviewed and updated in line with discussions at the Charitable Fund Committee. |
| Internal Audit/2025/229 | 13/02/2025 | Reasonable Assurance | PCH Supply Chain Management _2024/025 (Review Reference CTM-SSU-2425-40) | 1. Cashflow - Fluctuations<br>The September 2024 project progress report highlighted that 'The SCP has been requested to provide a report on the cashflow and explain how these variances have occurred and what actions are being taken to improve financial management'. Some evidence of assessment had been shared by the SCP, but this was not comprehensive and does not negate the need for a formal report. Movements in the cashflow need to be easily reconciled so that ongoing reporting and scrutiny can take place at the Project Board. Additionally, lessons can be learned from the SCP to inform the setting of the CRL for 2025/26. | Internal Audit/2025/229/MD1/1 | CTMUHB to seek assurance from the Supply Chain Partner that measures have been put in place as a result of lessons learned at the closure of the financial year 24/25 that will give assurance for better cash-flow management for CRL 25/26. | Capital and Estates<br><br>Executive Director of Finance | 30.04.2025 | 30.04.2025 | Medium | Fully complete (Awaiting approval) | April / May 2025 Update - The Supply Chain Partner has reported on the adoption of lessons learned from previous years as they have informed the setting of the current CRL request. |
| Internal Audit/2025/229 | 13/02/2025 | Reasonable Assurance | PCH Supply Chain Management _2024/025 (Review Reference CTM-SSU-2425-40) | 2. Cashflow – Defined Cost<br>As of November 2024, Section 4 was live, and Section 5 was planned to start in December 2024. The current cashflow forecast for Section 4 (start: January 2024; target completion: January 2026), summarised in the Level 2 report, was as follows:<br><br>• Target Allowance: £1,392,869.06 (6%) – Based on agreed Target Cost items yet to be procured.<br>• Forecast Defined Cost: £5,632,869.84 (26%) – Based on supply chain orders placed.<br>• Anticipated Spend: £14,730,160.69 (68%) – Includes costs not yet identified as defined, such as anticipated steelwork and staff costs.<br><br>Given Section 4 was mid-programme, the defined cost percentage appears low. Additionally, there was no percentage breakdown of defined costs for Section 5.<br><br>The above would benefit from enhanced monitoring and reporting to the Project Board in the short term; to ensure these percentage are appropriate to provide more effective financial management. Consideration should be given to formally escalating this issue to ensure alignment with financial targets and tighter control over project expenditures. | Internal Audit/2025/229/MD2/1 | Responsible Officer to include an analysis of overall cost status in Project Board paper, to identify the level of Defined Cost in the remaining Sections. | Capital and Estates<br><br>Executive Director of Finance | 31.03.2025 | 31.03.2025 | High | Fully complete (Awaiting approval) | April 2025 Update - An analysis of the proportion of Defined Cost obtained in each remaining section has been incorporated in the Project Manager's report from April issue. |
| Internal Audit/2025/229 | 13/02/2025 | Reasonable Assurance | PCH Supply Chain Management _2024/025 (Review Reference CTM-SSU-2425-40) | 3. Supply Chain Partner Reporting<br>The SCP monthly contractor report formed a part of the progress update submitted regularly to the Project Board. While it effectively d documented the work packages that had been awarded, it did not include details on outstanding work packages and their associated sections.<br>This lack of visibility could hinder proactive planning and coordination. By including a more detailed breakdown of the remaining work packages, along with anticipated timelines for their award, the report could provide a clearer roadmap for upcoming activities. Additionally, a more informed view of pending work packages would aid in optimising programme scheduling and strengthening financial oversight and forecasting. | Internal Audit/2025/229/MD3/1 | Responsible Officer to include an analysis of works packages that remain to be Defined Cost for remaining Sections. | Capital and Estates<br><br>Executive Director of Finance | 30.04.2025 | 30.04.2025 | Medium | In progress | April 2025 Update - Discussions have taken place with the Supply Chain Partner (Tilbury Douglas Construction Ltd). Analysis of outstanding works packages for respective sections will be incorporated into the Contractor's report in the next round of monthly reporting. |
| Internal Audit/2025/229 | 13/02/2025 | Reasonable Assurance | PCH Supply Chain Management _2024/025 (Review Reference CTM-SSU-2425-40) | 4. Programme Management<br>As of the November 2024 project progress report, contract completion remains as 20th of July 2026. It should be noted that a change to the completion date for a 6-week delay had been instructed as part of the project manager's assessment for expanding the ITU (issued on the 12th of April 2024). This assessment was being challenged by the SCP; however, the time taken to enact this challenge had been circa 7 months since the initial assessment by the Project Manager.<br><br>The Health Board's advisers have not accepted the SCP's subsequently submitted programs (Revisions 43, 44, and 45) because the contract completion date remained unchanged and had not been updated; despite repeated attempts from the Health Board to escalate the issue. Not having an agreed programme could undermine the coordination, accountability, and the ability to deliver the project on time, within budget.<br><br>Noting that there are clauses within the contract for the SCP to challenge the Project Manager's assessment, a compliant programme should be tabled whilst those clauses are pursued. | Internal Audit/2025/229/MD4/1 | The SCP's grievance with the PM Assessment has led to a dispute being instigated through the Dispute Resolution Procedure. Following completion of this process the programme will be updated with Contract Completion Date. | Capital and Estates<br><br>Executive Director of Finance | 30.06.2025 | 30.06.2025 | High | Fully complete (Awaiting approval) | April / May 2025 Update - Revision 49 of the contract programme has incorporated the contract completion date of 1/9/26 in line with the Project Manager's assessment. |
| Internal Audit/2025/229 | 13/02/2025 | Reasonable Assurance | PCH Supply Chain Management _2024/025 (Review Reference CTM-SSU-2425-40) | 5. Change Management<br>An examination was undertaken of 39 approved changes from June – November 2024 across sections 3 and 4 of the works. Delays were identified in 19 changes from when the Project Manager initiated a request for the SCP to provide a quotation for the relevant change (three-week target). The duration of these delays varied, ranging from 1 day to 67 days over the three-week timescale.<br><br>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.<br><br>In the event of the SCP not being able to submit their quotation in the requisite timeframe, an extension to the date for submitting should be requested. | Internal Audit/2025/229/MD5/1 | Responsible Officer will write to the SCP requiring observance of contract procedure in this regard. | Capital and Estates<br><br>Executive Director of Finance | 13.02.2025 | 13.02.2025 | Medium | Fully complete (Awaiting approval) | Added to tracker February 2025; this action is marked as 'Actioned since audit fieldwork, Target Implementation Date: N/A' as per the audit report and will be presented to the Audit, Risk & Assurance Committee as Fully Complete. |
| Internal Audit/2025/229 | 13/02/2025 | Reasonable Assurance | PCH Supply Chain Management _2024/025 (Review Reference CTM-SSU-2425-40) | 6. Defects Management<br>According to the September 2024 Supervisor's report, 148 defects were overdue for rectification, which improved to 61 by the November 2024 report, demonstrating progress. However, it was unclear whether any overdue defects, including potential health and safety issues, were serious or minor.<br><br>Additionally, within areas handed over to the Health Board, defects and observations reduced from 152 in September 2024 to 39 in November 2024, reflecting further improvement. Despite this progress, no documented plan was identified to ensure timely rectification or assess defect significance. | Internal Audit/2025/229/MD6/1 | The Supervisor report to identify those outstanding defects that have over-run that are of significant concern. | Capital and Estates<br><br>Executive Director of Finance | 31.03.2025 | 31.03.2025 | Medium | Fully complete (Awaiting approval) | April / May 2025 Update - The Supervisor report now incorporates a table drawing attention to 'significant snags' and also the number of defects that have over-run. |
| Internal Audit/2025/230 | 31/01/2025 | Limited Assurance | Vaccination Policy Implementation_2024/25 (Review Reference CTM-2425-22) | 1. Whilst there are clear strategies in place which include specific deliverables for the Health Board to achieve, there is no overarching implementation plan to provide specific names, dates, and actions to achieve this, and to ensure that such actions are co-ordinated across the Health Board so that they are delivered in the most effective manner.<br><br>Similarly, there are no department or directorate operational plans, although we do acknowledge that specific plans are often produced for individual vaccination campaigns. | Internal Audit/2025/230/MD1/1 | Following recent recruitment activity, resource is now in place to produce an overarching implementation plan. Once this is complete, we will review planning at an operational level. | Public Health<br><br>Executive Director of Public Health | 30.06.2025 | 30.06.2025 | High | In progress | April 2025 Update - An update against this recommendation has not been provided on this occasion. |
| Internal Audit/2025/230 | 31/01/2025 | Limited Assurance | Vaccination Policy Implementation_2024/25 (Review Reference CTM-2425-22) | 2. The current model (permanent and bank staff) to deliver the winter respiratory campaign has struggled to acquire the additional staff availability needed. Bank staff availability has been especially low during the 24/25 season, and the Health Board anticipate that this will worsen in the future due to increasing nurse retirement. This has led to a more fragile vaccine offer across a variety of settings. Given national and local issues around vaccination engagement, especially for winter respiratory virus, a growing 'hard to reach' group puts additional pressure on resources and implementation approaches.<br><br>Staff flu vaccination rates have also been decreasing in recent years. 2022/23 saw a decrease in uptake from 63.7% to 50% for patient facing staff, and in 2023/24 a further decrease to 41.4%. As at 13 January 2025 the staff vaccination rate was 31.4%.<br><br>The Vaccination Strategy contains a planned action of introducing a network of vaccination champions across the Health Board to try and improve vaccination rates amongst staff. We understand that there has been little enthusiasm from staff to put themselves forward to be a vaccination champion, but we are aware that this approach is due to be reconsidered for the 2025/26 vaccination campaign. | Internal Audit/2025/230/MD2/1 | Review existing vaccination resource and effectiveness against the implementation and equity plans.<br><br>Determine that appropriate delivery models, resources and processes are in place to ensure accountability for effective delivery and implementation of the strategic plan, focusing on winter respiratory vaccines and staff vaccine uptake. | Public Health<br><br>Executive Director of Public Health | 30.06.2025 | 30.06.2025 | High | In progress | April 2025 Update - An update against this recommendation has not been provided on this occasion. |
| Internal Audit/2025/230 | 31/01/2025 | Limited Assurance | Vaccination Policy Implementation_2024/25 (Review Reference CTM-2425-22) | 4. Reporting into the Health Board on vaccination performance is through multiple committees and groups, in addition to the external reporting that is also taking place. There is therefore a risk of duplication of effort and a failure for the Health Board to have a single, co-ordinated view of the vaccine programmes and performance. We acknowledge that there is an intention to streamline the governance framework in the coming months. | Internal Audit/2025/230/MD3/1 | There is a planned intention to review the current reporting arrangements for Vaccination programmes with a view to streamlining the current governance structure. | Public Health<br><br>Executive Director of Public Health | 30.06.2025 | 30.06.2025 | Medium | In progress | April 2025 Update - An update against this recommendation has not been provided on this occasion. |
| Internal Audit/2025/231 | 15/01/2025 | Reasonable Assurance | Regional Integration Fund_2024/25 ( Review Reference: CTM-2425-23) | 1. MoU is in draft format<br>RIF guidance states a MoU is required to set out the governance, accountability and decision-making processes, which should include 'appropriate arrangements to enable scrutiny of investment decisions by relevant sovereign bodies'. Prior to a MoU being agreed, some concerns were raised nationally as to what the respective parties were being asked to sign up to following changes to the rules regarding tapering of funding. Consequently, one RPB took the lead in trying to produce, with legal support, a template MoU that could be used across Wales. The results of this work are still awaited, hence the CTMRPB MoU is still in draft. | Internal Audit/2025/231/MD1/1 | As soon as the MoU format is confirmed, the MoU will be negotiated, agreed and signed by all statutory partners. | Strategy & Transformation<br><br>Executive Director of Strategy & Transformation | 31.03.2026 | 31.03.2026 | Medium | In progress | April 2025 Update - An update against this recommendation has not been provided on this occasion. |
| Internal Audit/2025/231 | 15/01/2025 | Reasonable Assurance | Regional Integration Fund_2024/25 ( Review Reference: CTM-2425-23) | 2. Variations in Adult's and Children's approaches<br><br>Our fieldwork identified:<br>- Adult Services currently receive the bulk of RIF funding due to these services being rolled over from the Integrated Care Fund, which we understand was focused on Adult Services.<br>- The Adult Programme Board has more senior Health Board representation than the Children's Programme Board, where there is more of a clinical presence in the membership and attendance.<br>- Reporting formats to each Board are different with the Adult Board using traffic light reports on progress, whilst the Children's Board sets out further actions. This again reflects the differences between the two boards where Adult Services tend to be longer established in terms of funded projects, whilst Children's projects are less mature. | Internal Audit/2025/231/MD2/1 | Membership and attendance at the Children's Programme Board will be reviewed and adjusted as necessary.<br><br>Reporting formats to the Children's Board will be reviewed as projects progress.<br><br>Health Board representatives at the Children's Programme Board will raise RIF funding allocations at Board meetings with a focus on achieving a percentage shift in allocation between Adults and Children (in favour of children). | Strategy & Transformation<br><br>Executive Director of Strategy & Transformation | 31.03.2026 | 31.03.2026 | Medium | In progress | April 2025 Update - An update against this recommendation has not been provided on this occasion. |
| Internal Audit/2025/231 | 15/01/2025 | Reasonable Assurance | Regional Integration Fund_2024/25 ( Review Reference: CTM-2425-23) | 3. Reporting<br>Whilst RIF updates were provided on a regular basis to the Population Health & Partnership Committee, the means of reporting was not always been consistent, as updates were often in relation to the wider RPB. This made it difficult to easily monitor the progress or performance of specific RIF projects.<br><br>With the disbandment of the Population Health & Partnership Committee, and its replacement with the Strategic Development Committee, there is an opportunity to revisit what information is reported and in what format. It would also be helpful to include trend analysis as this would better demonstrate whether the outcomes of the funding allocations are helping to achieve the desired goals. | Internal Audit/2025/231/MD3/1 | Reporting on RIF will be included as part of the regular RPB report to the Strategic Development Committee. | Strategy & Transformation<br><br>Executive Director of Strategy & Transformation | 30.04.2025 | 30.04.2025 | Medium | In progress | April 2025 Update - An update against this recommendation has not been provided on this occasion. |
| Internal Audit/2025/232 | 31/01/2025 | Limited Assurance | Medical Job Planning_2024/25 (Review Reference: CTM-2425-17) | 1. Lack of personal & service outcomes<br>The e-job planning system enables personal outcomes to be linked to service outcomes. We tested a sample of 32 fully signed off job plans:<br>• 17/32 job plans had no personal outcomes relating to SPA activity recorded.<br>• 0/32 job plans had service outcomes recorded.<br>We also noted that 4/32 job plans contained little or no detail in relation to the SPA activity to be undertaken. | Internal Audit/2025/232/MD1/1 | To ensure all job plans record personal and service outcomes that are linked. | People<br><br>Executive Director for People<br><br>Executive Medical Director | 30.09.2025 | 30.09.2025 | High | In progress | April 2025 Update - An update against this recommendation has not been provided on this occasion. |

| Inspection Code | Date of Inspection | Overall Assurance Rating | Inspection Title | Recommendation | AMaT Reference Number | Action | Executive / Inspection Lead | Original Due Date | Current / Revised Due Date | Action Rating | Progress Status | Comments/Updates |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Internal Audit/2025/232 | 31/01/2025 | Limited Assurance | Medical Job Planning_2024/25 (Review Reference: CTM-2425-17) | 2. Creation and annual review of job plans<br>The national and Health Board job planning guidance requires the annual job planning review to be undertaken 'in good time' but does not specify a timescale by which a job plan must be completed for new starters.<br><br>To meet WG targets, the Health Board has aimed to complete 60% of job plans by August 2024, and 85% by December 2024. Our analysis of the data, based on 'job plan start date' recorded in Allocate, has shown that of the 680 consultants and SAS doctors:<br>• 204 (30%) had a signed off job plan that started within the last year, so the targets have not been achieved.<br>• 171 (25%) had a signed off, but out of date job plan, some of which date back to 2019.<br>• 21% were at discussion, appeal, sign off or lockdown stage.<br>• 24% have never had a signed off plan.<br><br>Our analysis of the 171 job plans that were out of date identified 10 that were last agreed before 2021, 22 signed off in 2021, and 75 in 2022. | Internal Audit/2025/232/MD2/1 | • To agree and update guidance with a timescale for completing job plans for new starters. | People<br><br>Executive Director for People<br><br>Executive Medical Director | 30.06.2025 | 30.06.2025 | High | In progress | April 2025 Update - The job planning guidance will be updated to confirm a timescale for job plans for new starters within the first 6 months of joining CTM/new role. |
| Internal Audit/2025/232 | 31/01/2025 | Limited Assurance | Medical Job Planning_2024/25 (Review Reference: CTM-2425-17) | 2. Creation and annual review of job plans<br>The national and Health Board job planning guidance requires the annual job planning review to be undertaken 'in good time' but does not specify a timescale by which a job plan must be completed for new starters.<br><br>To meet WG targets, the Health Board has aimed to complete 60% of job plans by August 2024, and 85% by December 2024. Our analysis of the data, based on 'job plan start date' recorded in Allocate, has shown that of the 680 consultants and SAS doctors:<br>• 204 (30%) had a signed off job plan that started within the last year, so the targets have not been achieved.<br>• 171 (25%) had a signed off, but out of date job plan, some of which date back to 2019.<br>• 21% were at discussion, appeal, sign off or lockdown stage.<br>• 24% have never had a signed off plan.<br><br>Our analysis of the 171 job plans that were out of date identified 10 that were last agreed before 2021, 22 signed off in 2021, and 75 in 2022. | Internal Audit/2025/232/MD2/2 | • To reduce the presumed sign off timescales from 10 weeks to support an improvement in job planning compliance. | People<br><br>Executive Director for People<br><br>Executive Medical Director | 31.05.2025 | 31.05.2025 | High | Fully complete (Awaiting approval) | April 2025 Update - The 10 week presumed sign off has been reduced to 4 weeks with effect from 1 March 2025. The first 4 weeks sign off activated 3 April 2025. |
| Internal Audit/2025/232 | 31/01/2025 | Limited Assurance | Medical Job Planning_2024/25 (Review Reference: CTM-2425-17) | 2. Creation and annual review of job plans<br>The national and Health Board job planning guidance requires the annual job planning review to be undertaken 'in good time' but does not specify a timescale by which a job plan must be completed for new starters.<br><br>To meet WG targets, the Health Board has aimed to complete 60% of job plans by August 2024, and 85% by December 2024. Our analysis of the data, based on 'job plan start date' recorded in Allocate, has shown that of the 680 consultants and SAS doctors:<br>• 204 (30%) had a signed off job plan that started within the last year, so the targets have not been achieved.<br>• 171 (25%) had a signed off, but out of date job plan, some of which date back to 2019.<br>• 21% were at discussion, appeal, sign off or lockdown stage.<br>• 24% have never had a signed off plan.<br><br>Our analysis of the 171 job plans that were out of date identified 10 that were last agreed before 2021, 22 signed off in 2021, and 75 in 2022. | Internal Audit/2025/232/MD2/3 | • Arrange job plan review meeting with consultant / SAS doctor to review and facilitate sign-off of rolled forward job plan. | People<br><br>Executive Director for People<br><br>Executive Medical Director | 30.09.2025 | 30.09.2025 | High | In progress | April 2025 Update - An update against this recommendation has not been provided on this occasion. |
| Internal Audit/2025/232 | 31/01/2025 | Limited Assurance | Medical Job Planning_2024/25 (Review Reference: CTM-2425-17) | 2. Creation and annual review of job plans<br>The national and Health Board job planning guidance requires the annual job planning review to be undertaken 'in good time' but does not specify a timescale by which a job plan must be completed for new starters.<br><br>To meet WG targets, the Health Board has aimed to complete 60% of job plans by August 2024, and 85% by December 2024. Our analysis of the data, based on 'job plan start date' recorded in Allocate, has shown that of the 680 consultants and SAS doctors:<br>• 204 (30%) had a signed off job plan that started within the last year, so the targets have not been achieved.<br>• 171 (25%) had a signed off, but out of date job plan, some of which date back to 2019.<br>• 21% were at discussion, appeal, sign off or lockdown stage.<br>• 24% have never had a signed off plan.<br><br>Our analysis of the 171 job plans that were out of date identified 10 that were last agreed before 2021, 22 signed off in 2021, and 75 in 2022. | Internal Audit/2025/232/MD2/4 | • Monitor at MWPP:PEG | People<br><br>Executive Director for People<br><br>Executive Medical Director | 31.05.2025 | 31.05.2025 | High | Partially complete | April 2025 Update - Job planning compliance is reviewed at MWPP:PEG and will be aligned to the workforce efficiency programme to improve the process for annual job plans and for new starters/those never had a job plan. This will be updated in terms of actions in May 2025. |
| Internal Audit/2025/232 | 31/01/2025 | Limited Assurance | Medical Job Planning_2024/25 (Review Reference: CTM-2425-17) | 3. Presumed sign-off procedure<br>We reviewed the number of job plans that are classed as 'in discussion' to determine if the presumed sign off process is applied. At the time of our fieldwork 83/187 'in discussion' job plans had been in discussion since 2023, with the oldest in discussion since 2016.<br><br>We also identified 64 users (consultants / SAS doctors) that had never accessed the Allocate system. | Internal Audit/2025/232/MD3/1 | To reinforce Care Group scrutiny of the job planning data set issued monthly, specifically around those who have not had a job plan or those out of date.<br><br>Monitor at MWPP:PEG | People<br><br>Executive Director for People<br><br>Executive Medical Director | 31.12.2025 | 31.12.2025 | High | Partially complete | April 2025 Update - Data packs shared out to CGs in April 2025 and will be aligned to the workforce efficiency programme for regular reports to be issued. This will be reviewed again in May 2025. |
| Internal Audit/2025/233 | 29/01/2025 | Reasonable Assurance | Follow-up: Arrangements for Managing Service Level Agreements_January 2025 (Review reference: CTM-2425-33) | 2.1 The commissioning team should reiterate to care group management the importance of attending the routine meetings in order to have proactive governance arrangements in relation to managing their SLAs. | Internal Audit/2025/233/MD1/1 | A schedule of dates has been set up for commissioning meetings with care groups during 2025. | Commissioning<br><br>Executive Director of Strategy & Transformation | 31.01.2025 | 31.01.2025 | Medium | Overdue | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>Previous Matter Arising 2: A system to accurately capture SLA agreements (Operation) which formed part of Internal Audit/2023/37 - Arrangements for Managing Service Level Agreements_Final Internal Audit Report June 2023 (Review reference: CTMUHB-2223-17), Internal Audit/2023/37/MD2 is considered to be partially implemented and has been superseded by this new Recommendation / Action as was presented to the Audit, Risk & Assurance Committee on Thursday 13th February 2025. |
| Internal Audit/2025/233 | 29/01/2025 | Reasonable Assurance | Follow-up: Arrangements for Managing Service Level Agreements_January 2025 (Review reference: CTM-2425-33) | 2.2 Management should complete the ongoing work to ensure agreements not yet updated on the register are reviewed, and the register updated accordingly. | Internal Audit/2025/233/MD2/1 | The commissioning team will undertake a review of the RoA as part of the process to close the 2024-2025 copy of the RoA and will set up a 2025-2026 copy. Corporate and care group teams will be asked to review the agreements that they hold as part of this process. | Commissioning<br><br>Executive Director of Strategy & Transformation | 30.04.2025 | 30.04.2025 | Medium | In progress | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>Previous Matter Arising 2: A system to accurately capture SLA agreements (Operation) which formed part of Internal Audit/2023/37 Arrangements for Managing Service Level Agreements_Final Internal Audit Report June 2023 (Review reference: CTMUHB-2223-17), Internal Audit/2023/37/MD2 is considered to be partially implemented and has been superseded by this new Recommendation / Action as was presented to the Audit, Risk & Assurance Committee on Thursday 13th February 2025. |
| Internal Audit/2025/233 | 29/01/2025 | Reasonable Assurance | Follow-up: Arrangements for Managing Service Level Agreements_January 2025 (Review reference: CTM-2425-33) | 2.3 Key fields, such as the 'CTM lead' and 'end date for the SLA' should be recorded on the register.<br><br>Fields that are not currently populated in the register, such as 'monitoring frequency', should be either completed for all agreements or removed if not considered beneficial. | Internal Audit/2025/233/MD3/1 | The review of the key fields identified (SLA lead and SLA end date) will be updated as part of the review set out in action 2.2. | Commissioning<br><br>Executive Director of Strategy & Transformation | 30.04.2025 | 30.04.2025 | Medium | In progress | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>Previous Matter Arising 2: A system to accurately capture SLA agreements (Operation) which formed part of Internal Audit/2023/37 - Arrangements for Managing Service Level Agreements_Final Internal Audit Report June 2023 (Review reference: CTMUHB-2223-17), Internal Audit/2023/37/MD2 is considered to be partially implemented and has been superseded by this new Recommendation / Action as was presented to the Audit, Risk & Assurance Committee on Thursday 13th February 2025. |
| Internal Audit/2025/233 | 29/01/2025 | Reasonable Assurance | Follow-up: Arrangements for Managing Service Level Agreements_January 2025 (Review reference: CTM-2425-33) | 3.1 For new agreements and where existing agreements are renewed, the updated full template agreements should be used. | Internal Audit/2025/233/MD4/1 | New agreements are developed on the updated SLA template.<br><br>The SLA template will be re-issued to all care groups and corporate teams to ensure that renewals are able to be transferred to the new agreement document. | Commissioning<br><br>Executive Director of Strategy & Transformation | 28.02.2025 | 28.02.2025 | Medium | Overdue | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>Previous Matter Arising 3: Timeliness of SLA sign-off (Operation) which formed part of Internal Audit/2023/37 Arrangements for Managing Service Level Agreements_Final Internal Audit Report June 2023 (Review reference: CTMUHB-2223-17), Internal Audit/2023/37/MD4 is considered to be partially implemented and has been superseded by this new Recommendation / Action as was presented to the Audit, Risk & Assurance Committee on Thursday 13th February 2025. |
| Internal Audit/2025/233 | 29/01/2025 | Reasonable Assurance | Follow-up: Arrangements for Managing Service Level Agreements_January 2025 (Review reference: CTM-2425-33) | 3.2 Agreement documentation should be signed by both the Health Board and service partner. | Internal Audit/2025/233/MD5/1 | Alongside action 3.1 the guidance for agreeing SLAs will be recirculated with a reminder that all documents must be signed by both partners. | Commissioning<br><br>Executive Director of Strategy & Transformation | 28.02.2025 | 28.02.2025 | Medium | Overdue | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>Previous Matter Arising 3: Timeliness of SLA sign-off (Operation) which formed part of Internal Audit/2023/37 Arrangements for Managing Service Level Agreements_Final Internal Audit Report June 2023 (Review reference: CTMUHB-2223-17), Internal Audit/2023/37/MD4 is considered to be partially implemented and has been superseded by this new Recommendation / Action as was presented to the Audit, Risk & Assurance Committee on Thursday 13th February 2025. |
| Internal Audit/2025/233 | 29/01/2025 | Reasonable Assurance | Follow-up: Arrangements for Managing Service Level Agreements_January 2025 (Review reference: CTM-2425-33) | 3.3 The register of agreements should accurately reflect contract information such as start date, end date and funding amount. | Internal Audit/2025/233/MD6/1 | Please refer to action 2.3<br>(Internal Audit/2025/233/MD3) | Commissioning<br><br>Executive Director of Strategy & Transformation | 30.04.2025 | 30.04.2025 | Medium | In progress | April 2025 Update - An update against this recommendation has not been provided on this occasion.<br><br>Previous Matter Arising 3: Timeliness of SLA sign-off (Operation) which formed part of Internal Audit/2023/37 Arrangements for Managing Service Level Agreements_Final Internal Audit Report June 2023 (Review reference: CTMUHB-2223-17), Internal Audit/2023/37/MD4 is considered to be partially implemented and has been superseded by this new Recommendation / Action as was presented to the Audit, Risk & Assurance Committee on Thursday 13th February 2025. |

Cwm Taf Morgannwg University Health Board

# Audit, Risk & Assurance Committee Internal Audit Progress Report

## May 2025

NWSSP Audit and Assurance Services

# Contents


| | | |
|---|---|---|
| 1 | Introduction | 3 |
| 2 | Reports Issued | 3 |
| 3 | Delivering the Plan | 4 |
| 4 | Performance reporting | 4 |
| 5 | Feedback | 4 |
| 6 | Other activity | 4 |

Appendix A – Tables showing detailed progress against audit plans


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


Disclaimer notice - please note

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

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

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

## 1 Introduction

1.1 This progress report provides the Audit, Risk & Assurance Committee (the 'Committee') with the current position of the work undertaken by Internal Audit as at 14 May 2025. 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 13 reports have been finalised. We have four reports are in draft (one for the Joint Commissioning Committee (JCC)) and ongoing fieldwork in relation to five reviews, which includes one review for the JCC. A summary of the position of the finalised reports, including a summary of number of recommendations, is provided below in Table 1.

Table 1 – Summary of finalised reports

| Assignments | High | Medium | Total | Assurance rating |
|---|---|---|---|---|
| Service user experience | - | 1 | 1 | Substantial |
| Duty of candour | 2 | 2 | 4 | Reasonable |
| Follow up – Financial savings | 1 | - | 1 | Reasonable |
| Follow up – Performance management – 4-hour target | 1 | 4 | 5 | Reasonable |
| New PDR process | - | 3 | 3 | Reasonable |
| Cancer tracking process | 1 | 6 | 7 | Reasonable |
| PCH Delivery of Project Objectives | - | 2 | 2 | Reasonable |
| New care group model | - | 1 | 1 | Reasonable |
| Electronic whiteboards | 2 | 8 | 10 | Reasonable |
| Capital systems | 2 | 5 | 7 | Limited |
| Estates condition (23/24) | 2 | 4 | 6 | Limited |
| GI Pathways - Follow up | - | - | - | Advisory |
| JCC – Governance systems | - | - | - | Advisory |

## 3 Delivering the Plan

3.1 Our work in relation to 2024/25 is concluding. At the last Audit Committee we reported that we were having difficulty progressing a number of reviews: this situation has now improved. The position as at the date of this paper, excluding audit work relating to the JCC, is set out in table 2, below.

Table 2

| Review status | Count | Percentage | Previous Count | Percentage |
|---|---|---|---|---|
| Planning | 1 | 3% | 7 | 23% |
| Work in progress | 4 | 13% | 11 | 36% |
| Draft | 4 | 13% | 1 | 1% |
| Final | 22 | 71% | 12 | 40% |
| **Total** | **31** | | **31** | |

3.2 The detail of our work is included in appendix A to this report.

## 4 Performance reporting

4.1 We monitor aspects of the Internal Audit service and report this information in our annual report. Our year end performance indicators will be reported in our annual report.

## 5 Feedback

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

## 6 Other activity

### Joint Commissioning Committee (JCC)

6.1 We have agreed a programme of work for 2024/25 with officers of the JCC (Appendix A – Table 5). We have finalised two reports, have one report in draft and are concluding our fieldwork for our final review.

### Meetings

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

## Appendix A – Programme of work

### Table 3: Status of reports included in annual opinion for 2023/24 as draft

| Plan Ref. | Review | Rating | Status | Notes |
|---|---|---|---|---|
| 4 | Estates condition | Limited | Final | - |

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

| Plan Ref. | Review | Rating | Review period | Planned AC | Status | Draft report issued < 10 working days | Management response received <15 working days | Notes |
|---|---|---|---|---|---|---|---|---|
| T10 | Duty of candour | Reasonable | Q1 | ~~Oct~~ May | Final | Y | N | - |
| T18 | Capital systems | Limited | Q2 | ~~Oct~~ May | Final | Y | N | - |
| T31 | Follow up – Financial savings | Reasonable | Q1 | ~~Oct~~ May | Final | Y | Y | - |
| T28 | Follow up – Performance management – 4-hour target | Reasonable | Q2 | ~~Oct~~ May | Final | Y | N | - |
| T15 | New PDR process | Reasonable | Q1 | ~~Oct~~ May | Final | Y | Y | - |
| T02 | Cancer tracking process | Reasonable | Q3 | ~~Feb~~ May | Final | Y | Y | - |

| Plan Ref. | Review | Rating | Review period | Planned AC | Status | Draft report issued < 10 working days | Management response received <15 working days | Notes |
|---|---|---|---|---|---|---|---|---|
| T13 | Service user experience | Substantial | Q4 | May | Final | Y | Y | - |
| T30 | GI Pathways - Follow up | Advisory | Q4 | May | Final | Y | Y | - |
| - | PCH Delivery of Project Objectives | Reasonable | Q4 | May | Final | Y | N | - |
| T01 | New care group model | Reasonable | ~~Q2~~ Q4 | ~~Dec~~ May | Final | Y | Y | - |
| T11 | Electronic White Board | Reasonable | ~~Q3~~ Q4 | ~~Feb~~ May | Final | Y | Y | - |
| T08 | Digital benefits realisation | Limited | Q4 | May | Draft | Y | - | Updated draft report issued 13.05.25 |
| T04 | End of life care management | Limited | Q3 | ~~Feb~~ May | Draft | Y | - | Updated draft report issued 14.05.25 |
| T21 | Core financial systems | Substantial | Q3 | ~~Feb~~ May | Draft | Y | - | Draft report issued 09.05.25 |
| T14 | Welsh Risk Pool | - | Q4 | May | WIP | - | - | Fieldwork started 04.02.25 |
| - | PCH Financial and Technical compliance | - | Q4 | May | WIP | - | - | Fieldwork started 06.05.25 |

| Plan Ref. | Review | Rating | Review period | Planned AC | Status | Draft report issued < 10 working days | Management response received <15 working days | Notes |
|---|---|---|---|---|---|---|---|---|
| T03 | Elective care criteria – access to diagnostics | - | Q3 | ~~Feb~~ May | WIP | - | - | Fieldwork started 11.03.25 |
| T26 | Tracker review | - | Q4 | May | WIP | - | - | Fieldwork started 22.04.25 |
| T05 | Discharge planning | - | Q4 | May | Planned | - | - | Brief agreed |
| - | PCH Equipment | - | Q4 | - | Defer | - | - | Duplication with a review already undertaken with NWSSP audit. |
| T12 | Ensuring quality when commissioning care services | - | Q3 | – | Defer | - | - | Due to number of reviews at end of year did not have resource capacity. |
| T24 | Stroke | - | Q3 | – | Defer | - | - | To be undertaken early 2025/26. |
| **Reviews either previously reported or agreed defer** | | | | | | | | |
| - | Embedding the quality framework - Brought forward from 2023/24 | Reasonable | - | Oct | Final | Y | N | - |
| T07 | Information provision – Intelligence led organisation | Reasonable | Q1 | Oct | Final | Y | Y | - |

| Plan Ref. | Review | Rating | Review period | Planned AC | Status | Draft report issued < 10 working days | Management response received <15 working days | Notes |
|---|---|---|---|---|---|---|---|---|
| T27 | Follow up – Facilities governance arrangements | Substantial | Q1 | Oct | Final | Y | Y | - |
| - | PCH Validation of Management Actions | Substantial | Q2 | Dec | Final | Y | Y | - |
| T20 | Charitable funds | Reasonable | Q2 | ~~Oct~~ Dec | Final | Y | N | - |
| T16 | Additional medical pay | Limited | Q1 | ~~Oct~~ Dec | Final | Y | Y | - |
| T17 | Medical job planning | Limited | Q2 | ~~Oct~~ Feb | Final | Y | N | - |
| T23 | Regional integration fund | Reasonable | ~~Q2~~ Q3 | ~~Oct~~ Feb | Final | Y | Y | - |
| T33 | Follow up – SLA arrangements | Reasonable | Q2 | ~~Oct~~ Feb | Final | Y | Y | - |
| - | PCH – Supply chain partner management | Reasonable | - | ~~Oct~~ Feb | Final | Y | Y | - |
| T22 | Vaccination policy implementation | Limited | Q2 | ~~Oct~~ Feb | Final | Y | Y | - |
| T19 | Energy management | Reasonable | Q2 | ~~Oct~~ Dec | Final | Y | Y | - |
| T32 | Decarbonisation – Follow up | - | - | - | Defer | - | - | To allow completion of actions. |

| Plan Ref. | Review | Rating | Review period | Planned AC | Status | Draft report issued < 10 working days | Management response received <15 working days | Notes |
|---|---|---|---|---|---|---|---|---|
| T06 | Primary care | - | Q4 | - | Defer | - | - | To allow transformation/ cluster work to bed in. |
| T09 | Clinical coding | - | Q3 | - | Defer | - | - | DHCW has recently undertaken work and reported in this area. |
| T29 | Follow up - INNU | - | - | - | Defer | - | - | Brief agreed. Has been delayed due to all Wales working group – Defer to 2025/26. |
| T25 | Llantrisant Health Park | - | - | - | Defer | - | - | Project has had gateway review in year, so propose to undertake audit in early 2025/26. |

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

| Ref. | Review | Rating | Status | Notes |
|---|---|---|---|---|
| 1 | Mental Health quality assurance process | Reasonable | Final | - |
| 2 | Governance systems | Advisory | Final | - |
| 4 | Traumatic stress Wales | Limited | Draft | Draft report issued 03.05.25 |
| 3 | Financial systems | - | WIP | Fieldwork concluding. |

# Internal Audit Plan 2025/26

## Cwm Taf Morgannwg University Health Board

Contents


1. Introduction .....1
2. Developing the Internal Audit Plan .....2
3. Audit risk assessment .....5
4. Planned internal audit coverage .....5
5. Resource needs assessment .....6
6. Action required .....7

Appendix A: Internal Audit Plan 2025/26 .....8
Appendix B: Key performance indicators (KPI) .....12
Appendix C: Internal Audit Mandate and Charter .....13
Disclaimer .....22


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

# 1. Introduction

This document sets out the Internal Audit Plan for 2025/26 (the 'Plan') detailing the audits to be undertaken and information of the corresponding resources. It also contains the Internal Audit Mandate and 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's 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, Risk and Assurance Committee (or 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 key findings and agreed actions from internal audit reviews may be used by Cwm Taf Morgannwg University Health Board's (the 'Health Board's' or the 'organisation's') management to improve governance, risk management, and control within their operational areas.

In January 2025 new Global Internal Audit Standards (the 'Standards') became effective and apply to UK public sector audits from 1 April 2025 to align with the financial year. These new standards replace the previous guidance: the Public Sector Internal Audit Standards. The new Standards are accompanied by a UK public sector application note (the 'Application Note'), which provides public sector interpretations and additional requirements for the Standards The new Standards require that a risk based internal audit plan is created that supports the achievement of the organisation's objectives.

Accordingly, this document sets out the risk-based approach and the Plan for 2025/26. The Plan will be delivered in accordance with the Internal Audit Mandate and 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 other organisations on behalf of NHS Wales. These are: Digital Health and Care Wales (DHCW); NHS Wales Shared Services Partnership (NWSSP); and the NHS Wales Joint Commissioning Committee (JCC), which replaced EASC and WHSSC from April 2024. These audits will be included in Appendix A when agreed formally. These audits are part of the risk-based programme of work for DHCW, NWSSP and Cwm Taf Morgannwg UHB (for the JCC), but the results, as in previous years, are reported to the relevant health organisations 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 Global Internal Audit Standards

The Plan has been developed in accordance with Principle 9: Plan Strategically, which includes Standard 9.4 – Internal Audit Plan, of the Standards, and the accompanying Application Note, which provides public sector interpretations and additional requirements for the Standards, 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
- the audit resources required to provide a balanced and comprehensive view.

Our planning considers the NHS Wales Planning Framework and other NHS Wales priorities and is mindful of significant national changes that are taking place. In addition, the Plan aims to reflect the 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 Mandate and 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 Director of Corporate Governance (Board Secretary) 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 Plan is made up of several key components:

1) Consideration of key governance and risk areas: We have identified several areas where an annual consideration supports the most efficient and effective delivery of an annual opinion. These cover the Governance, the Board Assurance Framework, Risk Management, Clinical Governance and Quality, Financial Sustainability, Performance Monitoring & Management, and an overall assessment of Digital and Information Technology. 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 strategic risks and priorities from the Board Assurance Framework and the risks identified in 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 'unsatisfactory' assurance reports as well as other medium and 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 Finance, other executive peer groups, or Audit Committee Chairs in response to common risks faced by several organisations. This may be advisory work to identify areas of best practice or shared learning.
5) The impact of audits undertaken at other NHS Wales bodies that may impact on the Health Board, namely NHS Wales Shared Services Partnership (NWSSP), Digital Health and Care Wales (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 Health Board's vision, values and forward priorities as outlined in the Integrated Medium Term Plan (IMTP) and long term strategy.
- 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, Risk and Assurance Committee, the Operational Delivery Committee, and the Quality, Safety and Experience Committee).
- Strategic risks identified within the Board Assurance Framework and significant risks identified within the organisational risk register and assurance processes.
- Discussions with Executive Directors regarding risks and assurance needs in areas of corporate responsibility, including compliance and ethics programmes.
- 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.
- Work undertaken by other review bodies, including Audit Wales and Healthcare Inspectorate Wales (HIW).
- 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 the executive team and independent members to discuss current areas of risk and related assurance needs.

# 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 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 considers corporate risk, materiality or significance, system complexity, previous audit findings, and potential for fraud.

# 4. Planned internal audit coverage

## 4.1 Internal Audit Plan 2025/26

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 refers 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.

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

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 appraised of performance in delivery of the Plan, and any required changes, through routine progress reports to each Audit Committee meeting.

Most of the audit work will be undertaken by our regionally based teams with support from our national capital and 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. To this end, the need for flexibility and a revisit of the focus and timing of the proposed work will be necessary at some point during the year.

Consistent with previous years, and in accordance with best professional practice, an unallocated contingency provision has been retained in the Plan to enable Internal Audit to respond to emerging risks and priorities identified by the executive team

and endorsed by the Audit Committee. 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 based on 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 11.3 – Communicating Results, and Application Note 10B – Overall conclusions and annual reporting.

Audit & Assurance Services confirms that it has the necessary human, financial and technological 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 is required during the year over and above the total indicative resource requirement 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 and Corporate Governance Committee is invited to consider the Internal Audit Plan for 2025/26 and:

- approve the Internal Audit Plan for 2025/26;
- approve the Internal Audit Mandate and 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 2025/26

| Planned output, Outline scope, Review reference | Risk reference | Executive Lead/Responsible Director | Planned quarter to start |
|---|---|---|---|
| **1. Continuing Health Care**<br>To include controls process for approvals. | 5903 | Chief Operating Officer | Q1 |
| **2. Outpatient booking process**<br>Compliance with policy. | SRR1a | Chief Operating Officer | Q3 |
| **3. Medical annual leave and rostering**<br>To consider the annual leave and rostering processes. Focus TBC. | SRR3 | Chief Operating Officer | Q4 |
| **4. Operational response to critical incident**<br>To consider the actions taken by the Health Board to instigate and manage the critical incident. | 5932 | Chief Operating Officer | Q1 |
| **5. Medical sickness records**<br>To ensure medical staff have followed the sickness process for short term sickness - compliance with policy. | SRR3 | Medical Director/ Director of People | Q2 |
| **6. Speaking up safely (SuS)**<br>To review the arrangements in place for staff to raise concerns through the Speaking Up Safely process, and how these are reviewed, resolved and reported. | SRR7 | Director of Governance/ Director of People | Q4 |
| **7. Risk management**<br>Focus to be determined, but likely to focus on Board Assurance Framework. | - | Director of Governance | Q3 |
| **8. Establishment of new committee structure**<br>To consider the operating effectiveness of the new committee structure. | SRR3 | Director of Governance | Q4 |
| **9. Clinical coding**<br>To consider the Health Board's process and plan for timely and accurate clinical coding. Focus on waiting list patients. Work to be undertaken by our digital team. Deferred from 2024/25. | SRR6/4672 | Director of Digital | Q1/Q2 |

| Planned output, Outline scope, Review reference | Risk reference | Executive Lead/Responsible Director | Planned quarter to start |
|---|---|---|---|
| **10. Cyber Security**<br>Focus on governance and risk appetite. Would ensure that there is no overlap with Cyber Resilience Unit (CRU). | 4664 | Director of Digital | Q3 |
| **11. Bridgend Disaggregation**<br>Post project implementation to ensure the single PAS is operating effectively. | SRR5/4337 | Director of Digital | Q3 |
| **12. Welsh Risk Pool (WRP)**<br>Annual review as required by the WRP standards. | - | Director of Nursing | Q4 |
| **13. Falls management**<br>New programme and comes together with harm free events. | SRR2 | Director of Nursing | Q3 |
| **14. Ward audits**<br>Consideration of the process with particular focus on safe to start and quality metrics. | SRR2 | Director of Nursing | Q4 |
| **15. Long term strategy**<br>Consideration of implementation and reporting and governance arrangements. | SRR4 | Director of Strategy | Q4 |
| **16. Stroke management process**<br>Focus on process and outcomes. Possible consideration of deployment of action plans to improve stroke performance and risk mitigations. Deferred from 24/25. | SRR1/4632 | Dir of AHP&HS | Q2 |
| **17. Financial systems**<br>To agree focus, but to consider arrangements between the Health Board and NWSSP. | - | Director of Finance | Q4 |
| **18. Savings**<br>To consider the process, governance, reporting and management of mitigating actions. Focus on the four centrally lead schemes. | SRR10/5765 | Director of Finance | Q2 |
| **19. Princess of Wales Hospital (PoW) roof replacement** | 5932 | Director of Finance | Q3 |

| Planned output, Outline scope, Review reference | Risk reference | Executive Lead/Responsible Director | Planned quarter to start |
|---|---|---|---|
| This audit of the PoW roof replacement project recognises the approved Welsh Government funding provision and the targeted completion during Autumn 2025. The audit will focus on the project delivery arrangements through to completion and handover. | | | |
| **20. Estates assurance – Asbestos Management**<br>To evaluate the controls and practices in place within the Health Board to ensure that the key asbestos regulatory requirements are adequately addressed and appropriate management arrangements were embedded within the organisation. | SRR8 | Director of Finance | Q2 |
| **Follow up work** | | | |
| **21. End of life care management**<br>To re-audit objectives from the previous year limited assurance report. | - | Chief Operating Officer | TBC |
| **22. Gastro-Intestinal demand management**<br>To re-audit objectives from the previous year limited assurance report. | - | Chief Operating Officer | TBC |
| **23. Medical job planning**<br>To re-audit objectives from the previous year limited assurance report. | - | Medical Director | TBC |
| **24. Additional medical pay**<br>To re-audit objectives from the previous year limited assurance report. | - | Medical Director/ Director of People | TBC |
| **25. Interventions not normally used (INNU)**<br>To re-audit objectives from the previous year limited assurance report. | - | Chief Operating Officer | TBC |
| **26. Capital systems**<br>Previous year limited assurance report. To review the progress made against actions agreed in the original audit report. Timing of follow up work will be after management have reported actions as closed to the Audit Committee. | - | Director of Finance | TBC |

| Planned output, Outline scope, Review reference | Risk reference | Executive Lead/Responsible Director | Planned quarter to start |
|---|---|---|---|
| **27. Estates assurance**<br>Previous limited assurance report. To review the progress made against actions agreed in the original audit report. Timing of follow up work will be after management have reported actions as closed to the Audit Committee. | - | Director of Finance | TBC |
| **28. Digital benefits realisation**<br>Previous year limited assurance report. To review the progress made against actions agreed in the original audit report. Timing of follow up work will be after management have reported actions as closed to the Audit Committee. | - | Director of Digital | TBC |
| **29. Vaccination policy implementation**<br>Previous year limited assurance report. To review the progress made against actions agreed in the original audit report. Timing of follow up work will be after management have reported actions as closed to the Audit Committee. | - | Director of Public Health | TBC |
| **30. Decarbonisation**<br>Previous limited assurance report. To review the progress made against actions agreed in the original audit report. Timing of follow up work will be after management have reported actions as closed to the Audit Committee. | - | Director of Strategy | TBC |
| **Other activity** | | | |
| **NHS Wales - Joint Commissioning Committee (JCC)**<br>We plan to meet with the JCC to identify a programme of work for 2025/26. | - | - | - |
| **Integrated Audit and Assurance plans** | | | |
| **Management of Prince Charles Hospital capital project**<br>See Separate Integrated Audit & Assurance Plan (IAAP). | - | Director of Finance | Q1-Q4 |

# Appendix B: Key performance indicators (KPI)

| KPI | SLA required | Target 2025/26 |
|---|---|---|
| Audit plan 2025/26 agreed/in draft by 30 April | ⚑ | To deliver plan |
| Audit opinion 2024/25 delivered by 31 May | ⚑ | To deliver opinion |
| 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 working days] | ⚑ | 95% |
| Report turnaround management response to draft report [15 working days maximum] | ⚑ | 80% |
| Report turnaround draft response to final reporting [10 working days] | ⚑ | 95% |

# Appendix C: Internal Audit Mandate and Charter

## 1 Introduction

1.1 This Mandate and Charter is produced and updated annually to comply with the Global Internal Audit Standards (introduced from 1 April 2025 for the UK Public Sector). The Standards (with specific reference to Standard 6.1 Internal Audit Mandate and 6.2 Internal Audit Charter) require the production and maintaining of an Internal Audit Mandate and Charter that, at a minimum, sets out:

- The purpose of Internal Auditing;
- a commitment to adhere to the Global Internal Audit Standards;
- the Mandate, including the scope and types of services to be provided, and the Board's responsibilities and expectations regarding management's support of the internal audit function; and
- the organisational position and reporting relationships, including Independence.

The Mandate and Charter are 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 Mandate and 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 Mandate and Charter for an operational interface with internal audit activity through the Director of Corporate Governance (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 the 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:

- 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 is described in the Global 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 mandate and 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.

3.3 While maintaining effective liaison and communication with the organisation, as provided in this Mandate and 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 Mandate and 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 Global 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 Director of Corporate Governance 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 Director of Corporate Governance 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. 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, the Joint Commissioning Committee.

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.

# 6 Standards, Ethics, and Performance

6.1 Internal Audit must comply with the Global Internal Audit Standards and the UK Public Sector Application Note in discharging its responsibilities.

6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2024) and associated performance standards agreed with the Audit Committee and the Shared Services Partnership Committee. The Service Level Agreement includes several 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 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 other regulators.
- 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 Mandate and 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 Mandate and 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 equirements of the Mandate & Charter |
| Organisation Level | Entity strategic 3-year audit plan | Entity level medium term audit plan linked to organisational objectives priorities and risk assessment |
| | 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 Director of Corporate Governance.

# 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 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 Global 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.
- Operational management will receive discussion draft reports which will include any proposed recommendations for improvement within 10 working days following the discussion of findings. A copy of the draft report will also be provided to the relevant Executive Director.
- The 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 draft report will also indicate priority ratings for individual report findings and recommendations.
- 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.
- The Head of Internal Audit will seek to resolve any disagreement with management in the clearance of the draft report. However, where the management response is deemed inadequate, or disagreement remains then the matter will be escalated to the Director of Corporate Governance. The Head of Internal Audit may present the draft report to the Audit Committee where the management response is inadequate or where disagreement remains unresolved. The Head of Internal Audit may also escalate this directly to the Audit Committee Chair to ensure that the issues raised in the report are addressed appropriately.
- Reminder correspondence will be issued after the set response date where no management response has been received. Where no reply is received within 5 working days of the reminder, the matter will be escalated to the Director of Corporate Governance. The Head of Internal Audit may present the draft report to the Audit Committee where no

management response is forthcoming.

- 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, Director of Corporate Governance and the Chair of the Audit Committee will be copied into any correspondence.
- The final report will be copied to the Accountable Officer and Director of Corporate Governance 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 maybe 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 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 is 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 Global 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 Global 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 Mandate and Charter

14.1 This Internal Audit Mandate and Charter shall be reviewed annually and approved by the Board, taking account of advice from the Audit, Risk and Assurance Committee.

Simon Cookson
Director of Audit & Assurance
NHS Wales Shared Services Partnership
May 2025

# Disclaimer

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

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

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

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of 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.

## Global Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023. Please note that new Global Internal Audit Standards apply from April 2025, and all future audit work will comply to these new Standards.

# Estates Condition

## Final Internal Audit Report

## 2023/24

## Cwm Taf Morgannwg University Health Board

Limited Assurance

**Contents**


Executive Summary .....1
Estates Condition - At a Glance.....3
Findings & Agreed Action Plan .....4
Appendix A .....15


| | |
|---|---|
| Review Reference | CTM-SSU-2324-02 |
| Fieldwork | May – July 2023 |
| Executive Sign Off | 17th April 2025 |
| Audit Committee | 15th May 2025 |
| Executive Lead | Sally May, Director of Finance, Procurement, Capital & Estates |
| Audit Team | Huw Richards, Head of Internal Audit |
| | Paul Stocker, Audit Manager |

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

# Executive Summary

## Purpose

The NHS in Wales faces unprecedented challenges balancing the management of the current estate condition against other competing priorities and within existing funding constraints – whilst also developing a deliverable Estate Strategy for the future.

The backlog maintenance figures for NHS Wales recently exceeded £1bn (the substantial element being High and Significant risks) and is likely to increase further due to the ageing estate in Wales.

The audit sought to evaluate the arrangements put in place by the UHB to identify and manage key risks associated with the existing estate and the implementation of resulting strategies to manage/mitigate the risk.

## Overview

Key to understanding the challenge is the following:

- Detailed surveys had been undertaken of the Princess of Wales Hospital (as part of the transfer from Swansea UHB) and the Prince Charles Hospital (as a part of the refurbishment programme). Though noting at the time of audit fieldwork it was coming up to 5 years since the survey had been completed of the Princess of Wales Hospital. Historically, the remainder of the estate had not been surveyed; the UHB citing the prohibitive costs and perceived poor value of these surveys.
- More recently, In lieu of the above, annual reviews were completed locally by UHB Estates professionals informed by detailed knowledge of the estate. However, the evidence provided to support these assessments did not reflect the detail that would be offered by a detailed risk-based survey. It is important that the decision to move away from established best practice guidance is appropriately reported and approved by an appropriate forum.
- As experienced by other NHS organisations, and acknowledged by the UHB, where detailed surveys had been completed recently, this had resulted in an increase in the associated costs within the reported data.
- Further concerns had been raised nationally on the comparability of the data, given the significantly varied methods of computation by each NHS organisation – impacting the ability to benchmark and compare performance.
- In the short to medium term, the UHB uses a combination of all Wales Capital funding, targeted EFAB funding, planned/ reactive maintenance, and discretionary funding to address identified high-priority areas. Noting the above, there were arrangements in place to focus the limited available resources on progressively addressing the high priority areas within the UHBs estate – and targeting business cases accordingly.
- In the longer-term, the UHBs 10-year programme highlights an indicative funding requirement of circa £534m for the estate to meet the future healthcare needs of the population. Noting the scale of investment required is outside of the direct control of the UHB; this would require a co-ordinated approach to capital bid submissions.
- Whilst operational risks were well documented, reported and escalated, the Board should seek further assurance that the identified actions within the Board Assurance Framework are effective – noting their impact to date.

An overall **limited assurance** has been determined recognising that it may not be possible to manage all identified risks within available funding.

This assurance opinion is in line with that determined across NHS Wales, given the common challenges faced by each organisation.

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

Whilst not a specific focus of this review, the recently nationally reported Reinforced Autoclaved Aerated Concrete (RAAC) issues had further increased the risk profile of the NHS Wales estate. The centrally commissioned surveys had identified only isolated instances of RAAC requiring urgent attention - at the time of reporting, the surveys identified no areas requiring urgent action within the UHB estate.

## Scope & Assurance Summary

| | Objectives | Related Findings | Assurance |
|---|---|---|---|
| 1 | **Governance:** To obtain assurance that robust governance arrangements were applied to ensure the organisation stays abreast of matters and associated risks relating to the estates condition. | 4,5 | **Reasonable** |
| 2 | **Baseline Information:** To ensure that the UHB had detailed records of the condition of the estate based on a combination of robust condition surveys and risk assessments. The information was managed and retained within robust management systems that were subject to regular review. | 1,2 | **Limited** |
| 3 | **Estates Planning:** To ensure that an appropriate Strategy and/or plans was in place, including linkage to major investment, estates condition, statutory compliance, decarbonisation requirements, service needs etc. | 3 | **Limited** |
| 4 | **Funding Strategy:** To ensure there was a co-ordinated approach to the targeting of All-Wales, Estates Funding Advisory Board (EFAB) and Discretionary funding to implement the Estate Strategy. | 4,5 | **Limited** |
| 5 | **Monitoring and Reporting:** To ensure appropriate management information was presented with regularity on key issues, including the estate condition and progress to implement the estates / funding strategy. Monitoring and reporting included an assessment of the success of the combined strategies in improving estates condition (and reducing risk exposure), and confirmation that expenditure of funding was in line with agreed conditions. | 5 | **Limited** |
| 6 | **Risk Management:** Assurance that risks were appropriately logged and escalated through the corporate risk reporting arrangements. The risk exposure of the UHB in relation to estates condition was clearly reported. | 6 | **Limited** |

### Management Actions

**2** High Priority

**4** Medium Priority

### Themes

### Risk Types

Financial Loss

Legal & Regulatory Non-Compliance

Quality or Safety Issues

Public Perception & Reputational Risk

# Estates Condition - At a Glance

The key guidance in relation to assessing backlog: '*A Risk-Based Methodology for Establishing and Managing Backlog'* (updated March 2013), describes the steps involved in establishing and managing backlog, as follows:

In respect of the detailed condition survey, the guidance recommends that:

> *"NHS organisations carry out a detailed survey of their assets on a five-yearly basis."*

and,

> *"You should update the findings of your detailed survey on an annual basis. This will inform your investment planning process and ensure your assets are safe and fit for purpose."*

The backlog maintenance figures for NHS Wales recently exceeded £1bn (the substantial element being High and Significant risks) and is likely to increase further due to the ageing estate in Wales. The latest nationally reported data (2021/22) for the UHB confirmed a total backlog maintenance requirement of £87m – although the Capital investment requirement to clear the backlog is likely to be materially higher.

In the longer-term, the UHBs 10-year programme highlights an indicative funding requirement of circa £534m for the estate to meet the future healthcare needs of the population. Noting the scale of the investment required, there is a significant risk to the UHB that this Strategy may not be affordable. It had been recommended that the Board continue to receive regular updates on the delivery of the Estate Strategy and the 10-year Capital programme, particularly any risks/impact resulting from delay/non delivery.

In the short to medium term, the UHB uses a combination of all Wales Capital funding, targeted EFAB funding, planned/ reactive maintenance, and discretionary funding to address identified high-priority areas as follows:

- Significant investment had been made utilising All Wales Capital Programme Funding, with ongoing large-scale investment at Prince Charles Hospital along with those at Ysbyty Cwm Cynon, Ysbyty Cwm Rhondda and Kier Hardy University Health Park.
- The UHB had successfully secured EFAB funding of £7.7m across 2023/24 & 2024/25 to tackle high/significant backlog priorities
    - Estates Infrastructure £4.644m.
    - Decarbonisation £1.564m.
    - Fire Safety £1.553m.
- Across NHS Wales, due to pre-commitments and other pressures on the discretionary Capital funding, the allocation for backlog maintenance had historically been insufficient to effectively manage the position – with £1.021m earmarked at the UHB specifically for backlog in 2023/24 (over and above UHB contributions to EFAB funding).

# Findings & Agreed Action Plan

| Objective 1: Governance | Reasonable |
|---|---|

**Overview / Summary of Observations**

Governance arrangements were in place with escalation processes to a corporate level noted. The executive lead for the estate was the Director of Finance, Procurement, Capital & Estates, who chairs the Capital & Estates Governance Committee Meetings and presents estates issues at the UHB's Planning, Performance & Finance Committee (PPFC).

The UHB had defined organisational structures in place covering the management of estates and capital.

Board assurance had been informed via the inclusion of estate condition risks on the Organisational Risk Register (see ***risk management*** section). We have made several recommendations throughout this report aimed at strengthening the level of assurance received by the Board in respect of the significant estate condition risks faced by the UHB (see **key findings 4 & 5**).

Whilst no issues were identified with the specific governance arrangements in place, sound decision making was predicated upon the quality of management information.

| Objective 2: Baseline Information | Limited |
|---|---|

## Overview / Summary of Observations

The key guidance in relation to assessing backlog: '*A Risk-Based Methodology for Establishing and Managing Backlog'* (updated March 2013), specifically:

> *"NHS organisations carry out a detailed survey of their assets on a five-yearly basis."*

Generally, management considered externally commissioned surveys to be poor value for money given that the surveys are non-invasive, only a snapshot, estimate rather than market tested costs and unadjusted for inflation.

The Princess of Wales Hospital and the Prince Charles Hospital sites were fully surveyed re: estate condition, the former as part of the creation of CTMUHB and the latter as part of the major investment programme. Noting however that the PoW Hospital will shortly meet the time-based criteria (every 5 years) for a reassessment to be undertaken.

For the remaining areas of the UHB, management outlined that the approach adopted was for senior estates staff to update the data based on their own existing local knowledge/ experience of the estate, costs from contractor quotations and/or estimates from appointed consultants.

A level of risk assessed information was retained to plan the discretionary works, statutory compliance programmes and respond to Welsh Government initiatives (such as EFAB funding and end of year slippage). Management saw little benefit in spending time and money establishing the costs of low to medium risks as it was deemed highly unlikely that the capital will be available to address them – however, should discretionary capital increase significantly then internal resources would have to be ramped up to address the additional consequential works.

Recognising the approach outlined, the methodology and formulation of the original costed data was not determined, and little substantive evidence was provided relating to the annual estimated costs. The information retained related to specific identified risks within various locations, rather than the full detail of room-by-room information that would be offered by a detailed risk-based survey. Management outlined that the approach focused on the high-risk aspects proportional to the likelihood of securing capital funding.

The concern is that overall backlog cost may therefore be understated, noting where other NHS Wales Health Bodies had recently commissioned full surveys, the backlog maintenance figures had significantly worsened".

It was noted that, subsequent to the audit, dialogue had been held on an All-Wales basis with NWSSP: Specialist Estates Services to discuss the delivery, frequency and breadth of survey required.

| | Key Findings | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 1 | It was recommended within the Risk Based Methodology to Backlog (March 2013) that NHS organisations carry out a detailed survey of their assets on a five-yearly basis.<br><br>The UHB had historically chosen not to engage external parties to complete detailed estate condition surveys.<br><br>The costs of the backlog programme were gathered by the Estates teams from sources such as local knowledge / | The UHB may not fully understand the estate condition. | **Agreed Action:**<br><br>At its All-Wales Estates meeting held on 26th March 2025 NWSSP (SES) agreed to set up forum to discuss a common all-Wales approach for site surveys and backlog management. CTMUHB will be represented at these meetings<br><br>**Expected Evidence of Implementation**<br><br>Updates to be provided to a nominated UHB Committee on: |

| | | | |
|---|---|---|---|
| | experience, professional judgement, contractor quotations and estimates from appointed consultants.<br><br>Limited substantive information was provided in support of the assessments outlined above; evidence was provided of limited dialogue via email and a specific example of one costed element of works. The overarching excel spreadsheet that summarised the backlog information did detail identified risks within the various UHB sites but did not include the full room-by-room detail that would be provided by detailed surveys. The concern is that the full cost of backlog maintenance may be understated. | | 1.The development of an agreed common approach for NHS Wales (outside of the direct control of the UHB); and<br><br>2.The subsequent development of a UHB specific implementation plan. |
| | The UHB has recognised that the data entry into the three-year plan would benefit from strengthening and have consequently implemented a revised process. | **Medium Priority** | **Officer:** Assistant Director of Estates<br><br>**Target Implementation Date:** October 2025 |
| | **Theme:** Quality, Safety & Patient Experience | Control Operation | |
| 2 | The NHS Estates Risk Based Methodology to Backlog guidance (2013) outlines a process for updating the findings of the detailed survey (condition and risk rankings and associated costings) on an annual basis. This guidance highlights that an annual update should take account of the following, for example:<br><br>1. inflation.<br>2. service schedules.<br>3. vacant assets awaiting disposal.<br>4. new sub-standard elements.<br>5. further deterioration of previously identified elements.<br>6. recent acquisition of property.<br>7. refurbishments/alterations since previous survey.<br>8. regulatory changes.<br>9. proposed strategic shift in service provision.<br><br>Management had advised that an annual meeting takes place to update results for the EFPMS submission to Welsh Government. However, there were no local procedures surrounding how the UHB would undertake this review i.e.:<br><br>1. How and who would be involved in the process. | Baseline information is not kept up to date. | **Agreed Action:** A standard operating procedure will be developed to ensure consistency of approach at the annual desk top updates.<br><br>**Expected Evidence of Implementation:**<br><br>The implementation of the approved operating procedure. |

| | | | |
|---|---|---|---|
| | 2. What methods would be used to calculate inflation.<br>3. How further or new deterioration of the estate would be validated.<br>4. Where the results of the review would be reported (internally within the UHB).<br>The formulation and application of standard procedures would ensure consistency over financial years and help provide benchmarking criteria across the NHS Wales estate. Also, an annual review puts pressure on the availability and accuracy of information, it may be prudent for reviews to be undertaken more frequently if resources allow. | | |
| | | **Medium Priority** | **Officer:** Assistant Director of Estates |
| | **Theme:** Quality, Safety & Patient Experience | Control Operation | **Target Implementation Date:** June 2025 |

## Objective 3: Estates Planning — Limited

**Overview / Summary of Observations**

Welsh Health Building Note 00-08 '*Estate code*' (2018) highlights:

> *"Once a comprehensive analysis of the condition and performance of the existing estate had been completed, the organisation will have the baseline data used when developing an estate strategy.*
>
> *An estate strategy should represent the vision for the future of the organisation's estate…in order to deliver and satisfy the current and perceived business plans, the expected operational service requirements, aligned with objectives of contributors to health and social care delivery.*
>
> *The purpose of an organisation's board approved estate strategy is to provide the strategic framework for the provision of an efficient, sustainable and fit-for-purpose estate that is both safe and secure. Current drivers include improving efficiency and rationalising occupancy whilst reducing ongoing revenue and capital commitments.*
>
> *The estate strategy should be reviewed annually using EFPMS data and the information from the five-facet survey. The clinical strategy should be the driver of the estate."*

The development of the UHB's Acute Clinical Services Plan (ACSP) will provide an integrated approach for the organisation. This is key to help shape the future infrastructure and estate requirements going forward.

In the shorter term the UHB's Integrated Medium-Term Plan (IMTP, 2023-2026) makes multiple references to the estate and includes a specific section under Capital & Estates which detailed capital programmes and associated Welsh Government Funding requirements. This being compliant with the approach endorsed by WG.

| | Key Findings | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 3 | WHBN 00-08 2018 Estate code outlines that the Estate Strategy should represent the vision for the future estate to deliver and satisfy the current/anticipated business plans and operational services.<br><br>Management confirmed that a standalone Estate Strategy was not in place, as they view this as integral to their overall Acute Clinical Services Plan (ACSP).<br><br>Whilst noting that the current IMTP does address aspects of the ongoing management of the estate it does not | Lack of a coherent strategic framework for the ongoing development and management of the estate. | **Agreed Action:** The UHB are currently developing their Acute Clinical Services Plan (ACSP). This plan is integral in establishing the future estates requirement of the Health Board and it is this which will inform ongoing strategy.<br><br>**Expected Evidence of Implementation:**<br><br>Noting that the full implementation of the plan may be some years away, regular progress updates will be provided to an appropriate |

| | | | |
|---|---|---|---|
| | comprehensively cover the details that would be expected within a Specific Service Strategy (covering estate issues). | | UHB Committee, specifically relating to the associated capital/estate requirements. |
| | | **High Priority** | **Officer:** Assistant Director of Estates |
| | **Theme:** Strategy | Control Operation | **Target Implementation Date:** June 2025 |

## **Objective 4:** Funding Strategy — **Limited**

### Overview / Summary of Observations

There had been historical under-investment across the NHS in Wales in this area, resulting in a deterioration of the NHS estate condition. The cost of the UHB's backlog maintenance was estimated as £87,089,544 in 2021/22.

The UHB's IMTP for 2023/24 identified capital funding from all sources of circa £63.461m, of which £45.5m related to the Prince Charles Hospital refurbishment phases 2 and 3. Historically, the UHB had been successful in securing major investment for example Ysbyty Cwm Cynon (opened 2012), Ysbyty Cwm Rhondda (opened 2010) and Kier Hardie University Health Park (opened 2012).

For 2023/24 & 2024/25 EFAB funding of £7.76m was awarded to the UHB, this enabled a start in addressing some of the most urgent backlog maintenance issues. However, it was recognised that it can be difficult to forward plan given the availability of monies and the timeframe that monies had to be spent.

Discretionary capital funding was also available to the UHB on an annual basis as part of the allocated Capital Resource Limit (CRL), with £9.006m allocated in 2023/24. Slippage in the delivery (and funding) of major capital schemes and other service priorities had led to increasing pre-commitments being required from the discretionary programme, reducing the available funding for backlog maintenance works.

The Estates and Facilities Performance Management System (EFPMS) categorises the UHB's 'Total Building & Engineering Maintenance Cost per Occupied Floor Area' over the last three years" i.e.:

***Table 2***

| Measure | 2019/20 | 2020/21 | 2021/22 |
|---|---|---|---|
| UHB Total Building & Engineering Maintenance Cost per Occupied Floor Area (£/m²) | 29.98 | 34.13 | 31.85 |
| NHS Wales average: Total Building & Engineering Maintenance Cost per Occupied Floor Area (£/m²) | 23.86 | 27.43 | 28.77 |

Whilst noting the level of investment had fluctuated it had been consistently higher than the all-Wales average over the past three financial years. However, this had been insufficient to prevent a deterioration in the condition of the estate over that time. The current level of investment would therefore also be insufficient to effectively manage the condition of any new estate requirements identified within the Infrastructure Plan to be included as part of Acute Clinical Services Plan (ACSP).

A detailed list of the Estates Department's establishment was produced in August 2022, identifying the makeup of workforce by age, role, specialism and work base and also geographical area of responsibility. This highlighted gaps between the existing capacity and the needs going forward. It was unclear whether this list had resulted in any mitigating actions, as a report provided to the Capital & Estates Governance Board Meeting on the 13th of April 2023 records; "*reactive maintenance requirements across all sites to ensure Estate's deliver services to meet the operational requirements of the HB sites are severely stretched. Staff addressing the statutory and high-risk items first to ensure continued compliance".*

It was concluded therefore that the UHB had utilised a range of funding options for the estate. The assurance acknowledges the historical under investment in the estate and the material gap in approved levels of investment.

| Key Findings | | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 4 | The UHB had been targeting backlog investment through discretionary and other funding streams.<br><br>In addition to the above, the UHB produced a prioritised 10-year Capital Programme estimating a requirement of £534m.<br><br>As above, there were multiple funding sources available, however, the risk adjusted backlog maintenance position highlights an increasing negative trend.<br><br>There remains a significant risk, that estates and capital plans drawn up by the UHB will be unaffordable in the current financial climate, and in consideration of similar funding needs across NHS Wales.<br><br>WHBN 00-08 2018 Estatecode highlights the importance of life cycle investment planning as key to managing the performance of the estate.<br><br>Local and national resource constraints were evident i.e. local and national workforce issues present the UHB with challenges surrounding recruiting and retaining skilled labour to enable effective estates service provision. | The pending Service Specific Strategy for Estates as part of Acute Clinical Services Plan (ACSP) is unaffordable, meaning identified estates condition risks will not be addressed. | **Agreed Action:** The UHB have been proactive in identifying both future capital requirements and determining the extent of backlog maintenance required. It is accepted that the current funding provision available from WG will not fully address this, however the UHB continues to seek out all available funding to mitigate this risk.<br><br>In this context regular updates will be provided to the Board (and/or nominated Committee) on the Capital Plan and Estate Infrastructure risk<br><br>**Expected Evidence of Implementation:**<br><br>Regular updates to the Board and or nominated Committee. |
| | | **High Priority** | **Officer:** Director of Finance<br><br>**Target Implementation Date:** June 2025 |
| | **Theme:** Finance Management & Control | Control Operation | |

| Objective 5: Monitoring & Reporting | Limited |
|---|---|

## Overview / Summary of Observations

The Health and Safety Committee had received regular reports on statutory compliance, including assurance on the work being progressed as part of phase 2 of the Prince Charles Hospital refurbishment.

The annual Estates Operational Performance and Energy Performance report was a standing item at the Planning, Performance and Finance Committee Cycle of Business. The last being presented to the Committee at their meeting on the 26th of April 2022. The Cycle of Business noted that the 2022/23 report would be presented at the April 2023 meeting. However, this was not evidenced from a review of the minutes of the meeting.

It was noted that post audit fieldwork the EFPMS data report was shared with the Planning, Performance and Finance Committee on the 27th of February 2024.

The Board Assurance Framework (BAF) dated March 2022 and presented to the UHB Board Meeting held on 26th May 2022 noted that to mitigate a risk identified by Audit Wales around the reporting of estates performance information to Boards and Committees, the UHB should look to introduce regular reporting to the PPF Committee based on estates key performance indicators.

Subsequent Planning, Performance and Finance Committee meetings did not include increased levels of reporting in accordance with the recommendations made by the BAF and Audit Wales.

It was concluded therefore that whilst the UHB had established monitoring and reporting arrangements in place, further focus on the overall estate condition and backlog maintenance position was required. Accordingly, **limited assurance** has been determined in relation to monitoring and reporting.

| | Key Findings | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 5 | On reviewing Estates related reporting, the UHB Board and the Performance Planning and Finance Committee for the period March 2022 through till March 2023, the following was identified as the extent of reporting on estates condition:<br>• The EFPMS data report was shared with the Planning, Performance and Finance Committee in February 2024.<br>• The annual Estates Operational Performance and Energy Performance report is a standing agenda item at the Planning, Performance and Finance Committee (PPFC). This was presented in March 2022 and according to the cycle of business for 2023/24 it was due to be an agenda item at the March 2023 meeting, however the minutes of this and the June 2023 meeting do not record it having been presented.<br>• It is also recognised that other elements of this data would be covered within other UHB Committee reporting e.g. Quality and Safety Committee. | The Board / Committee does not receive timely and accurate assurance on the performance of the Estate Strategy in impacting the backlog position. | **Agreed Action:**<br>Monitoring of estate risks will continue to be monitored via nominated committees and to Board. The Board will consider what specific estate infrastructure risks should be added to the Board Assurance Framework in a May Risk session<br>**Expected Evidence of Implementation:**<br>Confirmation of agreed Board Assurance Framework actions |

| | | | |
|---|---|---|---|
| | Overall, over the period reviewed there had been limited reporting of the ongoing backlog position within the UHB and no reporting against targets in for the reduction in backlog.<br><br>Audit Wales previously noted Board-level oversight of the condition of the estate and other physical assets required strengthening. | | |
| | | **Medium Priority** | **Officer:** Director of Finance |
| | **Theme:** Reporting | Control Operation | **Target Implementation Date:** June 2025 |

| **Objective 6:** Risk Management | **Limited** |
|---|---|

## Overview / Summary of Observations

At an operational level, capital and estates risks were generally identified, assessed, and escalated in accordance with the well-established Health Board approach to risk management. The Risk Management Strategy allows pertinent risks to then be escalated through to the Corporate Risk Register if rated greater than 15.

The Organisational Risk Register did not highlight any specific risks pertaining to overall backlog. Similarly, on reviewing the latest BAF (March 2023), there was also an absence of risks relating to the estate (including backlog requirements/risks).

Whilst risks were routinely captured and recorded at an operational level, significant estates risks were not given board level priority reflective of the significance/ materiality. Accordingly, **limited assurance** had therefore been determined in respect of risk management.

| | Key Findings | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 6 | The UHB's Risk Management Strategy noted that the Board Assurance Framework (BAF) would be used by the Board to identify, monitor, and evaluate risks which impact upon strategic objectives.<br><br>On reviewing the latest BAF (March 2023), there was an absence of risks relating to estates including backlog, similarly a review of the Organisational Risk Register did not highlight any specific risks pertaining to overall backlog. | The Board is not assured that risk are appropriately captured and presented so that informed debate can arise. | **Agreed Action:**<br><br>The UHB has, post audit, agreed to address this with the inclusion of Estates risks within the BAF. The Board will consider what specific estate infrastructure risks should be added to the Board Assurance Framework in a May Risk session.<br><br>**Expected Evidence of Implementation:**<br><br>Confirmation of agreed Board Assurance Framework actions. |
| | | **Medium Priority** | **Officer:** Director of Finance |
| | **Theme:** Risk Management | Control Operation | **Target Implementation Date:** June 2025 |

# Appendix A

## Assurance Opinion

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

## Prioritisation of Findings

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

## Disclaimer

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

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

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

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

## Public Sector Internal Audit Standards

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

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

# Capital Systems

## Final Internal Audit Report

## 2024/25

## Cwm Taf Morgannwg University Health Board

Limited Assurance

**Contents**


Executive Summary .....1
Findings & Agreed Action Plan .....4
Appendix A .....11


| | |
|---|---|
| Review Reference | CTM - SSU-2425-18 |
| Fieldwork | September – January 2025 |
| Executive Sign Off | 12th April 2025 |
| Audit Committee | 15th May 2025 |
| Executive Lead | Sally May, Executive Director Finance |
| Audit Team | Huw Richards, Deputy Director Specialist Services Unit |
| | Murray Gard, Audit Manager |

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

# Executive Summary

## Purpose

This audit was commissioned in accordance with the agreed 2024/25 Internal Audit Plan. Capital systems coverage focussed on the selection, appointment and contractual arrangements applied at Estates projects.

## Overview

We have concluded that this area offers **limited** assurance due to deviations from corporate controls, including the Health Board's Standards of Behaviour and Standard Financial Instructions. While positive practices exist, implementing additional controls, as outlined below, would enhance overall assurance.

Overall, corporate governance arrangements were well established, with Standing Orders, Standard Financial Instructions (SFIs), and other financial control procedures in place. Key strengths include successful applications for Estates Funding Advisory Board (EFAB) monies (70% Welsh Government, 30% Health Board contribution), Executive Capital Management Group approvals, and purchase orders secured for all sampled projects. Additionally, where contracts were in place, they underwent effective scrutiny and annotation, demonstrating good practice in quality control and due diligence.

However, several areas require management attention to improve controls and consistency:

- Capital Procedures & Documentation – Expanding existing project checklists to include further proforma documentation to improve consistency and standardisation.
- Procurement & Contract Strategies – Ensuring procurement and contract strategies are developed at project inception, with deviations from SFIs clearly explained and approved.
- Training Opportunities – Exploring training initiatives to prepare for upcoming procurement rule changes and how this effects current practices.
- Compliance with Standards of Behaviour Policy – Implementing protocols to ensure individuals involved in procurement reaffirm any conflicts of interest before participating.
- Standardised Vetting Approach – Strengthening financial and technical vetting by obtaining assurance from framework partners regarding ongoing compliance.

Addressing these areas will enhance governance, transparency, and compliance across capital and procurement processes.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

- A review of the contractual documentation revealed that for one project (scheme code W536), the contract was formally executed only after the works commenced. Despite this delay, the contract was fully executed and in place before the project was completed, ensuring that key contractual obligations were formalised.

- Moving forward once agreed procurement strategies are in place, the Health Board should establish regular reporting mechanisms to provide assurance on procurement activities.

## Scope & Assurance Summary

| | Objectives | Related Findings | Assurance |
|---|---|---|---|
| 1 | Governance Arrangements – Ensure the Health Boards policies and procedures (Standard Financial Instructions, Standing Orders, Capital Procedures) included roles and responsibilities and approval requirements for tendering, contractual management, and that contract strategies were clearly communicated and approved. | 1,3,4,5 | **Reasonable** |
| 2 | Tendering and/or Selection– To ensure the appropriate application of Standing Order, Standing Financial Instructions, and national and local procurement policies at the selection and appointment of contractors and technical advisers; the application of appropriate competitive tender/quotation arrangements or use of frameworks (as applicable). To ensure that, regardless of the approach adopted, it culminated in a formal evaluation that confirmed that the preferred bidder's submission demonstrated value for money. | 2,3,4,5 | **Limited** |
| 3 | Approval to Award and Contract Completion – Appropriate recommendations and approval to enter contracts were documented and reported. Assurance on the timely completion, recording, and approval of agreements / contract versions in accordance with the approved contract strategy/SFIs (with appropriate inclusions and clauses completed). Tender and contract information was retained for the requisite period (in accordance with local/ national guidance) and that all contract documentation was held securely. | 6,7 | **Limited** |

### Management Actions

**2** High Priority

**5** Medium Priority

### Themes

### Risk Types

Financial Loss

Legal & Regulatory Non-Compliance

Public Perception & Reputational Risk

# Capital Systems - At a Glance:

A total of 9 projects were sampled for this audit covering a range of values and funding sources as follows:

| Code | Project title | (£) | Funding Mechanism |
|---|---|---|---|
| W536 | Princess Of Wales - Emergency Department Works | 801,640 | Estates Funding Advisory Board |
| W581 | Glanrhyd - Installation of PV Panels | 529,808 | Estates Funding Advisory Board |
| W555AW | Princess Of Wales- Fluoroscopy Room 3 | 420,000 | All Wales Capital Programme |
| W557 | Royal Glamorgan - CHP Room Repairs & Upgrade | 34,740 | Discretionary |
| W558 | Royal Glamorgan – Nurse Call System | 99,318 | Discretionary |
| W559 | Ysbyty Cwm Rhondda -Security Doors & Access System | 170,764 | Discretionary |
| W601 | Princess Of Wales - Mental Health En-Suite Bedroom W14 | 59,186 | Discretionary |
| W567 | Princess Of Wales – Electrical Install (Phase 1) | 584,475 | Estates Funding Advisory Board |
| W603 | Royal Glamorgan - Recommissioning Obstetric Theatre | 334,779 | Discretionary |

# Findings & Agreed Action Plan

| **Objective 1:** Governance Arrangements | **Reasonable** |
|---|---|

**Overview / Summary of Observations**

Corporate governance arrangements were defined within Health Board-approved control documents, including:

- Model Standing Orders.
- Standing Financial Instructions.
- Scheme of Delegation.

For example, the Scheme of Delegation (last updated in January 2024) defined authority levels for capital schemes funded through the discretionary programme.

- New approvals under £500k are approved by Executive Capital Management Group (ECMG).
- Schemes between £500k and £1m are approved by ECMG and noted by Finance Performance and Workforce Sub-committee.

Welsh Government's Estates Funding Advisory Board (EFAB) projects require submission and approval of pre-agreed proforma documents, with official approval via letter. The Health Board contribution to schemes approved via EFAB was 30%.

A sample of nine projects (detailed in the "At a Glance" section) confirmed compliance with approval mechanisms. However, project checklists intended to standardise the approach to managing capital projects were not completed. Additionally, there were several requirements within the checklist where proforma were not provided – leading to variability in the level of substantive information retained. The checklist may also benefit from a complementary capital procedure document.

Key findings 3, 4 and 5 provide material examples of the above.

| | Key Findings | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 1 | **Capital Procedures**<br>The Health Board adopted a project checklist to standardise the approach to managing capital projects, but the audit observed incomplete forms and inconsistent compliance. Noting that the checklist did not provide proforma for all aspects, variability in substantive information was also observed.<br>Increased provision of proforma documents would further enhance standardisation (key items have been separately reported).<br>Additionally, arrangements could be improved via the introduction of complementary capital procedures to outline | Incomplete or absent documentation can indicate non-compliance with governance or procedural standards, exposing the organisation to regulatory or reputational risks. | **Agreed Action:**<br>The project checklist will be reviewed and incorporated into a wider capital procedure document.<br><br>**Expected Evidence of Implementation:**<br>Capital Procedure to be produced and approved through the ECMG. |

| | | | |
|---|---|---|---|
| | expectations, such as predefined requirements for project initiation documents and risk registers based on value or other metrics, rather than case-by-case decisions.<br><br>Accessibility to project information was hindered by workforce pressures and absences. Implementing a standardised, centralised file structure should ensure information is easily accessible, supporting continuity and efficiency in project management. | | |
| | | **Medium Priority** | **Officer: Head of Capital** |
| | **Theme:** Policies & Procedures | Control Design | **Date: August 2025** |

| **Objective 2:** Tendering and/or Selection | **Limited** |
|---|---|

**Overview / Summary of Observations**

Where the Health Board used competitive tendering, strong compliance was noted with the Financial Control Procedure and Standing Financial Instructions for procurement between £25k and £1m. However, engagement with NWSSP Procurement was limited, despite being required under the SFIs. Additionally, no procurement strategy was evident when evaluating routes to market to derive best value (e.g. framework options, direct award vs. mini competition).

For tender evaluations and contractor award recommendations, a detailed analysis demonstrated value for money, representing an area of good practice.

Senior staff (band 8a and above) confirm annual declarations of interest, but the Standards of Behaviour Policy mandates reaffirmation before involvement in procurement exercises. This process was not being followed. Inconsistencies in undertaking and retaining information relating to financial and technical vetting. Additionally, there was no periodic reporting on procurement activity to provide assurance to the Health Board regarding contractor activity/awards and routes to market (frameworks, direct awards, mini competitions etc.).

| | Key Findings | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 2 | **Procurement Strategy**<br><br>SFI 10.3.1 mandates that *'all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of both any commitment being made and NWSSP Procurement Services being engaged…. Contracts above specified thresholds are advertised and awarded, through NWSSP Procurement Services, in accordance with EU and HM Treasury rules on public procurement'.*<br><br>However, NWSSP Procurement has had limited involvement in the capital projects sampled, with the Health Board managing tender and appointment processes internally. A procurement strategy should be implemented at project initiation to ensure appropriate safeguards are applied<br><br>Also, as UK procurement regulations are due to change in February 2025, the Health Board should obtain training to understand these changes and assess their impact on current processes. | Potential Inefficient/future non-compliant procurement practices. | **Agreed Action:**<br><br>Engage with Procurement Services to agree an operation strategy moving forward including necessary training requirements.<br><br>**Expected Evidence of Implementation:**<br><br>Incorporate agreed procurement strategy requirements into capital procedures. |
| | | **Medium Priority** | **Officer: Head of Capital**<br><br>**Date: August 2025** |
| | **Theme:** Planning, Delivery & Deadline Management | Control Operation | |

| | | | |
|---|---|---|---|
| 3 | **Declarations of Interest**<br><br>The Health Board's Standards of Behaviour Policy (page 10), mandates that *'employees involved in the procurement process must reaffirm their interests and confirm any relevant interests before participation'.*<br><br>During the audit review, it was found that employees above band 8a were required to submit an annual declaration of interest. However, those participating in the procurement process did not reaffirm their interests or provide nil returns.<br><br>This variation indicates a breach of the Health Board's Standards of Behaviour Policy, potentially leading to conflicts of interest and a lack of transparency in the procurement process. Measures are required to embed declaration of interests into operational activities. | Not ensuring that interest declarations are completed can reduce transparency in the procurement process, which may make it harder to hold individuals accountable for their decisions. | **Agreed Action:**<br><br>Issue standard forms for completing declarations of interest.<br><br>**Expected Evidence of Implementation:**<br><br>Actioned during review. |
| | | **High Priority** | **Officer: N/A**<br><br>**Date: N/A** |
| | **Theme:** Governance | Control Operation | |
| 4 | **Financial Vetting**<br><br>Financial vetting of contractors, even for small construction projects in the public sector, is essential to ensure the project's success and safeguard public resources. Vetting helps confirm that contractors have the financial stability to complete the project without delays caused by insolvency or cash flow issues.<br><br>From our sample of 9 projects, we identified an absence of retained financial vetting on 3 projects and reliance was placed on using frameworks for the remaining 6 projects. Management should establish clear guidelines that supports the following:<br><br>• Minimum financial criteria contractors must meet.<br>• Situations where reliance on external frameworks is acceptable.<br>• Documentation requirements for retained financial vetting. | Without retained financial vetting, there was a risk that contractors may not have the financial stability to complete the project, leading to potential delays, insolvency, or contract disputes. | **Agreed Action:**<br><br>To define an agree the level of financial vetting and incorporate this requirement into capital procedures.<br><br>**Expected Evidence of Implementation:**<br><br>Capital procedures to incorporate as appropriate. |
| | | **Medium Priority** | **Officer: Head of Capital**<br><br>**Date: August 2025** |
| | **Theme:** Governance | Control Design | |
| 5 | **Technical Vetting**<br><br>Ensuring that contractors retain appropriate insurances (including public liability insurance) is not just about protecting | Without evidence of insurance, the Health Board may | **Agreed Action:**<br><br>Reminders to be issued to ensure that appropriate insurances are maintained/evidenced prior to works commencing. |

| | | | |
|---|---|---|---|
| | the Health Board it is about safeguarding the public, minimising risk, and ensuring responsible use of public funds while upholding legal and ethical standards.<br><br>From our sample of 9 projects we identified that insurances were not fully evidenced on 2 projects and reliance was placed on using frameworks for 4 projects.<br><br>Management should establish clear guidelines that supports the following:<br>• Minimum insurance coverage amounts based on project size and risk.<br>• Frequency of insurance validation (e.g., annually).<br>• Frameworks to provide evidence of insurance checks for all engaged contractors. | face legal and financial challenges if an incident occurs, as there may be no guarantees that the contractor can absorb related costs. | These requirements will also be included within the Capital procedures.<br><br>**Expected Evidence of Implementation:**<br>Email reminders & incorporation of requirements within capital procedures |
| | | **Medium Priority** | **Officer: Head of Capital**<br>**Date: August 2025** |
| | **Theme:** Governance | Control Design | |

| **Objective 3: Approval to Award and Contract Completion** | **Limited** |
|---|---|

**Overview / Summary of Observations**

The All Wales Procure-to-Pay e-Manual provides the Health Board with guidance on procurement processes, including internal ratification. However, its use was inconsistent across the sampled projects, indicating a need for improved adherence to standard procedures.

The Health Board's SFIs specify the required contract types for goods, works, and services, based on financial value. Despite this, variations were noted within the reviewed projects. Notably, two projects (W557 & W558) did not have formal contracts in place, raising concerns about governance and compliance. Further details of these projects are outlined in the "At a Glance" section of this report.

Where contracts were established, all were executed as a deed, irrespective of financial value or project complexity; this approach ensured robustness and enforceability noting the liability periods extend to 12 years form 6 years when contracts are executed as a deed. Also, contracts underwent effective scrutiny and annotation, demonstrating good practice in quality control and due diligence.

To maintain security and accessibility, all contracts were stored in a locked filing cabinet on-site and would be retained in line with the Health Board's Records Management Policy.

| **Key Findings** | | **Risk & Impact** | **Agreed Management Action** |
|---|---|---|---|
| 6 | **Contract Strategy** | | **Agreed Action:** |

| | | | |
|---|---|---|---|
| | Procurement and contract thresholds are set out in the Health Board Standard Financial instruction (11.11) as detailed below:<br><br>**Goods/Services/Works Whole Life Cost Contract value (excl. VAT)** / **Form of Contract**<br><br><£5,000 / Purchase Order<br><br>>£5,000 - <£25,000 / Simple Form of Contract/Purchase Order<br><br>>£25,000 – Prevailing OJEU threshold / Formal contract and Purchase Order<br><br>>OJEU threshold / Formal contract and Purchase Order<br><br>Contracts above £1 million / Formal contract and Purchase Order<br><br>From the sample of nine projects over £25,000, purchase orders were in place for all but lacked formal contracts for contractors in 4 cases. Of these, 1 had a Service Level Agreement with a framework provider, 1 had an unsigned Installation Quality Plan, and two had no measures, having been deemed straightforward projects. Approval to vire from SFI requirements was not evidenced. To address this gap, a contract strategy should be developed at the start of each project, to ensure appropriate safeguards and improve compliance with SFIs. | Without formal contracts, the Health Board lacks legal recourse if a contractor fails to meet agreed deliverables, causing potential financial loss or project delays. | Incorporate contract strategy requirements into capital procedures.<br><br>**Expected Evidence of Implementation:**<br><br>Capital procedures to reflect agreed approach. |
| | **Theme:** Contractual | **High Priority**<br><br>Control Operation | **Officer: Head of Capital**<br><br>**Date: August 2025** |
| 7 | **Internal Approval**<br><br>As outlined within the All Wales Procure to Pay e-Manual, the approval and award sections state:<br><br>*"Obtaining internal ratification of the outcome of a competition process from the Project Team or Board is a separate and prior step to requesting approval to award a contract, in line with the organisation's Scheme of Delegation."* | Non-compliance with the All Wales Procure to Pay e-Manual, which mandates that internal ratification must occur before approval to award a contract. | **Agreed Action:**<br><br>To agree a standardised process for appointments and incorporate this into the capital procedures.<br><br>**Expected Evidence of Implementation:**<br><br>Capital procedures to reflect the above. |

| | | | |
|---|---|---|---|
| | From our audit sample of 9 projects, two lacked formal agreements for appointment prior to raising purchase orders, due to unclear internal processes regarding the use of frameworks. Additionally, no documentation was provided for one other project. The Health Board should clearly define the process to follow for requesting approval to award. | | |
| | | **Medium Priority** | **Officer: Head of Capital**<br>**Date: August 2025** |
| | **Theme:** Policies & Procedures | Control Operation | |

# Appendix A

## Assurance Opinion

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

## Prioritisation of Findings

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

## Disclaimer

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

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

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

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

## Public Sector Internal Audit Standards

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

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

# Gastro-Intestinal Pathways – Progress update

# Final Internal Audit Report

May 2025

Cwm Taf Morgannwg University Health Board

# Contents

1. Introduction ..... 3
2. Findings ..... 3
3. Conclusion ..... 4

| | |
|---|---|
| Review reference: | CTM-2425-30 |
| Report status: | Final |
| Fieldwork commencement: | 10 February 2025 |
| Fieldwork completion: | 24 April 2025 |
| Draft report issued: | 6 May 2025 |
| Final report issued: | 13 May 2025 |
| Auditors: | Emma Samways, Deputy Head of Internal Audit<br>Stuart Bodman, Principal Internal Auditor |
| Executive sign-off: | Gethin Hughes, Chief Operating Officer |
| Distribution: | Michelle Verrecchia, Directorate Manager, Directorate Manager for General Surgery and Gastrointestinal Services<br>Tarek Allouni, Director - Planned Care Group |
| Committee: | Audit, Risk and Assurance 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, Risk and Assurance 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.

# 1. Introduction

1.1 In April 2024 we issued a 'limited' assurance report on Gastro-Intestinal (GI) pathways. We made three high and two medium priority recommendations.

1.2 As part of our 2024/25 Internal Audit Plan for Cwm Taf Morgannwg University Health Board (the 'Health Board') we planned to undertake a follow up review of the actions taken against the original recommendations.

1.3 However, since finalising our original report, the Health Board has undergone a structural change at a directorate level. This has resulted in a change in key officers within the General Surgery and Gastrointestinal Services (GSGI) directorate, which included the officer responsible for implementing a number of the agreed actions in our original report. There has also been progress in moving the Health Board to one Welsh Patient Administration System (WPAS), again impacting the delivery of the agreed actions.

1.4 As a consequence of these changes, especially within the GSGI directorate, work to implement the agreed actions has not progressed as management originally intended. While there has been some progress, all recommendations remain open. Progress planned for the coming months will be monitored through the Health Board's tracker, which should include revised target dates for implementation and updated responsible officers.

1.5 We plan to follow up on the implemented agreed actions in 2025/26.

1.6 The potential associated risks considered in our original review, that could remain while actions are being taken are:

- Failure to deliver services potentially resulting in patient harm and associated financial and reputational implications.
- Unclear structures or responsibilities resulting in inconsistent service delivery.

1.7 This report provides an update on the progress made by the Health Board to date.

# 2. Findings

2.1 There were five overarching matters arising in our original report. These related to:

- Policies and procedures
- System to allow timely processing of referrals
- The triage process
- Quality checks
- Monitoring and reporting

2.2 We recommended the development of a policy to set out the Health Board's approach and responsibilities for GI pathways, including demand management.

2.3 Linked to this, we also recommended that the existing Standard Operating Procedure (SOP) should be reviewed and updated to ensure that all relevant matters such as GP referrals, internal referrals, the triage process, including timeframes and the process for peer quality reviews, were captured to ensure a consistent approach is applied.

2.4 Since agreeing these recommendations, management has determined that the development a single operating policy document to address the findings from our original report and to reflect the requirements of relevant National Optimal Pathway guides, would be more beneficial to the Health Board.

2.5 In addition, it is our understanding that the recent changes within the GSGI directorate, coupled with the complexity and breadth of coverage needed in the new operating policy, has meant the work has not progressed as originally planned. We have seen a draft of the updated operating policy, which provides guidance on the matters we identified in our original review.

2.6 We note that some work to better integrate systems and negate the need for resource intensive manual process has taken place. We understand that the move to a single WPAS within the Health Board is imminent and will enable a consistent approach to the flow of information between the Welsh Clinical Portal and WPAS across sites.

2.7 Some progress has also been made in relation to our recommendation on monitoring and reporting. Whilst this is now more developed, further work is required including ensuring information is discussed at GSGI directorate business meetings.

2.8 The Senior and Clinical Management team have developed a detailed action plan that sets our recommendations and steps needed to achieve implementation. The action plan is used to monitor progress within the GSGI directorate.

# 3. Conclusion

3.1 As part of our 2025/26 Internal Audit plan, we will undertake a follow up review to ensure the recommendations made during our original audit report have been implemented. The review will be timed to allow for the current draft policy to be completed, approved and rolled out. The follow up review will include an element of audit testing to confirm if the processes set out in the revised operating procedure are being adhered to.

3.2 In the interim period we would expect regular updates to be provided via the Health Board's tracker, to ensure Members are assured that actions are taken to address our original recommendations.

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

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

# Digital Benefits Realisation

## Final Internal Audit Report

## 2024/25

## Cwm Taf Morgannwg University Health Board

Limited Assurance

**Contents**


**Executive Summary** ..... **1**
**Findings & Agreed Action Plan** ..... **3**
**Appendix A** ..... **6**


| | |
|---|---|
| **Review Reference** | **CTM 242508** |
| **Fieldwork** | **January / February 2025** |
| **Executive Sign Off** | **15 May 2025** |
| **Audit Committee** | **May 2025** |
| **Executive Lead** | **Stuart Morris, Director of Digital** |
| **Head of Internal Audit** | **Paul Dalton** |
| **Deputy Head of Internal Audit** | **Emma Samways** |

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

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

# Executive Summary

## Purpose

To assess whether Cwm Taf Morgannwg University Health Board (the 'Health Board' or the 'organisation') is gaining the anticipated value from investment in digital solutions. Consideration of digital transformation team function, who have benefits realisation as part of their remit.

## Background

Benefits realisation is the definition, planning, structuring and actual realisation of the benefits of a business change or digital implementation project We have concluded Limited assurance on this area.

The matters requiring management attention include:

- The organisation currently lacks a comprehensive framework for both project and benefits management.
- Business cases do not always demonstrate measurable project.
- There are inconsistencies in benefits tracking.
- There is no coordinated reporting on benefits.

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

## Scope & Assurance Summary

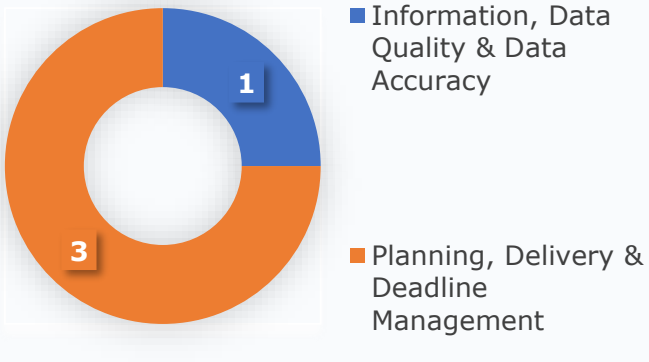
| | Objectives | Related Findings | Assurance |
|---|---|---|---|
| 1 | A framework for benefits realisation is in place which defines how benefits should be owned, identified, structured, planned and realised. | | **Limited** |
| 2 | Benefits focussed business cases show the value that project or programme will achieve by the proposition in the business case, by identifying specific benefits that will be achieved, with the current position being baselined | | **Reasonable** |
| 3 | Benefits are tracked and the structure ensures that these are achieved, with actions taken if they do not accrue | | **Limited** |

## Management Actions

**2** High Priority

**2** Medium Priority

## Themes




## Risk Types

Legal & Regulatory Non-Compliance

Quality or Safety Issues

Public Perception & Reputational Risk

# Findings & Agreed Action Plan

| **Objective 1: A framework for benefits realisation is in place which defines how benefits should be owned, identified, structured, planned and realised** | **Limited** |
|---|---|

The Health Board has recently appointed an Assistant Director for Digital Transformation responsible for overseeing the successful delivery of Digital Transformation projects. This includes providing leadership, strategically managing risks, monitoring finances, and ensuring each project phase is executed on schedule.

In addition, the Assistant Director for Digital Transformation, as part of a new function, is developing and implementing a benefits realisation framework to align digital transformation project outcomes with the Health Board's strategic objectives and maximise value. However, historically the Digital and Data Directorate lacks a comprehensive framework for benefits management for Digital Transformation Projects. There has been no overarching structure, guidance or documented process to standardise how digital projects are managed, assessed, or measured in terms of their benefits. Without such a framework, project planning and execution may be inconsistent with no clear mechanism to ensure benefits are appropriately identified, owned, planned and realised.

The Assistant Director for Digital Transformation is developing and implementing a benefits realisation framework to align digital project outcomes with the Health Board's strategic objectives and maximise value. To strengthen this approach, they are also creating supporting documentation, including procedures and standardised templates, to enhance benefits realisation. This initiative is still in progress and does not yet have a defined timeline for completion. Until a structured framework is established, the organisation will continue to face challenges in tracking, optimising, and sustaining digital project outcomes.

| **Key Findings** | | **Risk & Impact** | **Agreed Management Action** |
|---|---|---|---|
| 1 | The Digital and Data Directorate has historically lacked a comprehensive framework for benefits management. There is no overarching structure, guidance or documented process to standardise how benefits within digital projects are managed, assessed, and measured. | The organisation may not gain the maximum benefit from investment in digital technology. | The Benefits Framework that is being developed for Digital Programmes will be completed, approved and shared across the Digital & Data Directorate |
| | | | Expected Evidence of Implementation: Benefits Framework |
| | | **High Priority** | Officer: Assistant Director of Digital Transformation<br>Date: End of Qtr 4 2025/2026 |
| | Theme: Policies & Procedures | Control Design | |

| Objective 2: Benefits focussed business cases show the value that project or programme will achieve by the proposition in the business case, by identifying specific benefits that will be achieved, with the current position being baseline. | Reasonable |
|---|---|

We identified that the absence of clear guidance has led to inconsistencies in historical digital project documentation, with key details relating to anticipated benefits sometimes inferred rather than explicitly stated, although we note that where digital projects were initiated with formal business cases, the model used enabled greater identification of benefits. The digital project documentation that we reviewed did do not always demonstrate measurable project value which should be identified through specific benefits and baseline metrics. Instead, benefits were often described as broad objectives without quantification.

We note that in general benefits are considered at the project initiation stage with projects including some consideration of benefits. However, the process is neither standardised nor enforced, additionally there was limited evidence of stakeholder engagement in benefits identification and validation. Furthermore, there was a lack of formal baselining at project initiation which reduces the ability to measure and demonstrate benefits post implementation.

However, we note that the Assistant Director for Digital Transformation is improving the process. We saw evidence of a more structured approach to identifying and defining benefits within a recent project. This included working with stakeholders to define the benefits, quantifying and taking the baseline position.

| Key Findings | | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 2 | The digital project documentation that we reviewed did not always demonstrate measurable project value by identifying specific benefits and baseline metrics. Instead, benefits were sometimes described as broad objectives without quantification. We also note limited evidence of stakeholder engagement in benefits identification and validation and a lack of formal baselining at project initiation. | The organisation may not gain the maximum benefit from investment in digital technology. | As part of the Benefits Framework, there will be clear guidance of benefits identification and quantification.<br><br>The Health Board is investing in dedicated skills and capability to performance benefits analysis, including detailed baseline assessments, including the 'as-is' and 'to-be' |
| | | | Expected Evidence of Implementation:<br>Recruitment<br>Benefits Framework<br>Documented Tools & Techniques |
| | | **High Priority** | Officer: Assistant Director of Digital Transformation<br>Date: End of Qtr 4 2025/2026 |
| | Theme: Planning, Delivery & Deadline Management | Control Operation | |

| Objective 3: Benefits are tracked and the structure ensures that these are achieved, with actions taken if they do not accrue. | Limited |
|---|---|

The historical absence of clear guidance and identification of clear benefits at project outset has led to inconsistencies in benefits tracking, with no formal system uniformly applied across projects. While tracking and monitoring of benefits is referenced in update reports, there is no structured approach, with unclear ownership of benefits within historical digital projects. As such, although digital projects are delivering improvements there is no clear demonstration of benefit delivery and management.

As we identified above, the Assistant Director for Digital Transformation is improving the process, and a recent project demonstrates a clear and structured approach to benefits realisation, with benefits owners identified and a formal monitoring and reporting process.

In addition, there are no formal communication and escalation processes for digital benefits, which would enable corrective action to be taken should benefit delivery fall behind. In addition, in general there is no coordinated reporting on benefits outside of project structures with only general updates provided to the Digital and Data Committee.

| Key Findings | | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 3 | There are inconsistencies in benefits tracking, with no formal system uniformly applied across projects. While tracking and monitoring are referenced, they lack a structured approach, with unclear ownership of benefits.<br><br>We also note that there is no formal communication and escalation process which would enable corrective action to be taken. | The organisation may not gain the maximum benefit from investment in digital technology. | As part of the Benefits Framework there will be clear guidelines and processes drafted to ensure a standardised approach identifying benefits owners and mechanisms for tracking, reporting and escalation.<br><br>The team will work with Health Board PMO to ensure consistent approach to benefits across all projects and programmes |
| | | | Expected Evidence of Implementation:<br>Benefits Framework including an agreed, standardised set of templates |
| | | **Medium Priority** | Officer: Assistant Director of Digital Transformation<br>Date: End of Qtr 4 2025/2026 |
| | Theme: Planning, Delivery & Deadline Management | Control Operation | |
| 4 | There is no coordinated reporting on digital benefits outside of project structures with only general updates being provided to the Digital and Data Committee (now Operational Delivery & Strategic Development Committees). | There is reduced oversight over the digital project delivery process | Ensure there is a clear is identification of what is /is not a project and then agree a clear set of principles and expectations of the required documentation to support all projects and programmes within the Digital & Data Directorate irrespective of department/pillar. |
| | | | Expected Evidence of Implementation:<br>Documented Project Definition<br>Process in place to ensure appropriate classification |
| | | **Medium Priority** | Officer: Director of Digital and Senior Leadership Team<br>Date: End of Qtr 3 2025/2026 |
| | Theme: Performance Monitoring | Control Operation | |

# Appendix A

## Assurance Opinion

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

## Disclaimer

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

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

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

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

## Prioritisation of Findings

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

## Public Sector Internal Audit Standards

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

Website: [Audit & Assurance Services NHS Wales Shared Services Partnership]

Archwilio Cymru
Audit Wales

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

**Date issued:** May 2025

**Document reference:** 4695A2025

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.

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions as described above. Audit Wales is not a legal entity and itself does not have any functions.

© Auditor General for Wales 2025. No liability is accepted by the Auditor General or staff of the Wales Audit Office in relation to any member, director, officer, or other employee in their individual capacity, or to any third party, in respect of this report.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 Code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales, the Wales Audit Office and, where applicable, the appointed auditor are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit Wales at infoofficer@audit.wales.

# Contents

## Audit, Risk and Assurance Committee Update


About this document 4

Accounts audit update 5

Performance audit update 6

Other relevant publications 11

Additional information 11

# About this document

1 This document provides the Audit, Risk and Assurance Committee with an update on our current and planned accounts and performance audit work at Cwm Taf Morgannwg University Health Board. We will be presenting our Detailed 2025 Audit Plan to the committee in May 2025.

2 We also provide additional information on:

- Other relevant examinations and studies published by the Audit General.
- Relevant corporate documents published by Audit Wales (e.g. fee schemes, annual plans, annual reports), as well as details of any consultations underway.

3 Details of future and past Good Practice Exchange (GPX) events are available on our website.

# Accounts audit update

4 Exhibit 1 summarises the status of our current and planned accounts audit work.

Exhibit 1 – Accounts audit work

| Area of work and | Executive Lead | Focus of the work | Current status | Planned date for consideration |
|---|---|---|---|---|
| Audit of the Health Board's 2024-25 Annual Report and Accounts | Executive Director of Finance | To provide an audit opinion on the 2024-25 Annual Report and Accounts. | We received the accounts on the Welsh Government's deadline of 2 May; and we have commenced their audit. The Health Board is due to send us its performance report and accountability report by the Welsh Government's deadline of 9 May. Once received, we | The Welsh Government's deadline for audit certification is 30 June 2025. |

| | | | | |
|---|---|---|---|---|
| | | | will commence that part of the audit. | |
| Audit of the 2024-25 Charitable Funds Annual Report and Accounts | Executive Director of Finance | To provide an audit opinion on the 2023-24 Annual Report and Accounts. | We are scheduled to commence the audit in the autumn. | The Charity Commission's deadline for audit certification is 31 January 2026. |

# 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 |
|---|---|---|---|---|
| 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 | Fieldwork underway | November 2025 |

| Area of work | Executive Lead | Focus of the Work | Current Status | Planned Date for consideration |
|---|---|---|---|---|
| | | capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency. | | |
| 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.<br><br>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).<br><br>We are also reviewing progress being made in managing unscheduled care demand by helping patients access services which are most appropriate for their unscheduled care needs (Part 2). | Part 1 – Report being drafted<br><br>Part 2 – Report being drafted | August 2025<br><br>August 2025 |

| Area of work | Executive Lead | Focus of the Work | Current Status | Planned Date for consideration |
|---|---|---|---|---|
| All-Wales thematic review of planned care | Chief Operating Officer | This work follows on from the national report on tackling the planned care backlog and considers:<br>• The extent that health boards have achieved Welsh Government targets for recovering planned care services;<br>• The efficacy of local plans and activity to recover waiting lists; and<br>• Use of the additional Welsh Government financial allocations to improve waiting lists. | Report being drafted | August 2025 |
| Review of Eye Care Services | Chief Operating Officer | This work assesses the Health Board's eye care services to ensure they are delivered efficiently, effectively, and economically, and there are clear plans to meet current and future population needs.<br><br>The work also seeks an update from the Health Board on its progress in addressing previous audit recommendations arising from the | Report being drafted | August 2025 |

| Area of work | Executive Lead | Focus of the Work | Current Status | Planned Date for consideration |
|---|---|---|---|---|
| | | review of follow up outpatient appointments, particularly in the context of ophthalmology patients. | | |
| Structured Assessment 2025 – core | Director of Corporate Services / Board Secretary | This work will review the following core areas:<br>• Board and committee effectiveness, cohesion, and transparency.<br>• Corporate systems of assurance.<br>• Corporate planning arrangements, and<br>• Corporate financial planning, and performance arrangements. | Scoping | November 2026 |
| Structured Assessment 2024 – Deep Dive – Estates | Chief Executive Officer | This work will examine the effectiveness of corporate arrangements to manage the Health Board's estate with a particular focus on ensuring the current estate is fit for purpose, represents value for money, and supports organisation's wider strategic priorities. | Scoping | To be confirmed |

| Area of work | Executive Lead | Focus of the Work | Current Status | Planned Date for consideration |
|---|---|---|---|---|
| Review of cancer services | Chief Operating Officer | This work will follow on from the review of national leadership arrangements for cancer services.<br>Whilst the exact focus of this work is to be determined, it is likely to consider:<br>• The progress NHS bodies are making towards achieving Welsh Government targets and quality standards for cancer services;<br>• The efficacy of local plans and associated actions to recover cancer waiting lists; and<br>• Use of the additional Welsh Government financial allocations to improve cancer services. | Scoping | To be confirmed |
| Local project work – Follow-Up Outpatients | Chief Operating Officer | This work will examine the Health Board's arrangements for follow-up outpatient appointments, with the option to follow-up recommendations made in our 2015 and 2017 reviews of follow-up outpatient appointments. | 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 |
|---|---|
| **Lessons from our work under the Wellbeing of Future Generations Act** | **April 2025** |
| **The Biodiversity and Resilience of Ecosystems Duty** | **March 2025** |
| **Addressing workforce challenges in NHS Wales** | **February 2025** |
| Cancer Services in Wales | January 2025 |

## 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.

Exhibit 4 – Audit Wales corporate documents

| Title | Publication Date |
|---|---|
| Annual Plan 2025-26 | April 2025 |

8 There are no relevant Audit Wales consultations currently underway.

Archwilio Cymru
Audit Wales

1 Capital Quarter
Tyndall Street
Cardiff CF10 4BZ

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

| Agenda Item |
| --- |
| 7.6 |

# Audit, Risk & Assurance Committee

## Audit Wales National Reports

| | |
| --- | --- |
| **Dyddiad y Cyfarfod / Date of Meeting** | 22/05/2025 |
| **Statws Cyhoeddi / Publication Status** | Open/ Public<br>Not Applicable |
| **Awdur yr Adroddiad / Report Author** | Gareth Watts, Director of Corporate Governance/Board Secretary |
| **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 Through the year colleagues from Audit Wales include details of the National Reports which the Auditor General for Wales produces and which may be of relevance to Cwm Taf Morgannwg UHB and this Committee.

## 2. Specific Matters for Consideration

2.1 Included in the table below are the full list of national reports which have been shared with the Committee during the financial year 2024-25, together with a link to the report on the Audit Wales website. This is provided as a record for members of the committee to be able to access all reports in one place.

| Title | Publication Date |
|---|---|
| Board Effectiveness BCUHB - Follow Up | February 2024 |
| From Fire Fighting to Future Proofing - the Challenges for Welsh Public Services | February 2024 |
| Supporting Ukranians in Wales | March 2024 |
| Community Pharmacy Data Matching Pilot | May 2024 |
| NHS Wales Data Tool | August 2024 |
| National Fraud Initiative in Wales 2022-23 | October 2024 |
| National Fraud Initiative Self Assessment | December 2024 |
| Cancer Services in Wales | January 2025 |

2.2 Links to national reports published from February 2025 are included in the Audit Wales update paper which they have submitted to this meeting.

## 3. Key Risks / Matters for Escalation

3.1 Given its nature, in consultation with colleagues with Audit Wales, we felt it to be in the Committee's interest to receive further information with regards to the Cancer Services in Wales Report.

3.2 On 14 January 2025, the Auditor General published a report on Cancer Services in Wales which described various aspects of the performance of cancer services along with the national strategic approach and leadership

arrangements for cancer services in Wales. The report made 10 recommendations for Welsh Government, working with others as appropriate, to address the significant concerns identified in our review. The Welsh Government has prepared its response to those recommendations which is attached to this email.

3.3 The Senedd Public Accounts and Public Administration Committee (PAPAC) has held two evidence sessions to further explore the issues raised in the AGW's report. The first of those sessions, involving members of the Wales Cancer Alliance, was held on 26 March 2025 and can be viewed here . The second session involving Welsh Government officials and members of the NHS Executive took place on 1 May 2025 and can be viewed here.

3.4 Included in the pack of papers is both the report produced by the AGW and the responses from Welsh Government.

## 4. Assessment

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

| **Impact Assessment** | | |
|---|---|---|
| **Ansawdd**<br>*Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /*<br>**Quality**<br>*Have you undertaken a Quality Impact Assessment Screening?* | Yes: ☐ | No: ☒ |
| | Outcome: | If no, please include rationale below:<br><br>Not applicable |
| **Cydraddoldeb a'r Gymraeg**<br>*Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /*<br>**Equality and Welsh Language**<br>*Have you undertaken an Equality and Welsh Language Impact Assessment Screening?* | Yes: ☐ | No: ☒ |
| | Outcome for Equality (delete as appropriate):<br><br>POSITIVE/NEUTRAL<br>NEGATIVE<br><br>Outcome for Welsh Language (delete as appropriate):<br>POSITIVE/NEUTRAL<br>NEGATIVE | If no, please include rationale below:<br><br>Not applicable |
| **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 **note** the report and response from Welsh Government which Dave Thomas, Audit Director at Audit Wales, will present.

Archwilio Cymru
Audit Wales

# Cancer Services in Wales:

## A review of the strategic approach to improving the timeliness of diagnosis and treatment

January 2025

This report has been prepared for presentation to the Senedd under the Government of Wales Act 1998 and the Government of Wales Act 2006.

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

The Auditor General also audits local government bodies in Wales and conducts local government value for money studies.

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.

Audit Wales is the umbrella brand of the Auditor General for Wales and the Wales Audit Office, which are each separate legal entities with their own legal functions. Audit Wales is not itself a legal entity. While the Auditor General has the auditing and reporting functions described above, the Wales Audit Office's main functions are to provide staff and other resources for the exercise of the Auditor General's functions, and to monitor and advise the Auditor General.

© Auditor General for Wales 2025

You may re-use this publication (not including logos) free of charge in any format or medium. If you re-use it, your re-use must be accurate and must not be in a misleading context.

The material must be acknowledged as Auditor General for Wales copyright and you must give the title of this publication. Where we have identified any third party copyright material you will need to obtain permission from the copyright holders concerned before re-use.

For further information, or if you require any of our publications in an alternative format and/or language, please contact us by telephone on 029 2032 0500, or email info@audit.wales.

We welcome telephone calls in Welsh and English. You can also write to us in either Welsh or English and we will respond in the language you have used. Corresponding in Welsh will not lead to a delay.

Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

# Contents

Key Facts 4

Key Messages 5

## Detailed report

1 Performance and resources 13

2 Strategic direction 38

## Appendices

1 Strategic context 61

2 Additional data analysis 63

3 About our work 68

# Key facts

**Exhibit 1: key facts**

Cancer is the **leading cause of death** in Wales

Wales has the **second highest** cancer mortality in the UK. The UK has one of the highest cancer mortality rates of all OECD countries

Five-year cancer survival has improved. **62%** of people diagnosed with cancer between 2016-2022 survived at five years compared to **54%** of people diagnosed between 2002-2006

**4 in 10**
annual cancer cases in Wales could be prevented

At £719 million in 2022-23, spending on cancer services was the **third highest area of NHS spending** after mental health and trauma and orthopaedics

Real terms spending on cancer services has **increased by 54%** from 2009-10 to 2022-23

Since August 2020, no health board has met the overall target that **75%** of patients should start their first definitive treatment within **62 days** of first suspicion of cancer

From August 2023 to August 2024, between **53%** and **61%** of patients started treatment within **62 days**

In 2021, **24%** of cancer patients were diagnosed at stage 4 and **18%** at stage 3

Survival decreases as stage advances for all cancer types

Bowel screening eligibility has expanded in stages since October 2021. It now includes people aged **50 to 74** and uses a more sensitive test.

From July 2023 to July 2024, just **21%** of bowel screening participants referred to their health board for a colonoscopy were offered the procedure within 4 weeks against a standard of **90%**

Breast and cervical screening uptake were **below standard**

Non-melanoma skin cancer, bowel, female breast, lung and prostate cancers are the most **common cancers** in Wales

Source: Audit Wales

Notes: *Welsh Government data: NHS Expenditure by programme budget category and year, 'cancer and tumours', on StatsWales

# Key messages

## Context

1 One in two people in the UK born after 1960 will be diagnosed with some form of cancer during their lifetime[1]. Many people go on to survive cancer and lead healthy lives. Early diagnosis and timely treatment are key to survival for most cancers.

2 Services to detect, diagnose and treat cancers and to support cancer patients are provided by many public and third sector organisations. Some services, notably Systemic Anti-Cancer Therapy[2] and radiotherapy, mostly serve cancer patients. However, much of the outpatient, diagnostic and surgical capacity needed for cancer patients is part of the wider planned care system.

3 The Welsh Government is responsible for setting the vision and targets for health care and for the allocation of funding. It sets out a range of expectations for the NHS Executive, including supporting improvement in cancer services, through an annual remit letter. The National Strategic Clinical Network for Cancer[3] is part of the NHS Executive and brings together clinicians and health professionals to support improvement. Health boards are responsible for providing high quality care to patients and meeting performance targets. **Appendix 1** explains roles and responsibilities for cancer services and key elements of the strategic approach.

4 Our work has examined the coherence of the national arrangements to drive improvements in cancer services in Wales. The report includes an overview of NHS Wales' performance in providing cancer diagnosis and treatment and offers views on the prospects for improvement, including through prevention. The report does not comment on the performance of individual NHS bodies as this will be examined as part of the Auditor General's 2025 programme of local audit work at those bodies. **Appendix 3** provides more detail about our work.

1 Cancer Research UK.

2 Systemic Anti-Cancer Therapy includes chemotherapy, immunotherapy and hormonal therapy.

3 Called the Wales Cancer Network at the time. We refer to the Network as the 'Cancer Network' throughout the report for ease of reference.

# Overall conclusions

5 Overall, we found that despite increased investment, there is a continuing failure to meet the national performance targets for cancer with a minority of patients facing unacceptably long waits for diagnosis and/ or treatment. Cancer outcomes in Wales have improved over recent years but are still poor compared to other countries. Stronger and clearer national leadership is urgently needed to help drive the necessary improvements in the timeliness and sustainability of cancer diagnosis and treatment.

# Key findings

## Performance and resources

6 Demand from suspected cancer patients is increasing ahead of the NHS' ability to meet it. As a result, the waiting list for diagnosis and treatment is growing. Our indicative modelling shows that without a significant increase in activity to diagnose and treat patients, the waiting list will not return to pre-pandemic levels.

7 The national target that 75% of cancer patients should start their first definitive treatment within 62 days of first suspicion has not been met by any of Wales' health boards since August 2020. Performance deteriorated following the pandemic and has been stable since early 2022 with between 52% and 61% of patients starting their treatment within the target time. Waiting times for some cancer types are particularly long with some patients waiting over 100 days for treatment[4]. There are also growing waits between diagnosis and the start of treatment.

8 A significant minority of people are being picked up with late-stage cancer which impacts their likelihood of survival. In 2021, patients diagnosed with cancers of the gall bladder, pancreas and lung were more likely than patients with other types of cancers to be diagnosed at stage four (74%, 52% and 48% of patients).

9 Screening plays a vital role in early detection. While the standard for uptake of bowel screening is being achieved, this is not the case for breast and cervical screening programmes.

4 See **Exhibit 8.**

10 Patient outcomes have improved over time. But Wales has the second highest cancer mortality rate in the UK after Scotland. The UK itself has a worse rate than many OECD countries. Mortality rates in Wales are significantly worse for people living in deprived areas and the gap between the most and least deprived is growing.

11 Real terms spending on cancer care over the last 13 years has grown considerably more than the overall increase in real terms NHS spending. However, this increase does not necessarily translate into extra activity as there are a range of inflationary cost pressures, including costs of drugs and new treatments. There are also challenges around capacity – including gaps in the workforce and concerns about a shortage of modern scanning equipment.

## Strategic direction

12 The Welsh Government has set out its high-level strategic vision for cancer services in its 2021 Quality Statement for Cancer. In February 2023, at the request of the then Minister for Health and Social Care, the Cancer Network published a three-year Cancer Improvement Plan as a collated NHS response to the Quality Statement. The NHS Executive is developing a National Cancer Recovery Programme as part of the wider national approach to transforming planned care. The Welsh Government has also launched a 'Cancer: Improving Outcomes' initiative through its Life Sciences Hub aimed fostering innovation and collaboration between the NHS and industry.

13 Whilst these various developments demonstrate a clear national commitment to improve cancer services, their collective efficacy is undermined by a lack of clarity over the status of the three-year Cancer Improvement Plan. Welsh Government officials were clear that the Plan was not their document but rather the collated response of the NHS to the Quality Statement.

14 However, NHS and third sector bodies are confused about the Cancer Improvement Plan's status and what, if anything, they should be doing to implement it. Many were also confused about the links between the Improvement Plan, the National Cancer Recovery Programme and the Cancer: Improving Outcomes initiative.

15 There is similar confusion about the split of leadership and accountability between the Welsh Government and the NHS Executive and about roles within the NHS Executive. Overall, we identified a consensus, including within the Welsh Government and the NHS Executive, that the arrangements were not yet providing the strong leadership needed to drive system-wide improvement in cancer services.

16 We identified examples of important Welsh Government investment to improve cancer services and broader planned care including rapid diagnostic centres and a new cancer centre for Velindre NHS Trust. However, the pace at which some new developments are taken forward can be slow, in areas such as digital cellular pathology and lung cancer screening.

17 There is also a risk that the Welsh Government may not get a good return on its £3.4 million investment in a National Imaging Academy. The Academy is training more radiologists to address workforce shortages, but some NHS bodies have not been able to create jobs for newly qualified people.

18 The Welsh Government relies heavily on its performance management arrangements to oversee and drive improvement. However, these arrangements are focussed predominantly on the 62-day timeliness target, which only covers part of the patient pathway. The Welsh Government told us it also focuses on delivery of National Optimised Pathways, although at the time of drafting the NHS Executive was still developing plans for monitoring compliance with those pathways.

19 The Welsh Government's Quality Statement does not set out any specific expectations in respect of cancer prevention despite around 38% of cancers being preventable. Whilst there are other Welsh Government strategies and frameworks aimed at encouraging healthier lifestyles these do not constitute a coherent policy framework for population health and disease prevention.

20 Data and digital are two other key areas for improvement. We identified inaccuracies in national data and a need for more consistent national data that helps track delivery across the patient pathway. Work is underway to replace the previous outdated cancer information system. However, progress has been slow, and services continue to rely on fragmented digital systems that consume time and carry risks to patient safety.

The Welsh Government's Quality Statement, the identification of nationally optimised pathways and the publication of a Cancer Improvement Plan are all examples of a clear commitment to secure high quality cancer care for the people of Wales.

However, despite this and increased investment over recent years, too many people are experiencing unacceptably long waits for cancer diagnosis and treatment. Variations in performance and outcomes persist within and between health bodies in Wales, and insufficient attention is being placed on prevention of the lifestyle factors that can cause cancer and other major health conditions.

The arrangements for the national leadership and oversight of cancer services in Wales need to be clarified and strengthened as a matter of urgency. This must include a clear statement on the status of the NHS Wales Cancer Improvement Plan and how the Welsh Government and NHS Executive expect it to be used, alongside other programmes and initiatives, to shape the improvements which are needed in cancer services in Wales.

**Adrian Crompton**
Auditor General for Wales

# 4 Recommendations

**Exhibit 2: recommendations**

## Setting out a coherent, long-term strategic approach for cancer in Wales, supported by clear system leadership and informed oversight

R1 The Welsh Government should publicly clarify the status of the Cancer Improvement Plan and its links to the National Cancer Recovery Programme and the Cancer: Improving Outcomes initiative. As part of this the Welsh Government should clarify how it intends to hold NHS bodies to account for delivery of the Cancer Improvement Plan.

R2 The Welsh Government should set out a coherent model for system leadership in respect of cancer services that clarifies its own role and that of the NHS Executive and sets out how it will bring on board clinicians and other key stakeholders to build a common view of cancer service performance, quality and opportunities for improvement.

R3 The Welsh Government should review its oversight and performance framework in respect of cancer services to focus on a broader range of issues, including a more explicit alignment to the ambitions and quality attributes set out in the Quality Statement for Cancer.

## Developing the strategic approach to population health improvement and disease prevention

R4 The Welsh Government should develop a more coherent approach to population health improvement by setting out how it intends to use its Science Evidence Advice: NHS in 10+ Years to harness the opportunities associated with prevention to reduce the incidence of cancer and other major conditions.

## Exploiting specific opportunities for improvement

R5 The Welsh Government should work with Public Health Wales to accelerate decision making for a national lung screening programme. It should clarify as soon as possible whether it will fund national lung screening for Wales and the timescale for implementing such a programme.

R6 As part of a wider approach to encourage greater regional working between health boards, the Welsh Government and the NHS Executive should work with the service to understand and help address any key barriers to delivering regional services. This should include working with DHCW to identify digital solutions to support shared waiting lists for cancer diagnosis and treatment, where it is appropriate to do so.

R7 The Welsh Government should work with the NHS Executive, HEIW and other NHS bodies to ensure there are employment opportunities for radiologists who have been trained in the National Imaging Academy.

## Improving Data and Digital

R8 The Welsh Government should clarify national roles and responsibilities for monitoring and ensuring compliance with its data standards including how it will hold NHS bodies to account for poor compliance.

R9 The Welsh Government should work with the NHS Executive (particularly the Cancer Network), DHCW and Public Health Wales NHS Trust to develop a more comprehensive set of publicly available data on cancer services, which as a minimum should include:

- the number of people currently waiting for cancer diagnosis or treatment (open pathway data).
- performance against the 62-day target for the health board providing diagnosis and treatment and health board of residence, including people living Powys Teaching Health Board area.
- performance across the patient pathways including timeliness of diagnostic reporting across different tumour sites; timeliness from the decision to treat a patient to the start of that treatment (including surgery, radiotherapy and Systemic Anti-Cancer Therapy); and diagnosis and treatment of recurrent disease. Performance information should be provided at cancer sub-tumour level where possible.
- timeliness of diagnosis and treatment for patients referred from the breast and cervical screening programmes.
- accurate information on equity of access, including ethnicity of cancer patients as well as the experiences of different patient groups (this should include children and young people).

R10 The Welsh Government should work with DHCW and NHS England to share regular and consistent data on the timeliness of diagnosis and treatment for Welsh cancer patients treated by NHS England.

Source: Audit Wales

# Performance and resources

01

1.1 This part of the report looks at how well services to diagnose and treat cancer are performing, including against national targets. It considers performance in the wider context of demand, financial and capacity pressures.

## What we looked for

We looked for evidence that the NHS is sustainably meeting demand to diagnose and treat cancer; whether it is meeting the national performance targets for timeliness of cancer diagnosis and treatment; and for evidence that outcomes for cancer patients are improving and compare well internationally.

# Demand is increasing ahead of the NHS's ability to meet it and the waiting list for diagnosis and/ or treatment is growing

## The number of people referred for suspected cancer has continued to rise following a sharp drop during the pandemic

1.2 Suspected cancer referrals create demand for NHS services even though the vast majority of those referrals (over 84%[5]) go on to find out that they do not have cancer. Around 80% of patients with suspected cancer are referred by GPs. However, because they are far less likely than those coming from other routes[6] to actually have cancer, those referred by GPs only make up around 54% of patients who go on to start treatment.

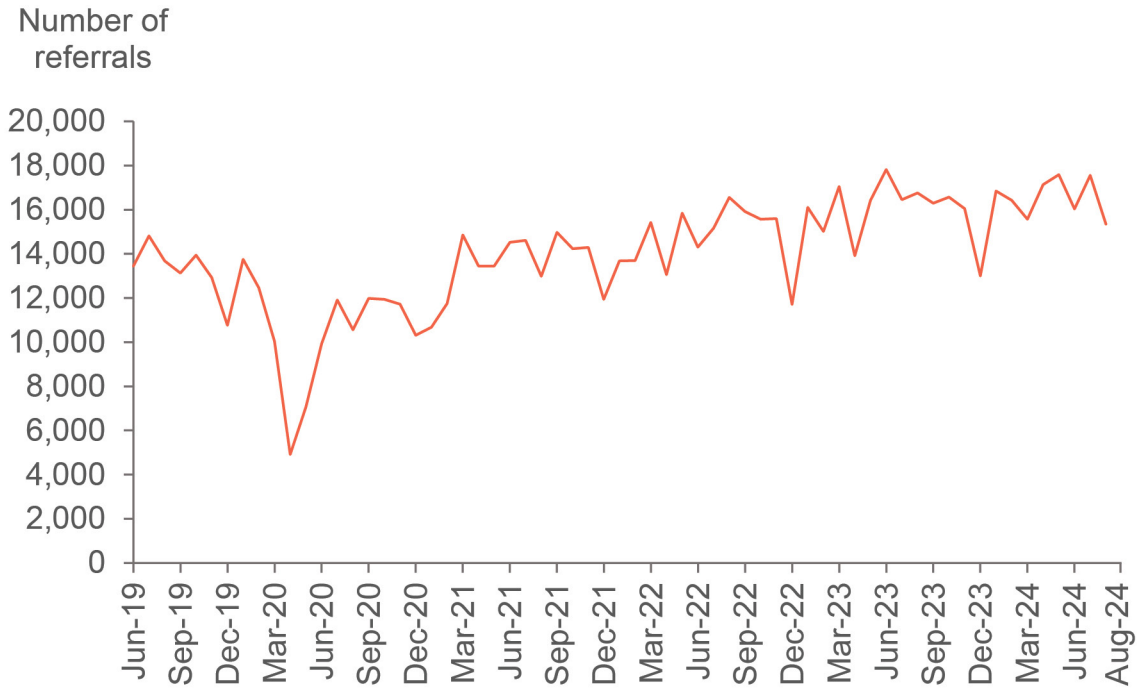
1.3 The number of suspected cancer referrals increased by 14% from June 2019 to August 2024 (**Exhibit 3**); equivalent to around 3% growth each year. Referrals have increased after a drop at the start of the pandemic. The highest numbers of referrals in August 2024 were for skin (excluding basal cell carcinoma[7]) and lower gastrointestinal cancers (17% and 15% of referrals respectively).

5 Since November 2020.

6 Other routes include screening services, emergency departments, and other secondary care professionals.

7 Basal cell carcinoma is the most common type of skin cancer and less likely than other skin cancers to spread to other parts of the body. NHS Wales does not refer suspected basal cell carcinomas via the suspected cancer pathway unless there is a concern that delayed investigation may cause significant impact to the patient in line with NICE Guidance NG12, last updated October 2023.

**Exhibit 3: urgent suspected cancer referrals, June 2019 – August 2024**




Source: DHCW, Suspected Cancer Pathway – Open Pathways Dataset, on StatsWales.

Note: data from June 2019 to November 2021 is based on experimental analysis on StatsWales and may not be directly comparable to the validated data from December 2021 onwards.

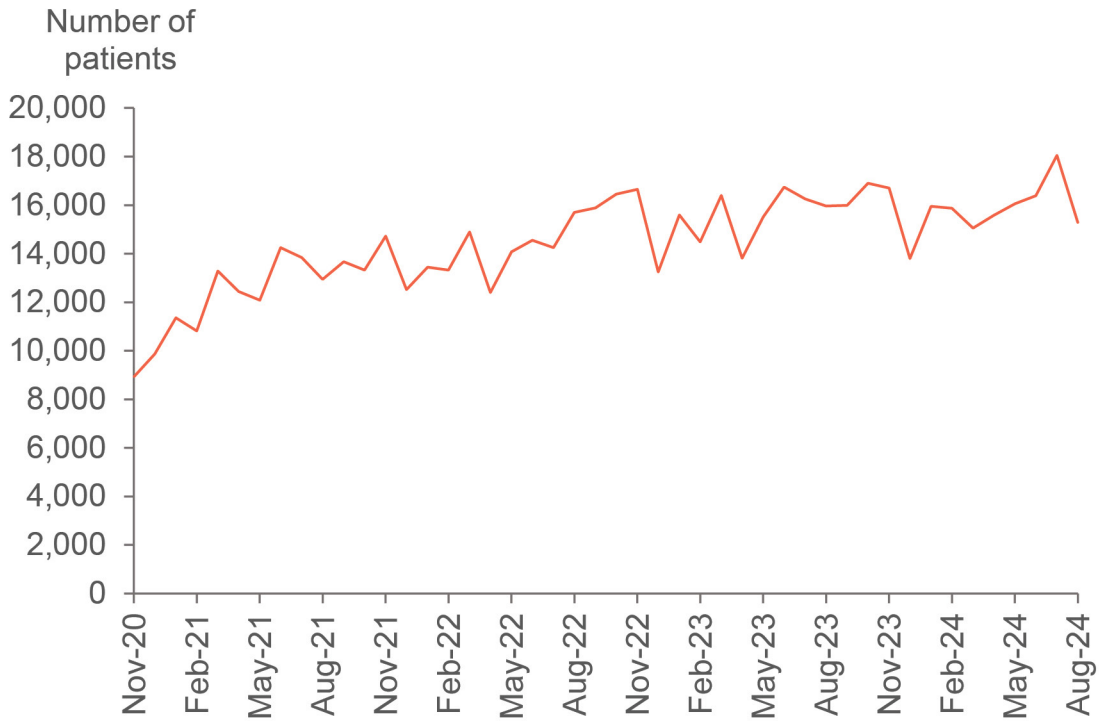
1.4 The number of newly diagnosed cancer patients has also increased over time (by 22% from 2002 to 2021) (see **Appendix 2, Exhibit 26**). Numbers fell in 2020, probably because fewer people accessed healthcare during the pandemic. Numbers of newly diagnosed cancers increased in 2021 but have not yet returned to pre-pandemic levels. The Welsh Cancer Intelligence and Surveillance Unit (WCISU)[8] has not yet published clinical cancer registry data beyond 2021.

8 WCISU is part of the Public Health Wales NHS Trust.

## The sharp increase in activity after the pandemic seems to have levelled off

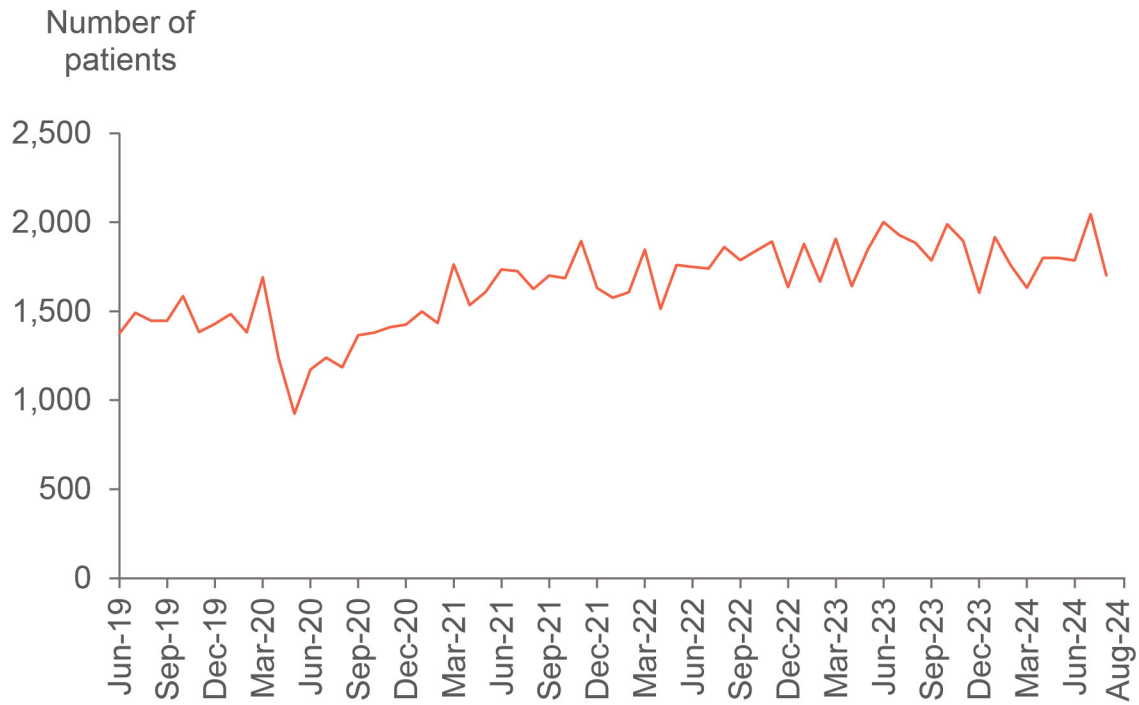
1.5 Activity to diagnose and treat suspected cancer patients[9] has increased since the pandemic but seems to be levelling off. The overall number of pathways closed – including those who were told they do not have cancer and those who started treatment – has increased since November 2020 (**Exhibit 4a**). There is no comparable historic data to show how overall activity levels compare with pre-pandemic levels. However, the number of patients starting treatment for cancer increased quickly after a drop at the start of the pandemic and exceeded pre-pandemic figures by March 2021 (**Exhibit 4b**). The number of patients starting treatment appears to have to broadly levelled out from November 2022.

**Exhibit 4a: all closed pathways November 2020 – August 2024**




9 As measured by pathways closed.

**Exhibit 4b: pathways closed due to patient starting first treatment, June 2019 – August 2024**




Source: DHCW, Suspected Cancer Pathway – Closed Pathways Dataset, on StatsWales.

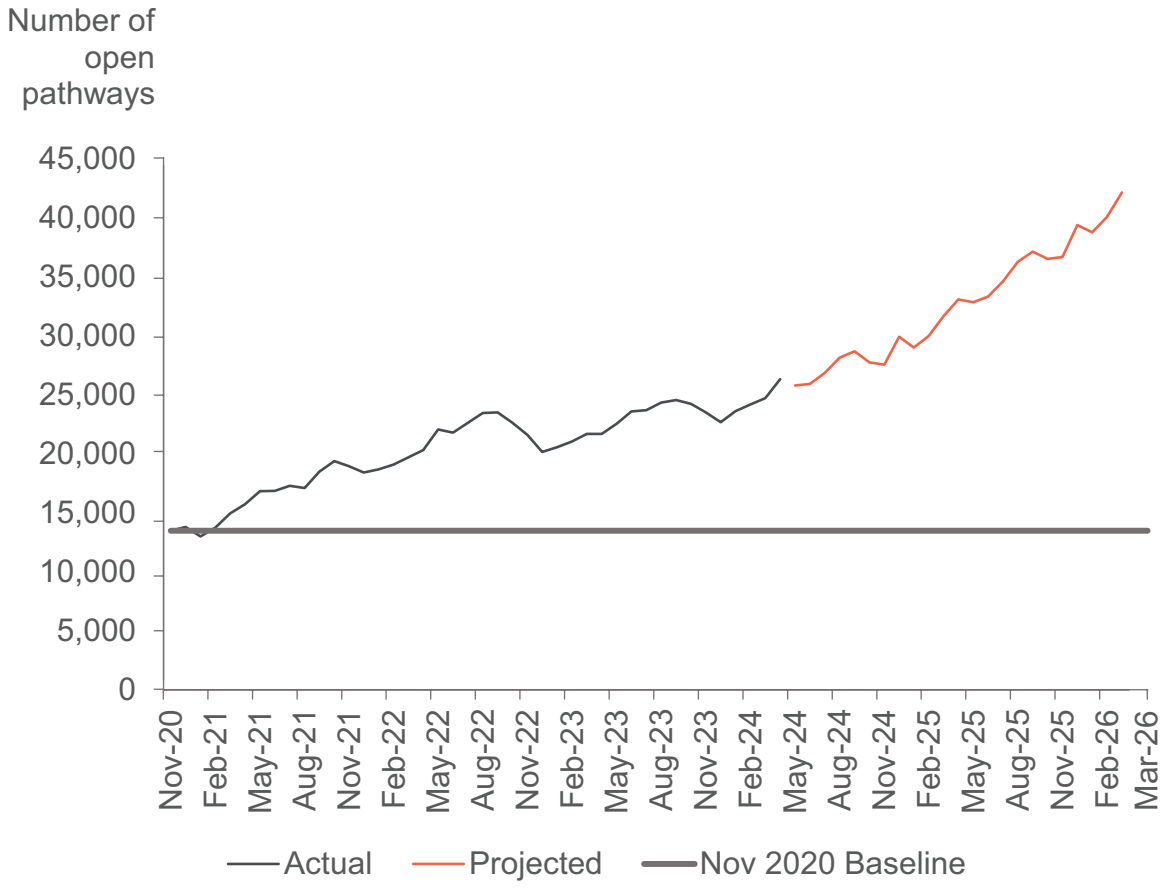
1.6 The available data understates the amount of activity because it only includes activity to the point of first treatment. Many people will need multiple episodes of care after they start their first treatment. It is likely that the amount of activity after first starting treatment is growing with the increasing complexity of new treatments, particularly in immunotherapy. The three cancer centres in Wales[10] hold information on the timeliness of access to radiotherapy and Systemic Anti-Cancer Therapy. However, inconsistencies in the way some of the data is collected means it cannot currently provide any insight on national trends or comparative timeliness of ongoing treatment across Wales.

10 In north Wales, southwest Wales, and south Wales. The centres are managed individually by Betsi Cadwaladr University Health Board, Swansea Bay University Health Board and Velindre NHS Trust.

## The numbers of patients awaiting diagnosis or treatment is growing and our analysis suggests the NHS needs to further increase activity if it is to reduce the backlog and sustainably meet demand

1.7 As part of its vision for quality cancer care, the Welsh Government wants to see the waiting list volume return to pre-pandemic levels. It has also set a target that 80% of cancer patients start treatment within 62-days by March 2026. However, the waiting list for diagnosis and/ or treatment has continued to increase, and it is difficult to see how that target will be achieved (**Exhibit 5**). Our indicative modelling shows that the list will continue to grow based on recent trends of demand and activity. It is clear that without a significant increase in activity to diagnose and treat more patients the waiting list is unlikely to return to previous levels.

**Exhibit 5: actual and modelled numbers of open suspected cancer pathways to March 2026**




Source: Audit Wales analysis of DHCW data, open suspected cancer pathways at month end

Note: Patients may have more than one pathway if they are waiting for diagnosis or treatment for more than one cancer.

Our projection assumed demand, as measured by referrals, increases by 3% a year in line with recent trends and that activity increases by 1% a year.

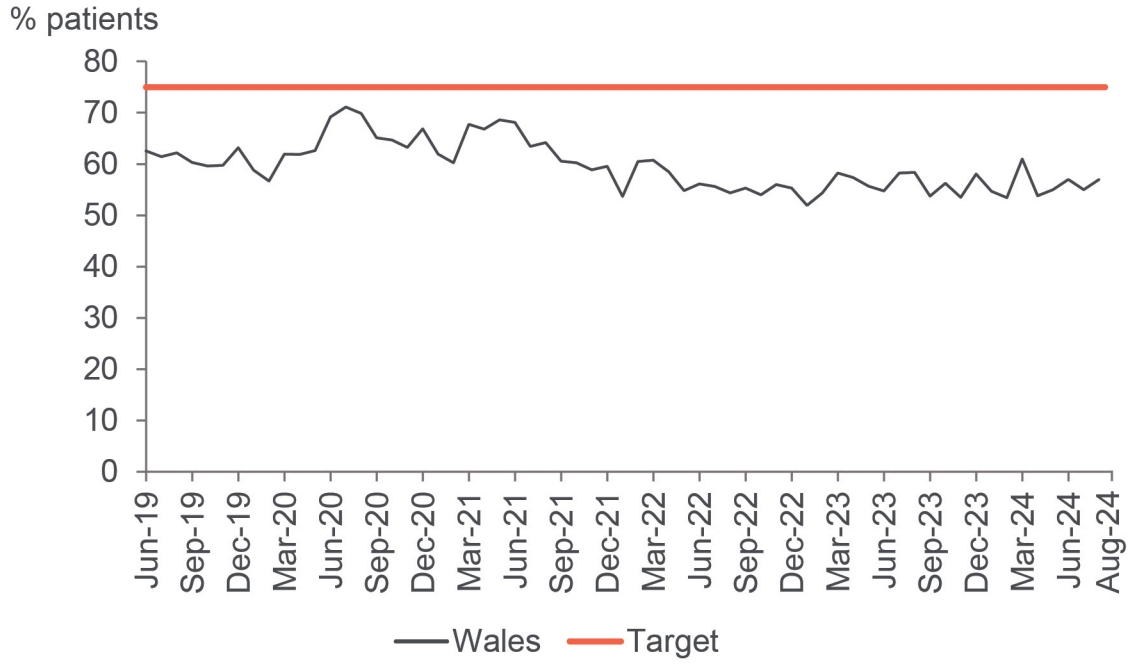
1.8 Much of the capacity the NHS uses to diagnose and treat cancer patients is also used for other non-cancer patient pathways. Achieving the political and policy ambitions to improve access to both cancer and wider planned care within the system's existing capacity will therefore be challenging. Priorities on cancer care will need to be balanced with other planned care priorities. A consideration of how existing capacity can be better used or expanded will also be needed.

# The NHS in Wales is continuing to miss the national performance target for cancer treatment

## While the majority of patients start their treatment within 62 days, performance is well short of the national target of 75%

1.9 The Welsh Government started implementing its Suspected Cancer Pathway in June 2019, with a target that 75% of cancer patients should start their first definitive treatment within 62 days of the first suspicion of cancer[11]. No health board has met the overall 75% target since August 2020 although performance has been better for some individual tumour sites (**paragraphs 1.10 and 1.11**). During the summer of 2020, referrals were lower and health boards were prioritising urgent and cancer care over other patients due to the pandemic. Since then, despite some month on month variations, performance has stayed between 52 and 61% (**Exhibit 6**).

**Exhibit 6: performance against the 62-day Suspected Cancer Pathway Target, June 2019 – August 2024**

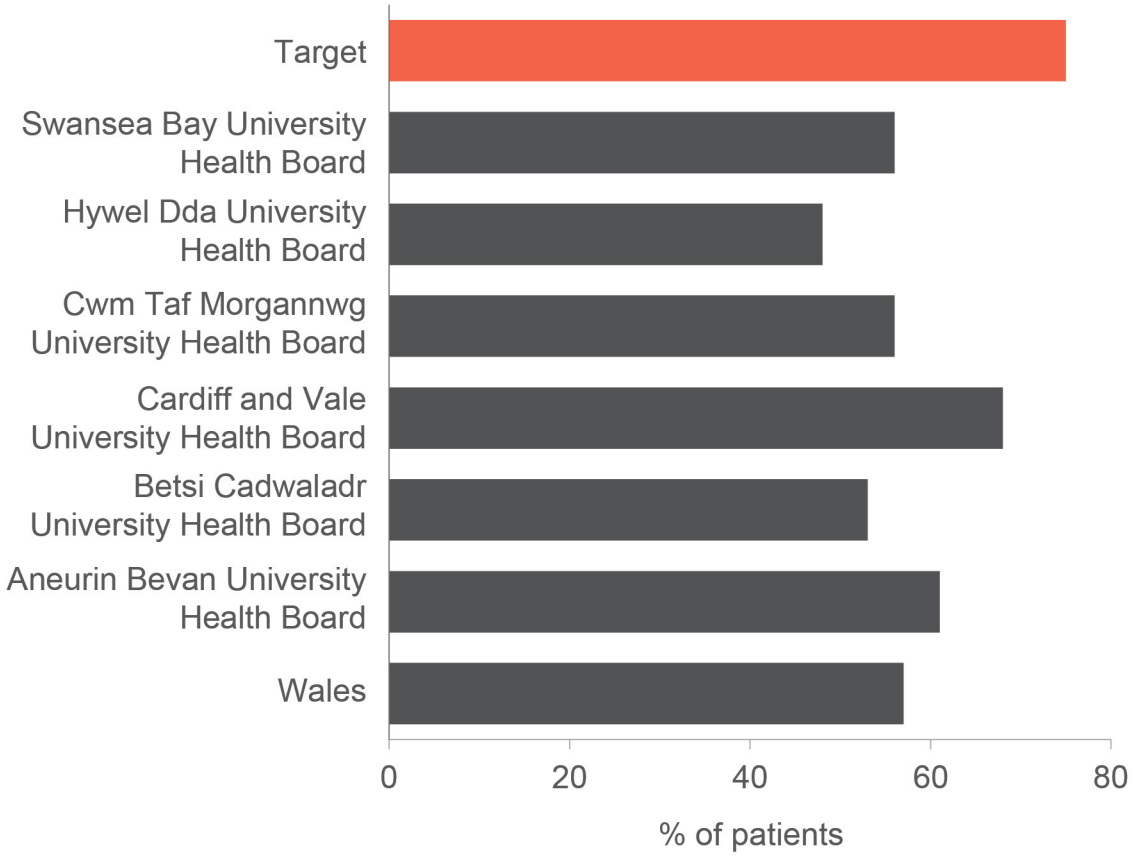



Source: DHCW, Suspected Cancer Pathway – Closed Pathways Dataset, on StatsWales.

11 Some data on performance against the target is available from June 2019 and the Welsh Government officially required health boards to report against the target from February 2021.

1.10 There is considerable variation and fluctuation in performance against the target by health board area. In August 2024, Cardiff and Vale University Health Board was closest to meeting the target at 68%, and Hywel Dda University Health Board was the worst performer at 48% (**Exhibit 7**). Health board performance has fluctuated considerably since 2019 (see **Appendix 2, Exhibits 27a to f**).

**Exhibit 7: health board performance against the 62-day Suspected Cancer Pathway Target, August 2024**




Source: DHCW, Suspected Cancer Pathway – Closed Pathways dataset, on StatsWales.

Note: StatsWales publishes data for residents of each health board unless they are treated by NHS England. Residents of Powys Teaching Health Board treated by other Welsh health boards are included in that health boards' figures. StatsWales does not distinguish between residents of Powys and residents of the health board they are treated by.

## Time to start treatment varies by type of cancer and some patients can face unacceptably long waits

1.11 Waiting times vary depending on the site of the cancer. Waiting times for skin cancer, excluding basal cell carcinoma (BCC) have been consistently above the 75% target, aside from a brief dip in November 2023. However, waiting times for other tumour sites have rarely been at or above the target at an all-Wales level[12]. Waiting times for gynaecological, lower gastrointestinal and urological cancers, and sarcoma are particularly poor with less than half of patients starting their first treatment within 62 days of first suspicion in August 2024 (**Exhibit 8**). Performance may vary within the sub-tumour sites[13] for these cancers but there is no nationally available information to understand performance by sub-tumour site (**recommendation 9**).

12 Performance for breast and lung cancers briefly met the target in June 2021 but has deteriorated since. Brain and central nervous system and haematological cancers, acute leukaemia and sarcoma have all met the target at various points from November 2020 to June 2024 but represent low numbers of patients.

13 For instance, cervical and ovarian cancers are both gynaecological sub tumour sites.

**Exhibit 8: performance against the Suspected Cancer Pathway target, median and 75th percentile waits for gynaecological, lower gastrointestinal, skin, and urological cancers, and sarcoma, and August 2024**

| | Performance against the 75% target | Median waiting times | 75th percentile waiting times |
|---|---|---|---|
| Skin (excluding BCC) | 80% | 35 days | 61 days |
| Sarcoma | 20% | No data | No data |
| Urological | 40% | 86 days | 132 days |
| Gynaecological | 35% | 83 days | 115 days |
| Lower gastrointestinal | 45% | 70 days | 106 days |

Source: DHCW, Suspected Cancer Pathway – Closed Pathways Dataset on StatsWales (data on performance against the 75% target) and DHCW data on the Suspected Cancer Dashboard (data on median and 75th percentile waits).

Note: Median waiting time is point where half the people have had their treatment and the other half are still waiting. The 75th percentile represents the time when 75% of people have had their treatment but 25% are still waiting.

## While diagnostic waits are getting shorter, waits between diagnosis and starting treatment are getting longer

1.12 Health board, NHS Executive and Welsh Government officials told us that delays at diagnostic stage are one of the main reasons for poor performance against the 62-day cancer target. Median waits from first suspicion of cancer to first diagnostic test have fallen from 20 days in February 2021 to 16 in August 2024. Depending on the type of cancer, patients usually face another wait between having a diagnostic test and finding out whether they have cancer (diagnosis). Median waits from first suspicion to actual diagnosis increased from 26 days in February 2021 to 36 in January 2022 but fell to 27 in August 2024[14].

1.13 Our analysis[15] points to problems between diagnosis and starting treatment. Between February 2021 and August 2024, median waits from diagnosis to treatment increased by 38% from 21 days to 29. Waits between diagnosis and treatment vary between tumour sites, with patients with lower gastrointestinal and breast cancers waiting longer than those with other cancer types in August 2024[16] (**Exhibit 9**).

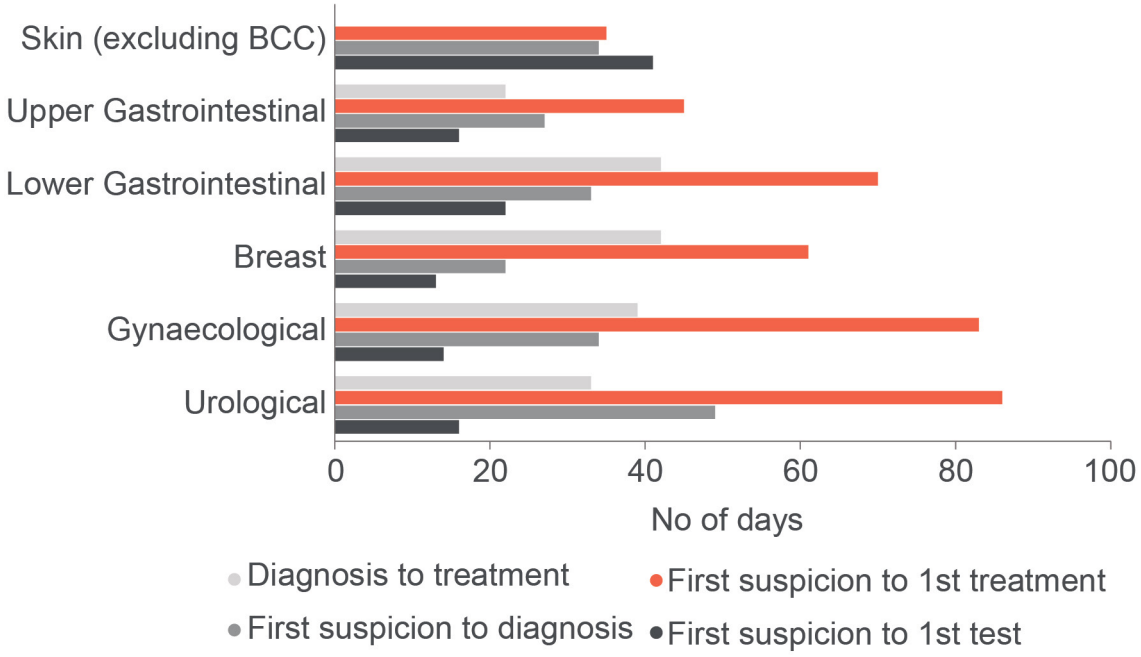
1.14 There are also considerable variations in waits at other stages of the pathway across tumour sites. For instance, in August 2024, the median wait for urological cancers was 16 days from first suspicion to diagnostic test, 49 days from first suspicion to diagnosis, and 86 days from first suspicion to the start of treatment. By comparison, the median wait for skin cancers was 41 days from first suspicion to diagnostic test and 34 days from first suspicion to diagnosis, and 35 days from first suspicion to the start of treatment (**Exhibit 9**).

14 **Appendix 2, Exhibit 28** gives median waits from first suspicion to diagnosis over time.

15 Of DHCW data from the Suspected Cancer Pathway Dashboard. DHCW only publishes median waits for the tumour sites included in **Exhibit 9.**

16 The Welsh Government does not publish median waits for all tumour sites.

**Exhibit 9: median wait from first suspicion of cancer to first test, diagnosis and starting first treatment, August 2024**



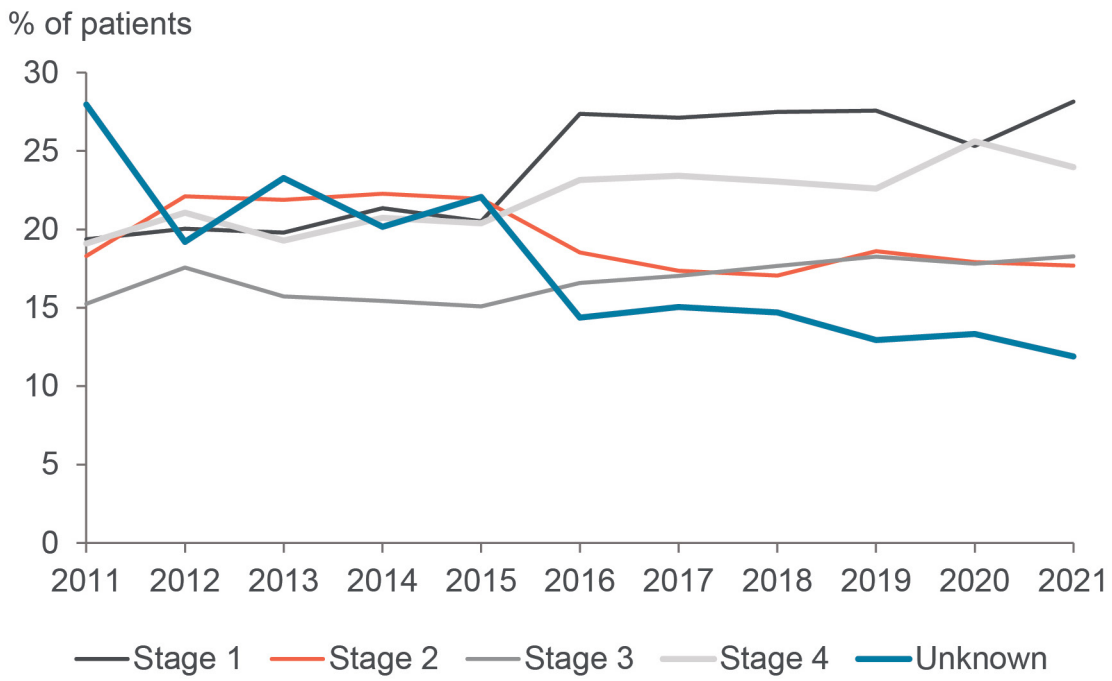

Source: DHCW data from the Suspected Cancer Pathway Dashboard

## A significant minority of people are being picked up with late-stage cancer which impacts their likelihood of survival

1.15 Survival decreases as stage at diagnosis advances for all cancer types[17]. In 2021, 24% of cancer patients were diagnosed at stage four and 18% at stage 3 (**Exhibit 10**). The increase in the proportion of cancer patients diagnosed at stage 1 between 2011 and 2021 corresponds with a fall in patients diagnosed at stage 2 and patients whose stage is unknown at diagnosis. With the exception of an increase in 2020, the proportion of cancer patients diagnosed at stage 4 has ranged between 19% and 24% during the same period. Positively, the overall proportion of cancer patients whose stage at diagnosis was 'unknown' has significantly decreased since 2011.

17 WCISU, Cancer Survival in Welsh Residents Diagnosed Between 2002 and 2020, November 2023.

**Exhibit 10: proportion of cancer patients by stage at diagnosis, 2011 to 2021**




Source: WCISU cancer incidence data

Note: Our analysis is based on WCISU cancer incidence data which does not include 'non-stageable' cancer, non-melanoma skin cancer, and some rare cancer types.

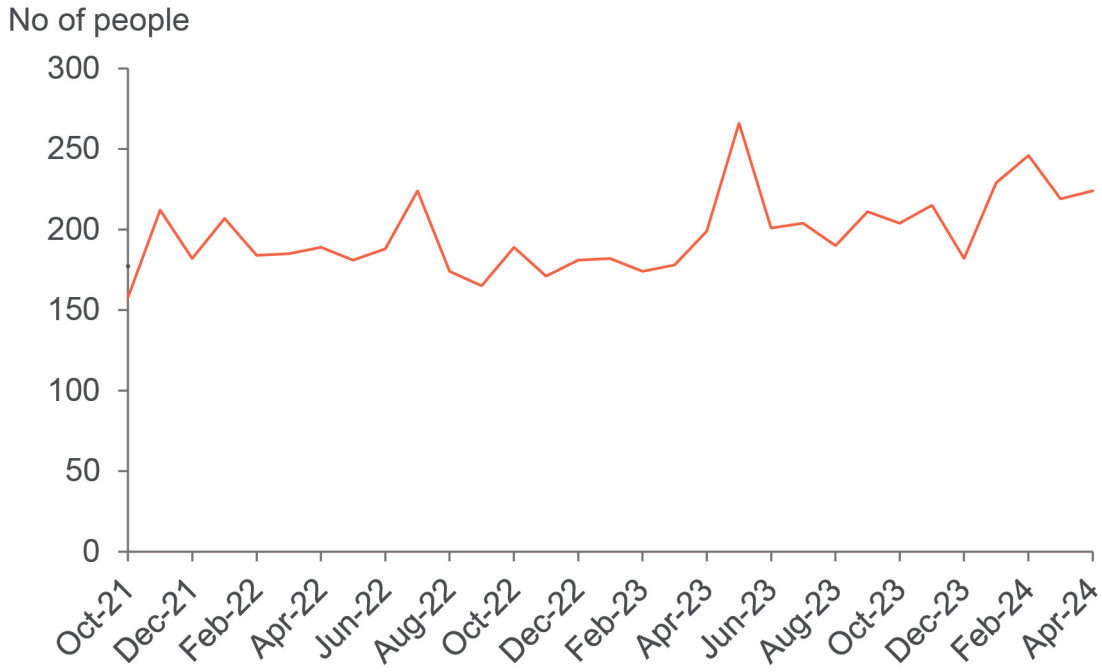
1.16 Some cancers are more likely than others to be diagnosed at a late stage, particularly asymptomatic cancers. In 2021, patients with gall bladder, pancreatic, and lung cancer were more likely than other cancer patients to be diagnosed at stage four[18]. 48% of lung cancer patients were diagnosed at stage four in 2021 (1,175 people). To illustrate the importance of early diagnosis, five-year survival for lung cancer diagnosed during 2016-2020 is 55% at stage one, 30% at stage two, 13% at stage three, and just 3% at stage four[19].

1.17 Although the numbers are relatively small, the number of people whose suspected cancer was identified via emergency departments has increased by over 40% from October 2021 to April 2024 (**Exhibit 11**).

18 74% of patients with gall bladder cancer and 52% of patients with pancreatic cancer were diagnosed at stage 4 in 2021.

19 WCISU, Cancer Survival in Welsh Residents Diagnosed between 2002 and 2020, November 2023.

**Exhibit 11: number of urgent suspected cancer referrals via emergency departments from October 2021 to April 2024.**




Source: Audit Wales analysis of DHCW Suspected Cancer Pathway Data – closed pathways by source of suspicion.

1.18 Research by the International Cancer Benchmarking Partnership[20] found that countries with higher rates of cancer diagnosis after emergency presentation had poorer survival rates[21]. It explained that Wales and Scotland have some of the highest rates amongst comparable countries. Our own analysis found that suspected cancer patients referred from emergency departments were more likely than those referred via other routes to die before being diagnosed or starting treatment[22]. While some caution is needed due to the small numbers, there is an upwards trend in patients referred from emergency departments dying before treatment or diagnosis.

20 The Partnership brings together international clinicians, policymakers and researchers to identify best practice and support improved cancer outcomes for patients.

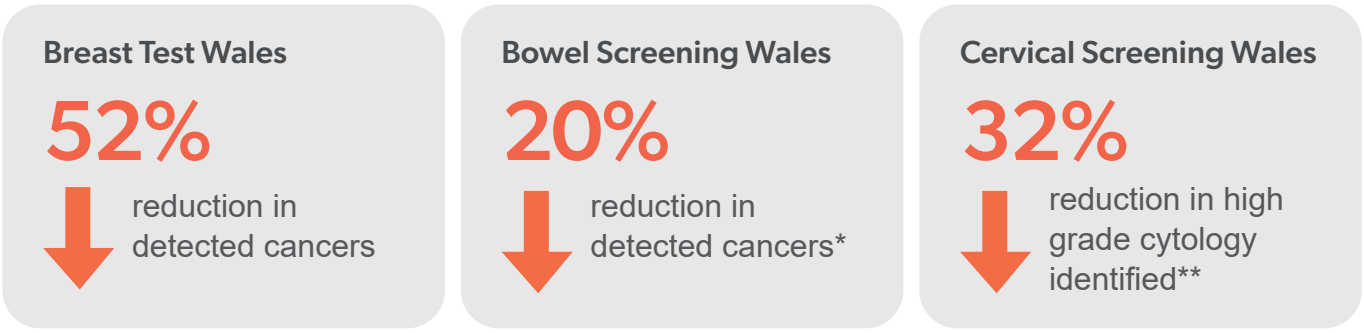
21 Abd Elkader, Alv, R; Barclay, M; Johnson, S; McPhail, S; Swann, R, Risk Factors and Prognostic Implications of Diagnosis of Cancer Within 30 Days After and Emergency Admission (Emergency Presentation): An International Cancer Benchmarking Partnership Population Based Study, 2022.

22 Based on our analysis of on our analysis of DHCW Suspected Cancer Pathway Data. In April 2024, 4% of suspected cancer patients referred from an emergency department died before starting treatment or finding out they did not have cancer compared to 1% of all suspected cancer referrals.

## There is scope to increase uptake of screening to detect cancers earlier

1.19 Screening plays a vital role in early detection. Public Health Wales NHS Trust (PHW) runs Wales's three cancer screening programmes: Breast Test Wales, Bowel Screening Wales and Cervical Screening Wales. The Trust estimates that brief pauses to its screening programmes[23] at the start of the pandemic reduced the number of detected cancers in 2021 compared to previous years (**Exhibit 12**).

**Exhibit 12: reduction in cancers detected via screening, from April 2020 to March 2021 compared to the previous year**




Source: PHW, Update on Population Based Screening Programmes in Wales to the Quality, Safety and Improvement Committee, June 2021

Note: * from April 2020 to February 2021.

**abnormal cells with the potential to develop into cervical cancer.

1.20 Whilst bowel screening is achieving its uptake standards, there are opportunities to increase screening uptake for the breast and cervical screening programmes which were both below the standard in August and April 2024 respectively (**Exhibit 13**). In 2022, the Trust reported differences in screening uptake for all three programmes depending on age, the health board area people live in, and whether the area is deprived or not[24]. It is working to address inequity in screening uptake via its Screening Equity Strategy but has not published a progress report on screening equity since June 2022.

23 Audit Wales, A Review of Arrangements to Recover Screening Services at Public Health Wales NHS Trust, August 2023, provides more information the pause and recovery screening services including performance measures, eligibility and coverage standards for each programme.

24 Public Health Wales NHS Trust, Screening Division Inequities Report 2020-21, June 2022.

**Exhibit 13: screening coverage against target, April and August 2024**

| | Eligibility | Standard | Uptake |
|---|---|---|---|
| Breast Test Wales | Women aged 50 to 70 years invited for screening every three years | 70% | 68%* |
| Bowel Screening Wales | People aged 50 to 74 years invited for screening every two years | 60% | 65%** |
| Cervical Screening Wales | Women and people with a cervix aged 25-64 years invited for screening every 5 years if Human papillomavirus (HPV) negative or more frequently if HPV positive | 80% | 69%*** |

Source: Audit Wales, based on information and wording from PHW, October 2024.

Note:

*Rolling annual rate at August 2024
**Average over the previous year at August 2024
***Age appropriate coverage at April 2024

1.21 Referrals from breast and bowel screening programmes were amongst the most likely to go on to start cancer treatment (92% and 28% respectively in 2023-24 compared to 12% overall)[25]. However, there is no national data on the timeliness of subsequent cancer diagnosis and treatment for people referred from breast or cervical screening. From July 2023 to July 2024, just 21% of eligible people referred from bowel screening were offered a colonoscopy by the relevant health board within four weeks of phoning to book[26]. The target is 90%. Waiting times for colonoscopies varied between health boards from four to 14 weeks.

25 Based on our analysis of DHCW Suspected Cancer Pathway Data. We have excluded cervical screening referrals from our analysis due to low numbers. Less than 5 people are referred with suspected cancer following cervical screening each month.

26 Public Health Wales NHS Trust, October 2024.

## Survey data suggests that patients are generally satisfied with their cancer care, though the latest survey pre-dates the recent decline in performance

1.22 Data on patient experience is collected via the annual Wales Cancer Patient Experience Survey commissioned by the Cancer Network and Macmillan Cancer Support. The most recent data is from 2021 and pre-dates the downturn in performance against the 62-day target.

1.23 The vast majority of cancer patients who responded to the survey rate their overall care highly. The average rating for overall care was 9 out of 10 across Wales, based on 5,859 responses. The positive results reflect the hard work and compassionate care of the many staff working across the NHS to care for and support cancer patients. 87% of respondents said that the different professionals treating and caring for them worked well together to give them the best possible care either ‘always’ or ‘most of the time’. The survey does not ask patients how they felt about the overall length of time they waited from first suspicion to starting treatment.

## Outcomes for cancer patients are generally improving but lag behind comparable countries and are worse for people living in deprived areas

1.24 Cancer is the leading cause of death[27] in Wales, accounting for 25% of all deaths in 2022. Lung, bowel, and prostate cancer account for the largest proportions of cancer deaths[28]. The number of cancer deaths has increased from 8,295 in 2002 to 9,154 in 2022 and is projected to increase by 27% by 2040 (based on 2021 levels)[29]. The rise in cancer deaths is primarily explained by the changing age structure of the population. The age standardised rate[30] of cancer deaths has generally decreased since 2011 although there was a slight increase in 2022 (**Exhibit 14**).

1.25 The cancer death rate in Wales compares poorly to other UK nations and internationally[31]. Wales has had the second highest age standardised cancer death rate in the UK almost consistently since 2010 (**Exhibit 14**). The OECD compared age standardised cancer death rates in 2023, based on 2021 data. It placed the UK 35th out of 45 countries[32].

27 In 2022, 24% of deaths were caused by diseases of the circulatory system, 12% by diseases of the respiratory system, 10% by dementia and Alzheimer's, and 29% by other causes.

28 WCISU cancer mortality data.

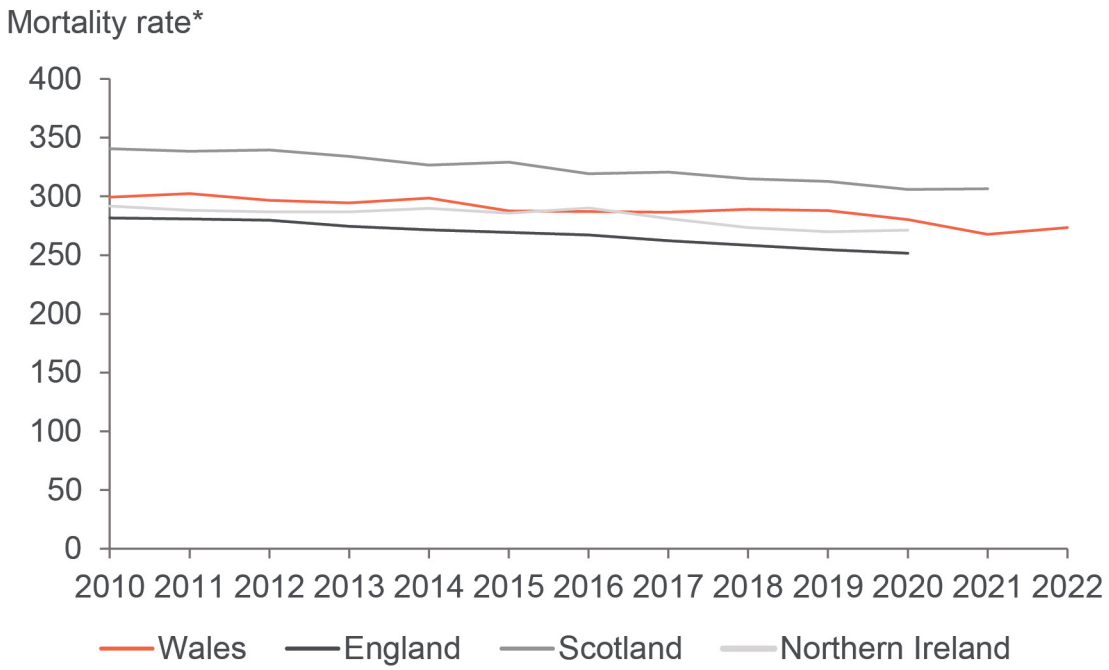
29 National Strategic Clinical Network for Cancer, A Cancer Improvement Plan for NHS Wales 2023-26, 2023.

30 Deaths per 100,000 of the population taking account of differences in the age structure of different parts of Wales.

31 Many factors affect cancer incomes including the relative wealth and spending on healthcare in each country, underlying population health, and deprivation.

32 OECD, Health At A Glance 2023: OECD Indicators, OECD, 2023.

**Exhibit 14: age standardised cancer mortality rates in UK countries (excluding non-melanoma skin cancer), 2010 to 2022**




Source: WCISU cancer mortality data

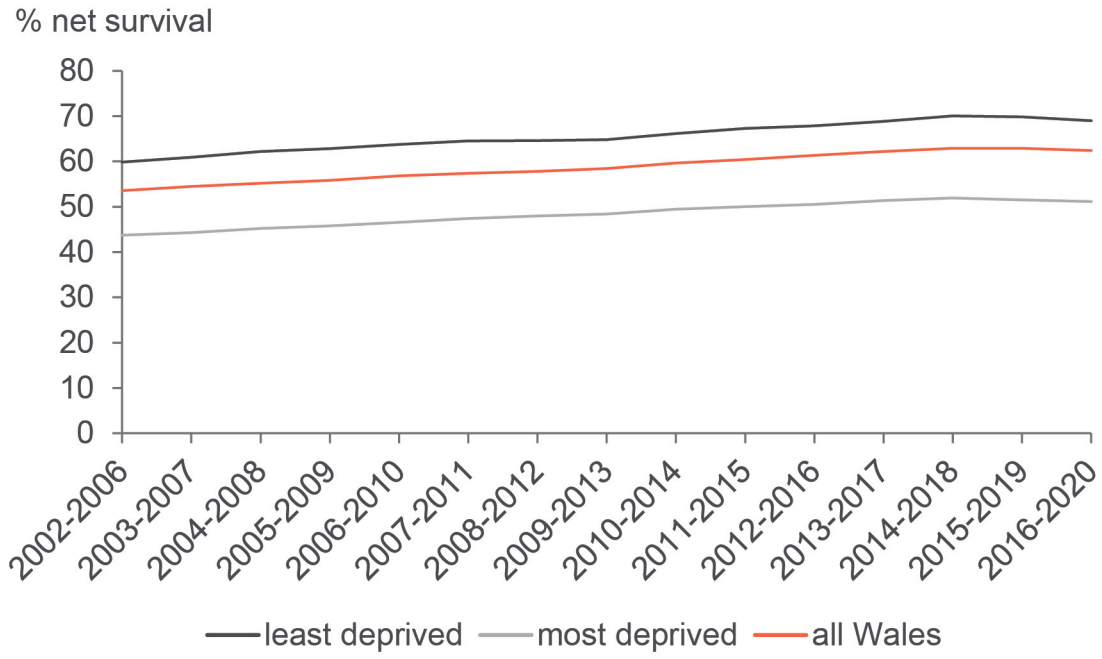
Note: *per 100,000, adjusted to reflect the age of the population

1.26 Cancer survival[33] improved between 2002 and 2020. 54% of patients diagnosed with cancer from 2002-2006 survived their cancer at five years compared to 62% of patients diagnosed between 2016 and 2020. There is not yet data available to track the impact of the pandemic on survival rates. Differences in data collection methods makes it difficult to compare overall survival figures across UK countries.

1.27 There is a significant deprivation gap in survival rates. While 69% of cancer patients living in the most affluent parts of Wales survive cancer at five years, that falls to 51% for those in the most deprived areas (**Exhibit 15**). Worryingly, the deprivation gap has widened from a difference of 16 percentage points for people diagnosed between 2002-06 to 18 percentage points for people diagnosed between 2016-20.

33 Cancer mortality figures show the number of deaths where cancer was the underlying cause whilst survival figures show how many people who have had cancer are still alive after a certain period of time so it takes several years for accurate data to be published.

**Exhibit 15: percentage unstandardised rolling net survival at five years comparing most and least deprived areas with the all Wales figure for patients diagnosed in the periods 2002-2006 to 2016-20 (excluding non-melanoma skin cancer).**




Source: WCISU cancer survival data

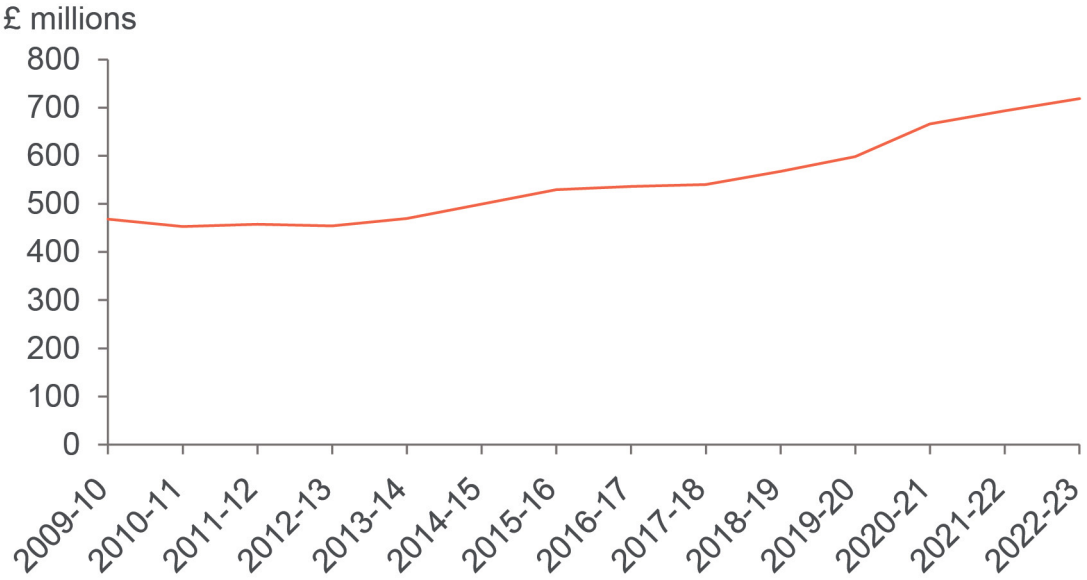
# Spending on services to diagnose, treat and support cancer patients has risen faster than overall NHS spending but there are gaps in staffing capacity

## Real terms spending on services to diagnose, treat and support cancer patients has grown more than overall growth in NHS Wales spending but there are significant cost pressures on those services

1.28 Real terms spending on services to diagnose, treat and support cancer patients increased by 54% from just over £450 million in 2009-10 to almost £720 million in 2022-23 (**Exhibit 16**). This increase is considerably greater than the overall 33% real terms growth in NHS Wales spending[34]. As a proportion of overall NHS spending, spending on services to diagnose, treat and support cancer patients has increased slightly from 7% in 2009-10 to 8% in 2022-23. Increased spending does not necessarily translate to additional capacity or activity. There are lots of cost pressures on services including rising workforce costs associated with pay growth and the use of agency staff; rising costs of existing drugs; new drugs and new technologies to improve treatment.

34 Based on revenue spending in the Welsh Government's NHS expenditure by programme budget category data on StatsWales for consistency with cancer spending figures. The NHS Finances Data Tool on our website is based on published Welsh Government budgets and gives a slightly different figure.

**Exhibit 16: real terms NHS spending on cancer, 2009-10 to 2022-23**




Source: Welsh Government, NHS Expenditure by programme budget category and year, 'cancer and tumours', on StatsWales.

Note: Real terms figures are adjusted to take account of inflation. We used HM Treasury GDP deflators at market prices and money for 2022-23, March 2024.

The Welsh Government confirmed that this data is based on NHS Wales patient activity costs including staff, consumables, medicines and overhead costs such as estates, catering, HR and finance costs.

1.29 In 2022-23 NHS Wales spent £230 per head of the population on services to diagnose, treat and support cancer patients[35]. Spend per head ranged from £206 in Cardiff and Vale to £270 in Swansea Bay University Health Board. An examination of the reasons behind differing spending figures across health board areas was outside the scope of this review but it is likely to reflect different local models of care and population factors including demography and deprivation.

1.30 Despite improvements in cancer waiting times being one of the key priorities for NHS Wales, the prospects for spending on services to diagnose, treat and support cancer patients are uncertain. UK public finances are under pressure. NHS bodies in Wales are already under financial strain, with six out of seven health boards overspending in 2023-24 and most projecting deficits for 2024-25. It is unclear whether they will be able to prioritise services for urgent suspected cancer patients to increase activity sufficiently to meet demand and reduce waiting times. Health boards are also under pressure to prioritise other parts of the system where performance is poor, including long waits for unscheduled care and for planned care.

35 There is no comparable data from other UK or comparable countries.

## Workforce capacity is a significant challenge and there is an absence of information on the availability and condition of equipment

1.31 Despite spending increases, workforce capacity remains a significant challenge and workforce shortages are reducing service capacity[36]. HEIW's Education and Training Plan 2025-26[37] describes 'significant national shortages and longstanding gaps' in specialist professional roles impacting diagnostics, cancer, emergency care and mental health. It highlights particular shortages in dermatologists, clinical oncologists, consultant urology surgeons, and histopathologists. It cites pressure from increasingly complex cancer reporting and the evolving field of geonomics on histopathology, and demand from cancer patients on urology.

1.32 The Royal College of Radiologists describes shortfalls of 34% and 12% in the radiology and clinical oncology workforces, likely to deteriorate to 38% and 28% respectively by 2028[38]. We also heard that there are shortages of medical physicists, specialist and district nurses, and in the geonomics, Systemic Anti-Cancer Therapy and radiotherapy workforce.

1.33 HEIW set out its plans to address workforce shortages in its Education and Training Plan and Integrated Medium-Term Plan 2024-27. In line with its commitment in the Cancer Improvement Plan, HEIW has published its workforce plans for pharmacy and for geonomics, and intends to publish its plan for nursing in early 2025. The Ten-Year Workforce Strategy for Health and Social Care 2020 sets out the broader strategic approach.

1.34 As well as sufficient staff, NHS Wales needs sufficient equipment to deliver timely and effective diagnosis and treatment. The NHS Executive is building up a picture of capacity associated with the age and availability diagnostic imaging equipment including the age and availability of equipment. We heard anecdotal evidence that Wales has fewer imaging machines than comparable countries, and that some machines are old and prone to breaking down. Whilst it was beyond the scope of this review examine those claims, we did hear that limitations in access to diagnostic equipment are putting pressure on staff, affecting recruitment and retention, and restricting HEIW's ability to offer training places for diagnostic students[39].

36 Audit Wales, Workforce Data Briefing, 2023, sets out broad workforce issues, with many affecting services for cancer patients where services are not specific to cancer patients (such as diagnostics and surgery).

37 The Plan sets out commissioning and training recommendations for the health professional workforce in Wales.

38 Royal College of Radiologists, Radiology Workforce Census 2023, June 2024.

39 It is exploring using simulated training environment as an alternative.

# Strategic direction

02

2.1 This part of the report looks at national strategic direction and leadership to improve cancer care in Wales. **Appendix 1** explains key elements of the strategic approach and broad roles and responsibilities for cancer services.

### What we looked for

We looked for evidence of a clear strategic direction for improving cancer outcomes and services, and for reducing demand for cancer services by preventing cancer occurring in the first place. We also looked for evidence of appropriate and clear leadership structures to direct, oversee and support improvement and tackle barriers at a national level.

## There is a lack of clarity on the status of the Cancer Improvement Plan and how it aligns with other cancer improvement initiatives

### The Cancer Improvement Plan has not been sufficiently integrated into the wider strategic approach for improving cancer services

2.2 The Welsh Government set out its vision of what 'good' cancer services should look like in the Quality Statement for Cancer (2021). The Statement is generally high-level but is underpinned by tumour specific national optimal pathways. The pathways set out what should happen at different stages of the patient journey according to professional guidance. The Welsh Government instructed health boards to start embedding the pathways by September 2022[40]. When it published the Statement, the Welsh Government said that the Cancer Network would develop a rolling, three-year plan to achieve the national vision.

40 Via Welsh Health Circular (2022) (021).

**Exhibit 17: vision set out in the Quality Statement for Cancer**

The Cancer Quality Statement sets out that its ultimate aim is to improve population survival and reduce cancer mortality rates. It identifies key areas for action:

- that cancer is effectively prevented where possible,
- that cases of cancer are detected at earlier more treatable stages,
- that complex treatment pathways are optimised, while throughout people are properly supported and co-produce their care.

The statement sets out a series of attributes, indicating what good quality care looks like, under six headings:

- Equitable
- Safe
- Effective
- Efficient
- Person centred
- Timely

Source: Welsh Government Quality Statement for Cancer, 2021.

2.3 In 2023, the Network published A Cancer Improvement Plan for Wales 2023-26 (the Plan) at the request of then Minister for Health and Social Services. The Plan encompasses a broad range of cross-sector actions to improve cancer patient outcomes and reduce health inequalities. It's three year horizon was deliberately aligned to local health board planning cycles. However, this means the Plan lacks focus on longer-term actions to build sustainable cancer services. It also lacks detail on prevention, palliative and end-of-life care, and on services for children and young people and does not cover the full range of ambitions in the Quality Statement.

2.4 The then Minister used the Plan to set the new expectation that by March 2026, 80% of patients would start their first treatment within 62 days. The Minister announced publication of the Plan in an oral statement, describing it as a collective NHS Wales approach to delivering the policy intentions in the Quality Statement for Cancer. The Welsh Government told us that it is not a Welsh Government Plan. It considers that it does not require a national plan to implement the Quality Statement because health boards and trusts are responsible for implementing the vision through their own local plans.

2.5 Nonetheless, the Plan exists at the request of the Minister and many of its actions require national direction and leadership to support successful implementation. This would include consideration of the funding needed to support the Plan's actions and using national planning and performance management frameworks to clarify requirements around the Plan's delivery (**recommendation 1**).

2.6 The Cancer Improvement Plan commits the Welsh Government to monitoring delivery of the Plan through its existing performance arrangements. However, during our fieldwork, Welsh Government officials told us that such monitoring was not taking place. Since then, at the then Minister's request, the Cancer Network has collated a retrospective progress 'update' on delivery of the Plan. However, the Welsh Government is not routinely monitoring implementation in line with its commitment in the Cancer Improvement Plan.

## New national initiatives to improve cancer services have merit but stakeholders are confused about how they link to the Cancer Improvement Plan

2.7 Since publication of the Plan in 2023, the Welsh Government and NHS Executive have set up new programmes aiming to improve cancer services (**Exhibit 18**). While there are merits in each programme, stakeholders are unclear about how they align with the Cancer Improvement Plan.

**Exhibit 18: new programmes to improve cancer services**

| Programme | Description |
|---|---|
| Cancer: Improving Outcomes initiative | The Welsh Government commissioned Life Science Hub Wales to develop the initiative, which is aimed at focusing innovation on key problem areas and removing the barriers to delivering innovation at pace. |
| National Cancer Recovery Programme | The NHS Executive set up the programme, which is aimed at reducing long waits to achieve a target that 80% of suspected cancer patients start treatment within 62 days by 31st March 2026. |

Source: Audit Wales.

2.8 The NHS Executive is currently finalising arrangements for its National Cancer Recovery Programme. The Programme focuses on five specific tumour sites[41] with some cross-cutting actions to improve more general services to diagnose and treat cancer patients. Rather than large-scale, whole-system transformation, the Programme aims to improve performance and improve compliance with the National Optimal Pathways within existing budgets.

2.9 The Welsh Government has repurposed Cancer Network funding to provide £2 million per annum for 2024-25 to 2026-27 for the NHS Executive to implement the Programme. Around half of this funding will pay for staff costs in line with the Programme aims around encouraging improvement within existing budgets. NHS Executive officials told us that the Programme may identify improvement opportunities which would then be costed and developed into business cases for additional Welsh Government funding.

41 Breast, gynaecological, lower gastrointestinal, skin, and urological cancers.

## Many NHS bodies and third sector partners are confused about the strategic direction

2.10 NHS and third sector organisations told us they are confused about the strategic direction for cancer services in Wales. Some all-Wales NHS bodies have embraced the commitments in the Plan (for example **paragraph 1.33**). Others have rejected actions attributed to their organisation and saw some actions in the Plan as irrelevant (for example **paragraph 2.37**).

2.11 Health boards have developed local initiatives to improve diagnosis, treatment and support for cancer patients but it is not clear how they link to the Cancer Improvement Plan. During our fieldwork it was apparent that NHS bodies were not clear about the status of the Plan and how it should be shaping their activities. NHS and third sector bodies told us that the development of the new initiatives and programmes so soon after the publication of the Cancer Improvement Plan has increased their confusion about the strategic direction.

# National leadership, decision-making and oversight arrangements are not effective and there is an over-reliance on narrow performance management

## There is a lack of clarity as to who is responsible and accountable for driving system wide improvement to cancer services

2.12 The Welsh Government established the NHS Executive to drive improvements in the quality and safety of care. It brings together existing improvement organisations to better coordinate and drive improvements to the quality and safety of care[42]. However, officials in NHS bodies and third sector representatives we interviewed, were confused about the differing roles of the Welsh Government and NHS Executive. We also heard that there was confusion about the different roles and functions within the NHS Executive. At the time of our review, three NHS Executive functions had responsibility for driving cancer improvement:

- the Strategic Planned Care Programme had responsibility for supporting improvement in the timeliness of cancer diagnosis and treatment;
- the Performance Assurance Directorate provided direct support to NHS bodies to improve cancer performance; and
- the Cancer Network worked with clinicians, health professionals, and third sector and patient representative organisations to improve outcomes and care for cancer patients.

2.13 We found a general consensus, including within the Welsh Government and NHS Executive, that the Executive is not yet providing the intended strong leadership to drive improvement. Many NHS and third sector bodies described arrangements after the establishment of the Executive as a 'step backwards' or 'worse than ever.'

42 The NHS Wales Delivery Unit, the NHS Wales Finance Delivery Unit, the NHS Wales Health Collaborative; and Improvement Cymru.

2.14 Stakeholders raised various concerns about the national leadership and accountability arrangements for cancer services including:

- the Cancer Network lacking the authority to make decisions and commit the level of resources needed to secure change;
- lack of integration of the Cancer Network within the NHS Executive's leadership and with the wider NHS, and gaps in arrangements to share frontline insight from clinicians;
- third sector bodies are struggling to know who to engage with and how to share important intelligence and more generally feeling under-appreciated for the extensive support they provide to the system[43] and individuals and their families (**recommendation 2**);
- overlap and duplication between the cancer recovery work carried out by the Strategic Planned Care Programme and the intervention work led by the Performance Assurance Directorate; and
- lack of communication between the Welsh Government and NHS Executive to assess whether funding for additional capacity is being allocated to areas of greatest need.

2.15 Since our fieldwork the NHS Executive has established a Network Clinical Leadership Group to support closer working between clinicians and wider NHS Executive senior leadership. Whilst this is a positive development, wider action is needed to strengthen national leadership arrangements. The gaps, lack of clarity and duplication described above have led to a situation where many stakeholders from inside and outside of the NHS told us: 'we don't know who is in charge' (**recommendation 2**). The Senedd Health and Social Care Committee's report on gynaecological cancers[44] raised similar concerns and called on the Welsh Government to be 'more accountable' for driving improved cancer services.

43 The third sector has a wealth of knowledge and insight and provides funding for some services in Wales (such as the Teenage Cancer Trust cancer ward in Cardiff). We also found examples of third sector organisations attracting private sector funding to drive innovation, and developing data resources which are now used by NHS Wales.

44 Welsh Health and Social Care Committee, Unheard: Women's Journey through Gynaecological Cancer, December 2023.

## National decision-making and leadership arrangements are not sufficiently robust to systematically identify and prioritise opportunities to improve cancer services

2.16 Cancer treatment is an area of significant innovation, with opportunities to improve outcomes and efficiency. We identified examples of Welsh Government investment and decision making to improve cancer and planned care. For instance, it has worked with health boards and the NHS Executive to introduce rapid diagnostic centres; supported improvements to the bowel screening programme and is funding a new cancer centre for Velindre NHS Trust[45].

2.17 However, the Welsh Government recognises that it lacks a robust approach to identifying, assessing and prioritising such opportunities. Current arrangements need strengthening to ensure there is sufficient capacity to assess and prioritise initiatives for funding. Arrangements should address gaps in decision making structures to prioritise investment in areas such as digital, workforce and diagnostics (**recommendation 2**). **Exhibit 19** sets out two areas of opportunity to improve efficiency and outcomes, where decision making has been slow.

45 We are conducting a separate examination of decision-making relating to the development of the new Velindre Cancer Centre. We aim to publish that report in 2025.

**Exhibit 19: potential innovations where decision making has been slow**

| Programme | Description |
|---|---|
| **Digital cellular pathology** | During our review, NHS bodies and third sector organisations cited frustration with the speed of national decision making on the use of digital cellular pathology. Betsi Cadwaladr University Health Board was a pioneer of the approach and transformed its pathology service in 2014. Laboratories could scan and upload images onto digital systems to be analysed remotely rather than transporting samples between locations. Alongside a broader transformation programme*, the approach dramatically improved the timeliness of pathology results and helped the health board recruit and retain staff because it facilitated flexible working arrangements.<br><br>The National Pathology Programme has been working with the Welsh Government and health boards to develop a consistent all-Wales approach to digital cellular pathology since 2019. Despite general consensus on the benefits of the approach, progress has been restricted by uncertainty about who would fund modern scanning equipment and digital storage. Health boards have been reluctant to commit funds without clarity on the Welsh Government's financial contribution. Despite investing in other aspects of digital cellular pathology, at the time of our review, the Welsh Government was not clear about whether it would fund the equipment and storage to establish an all-Wales approach. The National Pathology Programme was still working with health boards to agree a business case share ongoing annual costs of around £3 million for the scanning equipment and storage.<br><br>Wales now lags behind the rest of the UK for digital cellular pathology capacity, making it a less attractive employment option for newly qualitied pathologists in an already competitive market. |

| Programme | Description |
|---|---|
| **Lung Screening** | In 2019, the Cancer Network started exploring evidence on the effectiveness lung screening. It concluded that screening could increase the percentage of cancers identified at an early stage and had the potential to reduce lung cancer mortality by 20%. The work informed a pilot lung health check programme in Cwm Taf Morgannwg University Health Board, which started in 2022 and was funded by third sector organisations and private industry.<br><br>The UK National Screening Committee recommended that UK nations develop targeted lung screening for people aged 55-74 years with a history of smoking in June 2022. Despite an endorsement from the Wales Screening Committee in November 2022, the Welsh Government did not task PHW with developing options for a national programme until July 2023. The Welsh Government has asked PHW to provide interim proposals on a national lung screening programme by May 2025. If PHW meets the 2025 deadline, it will have taken three years from the UK National Screening Committee's recommendation just to develop interim proposals. Finalising proposals and implementing a national programme would take more time after this point (**recommendation 5**). |

Source: Audit Wales.

Note: *The digital cellular pathology approach was part of a wider transformation programme including combining regional services into a single Betsi Cadwaladr University Health Board Cellular Pathology Service.

2.18 We also heard concerns about the Welsh Government's ability to secure the benefits from its investment in capacity and new ways of working. In particular, stakeholders frequently cited an incoherent approach that has seen the Welsh Government invest in the training and recruitment of radiologists only for many to be unable to find work in NHS Wales (**Exhibit 20**).

**Exhibit 20: investment in training and radiologists**

A National Imaging Academy opened in 2019, as a result of the Welsh Government providing £3.4 million to HEIW to establish the facility to help meet identified workforce gaps in respect of radiologists and imaging professionals.

However, many of the newly qualified radiologists are leaving Wales because, despite workforce gaps there are no jobs for them. Some health boards told us that financial pressures have led to recruitment freezes which limited their ability to recruit diagnostic staff. We also heard that weaknesses in health board workforce planning including projections of future need and slow recruitment processes were part of the problem*.

The NHS Executive's National Diagnostics Implementation Plan** contains a weak commitment to work with HEIW to 'advocate' for commitment to employment from health boards when requesting training numbers. It is unclear what role the Welsh Government intends to play in ensuring the benefits of its investment in training the future workforce are not lost to Wales (**recommendation 7**).

Source: Audit Wales

Notes:

* Our review of workforce planning made specific recommendations to health boards to improve workforce planning. Individual reports for each NHS body are available on our website www.Audit.Wales.

** NHS Executive, National Diagnostic Implementation Plan 2023-25.

2.19 Regional working across health board areas can help to share capacity and bolster fragile services. Health boards are developing regional approaches in some areas that can increase capacity in the system[46]. The NHS Executive is also developing plans for two regional diagnostic hubs in South Wales to provide additional shared diagnostic capacity for the region. However, the overall pace of regional collaboration is slow. Whilst there is a clear onus on health boards to take forward regional working, there is also a need for national leadership and co-ordination from the Welsh Government and the NHS Executive. In that regard the recent creation of a dedicated senior role within the NHS Executive to support regional working is a welcome development. However, success will also depend on action to tackle barriers to regional working such as a lack of integration between digital systems making it difficult to share waiting lists across health boards[47] (**recommendation 6**).

## Welsh Government oversight is narrowly focussed on the 62-day target

2.20 The Welsh Government's NHS Performance Framework (2024-25) sets out the measures (but not the targets) against which NHS bodies are accountable. The 62-day measure is the main cancer specific measure. There is a measure on the timeliness of colonoscopy for bowel screening referrals (**paragraph 1.21**) but no measures for breast or cervical screening referrals. Previous performance frameworks[48] included coverage measures for all three cancer screening programmes. There is also a measure for uptake of the human papillomavirus (HPV) vaccine (**paragraph 2.24**).

2.21 The Performance Framework does not include any measures on cancer incidence, mortality and survival rates. It does not clearly link to the six quality attributes set out in the Quality Statement for Cancer and the Framework makes no reference to compliance with the National Optimal Pathways that underpin the Quality Statement. While the Welsh Government has made the NHS Executive responsible for monitoring compliance with the pathways it is still developing methods for doing so.

46 Including developing regional approaches to diagnostics and treatment in North, Southeast and Southwest Wales using Welsh Government planned care recovery funding.

47 Welsh Health and Social Care Committee, Unheard: Women's Journey through Gynaecological Cancer, December 2023.

48 NHS Wales Performance Framework 2022-23.

2.22 There is a well-established framework for oversight of NHS bodies' planning and performance through activities such as scrutiny of NHS bodies' annual or medium-term plans, monthly Integrated Quality, Planning and Delivery meetings and twice yearly Joint Executive Team meetings between Welsh Government, the NHS Executive and individual NHS bodies. In addition, monthly cancer performance meetings provide a specific focus on the diagnosis and treatment of cancer patients. Collectively this represents a significant volume of performance management activity and includes positive developments around collaboration and information sharing between the Welsh Government and NHS Executive. However, the focus is largely on short-term delivery of the 62-day cancer performance target, rather than broader system change and wider delivery of the vision in the Quality Statement (**recommendation 3**).

# The strategic approach lacks a coherent focus on cancer prevention, and is undermined by gaps in data and fragmented digital services

## There is no coherent strategic approach to prevention, even though many cancers are preventable and doing so could save lives and reduce demand for NHS services

2.23 The Cancer Improvement Plan states that 38% of cancers each year in Wales are preventable. There are considerable opportunities to tackle lifestyle factors which increase the risks of some cancers. Many of the lifestyle risk factors for cancer are similar across major conditions accounting for the majority of planned and emergency care in the UK. Data from PHW's Public Health Outcomes Framework[49] showed that in 2022-23, 13% of adults in Wales smoked; 17% drank more alcohol than recommended guidelines[50]; and only 36% of working age adults were a healthy weight[51].

2.24 There are also opportunities associated with increasing the uptake of the human papillomavirus (HPV) vaccine. Since its introduction in 2008, the vaccine has reduced cancer rates by almost 90% in women in their 20s and is expected to save hundreds of lives a year in the UK[52]. PHW reported that 74% of children in school year 9 during 2023-24 had the vaccine. There was considerable variation in uptake ranging from 60% in Cardiff and Vale University Health Board to 88% in Swansea Bay. Changes in eligibility for the vaccine make it difficult to compare changes in uptake over time[53].

49 Public Health Wales NHS Trust Observatory, Public Health Outcomes Framework.

50 Based on adults who reported drinking over 14 units of alcohol per week.

51 Smoking and alcohol consumption data uses age standardised rates to account for differences in age structures of different parts of Wales. Data on healthy weight is age specific.

52 Public Health Wales NHS Trust: immunisation and vaccines.

53 Public Health Wales, Vaccine Uptake in Children in Wales, Quarterly Report January to March 2024, May 2024.

2.25 The World Health Organisation states that prevention offers the most cost-effective long-term strategy for managing cancer[54]. The Welsh Government's Science Evidence Advice[55] agrees that there are considerable opportunities to reduce the burden of disease on the NHS by preventing cancer and other major conditions. It identifies scope for long-term financial savings and calls for 'drastic action' to address increases in lifestyle risk factors, making many suggestions to reshape services around prevention.

2.26 The Welsh Government's NHS Planning Framework 2024-27 refers health boards to the Science Evidence Advice, explaining that it expects to see evidence of prevention in health boards plans. However, the Welsh Government does not go further in encouraging and leading health boards to develop local preventative initiatives.

2.27 Preventing cancer would also reduce demand on NHS capacity. **Exhibit 21** sets in crude terms what impact a 10%, 20% and 38% reduction in cancer cases could have, based on 2022-23 activity levels. The potential annual financial savings from the reduction in bed days would be in the order of £8.2 million to £31.4 million[56]. There could also be significant savings from reducing outpatient appointments and drugs costs. However, there would also be costs associated with activity to prevent cancer.

54 World Health Organisation, Health Topics – Cancer Prevention.

55 Welsh Government, Science Evidence Advice – NHS in 10+ Years – An Examination of the Projected Impact of Long-Term Conditions and Risk Factors in Wales', September 2023.

56 Savings calculation based on £500 per day cost of an NHS bed in Wales.

**Exhibit 21: potential capacity gains associated with preventing cancer occurring in the first place based on 2022-23 activity**

| | | | | |
|---|---|---|---|---|
| **2022-23** | **90,532** finished consultant episodes | **84,583** admission episodes | **164,971** bed days | **10,864** regular attenders* |
| **-10%** | **81,479** finished consultant episodes (9,053 reduction) | **76,125** admission episodes (8,458 reduction) | **148,474** bed days (16,497 reduction) | **9,778** regular attenders (1,086 reduction) |
| **-20%** | **72,426** finished consultant episodes (18,106 reduction) | **67,666** admission episodes (16,917 reduction) | **131,977** bed days (32,994 reduction) | **8,691** regular attenders (2,173 reduction) |
| **-38%** | **56,130** finished consultant episodes (34,402 reduction) | **52,441** admission episodes (32,142 reduction) | **102,282** bed days (62,689 reduction) | **6,736** regular attenders (4,128 reduction) |

Source: Audit Wales analysis of DHCW data from the Patient Episode Database for Wales, Headline Figures and Primary Diagnosis Datasets, Welsh Providers

Note:

*Our analysis is indicative of potential capacity gains based on averages. We calculated potential gains associated with a 38% reduction in activity based on the assertion in the Cancer Improvement Plan that 38% of cancers each year are preventable.

*Regular attenders are patients who are admitted to hospital on a regular basis to receive treatment.

2.28 Despite compelling evidence and it being a long-standing ambition, the Welsh Government has yet to translate broader aims on prevention into more concrete and cohesive policy approaches aimed at shifting the balance of care towards prevention (**recommendation 4**). In particular:

- it has never set out a clear, over-arching strategic approach to achieving this shift across the many public sector bodies whose priorities, choices and behaviours would need to change;
- it has a piecemeal approach with individual strategies on healthy weight and tobacco control[57] but no plan related to the health impacts of alcohol use; and
- the Future Generations Commissioner, amongst others, criticised the Welsh Government for cutting its preventative health improvement budgets in 2024-25[58].

## There are gaps in the availability and quality of data to understand how well cancer care is being provided

2.29 Good quality data is essential for the planning, delivery and improvement of cancer care. The NHS Executive has improved the timeliness and accessibility of performance data in an unpublished interactive dashboard used by health boards, the Executive, and the Welsh Government. DHCW publishes a different Suspected Cancer Pathway Dashboard with less detailed information[59].

2.30 However, there are gaps in published data right across the patient pathway (**Exhibit 22**). The Welsh Government publishes data on 'closed' pathways showing how many patients were treated within 62 days but does not publish 'open' pathway waits to show how many patients are currently waiting for treatment.

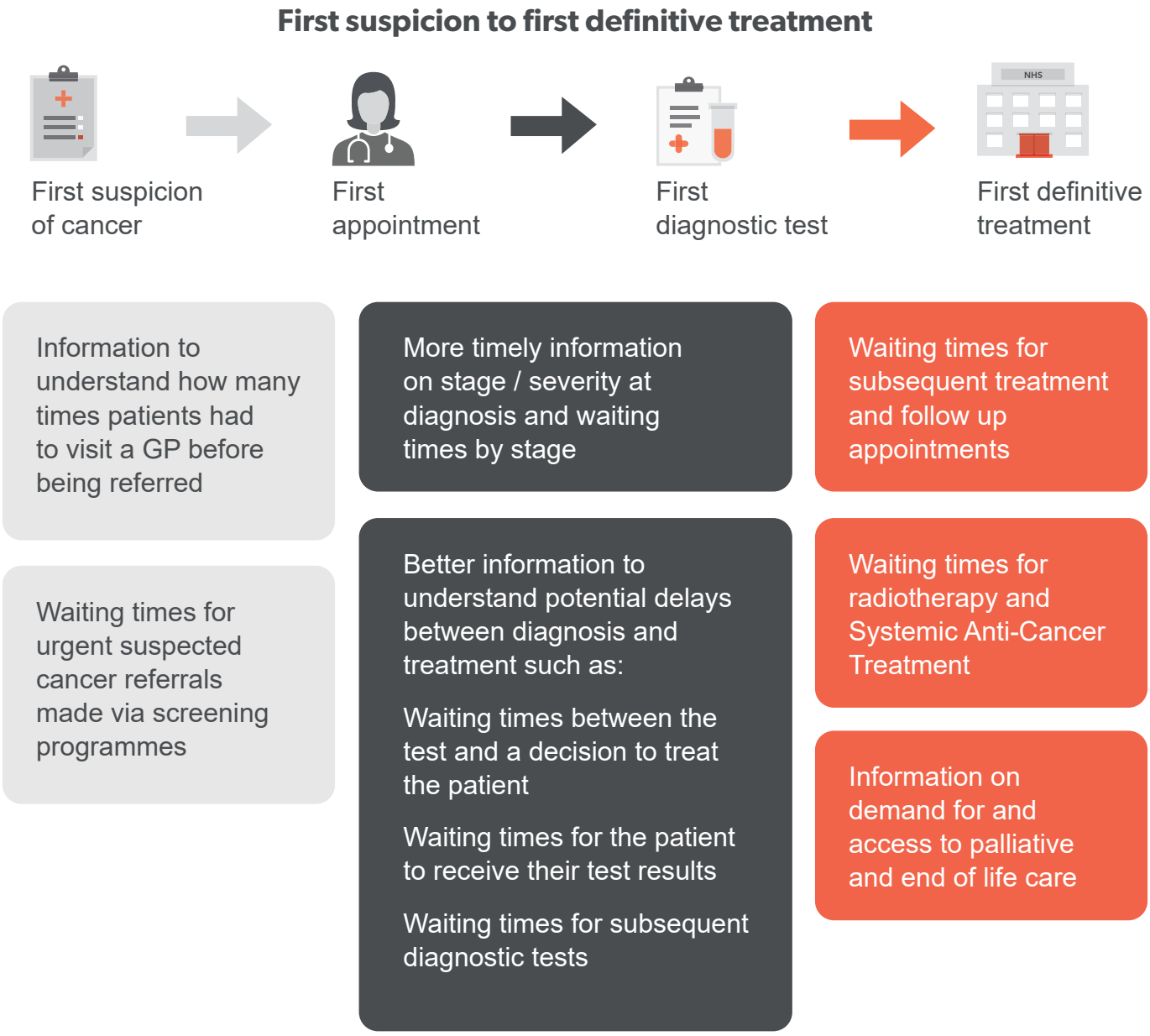
2.31 Much of the available data focusses narrowly on the period between referral and diagnosis or first treatment. There is no national data on the activity and timeliness leading up to a referral. There is also no available data on activity after the first treatment starts (see **paragraph 1.6**), including follow-up tests, ongoing treatment and access to palliative and end-of-life care (**recommendation 9**).

57 Welsh Government, Healthy Weight Healthy Wales, 2019 and Welsh Government, A Smoke Free Wales – Our Long-term Tobacco Control Strategy, 2022.

58 The budget for health improvement and healthy living reduced by £3.8 million bringing the total budget to £10.8 million; the substance misuse action plan fund by £2.5 million bringing the total budget to £47.5 million); and the health promotion budget fell by £710,000 to £12.2 million.

59 DHCW's dashboard uses data which has been validated to identify errors but the internal NHS Executive dashboard is unvalidated performance data.

**Exhibit 22: gaps in data at different stages of the cancer pathway**




Source: Audit Wales

2.32 There is very limited data to track progress against the ambitions in the Quality Statement. Against the overarching ambition of prevention and early detection, we found limited information on the causes of growing demand that can be used to prevent or detect cancer early amongst those most at risk. For instance, little is known about why some people are presenting at a more advanced stage, or as an emergency. There is also limited information about the demographic profile and location of people with unhealthy lifestyles. A new project led by WCISU has the potential to improve national intelligence on cancer risk factors. It will link Cancer Registry data to Census 2021 information via the SAIL databank to explore the influence of factors like ethnicity, income and educational status on cancer outcomes[60].

2.33 There is also very limited information to understand how equitable cancer support services are. For example:

- the Welsh Government requires heath boards to record the ethnicity of cancer patients[61] but compliance is extremely low. We were unable to analyse waiting list and timeliness trends by ethnicity because over two thirds of the pathways had no information on patient ethnicity.
- DHCW reports performance against the 62-day target by sex but there is little information to understand patient experience and outcomes by sex. The Senedd inquiry into gynaecological cancers found that women can experience many barriers to accessing cancer treatment but there is little information to understand how many women are affected[62].
- there is insufficient public data to understand potential differences in the timeliness of cancer diagnosis and treatment across Wales, particularly for people living in Powys. Timeliness data for Powys residents treated by other Welsh health boards is included in data for those health boards. The data is not disaggregated to show timeliness for Powys residents or the residents of the health board providing treatment[63]. There is also a lack of data on Welsh patients from any health board who are treated by NHS England (**recommendation 10**).
- there is also little information to understand equity of provision for children and young people. DHCW groups all data for under 30-year-olds together in the Suspected Cancer Dashboard data whereas other patients are grouped ten-year age bands. Under 16-year-olds are excluded from the Macmillan cancer patient experience survey.

60 The project aims to report its findings in late 2024.

61 Under Data Standards Change Notices from 2020 onwards (DCSN 2020/21 and DSCN 23/45). The Notices mandate compliance with data standards.

62 Welsh Parliament Health and Social Care Committee, Unheard: Women's Journey Through Gynaecological Cancer, December 2023.

63 Other published NHS Wales data does include distinct health board 'residence' and 'provider' performance data. For instance the Referral for Treatment data on StatsWales.

2.34 There are problems with the quality of some of the available data. WCISU officials told us Wales is a year behind England in publishing Cancer Registry data because a high volume of errors in the source data is creating extra work for its staff. NHS bodies told us that poor compliance with data standards by NHS staff inputting patient information is creating data errors. We found that there is confusion around who is responsible for improving compliance (**recommendation 8**). We have not specifically reviewed data quality as part of this review but have uncovered several inaccuracies in published data and bespoke analysis provided by DHCW.

## Digital systems are fragmented and progress implementing the new cancer information system has been slow

2.35 Progress in updating the core digital system for cancer patients has been extremely slow. The previous system (Canisc) was constructed using a programming language in 1997 which Microsoft stopped supporting in 2014. Following our 2018 report on NHS Wales informatics systems[64], the Senedd Public Accounts Committee inquiry raised serious concerns about slow progress replacing Canisc[65]. It took a further five years to implement the first phase of the new cancer information system. DHCW told us that the pandemic has added to delays. The Welsh Government has recently confirmed funding for the second phase of the programme, aimed at improving integration and digital processes and dealing with requests for specific changes from individual NHS bodies.

2.36 More broadly, NHS bodies told us that lack of integrated digital systems is consuming valuable staff time because they are using manual 'workarounds' to transfer patients across the different patient administration systems. The process is frustrating staff and diverting their time from seeing patients. It also carries risks to patient safety because details could be transferred incorrectly or not at all. DHCW is responsible for delivering national digital systems for NHS Wales but not their local configuration. DHCW described considerable barriers to getting those systems to join up. In particular, there are numerous examples of NHS bodies either procuring their own digital systems rather than using the national products, or adapting the national products which limits interoperability.

2.37 The Cancer Improvement Plan committed PHW, the Cancer Network and DHCW to developing a cancer version of the national Digital and Data Strategy for Wales by the end of June 2023. No such plan had been created at the time of our review and we found confusion about the commitment to create one in the first place. DHCW told us there is no need to create a separate digital cancer plan because the overarching Digital and Data Strategy sets out the system wide approach to improve digital provision.

64 Wales Audit Office, Informatics Systems in NHS Wales, 2018.

65 National Assembly for Wales Public Accounts Committee, Informatics Systems in NHS Wales, 2018.

# Appendices

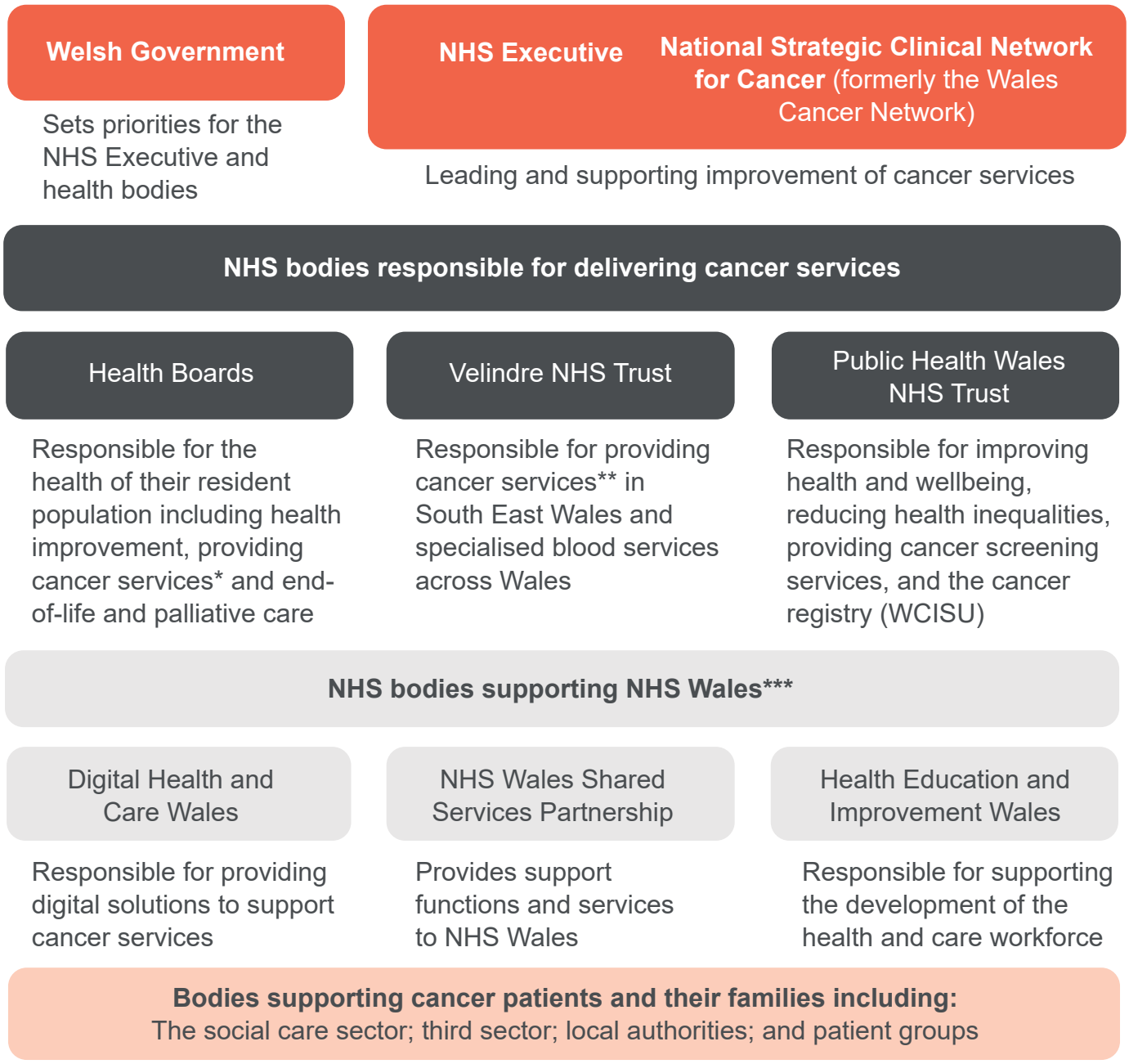
1 Strategic context

2 Additional data analysis

3 About our work

# 1 Strategic context

**Exhibit 23: broad roles and responsibilities for cancer services in Wales**



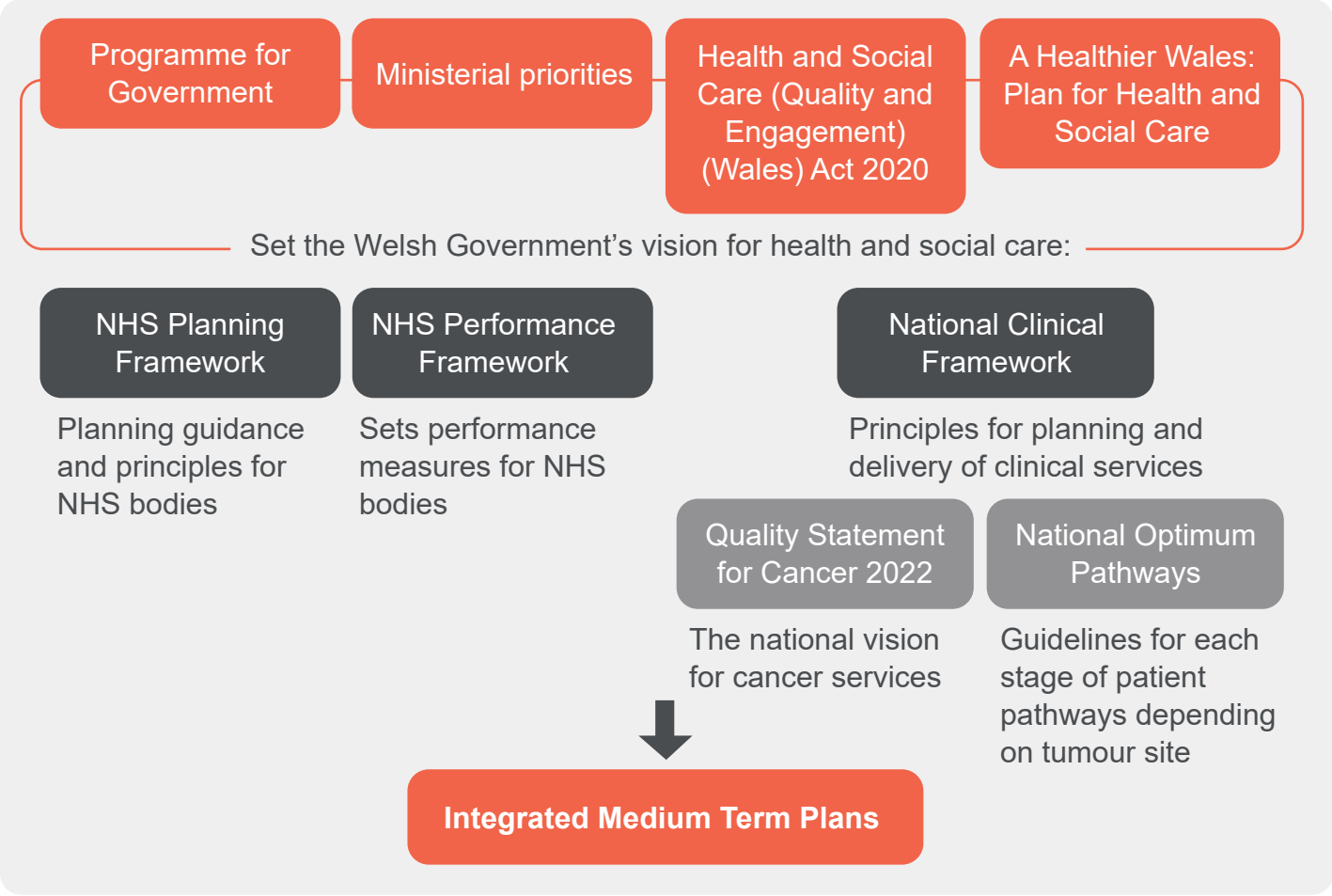

Source: Audit Wales

Note:

*Including diagnostic tests; treatment; and support and advice for patients. The level and type of services provided differs between health boards because some services are provided by other healthcare providers. For instance, Powys Teaching Health Board provides some diagnostic services but commissions other cancer services from other NHS providers in England and Wales.

**Including chemotherapy; radiotherapy; and support and advice for patients.
***There are also organisations and groups responsible for research, development and innovation including: Geonomics Partnership Wales; Health and Care Research Wales; Life Sciences Hub Wales; and the Wales Cancer Research Centre.

**Exhibit 24: key elements of the strategic approach to cancer services in Wales**




Wales Cancer Network: Cancer Improvement Plan 2023

A collective plan for NHS Wales to improve services for cancer patients

NHS Executive: National Cancer Recovery Programme 2024

National programme to improve cancer services

Life Sciences Hub Wales: Cancer: Improving Outcomes Initiative

A Welsh Government commissioned programme, aimed at delivering innovation at pace.

**Broader Welsh Government Strategy including:**

Diagnostics, Recovery and Transformation Strategy for Wales 2023-25

Digital and Data Strategy for Health and Social Care in Wales 2023

National Workforce Implementation Plan: Addressing NHS Wales Workforce Challenges 2023 and A Healthier Wales: Our Workforce Strategy for the Health and Social Care Workforce, 2020 (commissioned by the Welsh Government from Health Education and Improvement Wales)

Healthy Weight, Healthy Wales, 2019 including a 2022 to 2024 delivery plan

A smoke-free Wales: Long-term tobacco control strategy, 2022 including a 2022 to 2024 delivery plan

Source: Audit Wales

# 2 Additional data analysis

## Data on demand for cancer services

**Exhibit 25: Patients who were treated by source of suspicion, monthly average across 2023-24**

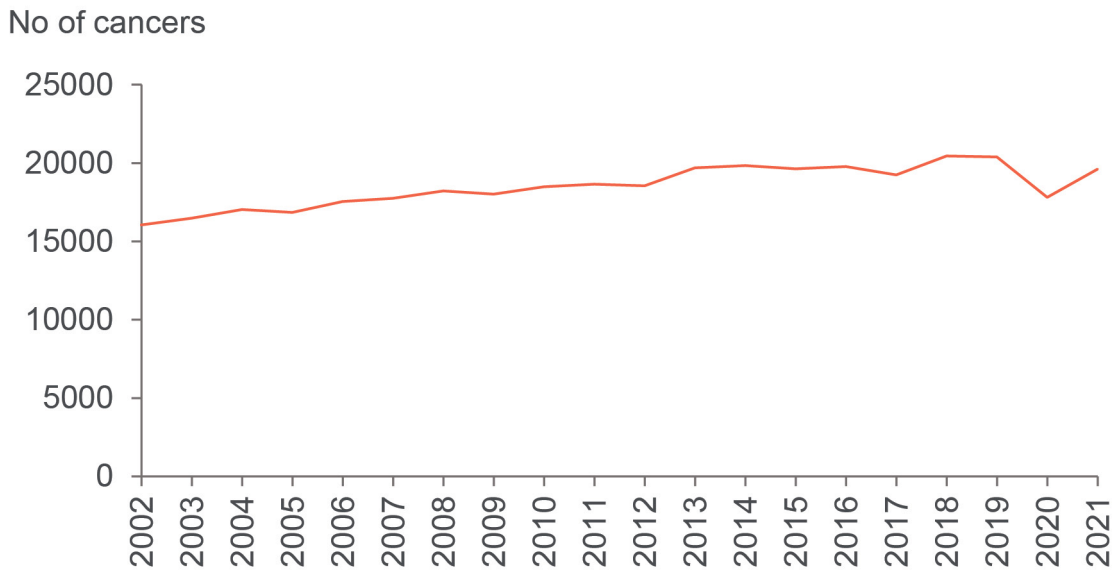
| Source of suspicion / referral | % overall suspected cancer referrals | % of patients starting treatment as a proportion of referrals by source of suspicion |
|---|---|---|
| **GP** | **80%** (12,635 people) | **8% of GP referrals** (975 people) |
| **Internal secondary care** | **10%** (1,570 people) | **17% of internal secondary care referrals** (266 people) |
| **Following a diagnostic test** | **6%** (911 people) | **37% of referrals following a diagnostic test** (341 people) |
| **Bowel screening** | **1%** (120 people) | **28% of bowel screening referrals** (33 people) |
| **Breast screening** | **1%** (106 people) | **92% of breast screening referrals** (98 people) |
| **Cervical screening** | **<1%*** | **50% of cervical screening referrals*** |
| **Emergency department** | **1%** (214 people) | **38% of emergency department referrals** (81 people) |
| **Other primary care professional** | **1%** (120 people) | **5% of referrals from other primary care professionals*** |
| **Other health professional** | **<1%** (66 people) | **15% of referrals from other health professionals*** |
| **Consultant from another health board** | **<1%** (38 people) | **21% of referrals from external consultants*** |

Source: Audit Wales analysis of DHCW Suspected Cancer Pathway Data – closed pathways by source of suspicion.

Note: A small number of patient pathways did not have data on the source of suspicion / referral.

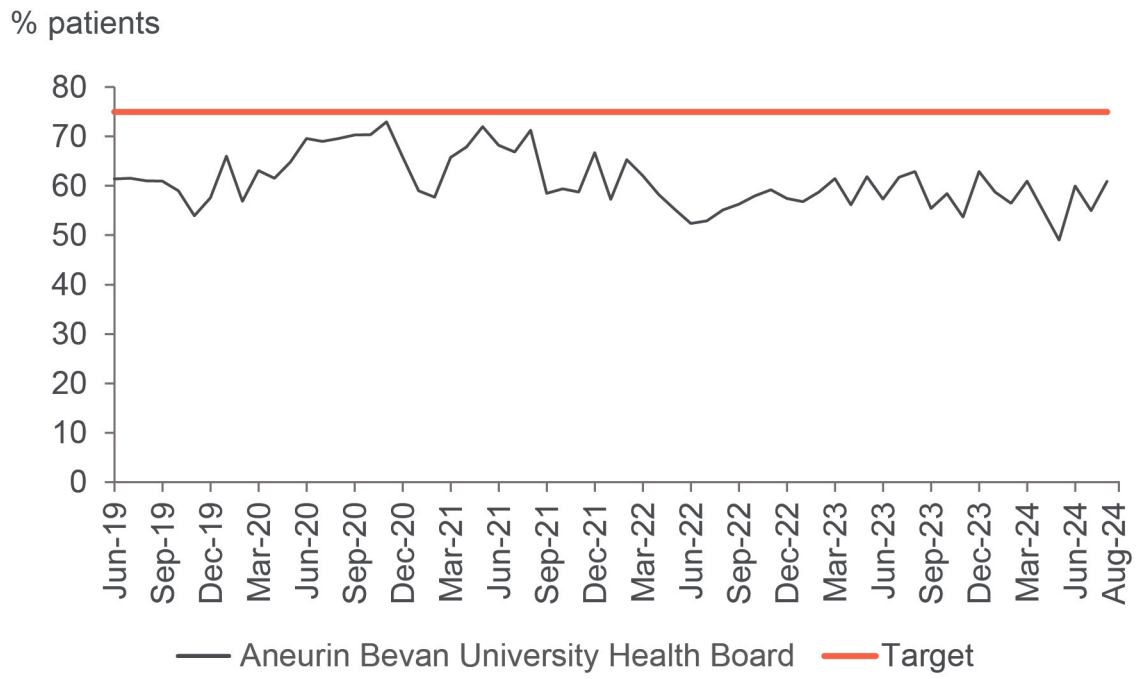
*Where there are 10 people or less.

**Exhibit 26: number of newly diagnosed cancers in Wales (excluding non-melanoma skin cancer), 2002-2021**



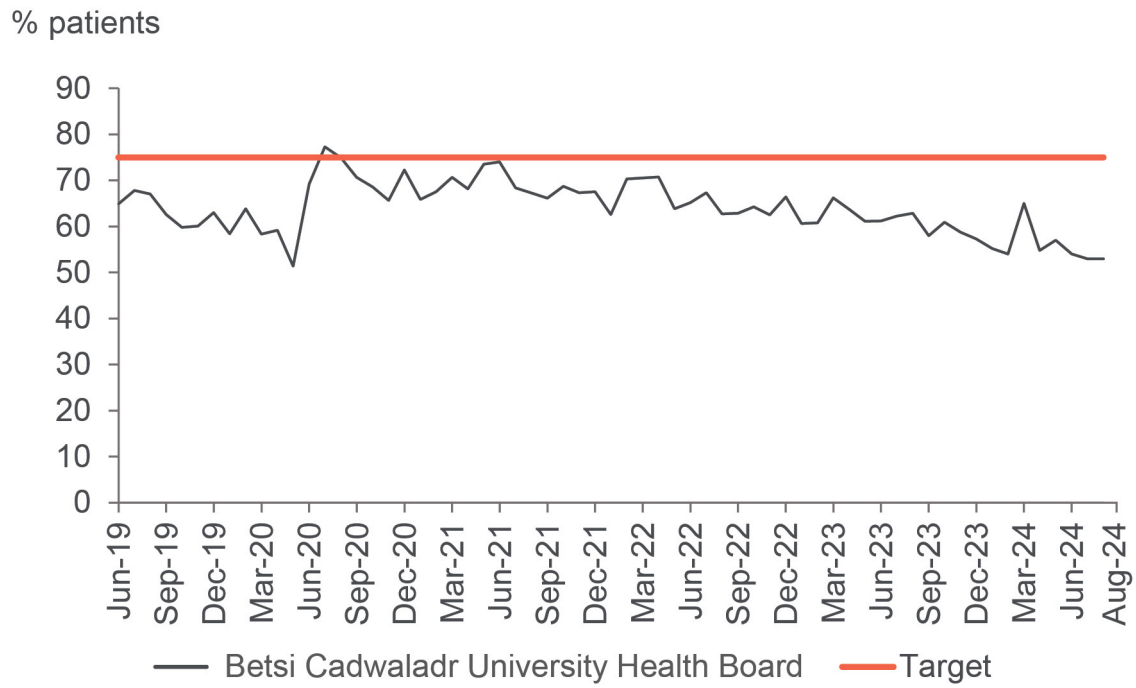

Source: WCISU cancer incidence data

**Exhibit 27a: performance against the 62-day target by Aneurin Bevan University Health Board, June 2019 to August 2024**



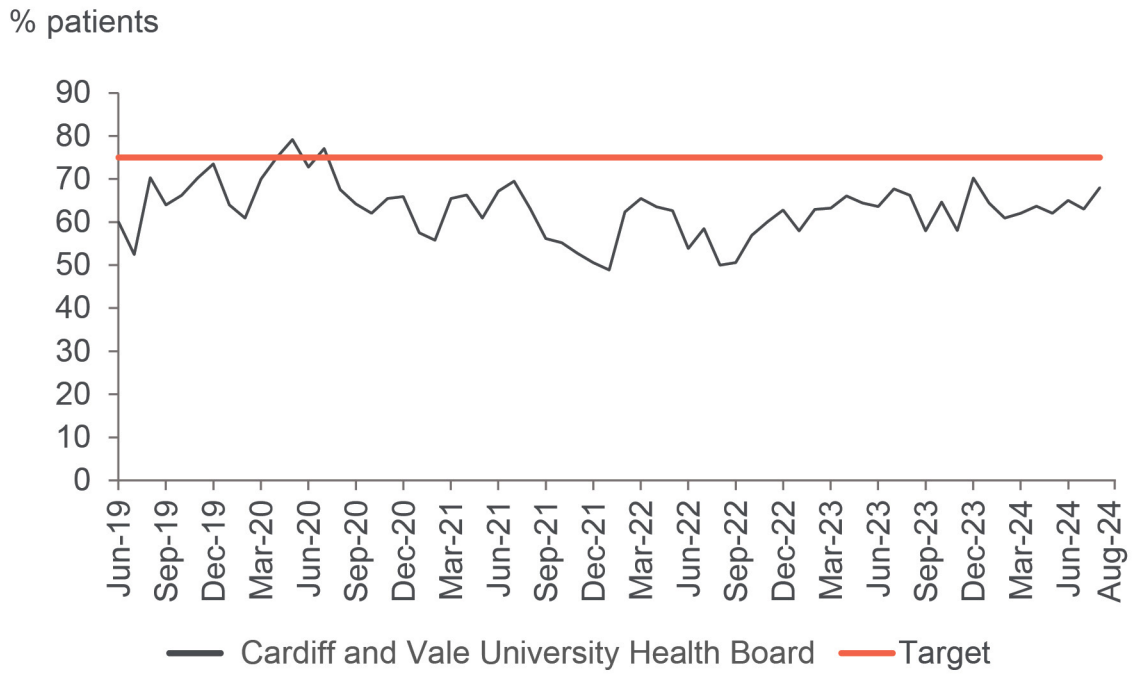

Source: DHCW, Suspected Cancer Pathway – Closed Pathways dataset, on StatsWales.

**Exhibit 27b: performance against the 62-day target by Betsi Cadwalladr University Health Board, June 2019 to August 2024**



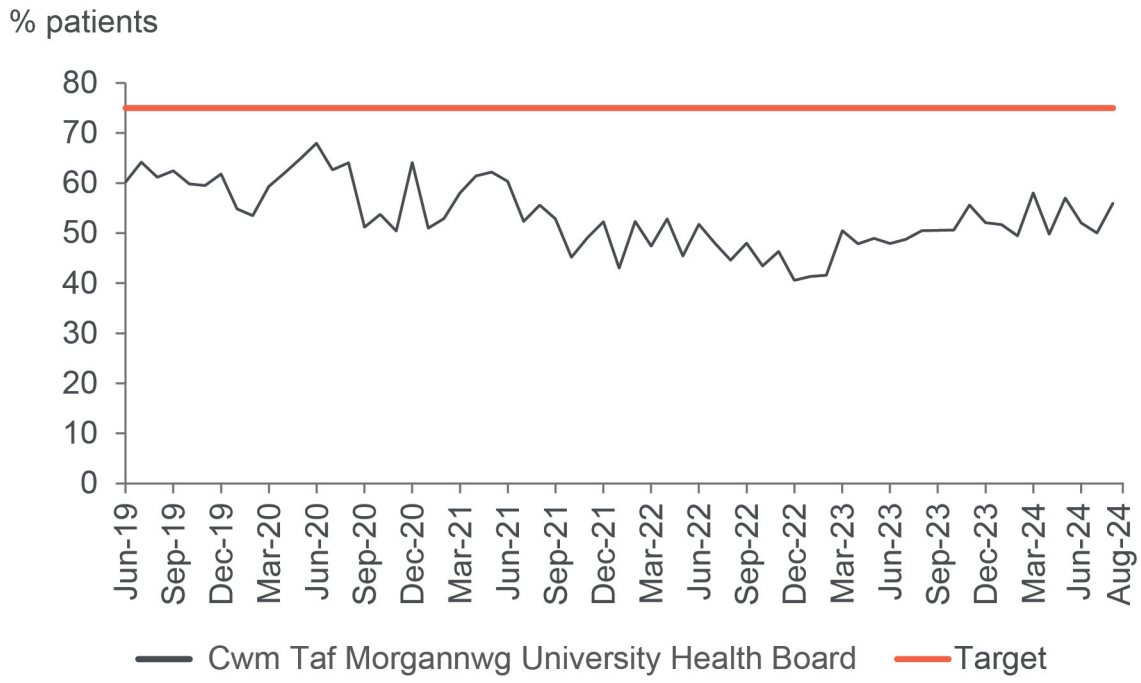

Source: DHCW, Suspected Cancer Pathway – Closed Pathways, on StatsWales.

**Exhibit 27c: performance against the 62-day target by Cardiff and Vale University Health Board, June 2019 to August 2024**



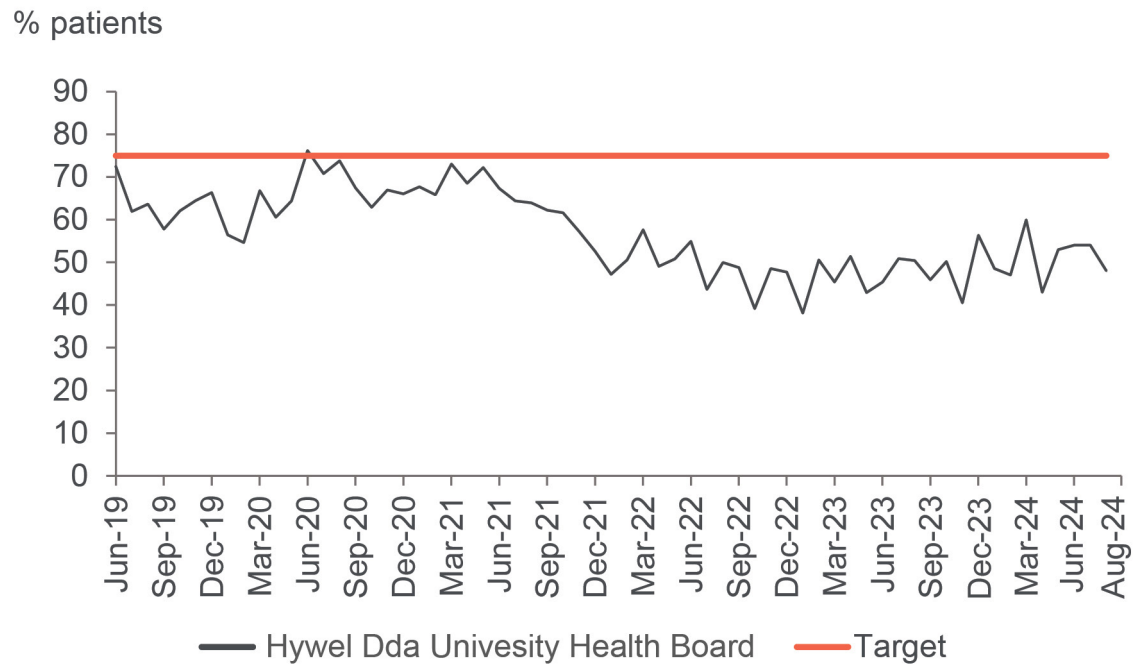

Source: DHCW, Suspected Cancer Pathway – Closed Pathways dataset, On StatsWales.

**Exhibit 27d: performance against the 62-day target by Cwm Taf Bro Morgannwg University Health Board, June 2019 to August 2024**



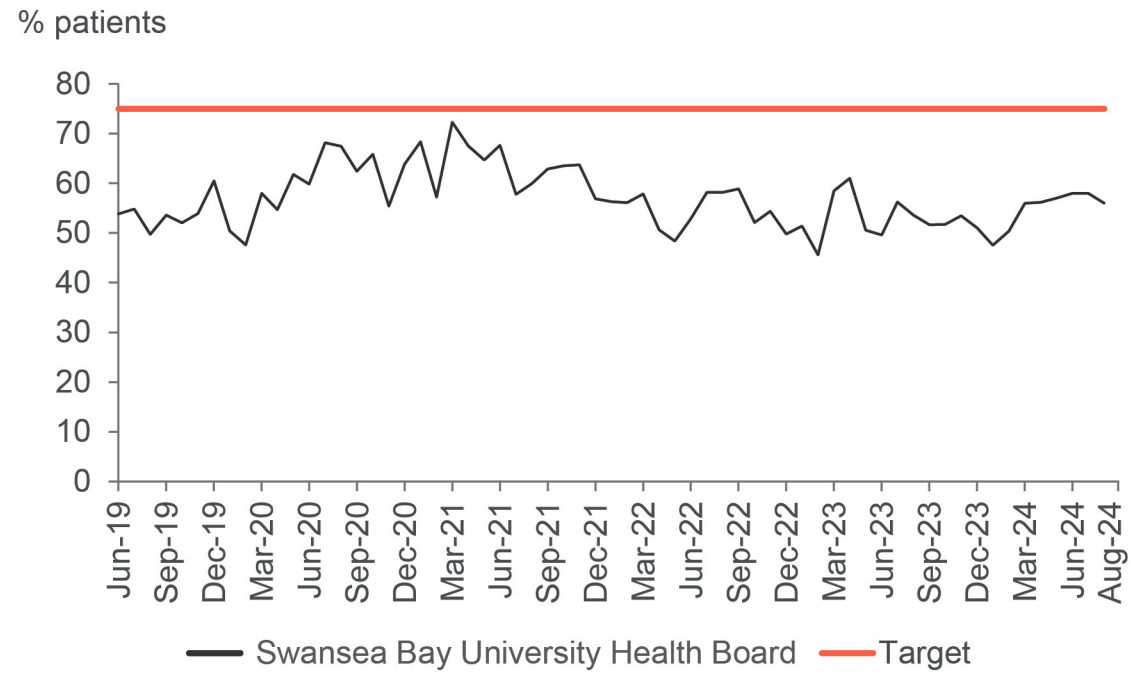

Source: DHCW, Suspected Cancer Pathway – Closed Pathways dataset, on StatsWales.

**Exhibit 27e: performance against the 62-day target by Hywel Dda University Health Board, June 2019 to August 2024**



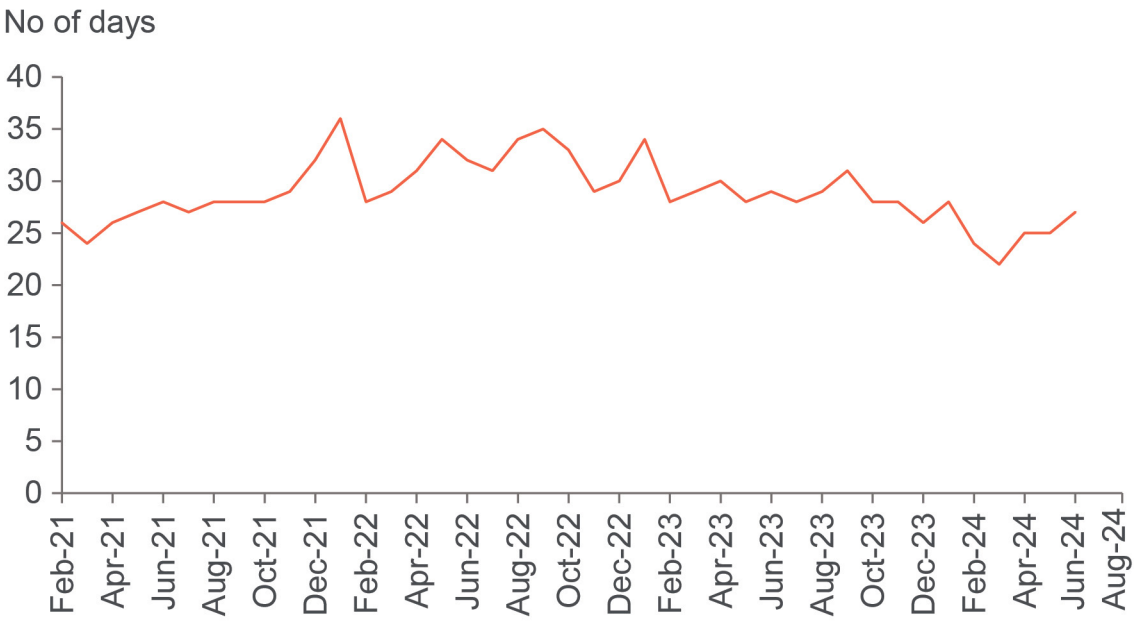

Source: DHCW, Suspected Cancer Pathway – Closed Pathways dataset, on StatsWales.

**Exhibit 27f: performance against the 62-day target by Swansea Bay University Health Board, June 2019 to August 2024**




Source: DHCW, Suspected Cancer Pathway – Closed Pathways dataset, on StatsWales.

**Exhibit 28: median waits from first suspicion to diagnosis, February 2021 to August 2024**




Source: DHCW data from the Suspected Cancer Pathway Dashboard

# 3 About our work

## Audit question, scope and criteria

We chose to focus on the national strategic approach to improving the timeliness of cancer diagnosis and treatment because we identified significant systemic challenges facing cancer services during our scoping. This review focuses on the Welsh Government and NHS Executive (and its National Strategic Clinical Network for Cancer) as system leaders, recognising that health boards and trusts have responsibility for the operational delivery of different aspects of cancer services. We will consider the merits of further work focusing on NHS bodies' approach to delivering cancer services in our 2025-26 work programme.

We developed our audit criteria based on learning from our previous audits of planned care[66] and local health audit work, analysis of key strategic documents[67], and research from relevant organisations on the challenges associated with cancer services in Wales.

66 Audit Wales, NHS Wales Waiting Times for Elective Care in Wales, 2015; Audit Wales, 10 Opportunities for Resetting and Restarting the NHS Planned Care System, 2020; and Audit Wales, Tackling the Planned Care Backlog in Wales, 2022.

67 Including Welsh Government, A Healthier Wales – a Long Term Plan for Health and Social Care, 2021; Welsh Government, Our Programme for Transforming and Modernising Planned Care and Reducing Waiting Lists in Wales, 2022, Welsh Government, The Quality Statement for Cancer, 2022, Welsh Government, Diagnostics Recovery and Transformation Strategy for Wales 2023 to 2025; and the National Strategic Clinical Network for Cancer, A Cancer Improvement Plan for NHS Wales 2023-26, 2023.

# Audit methods

## Document review

We reviewed relevant documentation including:

- documents setting out the national strategic approach. Key documents include the Quality Statement for Cancer, Cancer Improvement Plan, the Diagnostic Recovery and Transformation Strategy, National Clinical Framework, National Optimal Pathways and NHS planning and performance frameworks
- documents relating to the NHS Executive's national cancer recovery programme
- individual NHS body plans setting out their approach to delivering cancer services, and relevant board and committee papers on cancer performance
- papers from the Welsh Government's performance management meetings
- Public Health Wales NHS Trust information on the delivery of population screening servicesinformation on cancer data and population health including reports from the Welsh Cancer Surveillance and Intelligence Unit and the Welsh Government's Science Evidence Advice[68]
- the Senedd Health and Social Care Committee's report on its inquiry on gynaecological cancers[69] and supporting evidence

## Semi-structured interviews

We interviewed officials from the following organisations:

- the Welsh Government;
- the NHS Executive including its National Strategic Clinical Network for Cancer;
- a sample of health boards including officials from Betsi Cadwaladr, Hywel Dda and Swansea Bay University Health Boards, and Powys Teach Health Board;
- officials from other NHS bodies including Digital Health and Care Wales, Health Education and Improvement Wales, Public Health Wales and Velindre NHS Trusts; and
- we also met with officials from the NHS Executive, Cardiff and Vale, Hywel Dda and Swansea Bay University Health Boards to inform our scoping.

68 Welsh Government, Science Evidence Advice – NHS in 10+ Years – An Examination of the Projected Impact of Long-Term Conditions and Risk Factors in Wales', September 2023.

69 Welsh Parliament Health and Social Care Committee, Unheard: Women's Journey Through Gynaecological Cancer, December 2023.

## Workshop with third sector representatives

We held a workshop with representatives from the third sector on 1st May 2024 organised by the Wales Cancer Alliance[70]. We asked participants for their views of the strengths and weaknesses of the national strategic approach and invited further written responses with more detail on the same topic. We conducted follow-up interviews with some organisations for clarification where necessary. Representatives from the organisations below took part in the workshop:

- ALK Positive UK
- Association of the British Pharmaceutical Industry
- Blood Cancer UK
- Bowel Cancer UK
- Breast Cancer Now
- Cancer Research UK
- Fair Treatment for the Women of Wales
- Leukaemia Care
- MacMillan Cancer Support
- Marie Curie
- Prostate Cancer UK
- Royal College of Pathologists
- Royal College of Paediatrics and Child Health
- Royal College of Physicians
- Tenovus Cancer Care
- Young Lives vs Cancer
- We established an expert panel to inform our understanding of the systemic barriers to the timeliness of cancer diagnosis and treatment and provide critical challenge on our findings. The panel included representatives from Marie Curie, the Association of the British Pharmaceutical Industry, the Royal College of Physicians, and the Wales Cancer Alliance.

70 A coalition of charities working to prevent cancer, improve care, fund research and influence policy in Wales.

## Data analysis

We reviewed data from different sources including:

- DHCW published data on open and closed cancer pathways, on StatsWales;
- DHCW published data on hospital admissions. We also requested data on discharge destinations of cancer patients admitted to hospital;
- we requested data from the Suspected Cancer Pathway dataset managed by DHCW that is not published elsewhere. We analysed data on performance against the Suspected Cancer Pathway target by ethnicity; source of suspicion ; and closed pathways by whether patients started treatment for cancer, were downgraded for not having cancer, or died before being downgraded or starting treatment; and
- Welsh Cancer Surveillance and Intelligence Unit data on cancer incidence, mortality and survival.

Archwilio Cymru
Audit Wales

Audit Wales
1 Capital Quarter (ground & first)
Tyndall Street
Cardiff CF10 4BZ

Tel: 029 2032 0500

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.

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

# Management response form

**Report title:** Cancer Services in Wales: A review of the strategic approach to improving the timeliness of diagnosis and treatment

**Completion date:** 14/01/25

| Ref | Recommendation | Management response<br>Please set out here relevant commentary on the planned actions in response to the recommendations | Completion date<br>Please set out by when the planned actions will be complete | Responsible officer (title) |
|---|---|---|---|---|
| R1 | The Welsh Government should publicly clarify the status of the Cancer Improvement Plan and its links to the National Cancer Recovery Programme and the Cancer: Improving Outcomes initiative. As part of this the Welsh Government should clarify how it intends to hold NHS bodies to account for delivery of the Cancer Improvement Plan. | Accept.<br><br>The Welsh Government will update the Quality Statement for Cancer to clarify the respective roles of the Cancer Recovery Programme, Cancer improvement Plan, and other important national work streams such as the Making it Happen initiative. This will include a description of accountability arrangements. | End quarter 1 2025-26 | Sue Tranka<br><br>Chief Nursing Officer |
| R2 | The Welsh Government should set out a coherent model for system leadership in respect of cancer services that clarifies its own role and that of the NHS Executive and sets out how it will bring on board clinicians and other key stakeholders to build a common view of | Accept.<br><br>The Welsh Government is in the process of finalising a revised governance and leadership model for cancer service development. This will include the introduction of a National Cancer Leadership Board | End quarter 4 2024-25 | Nick Wood<br><br>Deputy Chief Executive, NHS Wales |

| Ref | Recommendation | Management response<br>Please set out here relevant commentary on the planned actions in response to the recommendations | Completion date<br>Please set out by when the planned actions will be complete | Responsible officer (title) |
|---|---|---|---|---|
| | cancer service performance, quality and opportunities for improvement. | that will coordinate or lead on national actions. The NHS Executive will provide the clinical, third sector, and private sector input to its work. This model will continue to develop in response to the feedback of those directly involved and those involved through related leadership groups. These arrangements will be described in the updated Quality Statement for Cancer. | | |
| R3 | The Welsh Government should review its oversight and performance framework in respect of cancer services to focus on a broader range of issues, including a more explicit alignment to the ambitions and quality attributes set out in the Quality Statement for Cancer. | Accept.<br><br>The NHS Performance Framework only includes the top-level strategic metrics for the NHS; it does not include all the metrics that are routinely applied in accountability processes. There are a broader set of metrics which sit outside the Framework. This includes component waits in the cancer pathway, access to treatment measures, data on care quality and outcome, screening and immunisation uptake, and patient outcomes. The broader set of metrics | End quarter 1 2025-26 | Jeremy Griffith<br><br>Director of Operations |

| Ref | Recommendation | Management response<br>Please set out here relevant commentary on the planned actions in response to the recommendations | Completion date<br>Please set out by when the planned actions will be complete | Responsible officer (title) |
|---|---|---|---|---|
| | | are used as part of routine accountability process as required. The updated Quality Statement for Cancer will include additional detail to explain how cancer service delivery will be measured. | | |
| R4 | The Welsh Government should develop a more coherent approach to population health improvement by setting out how it intends to use its Science Evidence Advice: NHS in 10+ Years to harness the opportunities associated with prevention to reduce the incidence of cancer and other major conditions. | The Welsh Government pursues an evidence-led approach to prevention and to reducing population-level risk for cancer and major conditions. There are established programmes for smoking prevention through the Smoke Free Wales Strategy and Tobacco Control Delivery Plan (with additional supportive legislation imminent) and on tackling overweight and obesity, through the Healthy Weight Healthy Wales strategy and delivery plan, including through the facilitation of physical activity. These programmes are under constant review and development as new evidence and technologies emerge.<br><br>The NHS Planning Framework for 2025-28 has population health and prevention as one of the five | Establishment of preventing ill-health advisory group by end quarter 1 2025-26 | Sioned Rees<br><br>Director for Public Health Protection |

| Ref | Recommendation | Management response<br>Please set out here relevant commentary on the planned actions in response to the recommendations | Completion date<br>Please set out by when the planned actions will be complete | Responsible officer (title) |
|---|---|---|---|---|
| | | priority areas and this will support a further drive and focus on primary, secondary and tertiary prevention interventions in the plans of NHS organisations.<br><br>We are also in the process of establishing a preventing ill-health advisory group under the Chief Medical Officer to support and harness opportunities to implement sustainable, evidence informed policies that focus on preventing ill-health and related inequalities. The initial focus will be on securing and measuring funding of ill-health prevention, strengthening the current architecture, progressing work on data, and supporting the cross-government role in prevention of ill-health. The establishment of this group will assist in providing sustained engagement and a coherent, coordinated approach to the development of appropriate policy and system responses. | | |

| Ref | Recommendation | Management response<br>Please set out here relevant commentary on the planned actions in response to the recommendations | Completion date<br>Please set out by when the planned actions will be complete | Responsible officer (title) |
|---|---|---|---|---|
| R5 | The Welsh Government should work with Public Health Wales to accelerate decision making for a national lung screening programme. It should clarify as soon as possible whether it will fund national lung screening for Wales and the timescale for implementing such a programme. | Accept.<br><br>The Welsh Government has asked Public Health Wales to accelerate its work on scoping lung screening to permit a decision by Welsh Ministers on its introduction and funding. Public Health Wales is due to provide an interim report by end of March and a final report by end of September to permit Welsh Ministers to make a decision on introducing a national lung screening programme. | End quarter 2 2025-26 | Sioned Rees<br><br>Director for Public Health Protection |
| R6 | As part of a wider approach to encourage greater regional working between health boards, the Welsh Government and the NHS Executive should work with the service to understand and help address any key barriers to delivering regional services. This should include working with DHCW to identify digital solutions to support shared waiting lists for | Accept.<br><br>The Welsh Government will work with NHS organisations to support regional working for services, where appropriate, to address service fragility. This will include working with Digital Health and Care Wales on the development of digital solutions to permit shared waiting lists. | Ongoing | Mike Emery<br><br>Chief Digital Officer |

| Ref | Recommendation | Management response<br>Please set out here relevant commentary on the planned actions in response to the recommendations | Completion date<br>Please set out by when the planned actions will be complete | Responsible officer (title) |
|---|---|---|---|---|
| | cancer diagnosis and treatment, where it is appropriate to do so. | | | |
| R7 | The Welsh Government should work with the NHS Executive, HEIW and other NHS bodies to ensure there are employment opportunities for radiologists who have been trained in the National Imaging Academy. | Accept.<br><br>The Welsh Government will work with health boards in Wales, which are responsible for planning their workforce, to enable employment of Imaging Academy graduates in line with local or regional workforce needs. | Quarter 2 2025-26 | Helen Arthur<br><br>Director of Workforce and Government Business |
| R8 | The Welsh Government should clarify national roles and responsibilities for monitoring and ensuring compliance with its data standards including how it will hold NHS bodies to account for poor compliance. | Accept.<br><br>Digital Health and Care Wales develop and design data standards, including minimum data sets for NHS Wales. DHCW advises the Welsh Government on what should be included and how they should be collected. Only the Welsh Government can mandate | Quarter 3 2025-26 | Mike Emery<br><br>Chief Digital Officer |

| Ref | Recommendation | Management response<br>Please set out here relevant commentary on the planned actions in response to the recommendations | Completion date<br>Please set out by when the planned actions will be complete | Responsible officer (title) |
|---|---|---|---|---|
| | | requirements through national policy, planning guidance or Welsh Health Circulars. To ensure compliance, the Welsh Government expects organisations to audit themselves against the standards and DHCW to deliver a quality assurance and review process. Regulatory bodies such as Audit Wales and Healthcare Inspectorate Wales also have a role in auditing organisations against national standards. DHCW and regulatory bodies should report to the Welsh Government any significant failure to comply with national data requirements, so that these can be addressed with NHS organisations through accountability processes and meetings. | | |
| R9 | The Welsh Government should work with the NHS Executive (particularly the Cancer Network), DHCW and Public Health Wales NHS Trust to develop a more comprehensive set of publicly available data on cancer services, which as a minimum should include: | Accept in principle.<br><br>The Welsh Government will develop a cancer data road map to improve the available data on cancer service delivery for use by the NHS, the Welsh Government, and the public. However, it may not be | Quarter 3 2025-26 | Mike Emery<br><br>Chief Digital Officer |

| Ref | Recommendation | Management response<br>Please set out here relevant commentary on the planned actions in response to the recommendations | Completion date<br>Please set out by when the planned actions will be complete | Responsible officer (title) |
|---|---|---|---|---|
| | • the number of people currently waiting for cancer diagnosis or treatment (open pathway data);<br>• Performance against the 62-day target for the health board providing diagnosis and treatment and health board of residence, including people living Powys Teaching Health Board area;<br>• Performance across the patient pathways including timeliness of diagnostic reporting across different tumour sites; timeliness from the decision to treat a patient to the start of that treatment (including surgery, radiotherapy and Systemic Anti-Cancer Therapy); and diagnosis and treatment of recurrent disease. Performance information should be provided at cancer sub-tumour level where possible;<br>• Timeliness of diagnosis and treatment for patients referred from the breast and cervical screening programmes; and | possible to provide all of this data to the public for reasons of data accuracy, reporting burden on NHS services, and patient confidentiality. In addition, the barriers to providing data on treatment in England must first be understood before commitments can be made to publishing this data, but we support the principle of doing so, subject to their further analysis. | | |

| Ref | Recommendation | Management response<br>Please set out here relevant commentary on the planned actions in response to the recommendations | Completion date<br>Please set out by when the planned actions will be complete | Responsible officer (title) |
|---|---|---|---|---|
| | • accurate information on equity of access, including ethnicity of cancer patients as well as the experiences of different patient groups (this should include children and young people). | | | |
| R10 | The Welsh Government should work with DHCW and NHS England to share regular and consistent data on the timeliness of diagnosis and treatment for Welsh cancer patients treated by NHS England. | Accept.<br><br>The Welsh Government will work with health boards, NHS England, and Digital Health and Care Wales to ensure relevant data on the diagnosis and treatment of Welsh residents seen in England is appropriately shared. | Quarter 4 2025-26 | Mike Emery<br><br>Chief Digital Officer |

Archwilio Cymru
Audit Wales

# Cwm Taf Morgannwg University Health Board – Detailed Audit Plan 2025

Audit year: 2024-25

Date issued: April 2025

Document reference: 4758A2025

# Contents


| | |
|---|---|
| Contents | 2 |
| Introduction | 4 |
| Our aims and ambitions | 6 |
| Financial audit work | 7 |
| Performance audit work | 17 |
| Audit fee | 22 |
| Audit team | 25 |
| Audit quality | 26 |
| Supporting you | 27 |

This document has been prepared as part of work performed in accordance with statutory functions.

The Auditor General, Wales Audit Office and staff of the Wales Audit Office accept no liability in respect of any reliance or other use of this document by any member, director, officer or other employee in their individual capacity, or any use by any third party.

mailto:For further information, or if you require any of our publications in an alternative format and/or language, please contact us by telephone on 029 2032 0500, or email info@audit.wales.

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.

# Introduction

**Adrian Crompton**

Auditor General for Wales

I am pleased to share my 2025 Audit Plan. The Plan sets out how I will undertake your audit.

My audit team has developed the Plan following a structured and risk-based planning process, which will remain ongoing throughout the audit. My Code of Audit Practice provides further detail on how my audit and certain other functions are to be carried out by my auditors.

At the core of all our work is our commitment to maintaining the highest standards of professional integrity, objectivity, independence and audit quality. Our three lines of assurance model (page 26) sets out how we will ensure those standards of quality are met. Our latest annual quality report, Audit Quality Report 2024, provides more information about our audit quality arrangements.

My audit team will work constructively with your staff to understand the issues you are facing, ensure the audit process operates as smoothly as possible, and provide valuable insights about any areas for improvement.

For this year of audit we are required to implement a new auditing standard on the audit of groups, which will see us adopting a more risk-based approach to that work. My team is currently considering the extent to which the new standard applies to the Health Board's hosted body arrangement.

My local performance audit work programme, as outlined in this Plan, sits alongside other national audit work that may include coverage of your organisation. Local performance audit work may also inform wider national reporting.

Should you have any questions about your audit, my audit team will be happy to discuss them with you. They will also keep you regularly updated as work progresses.

# Our aims and ambitions

## Our purpose

- Assure people that public money is being managed well
- Explain how that money is being spent
- Inspire the public sector to improve

## Our vision

- Fully exploiting our unique perspective, expertise and depth of insight
- Strengthening our position as an authoritative, trusted and independent voice
- Increasing our visibility, influence, and relevance
- Being a model organisation for the public sector in Wales and beyond

## Our areas of focus

- A strategic, dynamic, and high-quality audit programme
- A targeted and impactful approach to communications and influencing
- A culture and operating model that enables us to thrive

You can find out more about Audit Wales in our Annual Plan 2024-25 and Our Strategy 2022-27.

# Financial audit work

## Audit of financial statements

I am required to issue a report on your financial statements which includes an opinion on their 'truth and fairness', their proper preparation in accordance with accounting and legal requirements, and the regularity of income and expenditure and the proper preparation of key elements of your Accountability and Performance Report. I lay them before the Senedd together with any report that I make on them.

I will also report by exception on a number of matters which are set out in more detail in our Statement of Responsibilities.

I am also required to certify a return to the Welsh Government which provides information about the Health Board to support preparation of the Whole of Government Accounts.

There have been no limitations imposed on me in planning the scope of this audit.

## Financial statements materiality

I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material and correct misstatements, that is, those that might result in a reader of the accounts being misled. Materiality applies not only to financial misstatements, but also to disclosure requirements and adherence to the applicable accounting framework and law.

I set planning and performance materiality to:

- determine the level of misstatement that could cause the user of the accounts to be misled;
- assist in the scoping of our audit approach and resultant audit tests;
- determine sample sizes;
- assess the effect of known and likely misstatements in the financial statements; and

- report to those charged with governance any unadjusted misstatements above a trivial level, our reporting threshold.

The levels at which I judge such misstatements to be material is set out below.

**Planning materiality**

represents 0.62% of gross expenditure based upon 2023/24 audited financial statements.

**£15.56m**

**Performance materiality**

represents 75% of materiality.

**£11.67m**

**Reporting threshold (trivial)**

represents 5% of materiality.

**£0.78m**

There are some areas of the accounts that may be of more importance to the user of the accounts, and we have set a lower materiality level for them:

| Remuneration report[1] | Related party disclosures |
| --- | --- |
| £1,000 | £10,000 (individuals)<br>£15.56m (other bodies) |

My audit team will assess materiality levels throughout the audit.

## Significant financial statements risks

Significant risks are identified risks of material misstatement for which the assessment of inherent risk is close to the upper end of the spectrum of inherent risk or those which are to be treated as a significant risk in accordance with the requirements of other International Standard on Auditing (ISAs). The ISAs require us to focus more attention on these significant risks.

### Risk of management override

The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.32-33].

**Our planned response**

My audit team will:

[1] Excluding the pension element of remuneration report.

- test the appropriateness of journal entries and other adjustments made in preparing the financial statements;
- review accounting estimates for bias; and
- evaluate the rationale for any significant transactions outside the normal course of business.

Further to these audit procedures, I may add additional procedures to address any specific risks of management override that are not addressed by the mandatory work above.

## Failure of first financial duty

There is a significant risk that the Health Board will fail to meet its first financial duty to break even over its statutory three-year rolling period; against its revenue and capital resource limits.

In April, the Health Board's month 12 financial reporting to the Welsh Government set out:

- a revenue year-end surplus of 100,000 for 2024-25, which would result in a deficit of some £24.272 million for the three years to 31 March 2025; and
- a capital year-end surplus of £63,000 for 2024-25, which would result in a surplus of £140,000 for the three years to 31 March 2025.

The current financial pressures increase the risk that management judgements and estimates could be biased in an effort to meet its resource limits and/or other key financial targets agreed with the Welsh Government.

If the Health Board fails to meet its three-year resource limit for revenue and/or capital, I would expect to qualify my regularity opinion on the 2024-25 financial statements. I would also expect to place a substantive report on the statements to explain the basis of the qualification and the circumstances under which it had arisen.

Your current financial pressures increase the risk that management judgements and estimates could be biased in an effort to achieve the financial duty.

### Our planned response

I will:

- monitor the Health Board's financial position for 2024-25 and the cumulative three-year position to 31 March 2025.
- consider the cumulative impact of any relevant uncorrected misstatements over the three years to 31 March 2025; and
- undertake appropriate classification testing across revenue and capital expenditure.

## Related party disclosures

The financial statements must disclose any related party relationships along with the transactions and year-end balances between the Health Board / NHS Wales Joint Commissioning Committee and the other body or party.

The Health Board/ NHS Wales Joint Commissioning Committee have many relationships that could be considered a related party. Many are well known, for example, Welsh Government as funder. However, where related party relationships arise via individual officer or member relationships, there is likely to be less transparency regarding these relationships. These transactions are of high interest and we consider them to be material by their nature.

There is a risk of material misstatement due to incomplete or inaccurate disclosures, even where these are of relatively low value.

### Our planned response

My audit team will:

- review management's process for identifying related party relationships and associated transactions and balances;
- undertake procedures to confirm the completeness of related party relationships; and
- ensure disclosures are complete, accurate, consistent with evidence and are in accordance with requirements.

## Other areas of focus

I set out below other identified risks of material misstatement which, although not determined to be significant risks as above, I would like to bring to your attention.

### Remuneration report disclosures

There have been some new permanent and interim appointments to senior officer and board member posts during 2024-25 which need to be captured in the remuneration report.

There is a risk that these are not appropriately disclosed in the remuneration report as remuneration paid to senior officers and board members continues to be of high interest and is material by nature. We have also previously identified material issues with these disclosures.

The remuneration paid to senior officers and board members continues to be of high interest and is material by nature. Therefore, there is a risk that even low value errors in the disclosure could result a material misstatement.

There is also the risk of material irregularity if any senior officers are remunerated above Welsh Government's pay bands, which are without Welsh Government's approval.

**Our planned response**

My audit team will:

- understand the movements in the senior management team during 2024-25;
- ensure that remuneration disclosed is consistent with supporting evidence;
- ensure that amounts paid are consistent with those approved by the Board and are in accordance with Welsh Government pay rates and approved by Welsh Government where needed; and
- ensure that disclosures are complete based on the team's knowledge and are prepared in accordance with requirements.

## Valuation of property assets

The value of property assets reflected in the balance sheet and notes to the accounts are material estimates.

Property assets are required to be held on a valuation basis which is dependent on the nature and use of the assets. This estimate is subject to a high degree of subjectivity, depending on the specialist and management assumptions, and changes in these can result in material changes to valuations.

Assets are required to be formally revalued every five years as a minimum, with indexation applied in interim years, but values may also change year on year, particularly where there are ongoing refurbishment projects resulting in subsequent expenditure being capitalised.

There is a risk that the carrying value of assets recognised in the accounts could be materially different to the current value of assets as at 31 March 2025.

**Our planned response**

My audit team will:

- review the indices used by management for reasonableness;
- evaluate the competence, capabilities and objectivity of the professional valuer who provide indices to management and undertake valuations as necessary;
- test a sample of assets revalued in the year to ensure the valuation basis, key data and assumptions used in the valuation process are reasonable, and the revaluations have been correctly reflected in the financial statements;
- confirm that indexation has been appropriately applied and has been correctly reflected in the financial statements;
- test the reconciliation between the financial ledger and the asset register.

## Provisions

The financial statements include provisions for legal obligations, particularly in relation to clinical negligence.

There is a significant degree of subjectivity and uncertainty in the measurement and valuation of these provisions.

This subjectivity and uncertainty increase the risk of material misstatement.

**Our planned response**

My audit team will:

- review management's estimation process for the valuation of provisions;
- consider the competence, capability and objectivity of the management experts who are prepare the estimates; and
- ensure that disclosures are in accordance with the FReM and Welsh Government's Manual for Accounts.

## Remedial works to the Princess of Wales hospital

The Health Board has been undertaking significant remedial works to its Princess of Wales Hospital, with anticipated costs of some £28 million. There is a risk that the works are not accounted for correctly, for example in terms of:

- the relevant year of account being applied, particularly for any costs incurred around the financial year end; and
- the classification of revenue and capital costs being appropriate.

**Our planned response**

My audit team will:

- review the nature, in accounting terms, of the contracted works;
- review and test in-year transactions;
- review and test year-end balances, including any that are estimated; and
- ensure that the accounting is in accordance with the FReM and Welsh Government's Manual for Accounts.

## Financial statements audit timetable

Below is a timetable showing the key stages of the audit and our key audit deliverables that we will provide to you.

**Exhibit 1: Financial statements audit timetable**

| | |
|---|---|
| **Planning**<br>**January to February 2025** | Planning meeting<br>High level risk assessment procedures<br>Fraud risk assessment<br>Accounting estimates planning<br>IT environment risk assessment<br>Indicative audit fee<br>Outline Audit Plan |
| **Interim**<br>**March to April 2025** | Information flows<br>Detailed risk assessment procedures<br>IT controls review<br>Develop testing strategy<br>Early sample testing<br>Detailed Audit Plan |
| **Fieldwork**<br>**May to June 2025** | Update risk assessment<br>Audit of financial statements (to include performance report and accountability report, where relevant)<br>Complete audit testing<br>Evaluate audit findings<br>Audit closure meeting<br>Audit of Accounts Report<br>Present findings to those charged with governance<br>Auditor General's certification<br>Submission of the certified financial statements to Welsh Government<br>Laying of accounts with Senedd Cymru |

| | |
|---|---|
| **Reporting**<br>**June to July** | Formal recommendations for improvement<br>Post project learning |

# Performance audit work

## Proper arrangements

As set out in the Code of Audit Practice, I must satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources ('value for money'), and conclude accordingly.

I do this by undertaking an appropriate programme of performance audit work each year. I base my work programme on an assessment of risks of the Health Board and the wider NHS in Wales not having the proper arrangements in place, with the work typically focusing on the areas of greatest risk.

In designing the programme, my auditors must have considered corporate and service level arrangements, including:

- Strategic planning
- Financial planning
- Performance and risk management
- Workforce planning
- Asset management
- Collaborative working
- Overall governance.

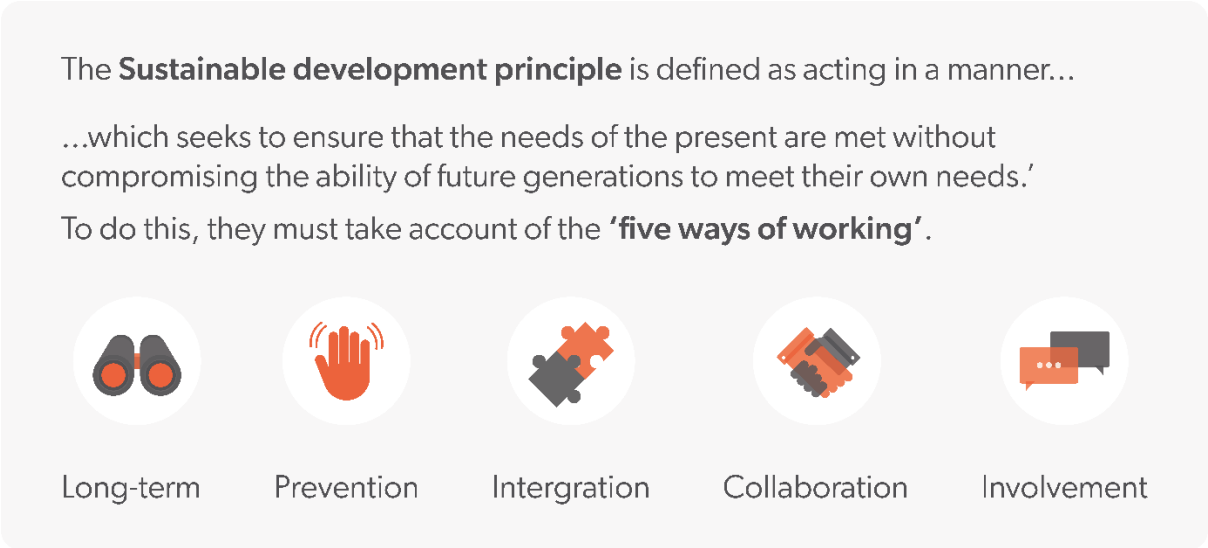
My auditors will also have taken account of relevant work that is being undertaken or planned by other audit, regulatory and inspection bodies at the Health Board.

I conduct my performance audit work using the ISSAI 3000 standard developed by the International Organisation of Supreme Audit Institutions (INTOSAI). INTOSAI is a global umbrella organisation for the performance audit community. It is a non-governmental organisation with special

consultative status with the Economic and Social Council (ECOSOC) of the United Nations.

## Well-being of future generations

Section 15 of the Well-being of Future Generations (Wales) Act 2015 (the Act) requires me to carry out examinations of public bodies for the purposes of assessing the extent to which a body has acted in accordance with the sustainable development principle when setting well-being objectives and taking steps to meet those objectives.




I must carry out these examinations at each public body covered by the Act at least once during a specified period.

These could be stand-alone examinations as part of my performance audit programme. However, where relevant and appropriate to do so, my auditors will integrate the work required into other planned performance audit work for the Health Board. My auditors will continue to engage closely with the Office of the Future Generations Commissioner for Wales to help coordinate our respective activities.

## Planned performance audit work

I set out below details of my performance audit work.

## Structured Assessment – core

### Scope of the work

Structured assessment will continue to form a key part of the work my audit teams do at each NHS body to examine the existence of proper arrangements for the efficient, effective, and economical use of resources.

My core 2025 structured assessment work will review the following areas:

- Board and committee cohesion and effectiveness.
- Corporate systems of assurance.
- Corporate planning arrangements; and
- Corporate financial planning and management arrangements.

My structured assessment work will also include a review of the arrangements that are in place to track progress against previous audit recommendations. This allows the audit team to obtain assurance that the necessary progress is being made in addressing areas for improvement identified in previous audit work. It also enables us to more explicitly measure the impact our work is having.

### Indicative timescales

Fieldwork to commence between September and November 2025 and reporting by the end of December 2025.

## Structured Assessment – review of the arrangements to manage estates

### Scope of the work

In addition to the core structured assessment work described above, my audit teams will also review certain arrangements at NHS bodies in more depth. This year, my audit teams will examine the effectiveness of corporate arrangements to manage the Health Board's estate with a particular focus on how NHS bodies are prioritising resources to meet strategic priorities whilst also ensuring the current estate remains fit for purpose.

### Indicative timescales

Fieldwork to commence between June and August 2025 and reporting by the end of December 2025.

## All-Wales thematic review of cancer services

### Scope of the work

I plan to undertake work following on from my recent review of the national leadership arrangements for cancer services. Whilst the exact focus of this work is still to be determined, it is likely to consider:

- The progress NHS bodies are making towards achieving Welsh Government targets and quality standards for cancer services;
- The efficacy of local plans and associated actions to recover cancer waiting lists; and
- Use of the additional Welsh Government financial allocations to improve cancer services.

### Indicative timescales

Fieldwork to commence between September and October 2025 and reporting by the end of March 2026.

## Local project work – Follow-up review of follow-up outpatients

### Scope of the work

Where appropriate, my audit team will also undertake performance audit work that reflects issues specific to the Health Board. The Health Board has the second highest number of patients waiting for follow-up outpatient appointments compared to other Health Board in Wales, which presents risks to patients receiving timely and appropriate care.

My local performance audit work will, therefore, focus on assessing the Health Board's arrangements for follow-up outpatient appointments, with the option to follow-up recommendations made in our 2015 and 2017 reviews of follow-up outpatient appointments. Whilst the exact scope of this work is yet to be determined, my team will assess arrangements to

ensure they are delivered efficiently, effectively, and economically, and there are clear plans to meet current and future demands and needs.

**Indicative timescales**

Fieldwork to commence between September and October 2025 and reporting by the end of March 2026.

## Timing of Performance Audit Work

My team will work with officers in the Health Board to arrange exact timescales for the individual projects and will be communicated regularly through our quarterly Audit Committee update. My auditors aim to substantially complete the performance audit work set out in this plan by the end of March 2026.

# Audit fee

In January 2025 we published our 2025-26 Fee Scheme following approval by the Senedd Finance Committee which details the average increase to fee rates of 1.7%.

The actual fee that any individual audited body will pay depends not just on our fee rates but on the quantum of work and the skill mix required.

You may recall that in 2023 we implemented a fundamentally different audit approach for our financial audit work, required by new international auditing standards. This required a richer, more costly skill mix that was reflected in higher fees. We have now reviewed the implementation of this new audit approach and identified efficiencies which allow us to reduce our financial audit fee-estimate (compared to last year's fee estimate) by 1.7%.

We have increased the performance audit fee-estimate by 1.7%, reflecting the increase in our fee rates.

**Your estimated total audit fee: £485,366**

Planning will be ongoing, and changes to my programme of audit work, and therefore my fee, may be required if any key new risks emerge. I shall make no changes without my auditors first discussing them with the Director of Corporate Governance and Executive Director of Finance. **Exhibit 2** sets out a further breakdown of your estimated audit fee.

Last year we provided a rebate of £7,046 to the Health Board because the cost of the financial audit was lower than the fee estimate.

**I base my audit fee on the following assumptions:**

- The agreed audit deliverables set out the expected working paper requirements to support the financial statements and include timescales and responsibilities.
- The audit requirements of my individual performance audit projects are met by the audited body, or suitable alternative arrangements are put in place that satisfy the needs of my audit team.
- No matters of significance, other than as summarised in this plan, are identified during the audit.

**Exhibit 2: Breakdown of my estimated audit fee for 2025 (and 2024 for comparison)**

| Estimated fee for 2025 (£)[2&3] | | Actual fee for 2024 (£) | |
|---|---|---|---|
| Audit of financial statements | Performance audit work[4] | Audit of financial statements | Performance audit work |
| £293,146 | £192,220 | £291,200[5] | £188,916 |

[2] The fees shown in this document are exclusive of VAT.

[3] Payable November 2024 to October 2025

[4] Payable April 2025 to March 2026.

[5] The fee estimate was £298,246. The actual cost was £291,200 and the Health Board therefore received a rebate of £7,046.

| | |
|---|---|
| **Total fee: £485,366** | **Total fee: £480,116[6]** |

[6] Taking account of the rebate of £7,046.

# Audit team

My audit team will continue to work and engage remotely using technology, but some on-site audit work may continue where it is appropriate to do so.

Indeed, my audit team who were onsite during the audit of accounts work last year found the close proximity to officers a more efficient way of working, and officers have fed back positively on their experiences.

Audited bodies have a responsibility to ensure the safety and wellbeing of Audit Wales staff when they are on your premises.

The main members of my team, together with their contact details, are summarised in **Exhibit 3**.

**Exhibit 3: My local audit team**

| | | |
|---|---|---|
| **Engagement Director** | Dave Thomas<br>dave.thomas@audit.wales | |
| | **Financial Audit** | **Performance Audit** |
| **Engagement Lead** | Anthony Veale<br>anthony.veale@audit.wales | Dave Thomas<br>dave.thomas@audit.wales |
| **Audit Manager** | Mark Jones<br>mark.jones@audit.wales | Darren Griffiths<br>darren.griffiths@audit.wales |
| **Audit Lead** | Steve Stark<br>steve.stark@audit.wales | Nathan Couch<br>nathan.couch@audit.wales |

I can confirm that my team members are all independent of Health Board and the NHS Wales Joint Commissioning Committee and their officers.

# Audit quality

Our commitment to audit quality in Audit Wales is absolute. We believe that audit quality is about getting things right first time.

We use a three lines of assurance model to demonstrate how we achieve this. We have established an Audit Quality Committee to co-ordinate and oversee those arrangements. We subject our work to independent scrutiny by the Institute of Chartered Accountants in England and Wales and our Chair of the Board, acts as a link to our Board on audit quality. For more information see our Audit Quality Report 2024.

## Our People

- Selection of right team
- Use of specialists
- Supervisions and review

## Arrangements for achieving audit quality
## Selection of right team

- Audit platform
- Ethics
- Guidance
- Culture
- Learning and development
- Leadership
- Technical support

## Independent assurance

- EQRs
- Themed reviews
- Cold reviews
- Root cause analysis
- Peer review
- Audit Quality Committee
- External monitoring

# Supporting you

Audit Wales has a range of resources to support the scrutiny of Welsh public bodies, and to support them in continuing to improve the services they provide to the people of Wales.

## Visit our website to find:

Our publications which cover our audit work at public bodies.

Information on our upcoming work and forward work programme for performance audit.

Data tools to help you better understand public spending trends

Details of our Good Practice work and events including the sharing of emerging practice and insights from our audit work.

Our newsletter which provides you with regular updates on our public service audit work, good practice, and events.

Archwilio Cymru
Audit Wales

Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.

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

| Agenda Item | 6.1.3 |
|---|---|

# Unapproved / Minutes of the Audit & Risk Committee

| | |
|---|---|
| **Date and Time of Meeting** | Thursday 13 February 2025 at 10:30 am |
| **Venue** | Virtual via Microsoft Teams |

| | | |
|---|---|---|
| **Members Present** | Patsy Roseblade | Independent Member (Chair) |
| | Kath Palmer | Health Board Vice Chair/Independent Member |
| | Ian Wells | Independent Member |
| | Dilys Jouvenat | Independent Member |
| | Helen Lentle | Independent Member |
| **In Attendance** | Sally May | Executive Director of Finance & Procurement |
| | Gethin Hughes | Chief Operating Officer (in-part) |
| | Sallie Davies | Deputy Medical Director |
| | Paul Dalton | NWSSP - Internal Audit & Assurance |
| | Emma Samways | NWSSP - Internal Audit & Assurance |
| | Murray Guard | NWSSP – Internal Audit & Assurance (in-part) |
| | Nathan Couch | Audit Wales |
| | Mark Jones | Audit Wales |
| | Owen James | Head of Corporate Finance |
| | Alison Williams | Local Counter Fraud Specialist |
| | Elizabeth Beadle | Assistant Director of Transformation Strategic & Operational Planning (in-part) |
| | Gareth Watts | Director of Corporate Governance/Board Secretary |
| | Kathrine Davies | Corporate Governance Manager/Meeting Secretariat |
| | Claire Brown | Head of Quality Assurance & Compliance |

| Agenda Item | Meeting Business |
|---|---|
| **1.** | **PRELIMINARY MATTERS** |
| **1.1** | **Welcome and Introductions** |
| | P. Roseblade, Committee Chair welcomed everyone to the meeting, particularly those joining for the first time, those observing and colleagues joining for specific agenda items. The format of the proceedings in its virtual form were also noted. Members noted that the meeting would be recorded to aid the Committee Secretariat in ensuring the accuracy of scrutiny related discussions |

| | |
|---|---|
| | and decisions made during the meeting. Members noted that the recording would be destroyed once the minutes had been confirmed as accurate. Members confirmed they were happy to proceed.<br><br>The Committee Chair advised that at the end of the meeting, she would be seeking Members views as to how the meeting went. |
| **1.2** | **Apologies for Absence** |
| | Apologies were received from:<br><br>• Matthew Evans – Local Counter Fraud Officer (Alison Williams Deputising) |
| **1.3** | **Declarations of Interest** |
| | No declarations were identified. |
| **2.** | **CONSENT AGENDA BUSINESS** |
| 2.1 | The Chair reminded Members that the agenda had been reformatted to include consent agenda items at the end of the agenda. She asked if there were any items from the consent agenda (Item 8) that the Committee Members wished to bring forward to the main agenda for discussion. There were none. |
| **3.** | **MAIN AGENDA** |
| **3.1** | **GOVERNANCE** |
| **3.1** | **Audit & Risk Committee Action Log**<br>G. Watts presented the Action Log and provided an update on the following:<br><br>• Paediatric Dentistry – A further update was provided in the narrative and also on the Organisational Risk Register<br>• Corporate Policies – The team were working on a project to improve the timeliness of policy reviews and updates working with the Office 365 team and proposed the action to be closed with a touch point update to be in June 2025.<br>• Audit Tracker Recommendations – The recommendations made by Committee Members in relation to enhancing the Tracker was being built in moving forward.<br>• Medical Pay – Implementation dates and discussions were being held with the People team and the Committee could take assurance that those actions were being taken forward.<br>• Local Counter Fraud Report – The long-standing primary care case had been added to the Forward Work Plan for the next meeting of the Committee.<br><br>The Chair referred to the Paediatric Dentistry risk and questioned whether it was premature to close the risk without ensuring that the plan would follow through as timetabled. G. Watts advised that they were not proposing to close the risk itself but the specific action from the last meeting and the risk would be kept live on the Organisational Risk Register. |

| | |
|---|---|
| | The Chair, in response, suggested that instead of closing the action, it should remain on the Action Log with a timescale for action and completion to ensure that the Committee is reassured that the action has been completed. G. Watts acknowledged the point made by the Chair and agreed to provide a substantive update later in the year so that they remained informed and reassured that the action had been completed.<br><br>This would be the same approach that would be taken to give an update on the policy project. |
| Resolution | The Committee **DISCUSSED** and **NOTED** the action log. |
| Action | • Paediatric Dentistry risk to remain on the Action Log<br><br>• A substantive update on the policy project and paediatric dentistry to be provided later in the year for the Committee to be reassured that the action had been closed. |
| **3.2** | **Matters Arising not contained within the Action Log** |
| Resolution | There were no matters raised. |
| **4.** | **SUSTAINING OUR FUTURE** |
| **4.1** | **Local Counter Fraud Report**<br>A Williams presented the report that provided detail on tasks and actions undertaken with the four strategic counter fraud work areas.<br><br>The Chair advised that at the last meeting she had suggested that if there were any new updates in the cases report could they be highlighted in a different colour which would be helpful for the Committee to pick out. A. Williams advised that she would take this suggestion back to the team as an action.<br><br>I Wells referred to the specific case referenced inv/24/02125 and queried why it had not been resolved earlier as it seemed to be a trivial issue. A. Williams explained that the allegation had related to a staff member and involved controlled drugs which required thorough checks and adherence to policy and procedure.<br><br>The Chair, in response to the above, emphasised the seriousness of issues involving controlled drugs and the process that has to be followed. |
| Resolution<br><br>Action | The report was **NOTED.**<br><br>To highlight any new updates in the Cases report in a different colour so these can be flagged for the Committee's attention. |
| **4.2** | **Losses and Special Payments Report**<br>S. May presented the report that provided the Committee with an update on the losses and special payments made by the University Health Board (UHB) |

| | |
|---|---|
| | for the three-month period from 1 October 2024 to 31 December 2024, as required by the Standing Financial Instructions.<br><br>S. May drew the Committee's attention to Section 3 where it reported an increase in net cash write off which reflected that the amount being paid out was higher than the amount being covered.<br><br>The Chair enquired about the current cash position and commented that whilst the specific issue raised by S. May might not be a huge amount. every bit of extra cash makes a difference at this time of year. S. May advised that the health board had not requested strategic cash for this year.<br><br>O. James confirmed that they were projecting a balanced position for cash at year end and would manage the cash position as they would normally and they did not foresee any issues.<br><br>D. Jouvenat referred to the completion of learning which was delayed and queried whether that was due to the Health Board or was it the Welsh Risk Pool. S. May confirmed that the obligation to identify the learning, disseminate it and discharge it to satisfy the Welsh Risk Pool lies with the Health Board. S. May added that the process sometimes takes time which leads to deferrals.<br><br>I Wells queried why the medical negligence costs had risen from £65m to £113m currently. I Wells also suggested that the data on the number of claims would be helpful to see. D. Hurford advised that this was partly due to the backlog being resolved and the team in clearing the cases and acknowledged the point made on the data regarding the number of claims which would help to put the costs into context. O. James referred the committee to the graph included in 2.13 which mapped the number of cases by type.<br><br>S. May confirmed that this was an area for the Quality, Safety & Experience to consider. D. Hurford advised that he would be happy to take this to the Committee via a Committee referral.<br><br>G. Watts confirmed that the Governance Team would action a cross Committee referral for discussion at the Quality, Safety & Experience Committee. |
| Resolution | The Committee **NOTED** the losses and special payments made for the period 1 October 2024 – 30 December 2024. |
| Action: | To implement a cross Committee Referral on the increase in medical negligence claims for the Quality, Safety & Experience Committee to scrutinise. |
| **4.2** | **Procurements and Scheme of Delegation Report**<br>S. May presented the report and highlighted the position on procurement matters for the period 1st December 2024– 31 January 2025.<br><br>S. May highlighted the following key matters:<br><br>• Single tender actions – these were detailed in section 2.1 including |

| | |
|---|---|
| | maintenance contracts, rental of a pathology digital pathology scanner, specialist orthodontic service and outsourcing relating to cataract.<br>• Retrospective orders were mainly related to agency staffing and particularly facilities staffing, industrial gases and hygiene services.<br>• CTM continue to have a higher number of invoices on hold due to NO PO compared to the average of all Welsh Health Boards. However, in the past two months CTM has seen an improvement of 15%, this follows discussion with Procurement colleagues and a focus on CTM invoices on hold over the December and January period.<br>• Purchase to pay remained within the target. |
| Resolution | The Committee;<br><br>**APPROVED** the updated FCPs<br>• **NOTED** the position on procurement matters for the period 01.12.2024 to 31.01.2025;<br>• **NOTED** the update regarding Purchase to Pay and achievement of PSPP target up to Month 9 of 2024/25; |
| **5.** | **IMPROVING CARE** |
| **5.1** | **Organisational Risk Register**<br>G. Watts presented the Report report and highlighted key updates to members.<br><br>G. Watts highlighted the follow key matters:<br><br>• Two risks with reduced scores – the year-end break-even position and medical and dental recruitment. The break-even position had improved due to additional financial support from Welsh Government. With regard to medical and dental recruitment, this has been discussed in detail at the Operational Delivery Committee with an action coming out of that for colleagues to undertake a piece of work on understanding the reduction in the risk.<br>• There was an emerging risk relating to the future sustainability of pathology services and whether this needs to be escalated onto the Risk Register.<br><br>The Chair referred to the discussion that had taken place at the Operational Delivery Committee in respect of the medical and dental staffing and confirmed that the main concern was with regard to the lack of sufficient dental staff within the organisation and not so much about medical staff as there were processes in place for cover with medical staff when there were any shortages. |
| Resolution: | The Committee **NOTED** the report. |
| Action: | No action was identified. |
| **5.2** | **Audit Recommendations Tracker**<br>G. Watts presented the report to the Committee which outlined the progress of implementing audit report recommendations and actions in the revised format |

| | |
|---|---|
| | following transition to an automated system using the Audit Management and Tracking (AMaT) inspection module.<br><br>K. Palmer expressed her appreciation for the progress being made on the Audit Tracker and advised that there was still too much detail to read through and suggested that it would be helpful to have more narrative around the high priority overdue actions and in particular the 23 high priority actions for Audit Wales and 36 for Internal Audit. K. Palmer emphasised the need for exception reporting and narrative which would help the Committee to focus on what they should be most concerned about.<br><br>G. Watts acknowledged the points made and advised that he was cognisant of the volume, however, it was about striking the balance of providing the Committee with enough data and information. G. Watts added that in terms of the work they were currently undertaking, they were looking at what could be taken off the Tracker and the benefits of this work would be seen later in the year.<br><br>The Chair advised that her understanding of the AMAT system was that it would not provide the detail that K. Palmer was suggesting, however, an extract from the system could be provided to enable Members to see it more clearly. G. Watts advised that they were in regular discussion with AMAT and there were some frustrations on what it can and cannot do and they were also working with other Health Boards on what they required the system to do for them.<br><br>G. Watts advised that he would fully take on board the comments and suggestions made. |
| Resolution | The Committee **NOTED** the Report and **AGREED** the assurances provided. |
| Action | To include the feedback received for the next iteration of the Tracker |
| | **INTERNAL AUDIT** |
| **5.3** | **Internal Audit Progress Report**<br>P. Dalton presented the progress report that provided the Audit & Risk Committee with the current position of the work undertaken by Internal Audit.<br><br>P. Dalton advised that the Estates Condition report was still in draft form but a meeting was being held on the 18th February with Capital colleagues where it was hoped that they could resolve the review.<br><br>K. Palmer commented on the volume of work being undertaken and wondered whether the Executive Team had any views on whether more support was required to help Internal Audit colleagues finalise their reviews and ensure completion of the Audit Programme.<br><br>P. Dalton acknowledged K. Palmer's comments and confirmed that they were receiving support from the Executive Team and particularly from the Governance Team who were working hard to support the internal audit process. |

| | |
|---|---|
| | S. May, in response, advised that with regard to the challenges to internal audit recommendations, over time people can lose some of the sense of why the recommendations were made and what they were aiming to achieve.<br><br>S. May added that the new internal audit format moves away from internal audit forming the recommendations to the responsible officer forming agreed management actions from the findings and it was important to ensure that actions are both deliverable and address the issues identified and can be implemented within the agreed timescales.<br><br>D. Hurford agreed with the points made by S. May and added that the process of internal audit often involves starting the process and then the focus narrows down to specific areas and it was important that there is good communication between the Executive Team and Internal Audit team to help resolve issues and ensure that the reviews are focussed on the most important areas.<br><br>The Chair referred to the deferrals and paragraph 2.3.2 that referred to two reviews that would need to be deferred and inquired the reason behind this decision. P. Dalton confirmed that one was because of the timelines of the implementation of the actions and the second one was in relation to primary care and the timings in relation to that. |
| Resolution: | The report was **NOTED** |
| **5.3.1** | **IA Review – Prince Charles Hospital Supply Chain Partner Management**<br>M. Gard presented the report which has been given a 'Reasonable' Assurance rating.<br><br>The Chair thanked M. Gard for the report and queried whether the issue referred to regarding the Intensive Care Unit and the contract resolution process was too detailed to get involved in and whether an overview was required.<br><br>S. May advised that there was a dispute resolution procedure in place with the responsible officer for the Prince Charles Hospital construction programme representing the Health Board in this process. S. May added that the parties had met last week and, following discussions, the Contractor had agreed to follow the contractual procedure for pricing the change and this was now in the process of being undertaken. The Health Board had taken the appropriate legal advice in respect of the correct contractual procedure. |
| Resolution: | The Committee **NOTED** the report. |
| Action: | No action was identified. |
| **5.3.2** | **IA Review – Medical Job Planning**<br>P. Dalton presented the report which has been given a 'Limited' Assurance rating.<br><br>D. Hurford drew attention to the following key points: |

| | |
|---|---|
| | • Job planning was an issue across Wales which had been acknowledged by the then Health Minister and now First Minister with a Welsh Government target group set up looking at job planning across all Health Board.<br>• There were positives highlighted within the report with regard to three substantial assurance areas which was a significant step forward but also challenges in getting job plans completed in a timely manner.<br>• Ongoing discussions were being held with the Local Negotiating Committee regarding individual and organisational activity requirements. They had also agreed with the LNC to reduce the job plan process from ten to four weeks and if no issues were raised within the four weeks the job plan was presumed to be signed off.<br>• There were challenges in completing job plans for colleagues who have never had a job plan or had been on the same plan for many years and the discussions could be quite protracted.<br>• Job Planning was deemed as a high priority for the Executive with the People Services team were pulling together a plan containing all aspects of job planning and would share this with the Committee once completed.<br><br>H. Lentle queried the plan for reviewing job plans going forward as a next stage as referenced within the report. D. Hurford confirmed that it has to be undertaken on an annual basis and there were a number of controls that were put in place to ensure that the annual follow ups take place.<br><br>The Chair referred to the targeted implementation date of the 25 December 2025 and queried if there will be a follow up review to see that the job plans completed in December 2025 would also be completed in December 2026 and whether the progress would be tracked through the audit tracker.<br><br>D. Hurford advised that they have set a target of eight clinical sessions and two supporting professional activities sessions as a minimum standard for everyone and it was important to get the plans done to enable them to understand the capacity within each service.<br><br>S. May advised that it was worth noting that within the Welsh Government planning guidance for this year, there was schedule of 35 Cabinet Secretary Enabling Actions and one of these is to ensure the effective implementation of the job planning policy which aims for over 90% of all consultants to have an agreed job plan in place at all times the 30 September 2025. This would be a performance managed target for the Health Board. |
| Resolution: | The Committee **NOTED** the report. |
| Action | To bring further detail on the job planning work back to a future meeting of the Committee. |
| **5.3.3** | **IA Review – Follow Up Arrangements for Service Level Agreement**<br>E. Samways presented the report that had received a 'Reasonable' Assurance rating. |

| | |
|---|---|
| | E. Samways advised that the follow up audit had showed progress with three areas of findings now closed and two still requiring action which mainly related to capturing SLA's and the process around them. E. Samways added that engagement with the Care Groups had been inconsistent which was impacting on the team's ability to keep their records up to date.<br><br>E. Samways advised that overall, the follow up review had provided a reasonable assurance rating and indicated positive movement from the previous limited assurance. |
| Resolution: | The Report was **NOTED.** |
| Action: | No action was identified. |
| **5.3.4** | **IA Report – Regional Integrated Fund**<br>E. Samways presented the report that had received a 'Reasonable' Assurance rating.<br><br>The Chair referred to the management agreed action on signing and having an all-Wales Memorandum of Understanding and that it is outside the gift of CTMUHB as an individual Health Board and that this needs to be reflected in the audit tracker that this was an aspirational goal and that the Health Board should demonstrate evidence of its actions to support achievement of the MOU. |
| Resolution | The Report was **NOTED** |
| Action: | No action was identified. |
| **5.3.5** | **IA Review – Vaccination Policy Implementation**<br>E. Samways presented the report that had received a 'Limited' Assurance rating.<br><br>K. Palmer expressed her surprise at the lack of an overall implementation plan for the vaccination policy and not had not been aware of this despite receiving regular updates on the vaccination take-up. K. Palmer added that it was important that the Health Board determined where this issue should sit, i.e., with the main Board, the Strategic Development Committee or the Operational Delivery Committee to ensure better oversight and assurance and the need for a comprehensive approach to address the challenges.<br><br>In response, D. Hurford acknowledged the historical issues with the funding and advised that the Director for People was leading on the staff aspect side of the vaccination programmes. D. Hurford added that the Director of Public Health was very passionate about driving the vaccination agenda and the Executive Team have agreed to bring a preliminary plan within the next couple of months outlining the requirements for planning for next winter which was starting much sooner that it did last year and once completed it would be shared via an Independent Member briefing or possibly a Board Development Session and also brought back to this Committee. |

| | |
|---|---|
| | The Chair queried whether this should be reported via the Integrated Performance Dashboard at the Operational Delivery Committee or the Quality & Safety Committee on the Consent Agenda for noting.<br><br>G. Watts, in response, advised that aspects of the vaccination policy are included within the overall Performance Dashboard presented to the Operational Delivery Committee and that this would be the appropriate Committee for discussing the vaccination policy.<br><br>K. Palmer advised that it had been raised in Quality, Safety & Experience Committee but would be useful for the organisation to do some looking back and re-evaluation before making a decision on where this should sit. |
| Resolution | The Report was **NOTED** |
| Action: | To consider where the reporting of the vaccination policy implementation should sit. |
| **5.4** | **Audit Wales - Audit & Risk Committee Update**<br>M. Jones presented the report.<br><br>M. Jones advised that the Charity Accounts had been certified on the 31st January 2025 with a clear and unqualified opinion. Planning for the 2024-25 annual report and accounts had started with the Welsh Government deadline for submission being the 30th June 2025.<br><br>N. Couch provided an update on the performance audit work and highlighted the following key points:<br><br>• The 2024 structured assessment and annual audit reports are included in the meeting papers.<br>• There were some unanticipated capacity issues impacting the progress of the unscheduled care reports, but they aim to present these reports to the committee at its May meeting.<br>• Reviews of planned care and eye care services are underway, with draft reports expected in the next few months.<br>• The review of digital transformation is due to commence in March 2025. |
| Resolution:<br><br>Action: | The Report was **NOTED.**<br><br>No action was identified |
| **5.4.1** | **Audit Wales Annual Report**<br>N. Couch presented the Audit Wales Annual Report.<br><br>N. Couch advised that the annual audit report is a summary of the audit work completed by the Auditor General at the Health Board over the last 12 months and includes findings from the last set of accounts audit work and the opinion given on the accounts. The report also summarizes the performance audit work |

| | |
|---|---|
| | completed during the year and that the Annual Report would be presented to the Health Board for noting. |
| Resolution: | The report was **NOTED.** |
| Action: | No action was identified. |
| **5.4.2** | **Audit Wales Report – Structured Assessment**<br>N. Couch presented the report.<br><br>N. Couch advised that the report has been taken through the usual clearance process and highlighted the following key conclusions:<br><br>• Overall, the Health Board's governance arrangements are generally effective, but there are opportunities to strengthen them further.<br>• The Health Board achieved a financial break-even position in 2023-24, but focusing on achieving this position in 2024-25 poses potential risks to the delivery of strategic objectives and long-term sustainability.<br>• The Health Board has a stable and cohesive Board that generally conducts its business appropriately, effectively, and transparently.<br>• The introduction of a new Committee structure in early 2025 will provide an opportunity to strengthen arrangements further.<br>• Systems of assurance are generally effective, but there are opportunities to address overdue recommendations and improvement actions.<br>• The Health Board has an effective approach to developing corporate strategies and plans but faces challenges in progressing key elements of its long-term strategy.<br>• Financial planning, management, monitoring, and reporting arrangements are generally effective, but the focus on immediate financial challenges presents risks to long-term financial sustainability.<br>• Recommendations for improvement have been made and agreed by management with appropriate actions and implementation dates.<br><br>N. Couch extended his thanks to the Corporate Governance team for their assistance and support in this work.<br><br>K Palmer welcomed the report and suggested that there were no surprises in it. She made one general comment around the finances recognising the challenges in this area, the rising costs and the difficulties of delivering further savings.<br><br>The Chair raised her concern in relation to mixed messages within the report regarding financial focus and financial stability. The Chair referred to specific paragraphs where the report seemed to suggest conflicting priorities such as focussing on break-even versus long term financial sustainability and questioned the references within the report to the timeliness of publishing Committee minutes and the relevance of an estates strategy in preventing unforeseen issues such as the Princess of Wales Hospital roof issue. |

| | |
|---|---|
| | The Chair raised an additional concern about the Structured Assessment's mention of the annual report and accounts not being received until five days before the meeting, which did not comply with the standing orders and pointed out that the report gave a very black-and-white view without acknowledging the context behind the delay. The Chair emphasised that whilst the Health Board had not met the deadline, a paper was put through the processes to explain the delay, and she wanted to ensure that the report reflected the improvements and progress made by the Health Board<br><br>N. Couch, in response, acknowledged the concerns raised and advised that the evidence for some of the financial decisions was not presented during the audit and that the report's wording was based on the information available at the time.<br><br>N. Couch clarified the recommendation in relation to Committee minutes advising that it was about timely access to records rather confirming minutes prior to the next meeting.<br><br>In response to the comments made in relation to finance, S. May advised that it was a statutory requirement for the Health Board to break-even.<br><br>With regards to the POWH roof and estates strategy, N Couch commented that the report was not saying an estates strategy would have avoided the POWH roof situation but was making the point of the wider importance of estates issues and that this wording had been accepted and cleared by the Health Board.<br><br>S. May recognised the importance of having an estates strategy but highlighted that this needed to be aligned with the acute services plan and the need for integrated planning.<br><br>In relation to the comment re the publication of papers, S. May emphasised that the Health Board did not delay the submission of the annual accounts despite significant staffing challenges. She clarified that the accounts were submitted on time, and the timeline was defined by when the audit was completed and wanted to ensure that it was clear that the Health Board worked around the clock to deliver everything on time under challenging circumstances.<br><br>M. Jones, in response, clarified that the accounts had been received on time but the audit process involved requesting and receiving additional information which sometimes caused delays. M. Jones added that the Health Board had a good track record of submitting their accounts on time.<br><br>G. Watts thanked N. Couch for the work on the report and for the work done behind the scenes which included Executive team feedback, to finalise the report. He reiterated the importance of adhering to the financial duty to break and mentioned that this point had been emphasised in their feedback to Audit Wales, which had resulted in some changes to the Finances section in the original draft. G. Watts assured Members that the Health Board was in line with standing orders regarding Committee minutes and that new revised standing |

| | |
|---|---|
| | order had been received which would be taken to the March Board meeting. G. Watts sought confirmation from the Committee if the report would go ahead as presented today or would there be a requirement for final approval.<br><br>N. Couch advised that he would be happy to link with in with G. Watts to discuss the report further offline but would not be proposing huge changes to the content. |
| Resolution | The report was **NOTED.** |
| Action: | To further discuss the content of the report offline prior to it being presented to the Board. |
| **5.4.3** | **Audit Wales 2025 Outline Plan**<br>N. Couch presented the report. |
| Resolution | The report was **NOTED.** |
| Action: | No action was identified. |
| **6.** | **CONSENT AGENDA** |
| **6.1** | **FOR APPROVAL** |
| **6.1.1** | **Unconfirmed Minutes of the meeting held on 17 December 2024** were **APPROVED.** |
| **6.1.2** | **Unconfirmed Minutes of the In Committee meeting held on 17 December 2024** were **APPROVED.** |
| **6.1.3** | **Annual Report Timetable 2025** was **APPROVED.** |
| **6.1.4** | **Committee Annual Cycle of Business 2025** was **APPROVED.** |
| **6.2** | **FOR NOTING** |
| **6.2.1** | **Committee Forward Work Plan** was **NOTED.** |
| **7.** | **CLOSE OF BUSINESS** |
| **7.1** | **Any Other Urgent Business**<br>There was no urgent business to report. |
| **7.2** | **How Did we Do in this meeting**<br>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. |
| **7.3** | **Committee Highlight Report** |
| Resolution: | The Committee Chair advised that this would be drafted outside the meeting by the Governance Team. |
| **8.** | **CLOSE OF MEETING** |

| Agenda Item | 6.1.2 |
|---|---|

# Unapproved Minutes of the Audit, Risk & Assurance (CLOSED) In Committee Meeting

| | |
|---|---|
| **Date and Time of Meeting** | Thursday 13th February 2025 at 12:30 pm |
| **Venue** | Virtual via MS Teams |

| | | |
|---|---|---|
| **Members Present** | Patsy Roseblade | Independent Member (Committee Chair) |
| | Kath Palmer | Vice Chair of CTMUHB |
| | Ian Wells | Independent Member |
| | Helen Lentle | Independent Member |
| | Dilys Jouvenat | Independent Member |
| **Present** | | |
| | Sally May | Executive Director of Finance |
| | Dom Hurford | Executive Medical Director |
| | Paul Dalton | Head of Internal Audit |
| | Emma Samways | Deputy Head of Internal Audit |
| | Mark Jones | Audit Wales – Finance Audit Lead |
| | Nathan Couch | Audit Wales – Performance Audit Lead |
| | Gareth Watts | Director of Corporate Governance / Board Secretary |
| | Kathrine Davies | Corporate Governance Manager |
| **Meeting Observers** | None | |

| Agenda Item | Meeting Business |
|---|---|
| **1.** | **PRELIMINARY MATTERS** |
| 1.1 | **Welcome and Introductions**<br>P. Roseblade, Committee Chair welcomed everyone to the meeting. |
| | |
| 1.2 | **Apologies for Absence** |
| | No apologies were received. |
| | |
| 1.3 | **Declarations of Interest** |
| | There were none to declare. |
| **2.** | **MAIN AGENDA** |

| | |
|---|---|
| 2.1 | **Organisational Risk Register (Business Sensitive Risks)**<br>G Watts presented the Organisational Risk Register noting that there were no substantive changes to the business sensitive risks captured in the report. The Committee were advised that the Digital & Data Directorate are currently reviewing their risks and are linked in with the Assistant Director of Governance Risk as appropriate for any guidance or support.<br><br>I Wells commented that it was positive news that two key staff had been appointed and good to see progress being made. |
| Resolution: | The Organisational Risk Register was **DISCUSSED** and **NOTED**. |
| Action: | None identified. |
| | |
| 2.2 | **Financial Controls Procedure - Medical Variable Pay – Summary of Authorised Breaches**<br>D. Hurford presented the report which provided a summary of all approved rates up to and above 10% of the Additional Duty Hours (ADHs) and agency rate cards for each Care Group relating to, 1st October to 31st December 2024.<br><br>The Chair queried whether the report needed to be presented to every meeting and suggested that perhaps the Committee should receive this every six months.<br><br>The Chair referred to the risk on the organisational risk register in regards to medical staff that had been reduced and advised that it was not just medical staff but dental staff and queried whether this report included dental staff. D. Hurford advised that it did not include dental staff. D. Hurford suggested that they could bring a one-off report back to the next meeting of the Committee and invite the R. Davies, dental lead to present and then consider whether the Committee would want regular updates on dental.<br><br>The Chair, in response, advised that this would be helpful and suggested that a discussion was held with the Director of Governance/Board Secretary with regard to the frequency of receiving this report.<br><br>K. Palmer advised that the Quality, Safety & Experience Committee were looking to receive a specific report on dental and also enquired if there were any trends analysis that the Committee could review. D. Hurford advised that this had already been done previously however, they were unable to resolve the issues until the Acute Clinical Services Plan was completed.<br><br>S. May advised that they did track the trends in pay expenditure for medical and dental staff through the finance report; however, dental contracts are contractor payments rather than employment and are reported within the Primary Care and Community Care Group expenditure position. S. May suggested that perhaps this was an area that the Operational Delivery Committee could review in more detail. |

| | |
|---|---|
| Resolution: | The report was **NOTED**. |
| Action: | To discuss the frequency of the report being presented to the Committee moving forward. |
| Action: | To receive a report on dental staffing at the next meeting of the Committee. |
| **3.** | **ANY OTHER BUSINESS** |
| | There was no urgent business to report on this occasion. |
| **4.** | **DATE AND TIME OF NEXT MEETING:** |
| | The next Committee meeting is scheduled for the 22 May 2025. |

| Agenda Item |
|---|
| 8.1.3 |

# Audit, Risk & Assurance Committee

## Review: Standards of Good Governance and Probity (in Public Service Roles) Policy

| | |
|---|---|
| **Dyddiad y Cyfarfod / Date of Meeting** | 22/05/2025 |
| **Statws Cyhoeddi / Publication Status** | Open/ Public<br>For Future Publication |
| **Awdur yr Adroddiad / Report Author**<br>*If you do not wish for your name to be included in the public domain, please only include your job title* | Gareth Watts, Director of Corporate Governance / Board Secretary |
| **Cyflwynydd yr Adroddiad / Report Presenter**<br>*If you do not wish for your name to be included in the public domain, please only include your job title* | 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** |
| Shared with the following functions for comment:<br>• Fraud<br>• Procurement<br>• People Team<br>• Charitable Funds<br>• Finance | 16/04/2025 | Comments received have been incorporated. |
| Executive Management Board for endorsement | 28/04/2025 | Policy title updated. |

| Acronyms / Glossary of Terms | |
|---|---|
| WHSSC | Welsh Health Specialised Services Committee |
| EASC | Emergency Ambulance Services Committee |

## 1. Situation /Background

1.1 The purpose of this Policy is to set out the Cwm Taf Morgannwg University Health Board (CTMUHB) commitment to ensuring that its Employees and Independent Board Members practice the highest standards of conduct and behaviour. This policy sets out those expectations and provides supporting guidance so that all employees and Independent Board Members are supported in delivering that requirement.

## 2. Specific Matters for Consideration

2.1 Engagement on this Policy and Procedure has taken place with:

| Name Title | Date Consulted/Completed |
|---|---|
| Equality Impact Assessment | 28 February 2025 |
| Informal Consultation with interested parties | 16 April 2025. |
| Formal Consultation | 22 April 2025 |
| Executive Management Board | 28 April 2025 |
| Committee / Board – For approval | Audit, Risk Assurance Committee – May 2025<br>Board – May 2025 |

2.2 The policy has been reviewed and is consistent with the approach across NHS Wales / legislation.

## 3. Key Risks / Matters for Escalation

3.1 In response to the review and consultation the following amendments have been made:

- Following feedback from EMB the policy has been retitled from Standards of Behaviour Policy to Standard of Good Governance and Probity (in Public Service Roles) Policy, so it more clearly describes the nature of the policy.
- Placed in new policy format which changed since the policy was last reviewed in 2022.
- Updated and corrected defective hyperlinks in the current policy documents
- Changed reference from Audit & Risk Committee to Audit, Risk and Assurance Committee and removed Management Board and replaced with Executive Management Board.
- Updated it to refer to the Joint Commissioning Committee and not WHSSC and EASC

- Included vouchers and gift vouchers as items colleagues should not accept in addition to cash
- Updated the reference to Raising Concerns to the wider umbrella term of Speaking up Safely.
- Sign posted colleagues to further information in relation the CTM Charitable Funds where appropriate
- Removed App 1 and App 5 from the current policy.
- Removed App 5 as covered in the Counter Fraud and Bribery Policy.
- Removed App 2-4 which is the forms and included links to the Corporate Governance dedicated SharePoint page.
- Minor grammar and typographical changes.
- Added link to ABPI Code of Practice.
- Instead of being specific about formal request to senior staff for declarations being in April it is now captured as the first quarter of the financial period for the forthcoming year.

## 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** *(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: |
| **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: 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):<br><br>EIA completed and policy will require translation in Welsh once approved as well as the dedicated website pages. | 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

5.1 The Audit, Risk & Assurance Committee are asked to **ENDORSE** the Standards of Behaviour Framework Policy for onward approval.

## 6. Next Steps

6.1 The policy is scheduled to go the Board for final approval on 29 May 2025.

# Standards of Good Governance and Probity (in Public Service Roles) Policy

| | |
|---|---|
| **Document Type:** | Non Clinical Organisational Wide Policy |
| **Ref:** | GC03 |
| **Author:** | Assistant Director of Governance & Risk |
| **Executive Sponsor:** | Director of Corporate Governance |
| **Approved By:** | **Health Board** |
| **Approval / Effective Date:** | (00/00/0000) |
| **Review Date:** | (00/00/0000) |
| **Version:** | 8 |

**Target Audience:**

| | |
|---|---|
| **People who need to know about this document in detail** | This Policy is applicable across the whole of the Health Board. It applies to all Employees and Independent Board Members. The term "Employees" includes all those who have a contract of employment or honorary contract with the Health Board. |
| **People who need to have a broad understanding of this document** | As above. |
| **People who need to know that this document exists** | As above. |

**Integrated Impact Assessment:**

| | |
|---|---|
| **Equality Impact Assessment Date & Outcome** | **Date:** 28.2.2025<br>**Outcome:** Supported with amendments made as required. |
| **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:** | 4.3.2025 |
| **Aligns to the following Wellbeing of Future Generation Act Objective** | Co-create with staff and partners a learning and growing culture |

| |
|---|
| **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

**Contents**

1. Introduction ....3
2. Context and Background ....3
3. Aim ....4
4. Objective ....5
5. Scope ....5
6. Roles and Responsibilities ....5
7. Register of Interests ....8
8. Declarations of Interest at Meetings ....9
9. Gifts, Hospitality and Sponsorship ....9
10.0 The Bribery Act 2010 ....16
11.0 Research, Development & Innovation ....17
12.0 Charitable Funds ....17
13.0 Secondary Employment & Private Practice ....17
14.0 Failure to adhere to the Standards of Behaviour Framework Policy ....18
15.0 Equality, Diversity, Inclusion and Welsh Language ....19
16.0 Resources ....19
17.0 Training ....19
18.0 Implementation ....19
19.0 Audit & Monitoring ....20
20.0 Retention and Archiving ....20
21.0 Distribution ....20
22.0 Review ....20
23.0 Further Information ....21
24.0 Legislative and NHS Requirements ....21

DRAFT

## 1. Introduction

1.1 The purpose of this Policy is to set out the Cwm Taf Morgannwg University Health Board (CTMUHB) commitment to ensuring that its Employees and Independent Board Members practice the highest standards of conduct and behaviour. This policy sets out those expectations and provides supporting guidance so that all employees and Independent Board Members are supported in delivering that requirement.

## 2. Context and Background

2.1 The Welsh Government's *Citizen-Centred Governance Principles* apply to all public bodies in Wales. These principles integrate all aspects of governance and embody the values and standards of behaviour expected at all levels of public services in Wales.

***"Public service values and associated behaviours are and must be at the heart of the NHS in Wales"***

2.2 CTMUHB is strongly committed to the Health Board being value-driven, rooted in the Nolan principles and high standards of public life and behaviour, including openness, customer service standards, diversity and engaged leadership.

2.3 The Board expects all Independent Board Members and Employees to practice high standards of corporate and personal conduct, based on the recognition that the needs of patients must come first.

2.4 The "Seven Principles of Public Life", or the "Nolan Principles" form the basis of the Standards of Behaviour requirements for Health Board employees and Independent Board Members. These are:

1. **Selflessness** – Individuals should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or friends;
2. **Integrity** – Individuals should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties;
3. **Objectivity** – In carrying out public business, including making public appointments, awarding contracts, recommending individuals for rewards and benefits, choices should be made on merit;
4. **Accountability** – Individuals are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate for their position;
5. **Openness** – Individuals should be as open as possible about all the decisions and actions they take. They should give reasons for their

decisions and restrict information only when the wider public interest clearly demands it;

6. **Honesty** – Individuals have a duty to declare any private interests relating to their duties and to take steps to resolve any conflicts arising in a way that protects the public interest, and;

7. **Leadership** – Individuals should promote and support these principles by leadership and example.

2.5 In support of these principles, Independent Board Members and all employees must be impartial and honest in the way that they go about their day-to-day functions. They must always remain beyond suspicion. They can achieve the "Seven Principles" above by:

- Ensuring that the interests of patients remain paramount;
- Being impartial and honest in the conduct of their official business;
- Using public funds to the best advantage of the service and the patients, always seeking to ensure value for money;
- Not abusing their official position for personal gain or to benefit family or friends;
- Not seeking advantage or to further private business or other interests during their official duties, and;
- Not seeking or knowingly accepting, preferential rates or benefits in kind for private transactions carried out with companies, with which they have had, or may have, official dealings on behalf of the Health Board.

2.6 This Policy re-states and builds on the provisions of CTMUHB Standing Orders. It re-emphasises the commitment of the Health Board to ensure that it operates to the highest standards, the roles and responsibilities of those employed by the Health Board and the arrangements for ensuring that declarations can be made.

## 3. Aim

3.1 The aim of this Policy is to ensure that arrangements are in place to support employees to act in a manner that upholds the Standards of Behaviour Framework as well as setting out specific arrangements for the appropriate declarations of interests and acceptance / refusal and record of offers of Gifts, Hospitality or Sponsorship. The Policy also aims to capture public acceptability of behaviours of those working in the public sector so that the Health Board can be seen to have exemplary practice in this regard.

3.2 CTMUHB is committed to ensuring that its employees and Independent Members practice the highest standards of conduct and behaviour. This policy sets out those expectations and provides supporting guidance so that all employees and Independent Members are supported to deliver this requirement.

## 4. Objective

4.1 The objective of this Policy is to clarify the relative responsibilities of Individuals / committees in the discharge of this Policy and adherence to the Standards of Behaviour Framework.

## 5. Scope

5.1 This Policy is applicable across the whole of the Health Board. It applies to all Employees and Independent Board Members. The term "Employees" includes all those who have a contract of employment or honorary contract with the Health Board.

5.2 Any reference in this Policy to the Health Board should also be applied to any bodies that CTMUHB hosts such as the Joint Commissioning Committee (JCC) and the National Imaging Academy Wales (NIAW) Programme.

## 6. Roles and Responsibilities

6.1 **Chair -** the Chair should:

- Ensure that Independent Members are aware of the requirements contained within this Policy.
- They lead by example and ensure that they personally declare any relevant interest or the offer of gifts, hospitality or sponsorship.
- Approve (or not) the acceptance of gifts, hospitality and sponsorship that have been offered to Independent Board Members **PRIOR** to the event.

6.2 **Chief Executive** - is the "Accountable Officer" with overall responsibility for ensuring that the Health Board operates efficiently, economically and with probity. The Chief Executive will ensure a policy framework is set and that arrangements are in place to support the delivery of that framework.

6.3 **Executive Directors have overall responsibility for their areas** -and must ensure that:

- Employees are aware of the requirements contained within this Policy and the Standards of Behaviour Framework.
- They lead by example and ensure that they personally declare any relevant interest or the offer of gifts, hospitality or sponsorship.
- Approve (or not) the acceptance of gifts, hospitality and sponsorship that have been offered within their Directorate **PRIOR** to the event.
    - They review the contents of the Registers of Declarations of Interest and Gifts, Hospitality and Sponsorship on an annual basis to assist with the verification of the accuracy of the information contained within it.
    - During periods of annual leave and prolonged absence they will ensure that they delegate the responsibilities to their Directorate

as appropriate to Clinical Directors, Managers or Head of Nursing or an Assistant Director.

6.4 **Director of Corporate Governance / Board Secretary -** The Director of Corporate Governance/Board Secretary has delegated responsibility for ensuring that the Health Board is provided with competent advice and support regarding the contents and application of this Policy and the Standards of Behaviour Framework. They will ensure that: -

- A Register of Interests is established and maintained as a formal record of interests declared by Employees and Independent Board Members. The Register will include details of Directorships, pecuniary (financial) and non-pecuniary interests in organisations that may have dealings with the NHS and membership of professional committees and third sector bodies. Where relevant it will also include details of interests of close family members or civil partners.

- Arrangements are in place to prompt specific groups of Employees and Independent Board Members to complete a Declaration of Interest Form on initial employment with the Health Board and at periodic intervals thereafter as follows:
    - **Board Members and Board Level Directors –** Annually in the first quarter of the financial year for the forthcoming financial period.
    - **Consultants, Very Senior Managers (VSM), Staff at Band 8d and 9 -** Annually in the first quarter of the financial year for the forthcoming financial period.
- A Register of Gifts, Hospitality and Sponsorship whether, accepted or declined, is maintained.

- Appropriate information from the Registers of Declarations of Interests and Gifts, Hospitality and Sponsorship is published on the Health Board Website in accordance with the requirements of the Freedom of Information Act Publication Scheme and staff information will therefore be publicised on the website including as part of the report to the Audit, Risk & Assurance Committee annually providing openness and transparency for CTMUHB.

- Reports detailing the content of the Registers of Declarations of Interests and Gifts, Hospitality and Sponsorship and the effectiveness of the arrangements in place will be provided on a quarterly basis to the Executive Management Board and Audit, Risk & Assurance Committee.

**6.5 Line Managers / Departmental Managers -** Line/Departmental Managers will:

- Ensure that this policy and the Standards of Behaviour Framework is brought to the attention of Employees for whom they are responsible, and that they are aware of its implications for their work;

- Ensure that Employees are aware of the requirement to follow and comply with the Policy and Standards of Behaviour Framework. The Standards of Behaviour Framework will be discussed at Individual Performance Reviews, Consultant Appraisals and as part of the Consultant Job Plan Reviews as appropriate;
- Support their Employees in the application of the Policy and the Standards of Behaviour Framework, seeking advice from the Director of Corporate Governance / Board Secretary if required.

**6.6 Employees and Independent Members -** All Employees, including those on Honorary Contracts will ensure that they:

- Understand this Policy and the Standards of Behaviour Framework, consulting their line manager if they require clarification;
- Are not in a position where their private interests and NHS duties may conflict;
- Declare to the Health Board for recording in the Register of Interests any relevant interests:
    - At the commencement of employment
    - Whenever a new interest arises, and
    - If asked to do so at periodic intervals by the Health Board.

"Relevant interests" will include: -

- Directorships, including Non-Executive Directorships held in private companies or PLCs, apart from dormant companies
- Ownership or part-ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the Health Board. This includes shareholdings, debentures or rights where the total nominal value is £5,000 or one hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less
- A personal or departmental interest in any part of the pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team
- Sponsorship or funding from a known NHS supplier or associated company/subsidiary
- A position of authority in a charity or voluntary body in the field of health and social care
- Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests
- Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.
- Inform patients and their relatives as appropriate, when referring them for treatment, investigation, or any aspect of their care if they have a material interest in an organisation to which they plan to refer a patient. The fact that the patient has been informed must be recorded appropriately.
- Verbally declare any relevant interest when a potential for conflict arises e.g. at Board, Board Committee or Board Sub Committee meetings, during procurement processes.

- Declare to the Health Board for recording in the Register of Gifts, Hospitality and Sponsorship any offer of a gift, hospitality or sponsorship which requires recording.
- Obtain permission from their Director before accepting gift, hospitality or sponsorship which require recording.
- Observe the Standing Orders, Standing Financial Instructions and procurement policies and procedures of the Health Board.
- **Note:** Employees should also refer to appropriate Professional Codes of Conduct and documents issued by the Welsh Government which will complement this Policy and the Standards of Behaviour Framework.
- It is the individual's (i.e. the employee or Independent Member) responsibility to make a declaration should their circumstances change within these timescales.

**It is recommended that where there is doubt, a declaration of interest should be made**

**6.7 Procurement Department -** The Procurement Department (provided by the NHS Wales Shared Services Partnership) scrutinise the Registers for Declarations of Interest and Gifts, Hospitality, Sponsorship and Honoraria to ensure that there is no opportunity for conflict of interest. A detailed protocol will specify the arrangements for undertaking this process and it will include:

- Details of the stages of the procurement process at which the Registers will be consulted;
- The arrangements for checking of the Registers;
- The arrangements for ensuring that all those involved in the procurement are given the opportunity to declare any relevant interest
- The arrangements for communicating this information to the Director of Corporate Governance / Board Secretary for its inclusion in the Register of Interests, and;
- The actions to be taken if there is a perceived conflict of interest at any point in the procurement process.

If an Employee is requested to participate in the procurement process, they will be asked to reaffirm their interests and to confirm that there are no other relevant interests that should be declared. If they have not previously completed a Declarations of Interest Form, they will be asked to do so before participating in the procurement process.

## 7. Register of Interests

7.1 The Director of Corporate Governance / Board Secretary will maintain Registers of Declarations of Interests and Gifts, Hospitality, Honoraria and Sponsorship. Appropriate information from these Registers is available on the Health Board website.

7.2 The Register is available for public inspection. Enquiries should be made to the Director of Corporate Governance/Board Secretary via the following email: CTM_Corporate_Governance@wales.nhs.uk

## 8. Declarations of Interest at Meetings

8.1 It is a requirement that at the beginning of every Health Board, Board Committee, Board Sub Committee or decision making / formal Health Board meeting that the members of the Board and those in attendance be invited to declare their interests in relation to any items on the agenda.

8.2 Where a potential conflict is material or the member has a financial / pecuniary interest in the matter under discussion, that person shall withdraw from discussions pertaining to that agenda item and shall note vote upon it. The potential conflict and the action will be recorded in the minutes of the meeting and the Register of Interests will be updated if required.

8.3 Where it becomes evident part way through a meeting that there may be a potential conflict the individual must declare their interest immediately. Under certain circumstances the Chair may choose to waive the need for the individual to leave the meeting. The advice of the Director of Corporate Governance / Board Secretary should always be sought prior to such a decision being made. From time to time, employees may need to declare interests at other Health Board or Partnership meetings. Such declarations will be recorded as if it were a Board, Board Committee or Board Sub Committee meeting, and the individual will be asked to withdraw from discussions pertaining to that agenda item.

8.4 **The Declarations of Interest Register form is available here:**
Hard Copy Format: CTM UHB Declaration of Interest Form (Updated 07-06-2024).docx
Online Submission: Declarations of Interest - Home

## 9. Gifts, Hospitality and Sponsorship

9.1 **Gifts -** A gift is an item of personal value, given by a third party e.g. a patient or a supplier. The definition includes prizes in draws and raffles at sponsored events / conferences.

It is an offence to accept any money, gift or consideration as an inducement or reward from a person or organisation holding or seeking to hold a contract with the Health Board. Such gifts should be refused and if they have already been received, they should be returned clearly advising why they cannot be accepted.

The appropriate Director and the Director of Corporate Governance / Board Secretary should be advised immediately.

9.2 **Gifts from Patients / Service Users or their relatives**

Employees may accept, subject to it not contravening their professional Codes of Conduct, gifts up to the value of £25 from patients /service users and relatives as a mark of their appreciation for the care that has been provided. This can include items such as chocolates, flowers, cards. There is no requirement to declare such gifts.

Where a gift is offered by patients or their relatives that is likely to be over £25 in value it should be politely declined. In some cases, the gift may have been delivered and it may be difficult to return it, or it may be felt that the bearer may be offended by the refusal. Under such circumstances the gift can be accepted, and the bearer advised that it will be utilised for the benefit of the Charitable Funds e.g. used as a prize in a raffle. A Gifts, Hospitality, Sponsorship and Honoraria Form declaring that the gift has been received must be completed.

Personal gifts of cash, vouchers or gift-cards from patients or their relatives are not acceptable. It may only be accepted as a donation to an appropriate Charitable Fund and recorded as such. The Cwm Taf Morgannwg NHS Charity team can provide advice regarding appropriately accepting, banking and receipting such items in accordance with the Charitable Funds Financial Control Procedures. The Charity team can be contacted via the following email: ctm.charity@wales.nhs.uk

9.3 **Gifts from Suppliers / Commercial Organisations -** No gifts, unless they are of low intrinsic value e.g. pens, calendars, etc. are allowable from suppliers, contractors and other commercial organisations. All such offers of gifts should be politely declined.

Whilst it is not necessary to declare gifts of low intrinsic value, where other items are offered and declined a Gifts, Hospitality, Sponsorship and Honoraria Form should be completed. This will allow the Health Board to monitor when such organisations are inappropriately offering gifts or potential inducements.

Under some circumstance's suppliers may send gifts to all its clients as custom and practice e.g. hampers at Christmas. Whilst such practices should be discouraged and it is not acceptable for staff to personally accept these gifts, following discussion with the supplier / commercial organisation and the appropriate Director it may be considered appropriate to accept the gift and utilise it for the benefit of Charitable Funds. The Cwm Taf Morgannwg NHS Charity team can provide support with the recognition and receipt of such items.

Gifts of cash (including gift vouchers/cards) from suppliers / commercial organisations are not acceptable in any circumstances.

9.4 **Gifts from Dignitaries / Overseas Organisations -** There may be occasions when visits are made by dignitaries or overseas organisations who consider it "culturally custom and practice" to exchange gifts. In such cases Employees should seek guidance from the Director of Corporate Governance / Board Secretary and declare these gifts on a Gifts, Hospitality, Sponsorship and Honoraria Form. A decision will then be jointly made as to the most appropriate way to manage the gift. This will depend on the nature of the "gift culture" and may include decisions to "keep and display in public", "donate to an internal user group", "auction for charity" etc.

9.5 **Hospitality** - Hospitality is where there is an offer of food, drink, accommodation, entertainment or entry into an event or function by a third party, regardless of whether provided during or outside normal working hours. Employees in contact with contractors should be particularly mindful of accepting any hospitality that might later be misconstrued as impacting on strict independence and impartiality.

Any acceptance of hospitality needs to be justified. Think about the context in which the offer has been made, and the effect on your position. For example, is the hospitality likely, or could it be likely, to influence you? The onus is on the individual to make sure that the acceptance of hospitality will not be misconstrued.

9.6 **Acceptable Hospitality -** Acceptable hospitality includes:

- Offers of food and non-alcoholic drink, provided it is equivalent to that offered in similar circumstances by the NHS, can be accepted during working visits and does not need to be recorded in the Gifts, Hospitality and Sponsorship Register.
- Other hospitality that may be accepted includes instances where:
    - There is a genuine need to impart information or represent the Organisation at Stakeholder Community Events e.g. Local Authority or Charitable organisations which have an association with the Health Board.
    - An employee has been invited to receive an award or prize in connection with the work of the organisation or their role within it.
    - An employee is invited to a Society or Institute Dinner or Function which is to be funded by a commercial organisation and where there is a genuine benefit to the professional standing of the individual or the Health Board.
- These types of hospitality must be authorised prior to their acceptance by a Corporate or Clinical Director and a Gifts, Hospitality, Sponsorship and Honoraria Form must be completed. The hospitality should be proportionate i.e. it should not be of significant value and only the

minimum number of Employees to achieve the purpose of representing the Health Board should attend.

9.7 **Unacceptable Hospitality** - Unacceptable hospitality includes the following examples as general guidance:

- A holiday or weekend / overnight break
- Offers of hotel accommodation when this is not associated with a sponsored course or conference (see below)
- Use of a company flat or hotel suite
- Attendance at a function or event restricted to Employees which is not for the purposes of training or organisational development
- Lunch or dinner provided by a private company or their representative which does not form part of a training or development event
- Entertainment and / or tickets / hospitality at sporting and other corporate entertainment events.

If employees are not clear whether an offer falls into one of these categories, then advice should be sought from their line manager in the first instance or if complex from the Director of Corporate Governance / Board Secretary.

Employees should report any case where an offer of hospitality is pressed which might be open to objection. They should also declare on the appropriate form any offers of hospitality which are declined.

9.8 **Sponsorship -** Sponsorship is sometimes provided by organisations to allow employees to attend conferences or working visits to view equipment. It may also include sponsorship of posts and research and development.

No sponsorship should be accepted without the prior agreement of the appropriate Corporate / Clinical Director. A Gifts, Hospitality, Sponsorship and Honoraria Form should also be completed prior to the acceptance of any sponsorship. If sponsorship is inappropriately offered and / or declined this should also be declared.

Any acceptance of sponsorship needs to be justified. Think about the context in which the offer has been made, and the effect on your position. For example, is the sponsorship likely, or could It be likely, to influence you? The onus is on the individual to make sure that the acceptance of any sponsorship will not be misconstrued.

9.9 **Commercial Sponsorship for Attendance at Courses / Conferences -** Employees may accept commercial sponsorship for attendance at relevant conferences and courses, but only where the employee seeks permission in advance from their Executive Director. The sponsorship should only be extended to the number of Employees who would have normally attended if funded by the Health Board. The Director must be satisfied that acceptance will not compromise purchasing decisions in any way.

9.10 **Commercial Sponsorship to attend demonstrations / technical evaluations** - Employees may be invited to view products or equipment at another location. There may be occasions when it is appropriate as part of a procurement exercise to visit a suppliers' reference site to observe equipment in operation in a medical or laboratory setting.

Such sponsorship is not appropriate, and the Health Board will meet the costs of such a visit to protect the integrity of subsequent purchasing decisions.

9.11 **Commercial Sponsorship – "Linked Deals" -** Pharmaceutical companies and other suppliers, for example, may offer to sponsor, wholly or partially, a post or equipment for the Health Board. The Health Board will not enter such arrangements, unless it has been made abundantly clear to the company concerned that the sponsorship will have no effect on purchasing decisions within the Health Board. Where such sponsorship is accepted, the Director of Finance shall ensure appropriate monitoring arrangements are established to ensure that purchasing decisions are not being influenced by the sponsorship agreement.

Under no circumstances should managers of the Health Board agree to "linked deals" whereby sponsorship is linked to the purchase of products, or to supplies from sources.

9.12 **Sponsorship of events in the context of Partnership Arrangements with the Pharmaceutical Industry or other Commercial Organisations -** The pharmaceutical industry and allied commercial sector representatives may organise meetings in support of specific functions or specialties within the healthcare sector. Under such arrangements they are permitted to fund the hiring of accommodation, meet any reasonable actual costs which may have been incurred and to provide appropriate hospitality. If no hospitality is required, there is no obligation or right to provide it, or indeed any benefit of equivalent value. An example of hospitality which would not be acceptable under these circumstances is where a company takes the attendees, on the conclusion of a course, for a meal in a restaurant.

The Pharmaceutical Industry is expected to adhere to the ABPI Code of Practice for the Pharmaceutical Industry which clearly specifies what is and what is not acceptable.

The Association of the British Pharmaceutical Industry

9.13 **Miscellaneous Payments / Honoraria -** Employees may be invited to give presentations at conferences, provide responses to surveys or attend professional meetings where a one-off payment or honoraria is offered.

If this activity is to be undertaken during hours when the employee is contracted to work for the Health Board the payment should be made to

the Health Board. Individuals may accept payment for activities that they undertake in their own time, subject to the provisions regarding outside employment contained within the various employee Contracts and Terms of Service. The activity should be reported using a Gifts, Hospitality, Sponsorship and Honoraria Form and it should be authorised by the appropriate Executive Director.

9.14 **Honoraria received for work undertaken DURING Health Board hours -** When appropriate authorisation has been granted to permit an employee to be involved in activity outside their normal contract **during** Health Board hours, any honoraria paid must be received back to the Health Board revenue budget to reimburse the Health Board for the employee's time.

To ensure good governance, the honoraria must be paid into a revenue budget that is ***not*** managed by the employee who has provided their services during Health Board time.

To avoid personal tax implications, the Health Board employee is urged to request the Honoraria is paid directly to the Health Board. This is then seen as reimbursement to the Health Board to cover the loss of employee time, and not honoraria. This money will then be transferred into the Health Board revenue budget. The Health Board employee who has undertaken the work must not be the budget holder for the budget receiving the funds in lieu of the honorarium due to a conflict of interest.

If the employee receives the honoraria directly and then reimburses the Health Board, the **employee remains liable for the payment of both tax and National Insurance Contributions (NIC),** regardless of the destination of the honoraria.

Honoraria received for work undertaken in an individual's own time (out of normal working hours or on authorised annual leave)_Individuals are **personally liable for the payment of both tax and NICs** on any honoraria payments received. Following their first honoraria declaration Individuals will be asked to sign a "Declaration Statement" confirming that they understand their responsibilities, and this will be held on file by the Director of Corporate Governance / Board Secretary.

**The Declaration of Honoraria Statement is available here:** Gifts, Hospitality, Sponsorship & Honoraria - Home

If such an employee wishes to suggest a donation may be made to the Cwm Taf Morgannwg University Health Board Charitable Funds in lieu of an honorarium, this must be received into the Charity's general fund, and it is then for the Charity Trustees to determine how the donated funds should be used. The basic principle being that the employee giving their own time should have no influence over how the donation is then used and therefore

lessens the risk of this being interpreted as being of any benefit to them as 'income' in any sense.

In cases of doubt, staff should seek advice from the Director of Corporate Governance / Board Secretary and should report any case where an offer of sponsorship or honoraria is pressed which might be open to objection. Instances where honoraria have been offered and declined should still be declared on the Gifts, Hospitality, Honoraria and Sponsorship Declaration Form.

9.15 **Bequests left in a Patient's or Service User's Will** - On occasion's staff are left bequests in a service user's will which they become aware of before the service user is deceased or because they have been informed by the deceased service user's legal representative. In such circumstances the member of staff must immediately inform their manager. It should be borne in mind that staff cannot benefit from a bequest by virtue of their position as a Health Board employee, undertaking their duties. If a member of staff receives a bequest, they should contact the Executive Director of Finance and the Director of Corporate Governance / Board Secretary.

9.16 **Gifts by way of inducement or reward** - The Prevention of Corruption Acts, 1906 and 1916, prohibit staff from soliciting or receiving any gift or consideration of any kind from contractors or their agents, or from any organisations, firms or individuals with whom they are brought into contact by reason of their official duties, as an inducement or reward for:

- Doing or refraining from doing anything in their official capacity; or
- Showing favour or disfavour to any person in their official capacity.

A breach of the provisions of these Acts renders staff liable not only to dismissal but to prosecution under the Acts, and it is expected that the Health Board would deal severely with any such breaches.

Staff should be aware that the Health Board is required in accordance with its Standing Orders to insert in every formal contract a clause entitling them to cancel the contract and recover any losses if any inducement or gifts are offered by the contractor or by his employees, whether with or without his knowledge. Any such offer of an inducement or gift should accordingly be reported by the person to whom it is made to the Executive Director of Finance.

9.17 **The Declaration Form – Gifts, Hospitality, Honoraria and Sponsorship form is available here:** Gifts, Hospitality, Sponsorship & Honoraria - Home

**10.0 The Bribery Act 2010** - The Bribery Act 2010 came into force on 1st July 2011. It reformed the criminal law of bribery, making it easier to tackle this offence proactively in both the public and private sectors. It is intended to respond to the extremely broad range of ways in which bribery can be committed by providing robust offences, enhanced sentencing powers, and wide jurisdictional powers. Broadly, the Act defines bribery as:

**"Giving or receiving a financial or other advantage in connection with the "improper performance" of a position of trust, or a function that is expected to be performed impartially or in good faith"**

10.1 The Bribery Act 2010 abolished all existing UK Anti-Bribery Laws and replaced them with a suite of new offences markedly different to what has gone before.

10.2 The Bribery Act 2010 made it a criminal offence to "give, promise or offer a bribe and to request, agree to receive or accept a bribe either at home or abroad". The maximum penalty for bribery is up to 10 years imprisonment, with an unlimited fine.

10.3 In addition, the Act introduced a 'corporate offence' of failing to prevent bribery by the organisation not having adequate preventative procedures in place. An organisation may avoid conviction if it can show that it had such procedures and protocols in place to prevent bribery. The 'corporate offence' is not a standalone offence but always follows from a bribery and/or corruption offence committed by an individual associated with the company or organisation in question.

10.4 Bribery does not have to involve cash, or an actual payment exchanging hands and can take many forms such as a gift, lavish treatment during a business trip or tickets to an event.

10.5 Some examples are captured below:

- Bribery to secure or keep a contract;
- Bribery to secure an order;
- Bribery to gain any advantage over a competitor;
- Bribery of a local, national or foreign official to secure a contract;
- Bribery to turn a blind eye to a health safety issue or poor performance or substitution of materials or false labour charges;
- Bribery to falsify an inspection report or obtain a certificate.

10.7 The impact of other Health Board policies which should be considered by staff include:

- Speaking up Safely Speaking Up Safely - Home

- The NHS Wales All Wales Social Media Policy. NHS Wales Social Media Policy
- The Counter Fraud Bribery and Corruption policy Counter Fraud Bribery and Corruption Policy.docx

## 11.0 Research, Development & Innovation

11.1 All Research, Development and Innovation activity sponsored by commercial companies, including those sponsored by the Pharmaceutical Industry must be approved by the appropriate mechanisms. It will be governed by specific policies and procedures.

11.12 The Research, Development and Innovation Leads along with the Corporate Governance Department will be able to offer advice and support in this area.

## 12.0 Charitable Funds

12.1 There may be occasions when commercial organisations offer to pay monies into Charitable Funds as a way funding attendances at courses or conferences. Monies may only be paid into Charitable Funds from commercial companies if it is a donation or sponsorship. It can only be used to fund expenditure which is in line with the terms of the funds use as set out within the Charitable Funds Policy.

12.2 Expenditure from Charitable Funds does not fall within the remit of this policy, however there may be a close association with the Standards of Behaviour Framework. For more information on Charitable Funds, please contact the Cwm Taf Morgannwg NHS Charity team via the following email: ctm.charity@wales.nhs.uk

## 13.0 Secondary Employment & Private Practice

13.1 **Secondary Employment** - Staff should inform their line manager of any secondary employment and ensure that any secondary employment or private practice does not affect their Health Board employment. A declaration of interest form should be recorded. There should be no conflict with their normal contractual employment obligations to the Health Board, and such work should not involve the use of any confidential or commercial information obtained during their employment with the Health Board.

13.2 Where employees have or are contemplating other employment, they must ensure this does not compromise their availability or physical or mental fitness to carry out their duties as an employee of the Health Board. Employees must also ensure this does not place them in a position where their judgement or actions might be influenced by considerations arising from their other employment. Employees have a responsibility to ensure that their line manager is made aware

of any hours worked in order that the Health Board fulfils its statutory requirement of the Working Time Directive; this is available via the following link. http://www.hse.gov.uk/contact/faqs/workingtimedirective.htm

13.3 An employee, absent because of sickness, is regarded as unfit to work and should not undertake any paid or unpaid work in any capacity during a period of sickness absence from the organisation, unless it is deemed jointly by their manager and the Occupational Health Department to be therapeutically beneficial to their recovery. Express written permission must be granted by the manager in advance in all such cases. An employee found to be undertaking other work during sickness absence without the prior written consent of the manager, may be considered in breach of contract and will be subject to disciplinary action which may result in the involvement of the Counter Fraud Department, the possibility of criminal investigation and/or dismissal. Such action will only be taken following advice from the Workforce & Organisational Development Department.

13.2 **Private Practice -** There are codes for good private patient practice which clearly include the fact that private practice should not adversely affect NHS duties. The time spent in private practice does not count towards the 48 hours of the Working Time Directive Regulations, however, health and safety law indicate that no employee of the Health Board should work in a way detrimental to their health and performance.

Additional information and advice is available for staff in the Financial Control Procedure 'Private Patients'. Policies - Finance

Failure to notify their line manager of secondary employment and/or private practice may invoke the Health Board's Disciplinary Policy.

## 14.0 Failure to adhere to the Standards of Behaviour Framework Policy

14.1 If any Health Board employee fails to declare an interest as defined within this policy, the Standards of Behaviour Framework, or the guidance that will be published to support it and then:

- participates in a decision-making process where special favour is shown to unfairly award a contract; or
- abuses their official position or knowledge for the purpose of benefit to themselves, their family or friends.

14.2 Disciplinary action may follow. The action taken will depend on the individual circumstances and will be in accordance with the appropriate disciplinary policy. Under some circumstances failure to follow this policy could be considered gross misconduct.

14.3 In addition to any potential disciplinary action being taken if there is any suspicion that fraud, corruption and / or bribery has been or is being committed, then all such cases must be reported at the earliest possible opportunity to the Local Counter Fraud Specialist (LCFS) within the Health Board in line with the Health Boards Counter Fraud policies.

14.4 Furthermore, if a member of staff breaches the Standards of Behaviour Framework this could in certain circumstances result in notification / reporting to the appropriate professional codes of conduct /registration / memberships i.e. Health Professions Council (HPC), General Medical Council (GMC), Nursing and Midwifery Council (NMC) etc. This could incur registrations being revoked and employees no longer being able to be employed in their current position within the Health Board.

14.5 This is also extended to include the inappropriate acceptance of any gifts, hospitality or sponsorship. Failure to declare a relevant interest by an Independent Member of the Health Board will be reported by the Chair and to the Cabinet Secretary for Health and Social Services, Welsh Government.

## 15.0 Equality, Diversity, Inclusion and Welsh Language

15.1 An Equality Impact Assessment and Welsh Language Assessment has been completed and is available upon request from the Director of Corporate Governance / Board Secretary.

## 16.0 Resources

16.1 The implementation and management of the arrangements associated with this Policy do not present any significant resource implications to the Health Board.

## 17.0 Training

17.1 There are no training implications arising from this Policy. However, awareness of the importance of compliance will require reference in induction programmes, during Individual Performance Reviews, Consultant Appraisals, Consultant Job Plan Reviews and at times when Employees are invited to make declarations.

## 18.0 Implementation

18.1 The Register of Declarations, Gifts, Hospitality, Sponsorship and Honoraria will be maintained by the Director of Corporate Governance / Board Secretary who will also be responsible for issuing periodic invitations to declare interests.

18.2 Directors and managers need to be aware of their responsibilities for advising Employees accountable to them of their responsibilities in connection with the policy.

## 19.0 Audit & Monitoring

19.1 The Director of Corporate Governance / Board Secretary will review the operation of the policy and Standards of Behaviour Framework as necessary and at least once a year a report on the findings of the review will be submitted to the Audit, Risk & Assurance Committee.

19.2 Directors will review the operation of the Policy within their Department.

19.3 Audit Wales and the NWSSP Internal Audit Service may also review the arrangements from time to time and their findings are also reported to the Audit, Risk & Assurance Committee.

19.4 Staff should note under the Freedom of Information Act 2000 the information contained within the Health Board Register will be subject to disclosure to any member of the public on request. The information will also be routinely reported to the Audit, Risk & Assurance Committee for oversight and scrutiny.

## 20.0 Retention and Archiving

20.1 In cases of complaints / claims and other legal processes it is often necessary to demonstrate the policy in place at the time of the investigation or incident. The Director of Corporate Governance / Board Secretary will therefore ensure that copies of this policy are archived and stored in line with the Records Management Strategy, Retention Schedule, and are made available for reference purposes should the situation arise.

## 21.0 Distribution

21.1 The Standards of Behaviour Framework Policy will be available via the Health Board intranet and internet sites. Where staff do not have access to the intranet their line manager must ensure that they have access to a copy of this policy.

21.1 The Standards of Behaviour Framework Policy will be available via the Health Board intranet and internet sites. Where staff do not have access to the intranet their line manager must ensure that they have access to a copy of this policy.

## 22.0 Review

22.1 Review of this Policy and the Standards of Behaviour Framework must be undertaken no later than three years after the date of approval.

## 23.0 Further Information

23.1 Further information and support in the completion of the forms can be obtained from Director of Corporate Governance / Board Secretary. CTM_Corporate_Governance@wales.nhs.uk

23.2 There is also a dedicated SharePoint page which includes further guidance, support and the required declaration forms. Declarations of Interest, Gifts, Hospitality, Sponsorship & Honoraria - Home

## 24.0 Legislative and NHS Requirements

24.1 This policy aims to ensure it complies with the requirements set out in: -

- (DGM (93)84) Standards of Business Conduct for NHS Staff
- WHC (2005)016 – The NHS and Sponsorship by the Pharmaceutical Industry
- WHC (2006)090 - The Codes of Conduct and Accountability for NHS Boards and the Code of Conduct for NHS Managers Directions 2006
- Director General, Health and Social Services, Chief Executive NHS Wales, Shared Values and Reinforcing Behaviour in NHS Wales (January 2011)
- Commercial Sponsorship - Ethical Standards for the NHS, Department of Health (November 2000)
- Code of Practice for NHS Wales Employers, Welsh Assembly Government (January 2011)
- Code of Conduct for Healthcare Support Workers in Wales, Welsh Assembly Government (January 2011)
- General Medical Council – Conflicts of Interest (September 2008)
- Health Board Standing Orders, Reservation and Delegation of Powers (March 2012)
- Nursing and Midwifery Council, The code - Standards of conduct, performance and ethics of nurses and midwives (May 2008)
- Royal College of Psychiatrists, Good Psychiatric Practice, Relationships with Pharmaceutical and Other Commercial Organisations (2008)
- Association of the Pharmaceutical Industry (ABPI), Code of Practice for the Pharmaceutical Industry (November 2011)
- The Institute of Chartered Secretaries and Administrators (ICSA), Model Conflicts of Interest Policy for NHS Trust Board Members (June 2010)
- The Bribery Act 2010 / NHS Protect – Bribery Act Guidance

DRAFT

| Agenda Item |
| --- |
| 8.1.3a |

# Audit Risk & Assurance Committee

## Committee Annual Cycle of Business 2025

| | |
| --- | --- |
| **Dyddiad y Cyfarfod / Date of Meeting** | 22/02/2025 |
| **Statws Cyhoeddi / Publication Status** | Open/ Public<br>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 & Assurance 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 2025 to 31 December 2025.

## 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 & Assurance Committee Cycle of Business for further detail.

## 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** *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))* | Safe |
| | If more than one applies please list below: |
| | No - Not Applicable |

| | | |
|---|---|---|
| **Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)** | 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:<br><br>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):<br><br>POSITIVE/NEUTRAL<br>NEGATIVE<br><br>Outcome for Welsh Language (delete as appropriate):<br>POSITIVE/NEUTRAL<br>NEGATIVE | If no, please include rationale below:<br><br>Not required |
| **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 asked to **NOTE** the Annual Cycle of Business.

## 6. Next Steps

6.1 There are no next steps required.

# Audit & Risk Assurance Committee – Annual Cycle of Committee Business

(1st January 2025 to the 31st December 2025)

The Annual Cycle of Committee Business has been developed to help plan the management of Committee matters and facilitate the management of agendas and committee business. The Annual Cycle of Committee Business will be complemented by a "Non-Routine Committee Business (Forward Plan)" for 'one-off' Adhoc items raised during the course of meetings.

The role of the Committee is set out in CTMUHB's standing orders and the Terms of Reference, both of which are available here: Standing Orders & Standing Financial Instructions - Cwm Taf Morgannwg University Health Board (nhs.wales)

The Audit & Risk Assurance Committee meets at **least 4 times per annum**. It is anticipated that an extra-ordinary Committee will need to be established in circa June / July to meet Annual Report requirements.

| | | |
|---|---|---|
| **Committee Chair:** Patsy Roseblade, IM Audit & Finance | **Committee Vice Chair:** Ian Wells, IM Digital & Data | **Executive Leads for Agenda Planning**<br>Sally May, Executive Director of Finance<br>Gareth Watts, Director of Corporate Governance/Board Secretary |

**CTMUHB Committee Business:**

| Items of Business | Executive Lead / Or External Representative | Reporting Frequency | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Consent Agenda | Main Agenda |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Committee Governance Arrangements** | | | | | | | | | | | | | | | | |
| 1. Action Log | Director of Corporate Governance / Board Secretary | All Regular Meetings | | ✓ | | | ✓ | | | ✓ | | | ✓ | | ✓ If all actions are complete | ✓ If there are actions in progress / overdue actions |
| 2. Minutes of the previous meeting (Public and Closed Session) | Director of Corporate Governance / Board Secretary | All Regular Meetings | | ✓ | | | ✓ | | | ✓ | | | ✓ | | ✓ | X |
| 3. Non-Routine Committee Business (Forward Plan) | Director of Corporate Governance / Board Secretary | All Regular Meetings | | ✓ | | | ✓ | | | ✓ | | | ✓ | | ✓ | X |
| 4. Annual Cycle of Business | Director of Corporate Governance / Board Secretary | All Regular Meetings | | ✓ Annual Review | | | ✓ | | | ✓ | | | ✓ | | ✓ Except for the annual review in February | ✓ Annual Review only |
| 5. Committee Annual Report | Director of Corporate Governance / Board Secretary | Annually | | | | | | | | ✓ | | | | | X | ✓ |
| 6. Outcome of Annual Committee Self-Assessment | Director of Corporate Governance / Board Secretary | Annually | | | | | | | | ✓ | | | | | X | ✓ |

| Items of Business | Executive Lead / Or External Representative | Reporting Frequency | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Consent Agenda | Main Agenda |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Committee Governance Arrangements CONTD** | | | | | | | | | | | | | | | | |
| 7. Terms of Reference Review | Director of Corporate Governance / Board Secretary | Annually | | | | | | | | | | | | | X | |
| **Corporate Governance & Risk Management Activity** | | | | | | | | | | | | | | | | |
| 8. Declarations of Interest and Gifts, Hospitality & Sponsorship Report | Director of Corporate Governance / Board Secretary | Twice per annum | | | | | | | | | | | | | X | |
| 9. Standing Orders – Annual Review | Director of Corporate Governance / Board Secretary | Annually | | | | | | | | | | | | | | X |
| 10. Standing Orders – Variation or Breach Report | Director of Corporate Governance / Board Secretary | All regular meetings if required | | | | | | | | | | | | | | X |
| 11. Annual Accountability Report (Governance Statement) | Director of Corporate Governance / Board Secretary | Annually | | | | | | An extra-ordinary meeting will be scheduled in June (Draft) and July (Final) as required in the Manual for Accounts | | | | | | | X | |
| 12. Approval of the Annual Review of the Risk Management Framework / Board Assurance Framework | Director of Corporate Governance / Board Secretary | Annually | | | | | | | | | | | | | X | |
| 13. Organisational Risk Register | Director of Corporate Governance / Board Secretary | All regular meetings | | | | | | | | | | | | | X | |
| 14. Data Lapses /Data Loss Updates / Reports | Director of Digital | All regular meetings (as required) | | | | | | | | | | | | | X | |
| **Items of Business** | **Executive Lead / Or External Representative** | **Reporting Frequency** | **Jan** | **Feb** | **Mar** | **Apr** | **May** | **Jun** | **Jul** | **Aug** | **Sep** | **Oct** | **Nov** | **Dec** | **Consent Agenda** | **Main Agenda** |
| **Audit Reviews & Assurance Activity** | | | | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 15. Clinical Audit Annual Plan | Executive Director of Nursing / Deputy CEO | Annually | | | | | ✓ | | | | | | | | ✓ | X |
| 16. Clinical Audit Annual Report | Executive Director of Nursing / Deputy CEO | Annually | | | | | ✓ | | | | | | | | ✓ | X |
| 17. Audit Recommendation Tracker (AW, IA and HIW) | Director of Corporate Governance / Board Secretary | All regular meetings | | ✓ | | | ✓ | | | ✓ | | | ✓ | | X | ✓ |
| 18. NWSSP Internal Audit Services – Progress Report | Head of Internal Audit | All regular meetings | | ✓ | | | ✓ | | | ✓ | | | ✓ | | X | ✓ |
| 19. NWSSP Internal Audit Services – Annual Audit Plan | Head of Internal Audit | Annually | | | | | ✓ | | | | | | | | X | ✓ |
| 20. NWSSP Internal Audit Review Reports | Head of Internal Audit | All Regular Meetings | | ✓ | | | ✓ | | | ✓ | | | ✓ | | X | ✓ |
| 21. NWSSP Internal Audit Services – Head of Internal Audit Opinion | Head of Internal Audit | Annually | | | | | ✓ | | | | | | | | X | ✓ |
| 22. Audit Wales Progress Update | Audit Wales - Performance Audit Lead | All Regular Meetings | | ✓ | | | ✓ | | | ✓ | | | ✓ | | X | ✓ |
| 23. Audit Wales – Audit Review Reports | Audit Wales - Performance Audit Lead | All Regular where applicable | | ✓ | | | ✓ | | | ✓ | | | ✓ | | X | ✓ |
| 24. Audit Wales Annual Audit Report | Audit Wales - Performance Audit Lead | Annually | | | | | ✓ | | | | | | | | X | ✓ |
| 25. Audit Wales Structured Assessment Report | Audit Wales - Performance Audit Lead | Annually | | | | | | | | | | | ✓ | | X | ✓ |
| 26. Audit Wales – Audit of the Financial Statement (ISA 260, Letter of Representation and Audit Opinion) | Audit Wales - Financial Audit Lead | Annually | | | | | | ✓ An extra-ordinary meeting will be scheduled in June (Draft) and July (Final) as required in the Manual for Accounts | | | | | | | X | ✓ |
| 27. Audit Wales - Audit of Financial Statements Addendum Report | Audit Wales - Financial Audit Lead | Twice per annum (if required) | | | | | | | | ✓ | | | ✓ | | X | ✓ |

| Items of Business | Executive Lead / Or External Representative | Reporting Frequency | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Consent Agenda | Main Agenda |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Financial Governance Activity** | | | | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 28. Annual Financial Accounts | Executive Director of Finance | Annually | | | | | | An extra-ordinary meeting will be scheduled in June (Draft) and July (Final) as required in the Manual for Accounts | | | | | | | X | |
| 29. Losses and Special Payments Report | Executive Director of Finance | All Regular Meetings | | | | | | | | | | | | | | X | |
| 30. Procurement & Scheme of Delegation Report | Executive Director of Finance | All Regular Meetings | | | | | | | | | | | | | | X | |
| 31. Post Payment Verification Mid-Year and Annual Report | Executive Director of Finance | Twice a Year | | | | | | | | | | | | Mid-Year | | X | |
| **Counter Fraud Activity** | | | | | | | | | | | | | | | | | |
| 32. Local Counter Fraud Report | Local Counter Fraud Specialist | All Regular Meetings | | | | | | | | | | | | | | X | |
| 33. Counter Fraud Annual Report | Local Counter Fraud Specialist | Annually | | | | | | | | | | | | | | X | |
| 34. Counter Fraud Annual Self-Assessment | Local Counter Fraud Specialist | Annually | | | | | | | | | | | | | | X | |
| 35. Counter Fraud Draft Work Plan | Local Counter Fraud Specialist | Annually | | | | | | | | | | | | | | X | |
| 36. National Fraud Initiatives Progress and Outcomes | Local Counter Fraud Specialist | Twice Per Annum | | | | | | | | | | | | | | X | |
| **CTMUHB Hosted Bodies Audit & Risk Committee** | | | | | | | | | | | | | | | | | |
| 37. Joint Commissioning Committee Audit Recommendations Tracker | Director of Corporate Governance (JCC) | All Regular Meetings | | | | | | | | | | | | | | X | |

| | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **CTMUHB Hosted Bodies Audit & Risk Committee** | | | | | | | | | | | | | | | | | |
| 38. Joint Commissioning Committee | Director of Corporate Governance (JCC) | All Regular Meetings | | | | | | | | | | | | | | X | |

| | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Corporate Risk Assurance Framework | | | | | | | | | | | | | | | | | |
| 39. National Imaging Academy Risk Register | Director of the National Imaging Academy | All Regular Meetings | | ₪ | | | ₪ | | | ₪ | | | ₪ | | X | ₪ |
| 40. Hosted Organisation - Annual Governance Statement & Accounts | Director of Corporate Governance /Director of the National Imaging Academy | Annually | | | | | | ₪ An extra-ordinary meeting will be scheduled in June (Draft) and July (Final) as required in the Manual for Accounts | | | | | | | X | ₪ |
| 41. Hosted Organisation External / Internal Audit Reports | Director of Corporate Governance /Director of the National Imaging Academy | All Regular Meetings if a report is received. | | ₪ | | | ₪ | | | ₪ | | | ₪ | | X | ₪ |

**Audit Risk & Assurance Committee – Non-Routine Committee Business Forward Plan**

(1st January 2025 to the 31st December 2025)

This forward plan is only to be used for one-off Adhoc items that do not require inclusion as routine business on the Annual Committee Cycle of Business.

| Date of Request | Origin of Request | Requestor | Item Summary / Title | Nature of Request | Lead Officer | Executive Lead | Intended Meeting Date | Status |
|---|---|---|---|---|---|---|---|---|
| February 2025 | Audit, Risk & Assurance Committee | Committee | Outcome of Committee Referral to Quality, Safety & Experience Committee | Committee raised concern in relation to increased medical negligence costs and requested that the Quality, Safety & Experience Committee review | Head of Corporate Finance | Gareth Watts, Director of Governance/Board Secretary | 14 August 2025 | Quality, Safety & Experience Committee meeting on 20 May 2025, the outcome of which will be presented to the August 2025 meeting. |
| February 2025 | Email | Assistant Director of Governance & Risk | Audit Wales Report – Cancer Services in Wales | Requested to add to agenda for Committee to note. | Audit Wales | Gareth Watts, Director of Governance/Board Secretary | 22 May 2025 | This item is on the agenda for the May 2025 meeting |
| December 2024 | Audit & Risk Committee | Internal Audit | IA Review – Estates Assurance Condition | Deferred from February meeting. | Internal Audit | Gareth Watts, Director of Governance/Board Secretary | 22 May 2025 | This item is on the agenda for the May 2025 meeting |
| December 2024 | Audit & Risk Committee | Internal Audit | IA Review – Capital Systems | Deferred from last meeting | Internal Audit | Gareth Watts, Director of Governance/Board Secretary | 22 May 2025 | This item is on the agenda for the May 2025 meeting |
| December 2024 | Audit & Risk Committee | Internal Audit | IA Review – Duty of Candour | Deferred from last meeting | Internal Audit | Gareth Watts, Director of Governance/Board Secretary | 22 May 2025 | This item is on the agenda for the May 2025 meeting |
| December 2024 | Audit & Risk Committee | Internal Audit | IA Review – Follow Up – Performance Management 4 Hour Target | Deferred from last meeting | Internal Audit | Gareth Watts, Director of Governance/Board Secretary | 22 May 2025 | This item is on the agenda for the May 2025 meeting |
| December 2024 | Audit & Risk Committee | Internal Audit | IA Review – Digital Transformation National Review | Internal Audit Progress Report | Internal Audit | Gareth Watts, Director of Governance/Board Secretary | 22 May 2025 | This item is on the agenda for the May 2025 meeting |
| December 2024 | Audit & Risk Committee | Internal Audit | IA Review – Continuing Health Care | Internal Audit Progress Report | Internal Audit | Gareth Watts, Director of Governance/Board Secretary | 22 May 2025 | This item is on the agenda for the May 2025 meeting |
| December 2024 | Audit & Risk Committee | Internal Audit | IA Review – Discharge Planning | Internal Audit Progress Report | Internal Audit | Gareth Watts, Director of Governance/Board Secretary | 22 May 2025 | This item is on the agenda for the May 2025 meeting |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| December 2024 | Audit & Risk Committee | Internal Audit | IA Review – Digital Benefits Realisation | Internal Audit Progress Report | Internal Audit | Gareth Watts, Director of Governance/Board Secretary | 22 May 2025 | This item is on the agenda for the May 2025 meeting |
| December 2024 | Audit & Risk Committee | Internal Audit | IA Review – Primary Care | Internal Audit Progress Report | Internal Audit | Gareth Watts, Director of Governance/Board Secretary | 22 May 2025 | This item is on the agenda for the May 2025 meeting |
| December 2024 | Audit & Risk Committee | Internal Audit | IA Review – Service User Experience | Internal Audit Progress Report | Internal Audit | Gareth Watts, Director of Governance/Board Secretary | 22 May 2025 | This item is on the agenda for the May 2025 meeting |
| December 2024 | Audit & Risk Committee | Internal Audit | IA Review – Welsh Risk Pool | Internal Audit Progress Report | Internal Audit | Gareth Watts, Director of Governance/Board Secretary | 22 May 2025 | This item is on the agenda for the May 2025 meeting |
| December 2024 | Audit & Risk Committee | Internal Audit | IA Review – Risk Management | Internal Audit Progress Report | Internal Audit | Gareth Watts, Director of Governance/Board Secretary | 22 May 2025 | This item is on the agenda for the May 2025 meeting |
| December 2024 | Audit & Risk Committee | Committee | Local Counter Fraud Report – Update on Long Standing Case with regards to the Dispensing Practice | Local Counter Fraud Report | Local Counter Fraud Officer | Sally May, Executive Director of Finance & Procurement | 22 May 2025 | This item is on the Agenda for the May 2025 meeting via the Local Counter Fraud Report. |
| February 2025 | Audit, Risk & Assurance Committee | Committee | IA – Medical Job Planning – to bring further detail on the Job Planning Work | Internal Audit Progress Report | Medical Director | Dom Hurford, Medical Director | 14 August 2025 | This item is on the Agenda for the August 2025 meeting. |

**COMPLETED ITEMS:**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| December 2024 | Audit & Risk Committee | Internal Audit | IA Review – Medical Job Planning | Deferred from last meeting | Internal Audit | Gareth Watts, Director of Governance/Board Secretary | 13 February 2025 | Received at the February 25 Meeting - **Closed** |
| December 2024 | Audit & Risk Committee | Internal Audit | IA Review – PCH Supply Chain Partner Management | Deferred from last meeting | Internal Audit | Gareth Watts, Director of Governance/Board Secretary | 13 February 2025 | Received at the February 25 Meeting - **Closed** |
| December 2024 | Audit & Risk Committee | Internal Audit | IA Review – Regional Integration Fund | Deferred from last meeting | Internal Audit | Gareth Watts, Director of Governance/Board Secretary | 13 February 2025 | Received at the February 25 Meeting – **Closed** |
| December 2024 | Audit & Risk Committee | Internal Audit | IA Review – Vaccination Policy Implementation | Deferred from last meeting | Internal Audit | Gareth Watts, Director of Governance/Board Secretary | 13 February 2025 | Received at the February 25 Meeting – **Closed** |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| December 2024 | Audit & Risk Committee | Internal Audit | IA Review – Service Level Agreements – Follow Up | Deferred from last meeting | Internal Audit | Gareth Watts, Director of Governance/Board Secretary | 13 February 2025 | Received at the February 25 Meeting – **Closed** |
| Email from Audit Wales | Audit Risk & Assurance Committee | Audit Wales | Audit Wales Annual Report | Requested via Email from Audit Wales | Audit Wales | Gareth Watts, Director of Governance/Board Secretary | 13 February 2025 | Received at the February 25 Meeting – **Closed** |
| Email from Audit Wales | Audit Risk & Assurance Committee | Audit Wales | Audit Wales Report – Structured Assessment | Requested via Email from Audit Wales | Audit Wales | Gareth Watts, Director of Governance/Board Secretary | 13 February 2025 | Received at the February 25 Meeting - **Closed** |
| Email from Audit Wales | Audit Risk & Assurance Committee | Audit Wales | Audit Wales 2025 Outline Plan | Requested via Email from Audit Wales | Audit Wales | Gareth Watts, Director of Governance/Board Secretary | 13 February 2025 | Received at the February 25 Meeting – **Closed** |
| Requested via email | Audit Risk & Assurance Committee | Gareth Watts, Director of Corporate Governance/Board Secretary | Annual Report Timetable 2025 | Requested via Email | Emma Walters, Head of Corporate Governance & Board Business | Gareth Watts, Director of Governance/Board Secretary | 13 February 2025 | Received at the February 25 Meeting – **Closed** |
| Action from October 24 meeting CLOSED In Committee Meeting | Additional Item Audit & Risk Committee | Audit & Risk Committee | Outcome of Committee Referral to People & Culture Committee – Recruitment Process Risk Assurance Report | Action arising from the October 2024 Audit & Risk Committee | Assistant Director of People Policy and Compliance/Local Counter Fraud Officer | Executive Director for People | 17 December 2024 | Received at the December 2024 meeting - **Closed** |
| December 2024 | Audit & Risk Committee | Internal Audit | IA Review – PCH Management Actions – Follow Up | Requested via Internal Audit | Internal Audit | Gareth Watts, Director of Governance/Board Secretary | 17 December 2024 | Received at the December 24 meeting - **Closed** |
| December 2024 | Audit & risk Committee | Internal Audit | IA Review – PCH Redevelopment of Management Actions Final | Requested via Internal Audit | Internal Audit | Gareth Watts, Director of Governance/Board Secretary | 17 December 2024 | Received at the December 24 meeting - **Closed** |
| October 2024 | Charitable Funds Committee | Gareth Watts, Director of Corporate Governance/Board Secretary | Ratification of Chairs Urgent Action – Charitable Fund Financial Control Procedure & Update of the Scheme of Delegation | A request seeking urgent support for approval of the Charitable Funds FCP and Scheme of Delegation was circulated on the 23rd October 2024 following agreement with the Audit & Risk Committee Chair | Head of Corporate Finance and Head of Charity and Income Generation | Gareth Watts, Director of Governance/Board Secretary | 17 December 2025 | Received at the December 2024 meeting - **Closed** |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| December 2024 | Audit & risk Committee | Internal Audit | IA Review – Energy Management | Requested via Internal Audit | Internal Audit | Gareth Watts, Director of Governance/Board Secretary | 17 December 2024 | Received at the December 24 meeting - **Closed** |
| December 2024 | Audit & risk Committee | Internal Audit | IA Review – Additional Medical Pay | Requested via Internal Audit | Internal Audit | Gareth Watts, Director of Governance/Board Secretary | 17 December 2024 | Received at the December 24 meeting - **Closed** |
| December 2024 | Audit & risk Committee | Internal Audit | IA Review – Charitable Funds | Requested via Internal Audit | Internal Audit | Gareth Watts, Director of Governance/Board Secretary | 17 December 2024 | Received at the December 24 meeting - **Closed** |
| December 2024 | Audit & risk Committee | Audit Wales | Audit Wales Report – Primary Care – Follow Up Review | Requested via Audit Wales | Audit Wales | Gareth Watts, Director of Governance/Board Secretary | 17 December 2024 | Received at the December 24 meeting - **Closed** |
| December 2024 | Audit & risk Committee | Audit Wales | Audit Wales Report – Review of Cost Saving Arrangements – Final Management Response | Requested via Audit Wales | Audit Wales | Gareth Watts, Director of Governance/Board Secretary | 17 December 2024 | Received at the December 24 meeting - **Closed** |

| Agenda Item |
| --- |
| 8.2.3 |

# Audit, Risk & Assurance Committee

## Cwm Taf Morgannwg University Health Board (CTMUHB) National Clinical Audit Programme Quarter 3 Update 2024-25

| | |
| --- | --- |
| **Dyddiad y Cyfarfod / Date of Meeting** | 22/05/2025 |
| **Statws Cyhoeddi / Publication Status** | Open/ Public<br>Not Applicable |
| **Awdur yr Adroddiad / Report Author**<br>*If you do not wish for your name to be included in the public domain, please only include your job title* | Mark Townsend – Head of Clinical Audit & Quality Informatics, Lauren Dyton – Clinical Audit Manager |
| **Cyflwynydd yr Adroddiad / Report Presenter**<br>*If you do not wish for your name to be included in the public domain, please only include your job title* | Dom Hurford, Executive Medical Director |
| **Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor** | Dom Hurford, Executive Medical Director |

| | |
| --- | --- |
| **Pwrpas yr Adroddiad / Report Purpose** | For Noting |

| **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)** | | |
| --- | --- | --- |
| **Committee / Group /Forum Individuals** | **Date** | **Outcome** |
| Quality, Safety & Experience Committee | 25/03/2025 | NOTED |

| Acronyms / Glossary of Terms | |
|---|---|
| CTMUHB | Cwm Taf Morgannwg University Health Board |
| TARN | Trauma Audit Research Network |
| NMTR | National Major Trauma Registry |
| CA&QI | Clinical Audit & Quality Informatics Department |
| NEIAA | National Early Inflammatory Arthritis Audit |
| NELA | National Emergency Laparotomy Audit |
| SWTN | South Wales Trauma Network |
| PWH | Princess of Wales Hospital |
| PCH | Prince Charles Hospital |
| RGH | Royal Glamorgan Hospital |
| AMaT | Audit Management and Tracking |
| NCEPOD | National Confidential Enquiry into Patient Outcome and Death |
| MINAP | Myocardial Ischaemia Audit Project |
| NICE | National Institute for Health and Care Excellence |
| HQIP | Healthcare Quality Improvement Partnership |
| WG | Welsh Government |
| NCA&ORP | National Clinical Audit and Outcome Review Plan |
| COPD | Chronic Obstructive Pulmonary Disease |
| NHFA | National Heart Failure Audit |
| CEC | Clinical Effectiveness Committee |
| EIA | Early Inflammatory Arthritis |
| NCDA | National Core Diabetes Audit |
| LFER | Learning From Events Reports |
| BI | Business Intelligence |

## 1. Situation /Background

1.1 The purpose of this report is to provide an update for the Quality and Safety Committee on progress against the CTMUHB Clinical Audit Forward Plan 2024-2025. The CTMUHB plan based on information from the HQIP directory of United Kingdom wide agreed audits and reviewed against the NCA&ORP for Wales (2024/25) published June 2024.

1.2 **32** out of 46 national audits (tier 1) are green fully compliant and 6 amber (NMTR / TARN, NEIAA (PWH), NJR (PWH), NELA (PCH, RGH), MINAP and Heart Failure where the audits are delayed, a backlog exists work is ongoing to partially or fully comply with the national audit deadlines. The NCDA report published 12 December 2024 confirmed that CTMUHB had achieved 100% compliance with data submission requirement for NCDA. The organisation is therefore no longer an 'outlier', and **0** audits are red.

1.3 The established CEC programme of meetings was affected by the remedial work required in the PoWH and associated impact on clinical services. The Falls, Frailty & Orthopaedics / Trauma CEC meetings scheduled for 12 November 2024 was postponed until April 2025. The main purpose of the CEC is to use national audit data to monitor quality of care across CTMUHB using evidence-based approaches.

1.4 The AMaT system continues to develop with work in progress to develop the use of the inspections module by the CTMUHB corporate governance team and to support ward accreditation and AMaT data to underpin the Ward Accreditation programme of work. Further work has been established to develop BI dashboards for the easy analysis of AMaT data at ward to board level with the Documentation and Record Keeping Audit dashboard going live in December 2024.

## 2. Specific Matters for Consideration

### 2.1 Clinical Audit Forward Plan 2024-2025 Current Position

A number of audits are amber due to competing demands on clinician time, these include:

NJR activity at the PWH is now being undertaken, by the Clinical Audit team and a significant reduction in the backlog of cases made during Quarter 3.

NEIAA due to clinical pressures and limited administration resources to support the service particularly in the PWH.

TARN / NMTR new data collection platform is now in place and has extensively used during quarter 3. Focus currently on completing Quarter 1 and 2 cases, to meet requirements of the SWTN. CTMUHB to host the

2025 South Wales Trauma Network Annual Conference, scheduled for October 2025.

NELA (RGH) new surgical NELA lead appointed in Quarter 3, NELA (PCH) additional cases identified for review, therefore activity is below expected level for both RGH and PCH 'amber'.

Fluctuating levels of clinical support for review activity for the cardiology national audits (Heart Failure and MINAP) at PWH, Quarter 1 submissions 'green', Quarter 2 submissions 'amber'.

## 2.2 Clinical Effectiveness Committee findings and actions (Quarter 3)

The planned Falls, Frailty & Orthopaedics / Trauma CEC meetings scheduled for 12 November 2024 was postponed until April 2025 due to the significant service pressures on the Orthopaedic and Trauma speciality as consequence of the remedial work required at the Princess of Wales hospital site.

The forward plan of themed CEC meetings, has been revised in light of the ongoing adjustments to clinical services.

## 2.3 Clinical Audit Training

To date over 658 Health Board staff have received training on the ward and area module.

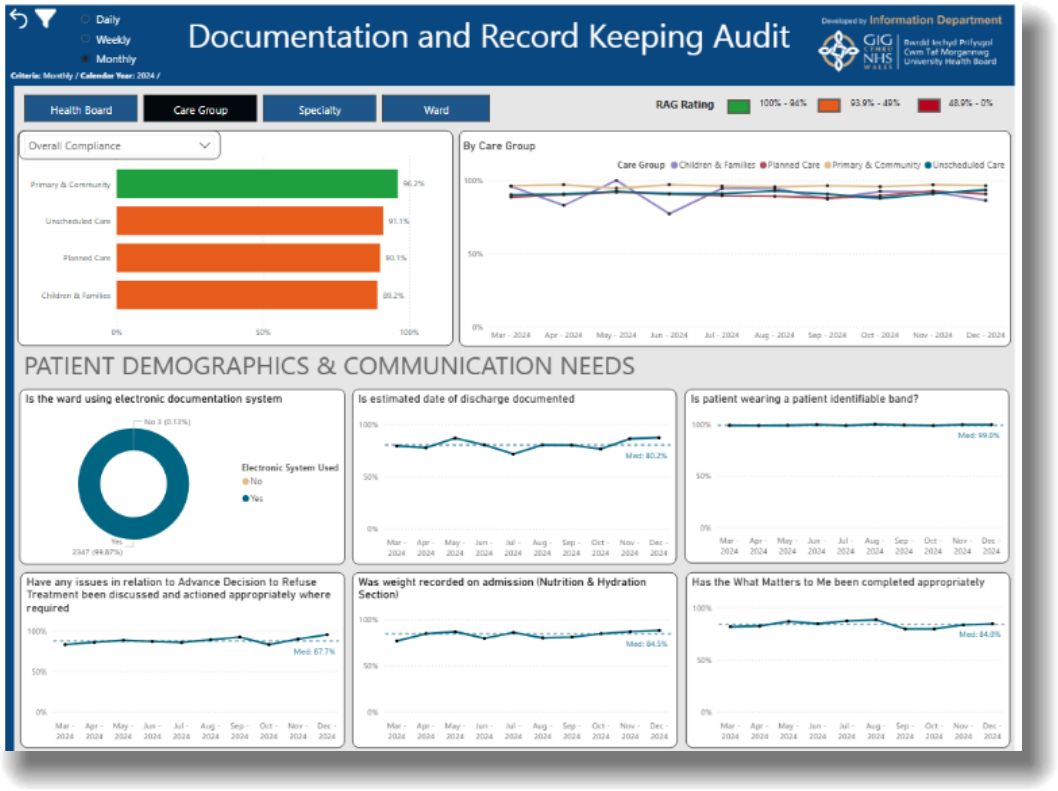
Clinical audit training was delivered to a large group of pharmacy staff in December 2024, with positive feedback received.

## 2.4 AMaT Implementation

A review has been undertaken of all core nursing ward / area audits in collaboration with the CTMUHB Quality Improvement team. The review identified a number of areas where the audits could be streamlined, stopped or modified to release clinical time to take forward improvement projects. The audit changes are currently under development with a planned go live date of the 1 April 2025.

Information gathered on the AMaT system has been utilised extensively to support evidence for LFERs and Ombudsman cases. The work includes provision of data from existing audits and/or developing new audits based on concerns e.g. Safeguarding audits).

The Documentation and Record Keeping Audit business intelligence dashboard has been launched for nurse managers and ward teams to support data analysis for improvement.




## 2.5 NICE Compliance Programme of work

The assurance oversight, scrutiny and a governance function in relation to NICE guidance within CTMUHB is the responsibility of the care groups. However, in collaboration with the Medical Director's office a process to disseminate new NICE guidance, receive feedback from care groups and annotate compliance statements on the AMaT system has been approved and this activity is planned to commence in quarter 4 with the Maternity Unit.

## 3. Key Risks / Matters for Escalation

3.1 No key risks or concerns to note for Quarter 3.

## 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 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** *(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: The potential consequences on quality of service have been considered and any necessary mitigating actions outlined in the paper | 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):<br><br>POSITIVE/NEUTRAL<br>NEGATIVE | If no, please include rationale below:<br><br>This is not a policy or service review |

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

## 6. Next Steps

6.1 To ensure completion of the full CTMUHB Clinical Audit Forward Plan 2024-2025, by the end of March 2025.

| Agenda Item |
| --- |
| 8.2.4 |

# Audit, Risk & Assurance Committee

# CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD (CTMUHB) CLINICAL AUDIT FORWARD PLAN FOR 2025-26

| | |
| --- | --- |
| **Dyddiad y Cyfarfod / Date of Meeting** | 22/05/2025 |
| **Statws Cyhoeddi / Publication Status** | Open/ Public<br>Not Applicable |
| **Awdur yr Adroddiad / Report Author**<br>*If you do not wish for your name to be included in the public domain, please only include your job title* | Mark Townsend, Head of Clinical Audit and Quality Informatics |
| **Cyflwynydd yr Adroddiad / Report Presenter**<br>*If you do not wish for your name to be included in the public domain, please only include your job title* | Dom Hurford, Executive Medical Director |
| **Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor** | Dom Hurford, Executive Medical Director |

| | |
| --- | --- |
| **Pwrpas yr Adroddiad / Report Purpose** | For Noting |

| **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)** | | |
| --- | --- | --- |
| **Committee / Group /Forum Individuals** | **Date** | **Outcome** |
| Quality, Safety and Experience Committee | 25/03/2025 | NOTED |

**Acronyms / Glossary of Terms**

| | |
|---|---|
| CTMUHB | Cwm Taf Morgannwg University Health Board |
| NCA&ORP | National Clinic al Audit & Outcome Review Plan |
| CA&QI | Clinical Audit and Quality Informatics |

## 1. Situation /Background

1.1 The purpose of this report is to provide the Audit Risk & Assurance Committee with the CTMUHB Clinical Audit Forward Plan 2025-2026. WG have not release an All Wales NCA&ORP for 2025-26 therefore the CTMUHB forward plan is based on information from the HQIP directory of United Kingdom wide agreed audits. (See Appendix 1: Clinical Audit Forward Plan 2025-26).

## 2. Specific Matters for Consideration

2.1 The Clinical Audit team are currently working to ensure completion of the full CTMUHB Clinical Audit Forward Plan 2024-2025, by the end of March 2025.

## 3. Key Risks / Matters for Escalation

3.1 The challenging backdrop of reduced budget, decreased staffing and increased demand to deliver an increasing programme of tier 1 national audits resulting in reduced capacity to support tier 2 essential organisation priority clinical audits.

## 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** | Effective |

| | |
|---|---|
| *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))* | 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: The potential consequences on quality of service have been considered and any necessary mitigating actions outlined in the paper | 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):<br><br>POSITIVE/NEUTRAL NEGATIVE<br><br>Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE | If no, please include rationale below:<br><br>This is not a policy or service review |
| **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 That the committee **NOTE** receipt of the CTMUHB Clinical Audit Forward Plan for 2025-2026.

## 6. Next Steps

6.1 To ensure delivery of the full CTMUHB Clinical Audit Forward Plan for 2025-2026, by the end of March 2026.

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Knowing How Well We Are Doing

# Clinical Audit Forward Plan 2025-26

**Standard 3.1:**
Safe and Clinically Effective Care
**Effective Care**

Version 1.0, 07 March 2025

**The following key criteria will also be used for judging success:**

- 100% participation, appropriate levels of case ascertainment and submission of complete data sets by all health boards and trusts (where applicable) in the full programme of National Clinical Audits and Clinical Outcome Reviews.
- Improvements in the quality and safety of patient outcomes and experience brought about by learning and action arising from the findings of National Clinical Audit and Clinical Outcome Review reports.

**The findings and recommendations from national clinical audit, outcome reviews and all other forms of reviews and assessments will be one of the principal mechanisms for assessing the quality and effectiveness of healthcare services provided by health boards and trusts in Wales.**

A Welsh Health Circular and Annual Plan is due to be published in June 2025 to clarify the mandatory audit list. The Cwm Taf Morgannwg University Health Board (CTMUHB) Clinical Audit Forward Plan has been developed based on the HQIP audit directory, but may need to be updated following the final release of the Welsh Health Circular by WG.

Clinical Effectiveness Committees (CEC) were established in 2024/25 to monitor quality of care across CTMUHB using evidence-based approaches, predominantly national audit findings for measurement and quality improvement; Provide assurance to the Board that our organisation has effective systems to deliver required standards, and identify areas to progress improvements in the delivery of patient care.

The CEC comprises of representation from Clinical Audit, Heads of Nursing and Clinical Leads, Allied Health Professionals and Pharmacy, Quality Improvement and Patient Safety. National audit action plans are reviewed and agreed through the CECs and enable the monitoring of compliance against the CTMUHB Clinical Audit Forward Plan.

**Compliance Key**

| | |
|---|---|
| **RED** | Cause for concern. Full compliance not achieved by audit deadline. |
| **AMBER** | Tier 1: **National audit** delayed, backlog exists but plan in place to comply with national audit deadline.<br><br>Tier 2: **Organisation priority audit** delayed by one quarter, but plan in place to comply with revised audit deadline. |
| **GREEN** | Audit on track at 31/03/2025 or completed, evidence of audit compliance documented on AMaT system. |
| **BLUE** | Audit and action plan completed by clinical audit leads and signed off on AMaT system. |

Submission deadlines and planned report release deadlines are constantly changing and in most cases being delayed.

## Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

| National Audit | Audit Period | Submission Deadline | Planned Report Publication | Specialty | Compliance Position 2024/25 | RAG Status 2024/25 |
|---|---|---|---|---|---|---|
| **Acute** | | | | | | |
| National Joint Registry (NJR) | operates continuous data capture | **February 2025** | September 2025 | Trauma and Orthopaedics | Organisation wide compliance | GREEN |
| National Emergency Laparotomy Audit (NELA) | operates continuous data capture | **N/A** | November 2025 | Surgery / Anaesthetics | PWH compliant, working towards compliance in RGH/PCH | AMBER |
| National Emergency Laparotomy Audit (NELA) – No Lap Audit (Non-laparotomy) | operates continuous data capture | **June 2025** | TBC | Surgery | New for 2024/25 | N/A |
| Case Mix Programme (CMP) ICNARC | operates continuous data capture | **Monthly** | March 2026 | Anaesthetics | Organisation wide compliance | GREEN |
| Major Trauma Audit # (TARN/ NMTR) | operates continuous data capture | **Awaiting details at time of reporting** | TBC | Emergency Medicine | National TARN System unavailable for data submissions until October 2024. Currently working to address the backlog case from 01/04/2024 | AMBER |
| **Long Term Conditions** | | | | | | |

## NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2025/26

**Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)**

| National Audit | Audit Period | Submission Deadline | Planned Report Publication | Specialty | Compliance Position 2024/25 | RAG Status 2024/25 |
|---|---|---|---|---|---|---|
| National Diabetes Audit *<br><br>**Note this covers the following areas :**<br>• National Diabetes Foot Care Audit (NDFCA) | operates continuous data capture | **N/A** | May 2025 (Continuous dashboard reporting now available) | Therapies | Organisation wide compliance | **BLUE** |
| • National Pregnancy in Diabetes Audit (NPID) | operates continuous data capture | **N/A** | TBC | Obstetrics and Gynaecology | Organisation wide compliance | **GREEN** |
| • National Diabetes Inpatient Audit (NDISA) | operates continuous data capture | **TBC** | TBC | General medicine | N/A | N/A |
| • National Core Diabetes Audit (NCDA) | Data capture from Primary Care at specific intervals | **N/A** | N/A | Primary Care / Secondary Care | Organisation data extracted | **GREEN** |
| National Diabetes Paediatric Audit (NPDA) * # | operates continuous data capture | **N/A** | March 2025 | Paediatrics | Organisation wide compliance | **GREEN** |
| National Diabetes Integrated Specialist Survey | Annual survey | **November 2025** | Dashboard Reporting | Organisation Wide | Organisation wide compliance | **GREEN** |
| National Respiratory Audit Programme (NRAP)*<br># **Note this covers the following areas:**<br>Adult Asthma Secondary Care | operates continuous data capture | **N/A** | June 2025 | General medicine | Organisation wide compliance | **BLUE** |

## NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2025/26

**Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)**

| National Audit | Audit Period | Submission Deadline | Planned Report Publication | Specialty | Compliance Position 2024/25 | RAG Status 2024/25 |
|---|---|---|---|---|---|---|
| COPD Secondary Care | operates continuous data capture | **N/A** | June 2025 | General medicine | Organisation wide compliance | **BLUE** |
| COPD Primary Care (Wales) | Data capture from Primary Care at specific intervals | **N/A** | TBC | Primary Care | Organisation wide compliance | **GREEN** |
| Paediatric Asthma Secondary Care | operates continuous data capture | **N/A** | June 2025 | Paediatrics | Organisation wide compliance | **GREEN** |
| Pulmonary Rehabilitation | operates continuous data capture | **In Progress** | June 2025 | Therapies | Service established in 2024/25 | **N/A** |
| National Early Inflammatory Arthritis Audit * # (NEIRT) | N/A | **May 2025** | October 2025 | Rheumatology | Action being taken to improve compliance at the PWH | **AMBER** |
| All Wales Audiology Audit # | operates continuous data capture | **N/A** | TBC | Ears, Nose and Throat | Organisation wide compliance | **GREEN** |
| **Older People** | | | | | | |
| Sentinel Stroke National Audit Programme (SSNAP) (SSNAP) * | operates continuous data capture | **N/A** | November 2025 | General medicine / Therapies | Organisation wide compliance | **GREEN** |

## NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2025/26

**Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)**

| National Audit | Audit Period | Submission Deadline | Planned Report Publication | Specialty | Compliance Position 2024/25 | RAG Status 2024/25 |
|---|---|---|---|---|---|---|
| Falls and Fragility Fractures Audit Programme Including:<br>• Inpatient Falls * (NAIF) | operates continuous data capture | **March 2025** | TBC | General Medicine / Trauma & Orthopaedics | Organisation wide compliance | **GREEN** |
| • National Hip Fracture Database (NHFD) | operates continuous data capture | **January 2025** | TBC | General Medicine / Trauma & Orthopaedics | Organisation wide compliance | **GREEN** |
| • Fracture Liaison Service Database (FLS-DB) | operates continuous data capture | **TBC** | N/A | General Medicine / Trauma & Orthopaedics | Service established 2024/25 | **N/A** |
| National Dementia Audit * (NDA) | Completed 5 Year cycle | **N/A** | N/A | Mental Health / Care of the Elderly | N/A | **N/A** |
| **End of Life** | | | | | | |
| National Audit for Care at the End of Life (NACEL) * | TBC | TBC | August 2025 | Palliative Care / Medicine | Organisation wide compliance | **GREEN** |
| **Heart** | | | | | | |
| National Cardiac Audit Programme (NCAP)<br>• National Heart Failure Audit * (NHFA) | operates continuous data capture | **June 2025** | TBC | Cardiology | Action being taken to improve compliance | **AMBER** |

## Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

| National Audit | Audit Period | Submission Deadline | Planned Report Publication | Specialty | Compliance Position 2024/25 | RAG Status 2024/25 |
|---|---|---|---|---|---|---|
| • Cardiac Rhythm Management * (CRM) | operates continuous data capture | **N/A** | TBC | Cardiology | Organisation wide compliance. (excludes Bridgend) | GREEN |
| • Myocardial Ischaemia National Audit Project (MINAP)* | operates continuous data capture | **June 2025** | TBC | Cardiology | Action being taken to improve compliance | AMBER |
| Cardiac Rehabilitation Audit (CRA) | operates continuous data capture | **N/A** | December 2025 | Cardiology | Organisation wide compliance | GREEN |
| **Cancer** ** | | | | | | |
| National Bowel Cancer Audit (NOGCA) * | operates continuous data capture | **N/A** | April 2025 | Surgery | Organisation wide compliance. Managed through cancer services. | BLUE |
| National Oesophago-Gastric Cancer Audit (NOGCA) * | operates continuous data capture | **N/A** | April 2025 | Surgery | Organisation wide compliance. Managed through cancer services. | GREEN |
| National Audit of Metastatic Breast Cancer (NAoMe) * | operates continuous data capture | **TBC** | April 2025 | Surgery | Newly added mid year compliance under review. Managed through cancer services. | **N/A** |
| National Audit of Primary Breast Cancer (NAoPri) * | operates continuous data capture | **TBC** | April 2025 | Surgery | Newly added mid year compliance under review. Managed through cancer services. | **N/A** |

## Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

| National Audit | Audit Period | Submission Deadline | Planned Report Publication | Specialty | Compliance Position 2024/25 | RAG Status 2024/25 |
|---|---|---|---|---|---|---|
| National Lung Cancer Audit (NLCA) * | operates continuous data capture | **N/A** | April 2025 | Respiratory Medicine | Organisation wide compliance. Managed through cancer services. | **BLUE** |
| National Prostate Cancer Audit (NPCA) * | operates continuous data capture | **N/A** | April 2025 | Surgery | Organisation wide compliance. Managed through cancer services. | **GREEN** |
| National Ovarian Cancer Audit (NOCA) | operates continuous data capture | **N/A** | TBC | Gynaecology | Newly added mid year compliance under review. Managed through cancer services. | **N/A** |
| National Pancreatic Cancer Audit (NPaCA) | operates continuous data capture | **N/A** | TBC | Gastroenterology | Newly added mid year compliance under review. Managed through cancer services. | **N/A** |
| National Non-Hodgkin Lymphoma Audit (NNHLA) | operates continuous data capture | **N/A** | TBC | | Newly added mid year compliance under review. Managed through cancer services. | **N/A** |
| National Kidney Cancer Audit (NKCA) | operates continuous data capture | **N/A** | TBC | | Newly added mid year compliance under review. Managed through cancer services. | **N/A** |
| **Women's and Children's Health** | | | | | | |
| National Neonatal Audit Programme Audit * # (NNAPA) | operates continuous data capture | **N/A** | October 2025 | Paediatrics | Organisation wide compliance. | **GREEN** |

## NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2025/26

**Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)**

| National Audit | Audit Period | Submission Deadline | Planned Report Publication | Specialty | Compliance Position 2024/25 | RAG Status 2024/25 |
|---|---|---|---|---|---|---|
| National Maternity and Perinatal Audit *# (NMPA) | operates continuous data capture | **N/A** | May 2025 | Obstetrics / Midwifery | Organisation wide compliance. | GREEN |
| National Perinatal Mortality Review Tool (PMRT) | operates continuous data capture | **N/A** | The PMRT is available for continuous use | Obstetrics / Midwifery | Organisation wide compliance. | GREEN |
| **Other** | | | | | | |
| National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12) *# (NASECYP) | Series of data collection cohorts within the audit | Various deadlines for cohorts | February 2025 | Paediatrics | Organisation wide compliance. | GREEN |
| National Clinical Audit of Psychosis * (NCAP)<br>EIP Audit | operates continuous data capture | **N/A** | Dashboard Reports being developed | Mental Health | Organisation wide compliance. | GREEN |

(* denotes NCAPOP Audits)
(# denotes reports likely to include information on children and / or maternity services)

## Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

### Clinical Outcomes Review Programme (2024/25)

The Clinical Outcome Review Programme (CORP) is designed to help assess the quality of healthcare, and stimulate improvement in safety and effectiveness by enabling learning from adverse events and other relevant data. It aims to complement and contribute to the work of other agencies such as NICE, the Royal Colleges and academic research studies which support changes to improve NHS healthcare.

| The Clinical Outcome Review Programme (Tier 1) | Audit Period | Completion Deadline | Report Publication | Programme | Compliance Position 2024/25 | RAG Status 2024/25 |
|---|---|---|---|---|---|---|
| • National Confidential Inquiry into Suicide and Safety in Mental Health | operates continuous data capture | **N/A** | April 2025 | Mental Health Programme | Organisation wide compliance. | **GREEN** |
| • Rehabilitation after Critical Illness | 2023/24 | **N/A** | Spring 2025 | Medical & Surgical programme | Organisation wide compliance. | **GREEN** |
| • Blood Sodium | 2024/25 | **April 2025** | November 2025 | Medical & Surgical programme | Data submitted | **N/A** |
| • Acute Limb Ischaemia | 2024/25 | **April 2025** | November 2025 | Medical & Surgical programme | Organisational Audit ONLY required | **N/A** |
| • MBRRACE – Perinatal Mortality Surveillance | operates continuous data capture | **TBC** | October 2025 | Maternal, Newborn and Infant Clinical Outcome Review Programme | Organisation wide compliance. | **GREEN** |
| • MBRRACE – Saving Lives Improving Mothers Care | operates continuous data capture | **TBC** | October 2025 | Maternal, Newborn and Infant Clinical Outcome Review Programme | Organisation wide compliance. | **GREEN** |

| Organisation Priority Audits (Tier 2) | Audit Period | Completion Deadline | Report Publication | Specialty | Compliance Position 2024/25 | RAG Status 2024/2025 |
|---|---|---|---|---|---|---|
| Case Note Documentation Audits: | Revised methodology TBC | | | | | |
| • Acute Hospital Documentation Audit | | **TBC** | TBC | Acute inpatient activity | Audit process currently under review | **N/A** |
| • Community Hospital Documentation Audit | | **TBC** | TBC | Community hospital inpatient activity | Audit process currently under review | **N/A** |
| • A&E Documentation Audit | | **TBC** | TBC | Emergency Medicine | Audit process currently under review | **N/A** |
| **Consent to Treat Audit** | Quarter 1, 2025/26 | **Quarter 1, 2025/26** | Quarter 2, 2025/26 | Medicine / Surgery | N/A | N/A |
| National Ophthalmology Audit (Adult Cataract surgery) * (NOD) | operates continuous data capture | **TBC** | TBC | Ophthalmology | Participation in RGH and PCH only. | **GREEN** |

| Agenda Item |
| --- |
| 8.2.5 |

# Audit, Risk & Assurance Committee

## Corporate Governance Notified Breaches of Standing Orders

| | |
| --- | --- |
| **Dyddiad y Cyfarfod / Date of Meeting** | 22/05/2025 |
| **Statws Cyhoeddi / Publication Status** | Open/ Public<br>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** | |
| --- | --- |
| CTMUHB | Cwm Taf Morgannwg University Health Board |
| WG | Welsh Government |

## 1. Situation /Background

1.1 Prior to the new model Standing Orders issued by WG and approved by CTM Board on the 27th March 2025, there was a requirement to publish Board and Committee papers 10 calendar days in advance of the formal public meetings.

1.2 In practice most Health Boards, including CTMUHB, routinely publish papers electronically 7 days prior to the meeting and therefore for full transparency this report captures the breaches to the previous order i.e. 10 calendar days, prior to the change made to the Standing Orders in March 2025. For awareness the recent change supports a 7 calendar day publication for public Board and Board Committee meetings

## 2. Specific Matters for Consideration

2.1 In response to the requirement to publish papers 10 calendar days in advance of the public meeting, prior to the change in March 2025, the following breaches are 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. This only relates to papers published for Board and Committees up to 27 March 2025.
- The papers for the Health, Safety & Fire Sub Committee meeting that took place on 5 September 2024 were only published six days in advance of the meeting.
- The papers for the Extra Ordinary Private Board meeting that took place on 17 October 2024 to discuss and approve the Business Case - Developing a Digital Solution to achieve a Single Clinical Record within Mental Health & Learning Disabilities were not received until the 15 October 2024 and therefore papers were only published two days in advance of the meeting.
- The papers for the Extra-Ordinary Private Board meeting that took place on 31 October 2024 to discuss and approve the Business Case for the Roof Covering Replacement Works at the Princess of Wales Hospital, were not received until the 29 October 2024 and therefore papers were only published two days in advance of the meeting.
- The papers for the Remuneration & Terms of Services Committee meeting that took place on 5 February 2025 to discuss three agenda items were not all received until 4 February 2025 and therefore papers were only published one day in advance of the meeting.
- The papers for the Audit, Risk & Assurance Committee meeting that took place in the 13 February 2025 were published 6 days in advance of the meeting.
- The papers for the Remuneration & Terms of Services Committee meeting that took place on 13 March 2025 to discuss one single agenda

item were not received until 13 March 2025 and therefore papers were published on the day of the meeting.

- The papers for the Remuneration & Terms of Services Committee meeting that took place on 27 March 2025 to discuss two agenda items were not received until the 25 March 2025 and therefore papers were published two days before the meeting.

2.2 Breach to the Scheme of Delegation – the Remuneration and Terms of Service Committee were notified of a breach to the Standing Orders in March 2025. Due to an administrative / process error a redundancy payment was paid to a staff Member in August 2024, without it being approved by the Remuneration and Terms of Service Committee, resulting in a breach to the Scheme of Delegation. The payment was retrospectively approved by the Remuneration & Terms of Service Committee on 27 March 2025. The breach was also proactively notified to Audit Wales for end of year reporting.

## 3. Key Risks / Matters for Escalation

3.1 The risk in relation to the 10-calendar day publication of formal Board and Committee papers has been mitigated by the new Model Standing Orders with a shorter publication requirement now in place. There are instances outlined in section 2 where the publication has been shorter than 7 days and it is acknowledged that this may not provide Board Members with sufficient time to review. This will remain a watching brief by the Corporate Governance Team.

3.2 In terms of the breach in approving a redundancy payment. The process has been reviewed and improvements made to the pathway to approval to mitigate similar breaches in future. The Remuneration and Terms of Service Committee were satisfied with the assurances provided around this matter in terms of lessons learned.

## 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: |
| | A Resilient Wales |

| | |
|---|---|
| **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)* | 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** *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:<br><br>Not applicable |
| **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):<br><br>POSITIVE/NEUTRAL NEGATIVE<br><br>Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE | If no, please include rationale below:<br><br>Not applicable |

| | |
|---|---|
| **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 **NOTE** the Breach to Standing Orders being reported.

# Duty of Candour
# Final Internal Audit Report

March 2025

Cwm Taf Morgannwg University Health Board

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

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

# Contents

Executive Summary ..... 4
1. Introduction ..... 5
2. Detailed Audit Findings ..... 6
Appendix A: Management Action Plan ..... 11
Appendix B: Assurance opinion and action plan risk rating ..... 21

| | |
|---|---|
| Review reference: | CTMUHB-2324-10 |
| Report status: | Final |
| Fieldwork commencement: | July 2024 |
| Fieldwork completion: | January 2025 |
| Debrief meeting: | January 2025 |
| Draft report issued: | January 2025 |
| Management response received: | March 2025 |
| Final report issued: | March 2025 |
| Auditors: | John Cundy, Lead Auditor<br>Emma Samways, Deputy Head of Internal Audit<br>Paul Dalton, Head of Internal Audit |
| Executive sign-off: | Greg Dix, Executive Director of Nursing, Midwifery & Patient Care |
| Distribution: | Kellie Jenkins-Forrester, Head of Concerns and Business Intelligence |
| Committee: | Audit, Risk and Assurance 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 the Cwm Taf Morgannwg University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

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**

Our review considered the processes and procedures implemented by the Health Board to ensure compliance with the Duty of Candour.

**Overview**

We have issued reasonable assurance on this area.

Our key finding relates to the need for Datix to be fully completed and completed with a consistent approach. To aid this, guidance needs to be in place and available to staff.

More accurate data captured will lead to better monitoring in relation to compliance with the Duty.

## Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

**Low to moderate impact** on residual risk exposure until resolved

## Assurance summary[1]

| Objectives | | Assurance |
|---|---|---|
| 1 | Process and procedures | Reasonable |
| 2 | Training and support | Reasonable |
| 3 | Operation and compliance | Limited |
| 4 | Monitoring and reporting | Reasonable |

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

## Key Matters Arising

| | | Objective | Control Design or Operation | Recommendation Priority |
|---|---|---|---|---|
| 2 | Amendments to the assessment of level of harm | 3 | Operation | Medium |
| 3 | Completion of Datix records | 1,2 & 3 | Operation | High |
| 4 | Following the Duty of Candour process | 3 | Operation | Medium |
| 6 | Accuracy of monitoring data | 4 | Operation | Medium |

# 1. Introduction

1.1 Our audit review in relation to the Duty of Candour arrangements was completed in line with the 2024/25 Internal Audit Plan for Cwm Taf Morgannwg University Health Board (the 'Health Board').

1.2 Duty of Candour legislation was introduced in April 2023 as part of the Health & Social Care (Quality and Engagement) (Wales) Act 2020 along with the Duty of Quality.

1.3 Duty of Candour (the 'Duty') means that NHS organisations have a duty to be open and honest with the service users for which they are providing healthcare. If things go wrong, and harm has occurred, organisations must recognise this and communicate with the service user. This builds upon the principles of the 'Putting Things Right Regulations' already in place within NHS Wales, with an overall objective of ensuring that when a person receives healthcare services, they are dealt with in an open an honest way by their care provider. The Duty ensures that NHS organisations are clear about avoiding any potential culture of blame and supports those where mistakes and errors have been made.

1.4 Where Duty of Candour incidents are identified they should be investigated by the relevant NHS organisation within the required timeframe. This helps to understand what happened, to provide the service user with truthful information and an apology, and to identify areas for improvement and lessons to be learnt.

1.5 This review has links to strategic risk two of the Health Board's strategic risk register: Ability to deliver improvements which transform care and enhance outcomes'.

1.6 The risk considered during our review include:

- Non-compliance with legislation if guidance is unclear and staff are unaware of their responsibilities.
- Patient harm or poor patient experience if there is a lack of monitoring and oversight to ensure lessons are learnt.
- Reputational damage with decreased public confidence.

1.7 The relevant lead for this review is the Executive Director of Nursing, Midwifery and Patient Care.

# 2. Detailed Audit Findings

**Objective 1: Clearly defined procedures are in place for the management of Duty of Candour cases, which are in line with Welsh Government guidance and include the roles and responsibilities for identifying, investigating and monitoring cases.**

2.1 In April 2023 the Welsh Government (WG) published their 'Duty of Candour Statutory Guidance', which details the necessary information to allow NHS organisations to deliver the requirements of the Duty of Candour. The Health Board has chosen not to produce a standalone Duty of Candour policy, as it is an integral part of the incident management process. In February 2024 the Health Board's Incident Management Framework was updated to incorporate information in relation to the Duty. The Health Board's concerns policy and procedure has also been updated to include reference to the Duty.

2.2 We have confirmed that the Incident Management Framework contains a Duty of Candour section, which includes the requirements in relation to contacting patients should a Duty of Candour matter arise. As the Duty is an integral part of the incident management processes, details about the roles and responsibilities for investigation and monitoring cases are included in that wider incident management context.

2.3 Whilst the Incident Management Framework provides high level guidance, there are no detailed operating procedures or guidance documents is in place. Our testing under objective 3 identified discrepancies in the interpretation of information and the completion of the Datix system, which is used to record and capture incident information and determine if a Duty of Candour matter has been triggered. We saw that information fields were not always completed, and the information required to be included in date fields had been interpreted differently by different staff. We understand that there is an intention to develop action cards that sit beneath the incident framework, to guide staff on the correct process to follow. **(See Matter Arising 3)**

Conclusion:

2.4 The Health Board's incident management framework has relevant information that aligns to the Welsh Government guidance, which includes roles and responsibilities and identifying, investigating and monitoring cases. However, there are no detailed operating procedures in place to guide staff. We have provided **Reasonable Assurance** for this objective.

**Objective 2: Health Board wide training and ongoing support is in place to help staff meet their Duty of Candour responsibilities.**

2.5 We understand that a number of events and activities took place within the Health Board to inform staff before the Duty came into effect. For example, presentations to care groups. In addition, the Health Board's staff newsletter contained an overview about the implementation of the Duty and contained links to the Duty of Candour information pages on the intranet. We also saw that the Primary Care internet pages contained a section on the Duty of Candour, and a link to a series

of fifteen virtual drop-in clinics being run across the year that primary care providers could attend.

2.6 We note that Duty of Candour awareness training is available for NHS staff via e-learning accessed through ESR. We understand that staff were made aware of the training module at the launch events. The Health Board has not made training on the Duty mandatory, and we have not seen monitoring of training uptake. We obtained information from the Learning & Development team and identified that since launching in March 2023, 434 staff had enrolled on the e-learning package up to the end of September 2024. Whilst most of those have viewed the training material, only 145 had completed the training package. Information on the training module is not identified on the Duty of Candour intranet pages. **(Matter Arising 1)**

2.7 No other specialist training on the Duty has been created or delivered for incident managers and reviewers. However, we acknowledge that any investigation required if a Duty of Candour is triggered forms part of the wider incident investigation process, for which training is provided.

2.8 From our fieldwork, it was clear that quality and safety teams have a leading role in relation to the Duty of Candour process and act as local support for staff that may have queries. However, through our testing we have identified numerous issues relating to the completion of Duty of Candour details in Datix and therefore the potential need for training in relation to this. **(see Matter Arising 3)**

Conclusion:

2.9 General information about the Duty has been made available to staff via the Health Board's intranet, and the quality and safety leads within care groups are able to provide more detailed, Health Board specific, guidance. Awareness could be enhanced further through promotion of the ESR training and monitoring of uptake. We have provided **Reasonable Assurance** for this objective.

**Objective 3: Robust processes are in place to ensure the Health Board complies with the Duty of Candour.**

2.10 The Duty requires the Health Board to follow a process when a service user suffers an adverse outcome, which has, or could result in unexpected or unintended harm that is more than minimal, and the provision of health care was, or may have been, a factor. As such, a Duty of Candour matter is triggered when the level of harm is assessed by a manager as 'moderate or above' and an answer of 'yes' is given against the question on whether healthcare provision was a contributing factor. Once the Health Board becomes aware that a Duty has been triggered, the statutory guidance sets out a series of actions to be taken including, initial 'in person' contact with the patient or their representative, a follow-up written notification, and a final letter following completion of the investigation.

2.11 Care group Quality & Patient Safety (Q&PS) teams oversee the incident management process for their areas, and the Duty of Candour is integrated into this process. A duty is triggered by the Q&PS team following the completion of an

incident 'triage' process where the team review the initial level of harm allocated by the incident reporter and attribute a 'manager's harm' assessment level.

2.12 We obtained a report from the Datix system showing the changes in harm level between the reporter's initial assessment, the manager's triaged assessment, and the post investigation assessment. Our analysis showed that in 60% of cases the level of harm attributed by the manager differed to that attributed by the reporter. While the assessed level of harm was increased in some cases, most were decreased. We understand that the reporter's initial harm assessment is often based on the incident outcome which can be more severe, as opposed to an assessment of the harm caused at that time, hence the level is often overstated.

2.13 However, we also identified that all cases that had a harm level of low or none following manager assessment, went on to be upgraded to moderate harm or above following investigation. Whilst these cases would have still been investigated using the incident management framework, the Duty of Candour element of that process would not have been instigated as the low or no harm manager assessment meant the Duty had not triggered. Furthermore, given that all cases downgraded to low or no harm at manager assessment stage were subsequently upgraded to moderate and above, would indicate additional training and guidance is needed for managers. **(Matter Arising 2)**

2.14 We reviewed data from cases recorded in Datix between April and July 2024. We identified cases where information relevant to the Duty had not been populated. This included instances where the manager's harm assessment was not recorded, and instances where the answer to the healthcare factor question had not been populated. Some of these cases had already been closed, which could mean that a potential Duty of Candour matter may have been missed. **(Matter Arising 3)**

2.15 We also saw cases where information was captured in these key fields and a Duty of Candour matter was triggered, but the 'date the health board became aware' field was blank. We are aware that a key report generated from the Datix system uses the 'date the health board became aware' as part of its criteria. As such, reports generated of cases that have triggered a Duty of Candour matter may not be accurate. **(Matter Arising 3)**

2.16 We undertook more detailed testing on a sample of cases where a Duty of Candour matter had been triggered. In the majority of cases we could evidence that the correct process had been followed. We did note some cases where required information had not been captured, key documents such as copies of letters had not been saved to Datix, or the dates recorded in Datix did not correspond to the dates on the letters. Also, many of the initial letters and final letters had not been sent within the required timeframes. **(Matter Arising 4)**

2.17 A small number of more complex cases that were likely to trigger a Duty of Candour matter were identified during out fieldwork. These cases involved other NHS bodies. There appeared to be some delays in instigating the Duty of Candour process while it was determined where responsibility lay. While the WG statutory guidance provides direction on the process to follow in complex cases, there are

no detailed procedures in place to support the application of the statutory guidance. **(Matter Arising 5)**

Conclusion:

2.18 Our review of reports generated from the Datix system and our testing of a sample of cases has identified gaps in the information that should be captured in relation to the Duty of Candour and inaccuracies where data is recorded. There are currently no operating procedures in place to guide staff. We have provided **Limited Assurance** against this objective.

**Objective 4: Timely monitoring and reporting arrangements are in place at appropriate levels within the Health Board, which include lessons learnt and contribute to a system of continuous improvement.**

2.19 In the care groups that we sampled, we saw evidence of spreadsheet trackers of Duty of Candour cases. We also saw dashboards within Datix to facilitate monitoring.

2.20 At the weekly Executive team meeting an incident management update report is provided. This incorporates monthly data on the number of incidents where a Duty of Candour matter has been triggered, and a brief overview of the cases that have triggered since the previous meeting.

2.21 Since its launch in April 2023, Duty of Candour data and information has been included in the patient safety, quality and experience dashboard that is presented at each Quality & Safety Committee meeting.

2.22 While we saw reporting and monitoring in relation to the Duty of Candour at various levels within the Health Board we identified instances where the data appeared to be incomplete. **(Matter Arising 6)**

2.23 In addition, in March 2024 there was an all-Wales update to the Datix system. A question was added to help determine if a Duty of Candour matter had occurred which identified if healthcare provision was a factor in the patient suffering harm. Previously, a nursing care question was used to inform if an incident should be considered a Duty of Candour matter. The new question was retrospectively added to cases already in Datix and a 'yes' answer applied in cases where the manager's assessment of the level of harm was 'moderate or above'. This amendment to 2023/24 data may have affected the accuracy of reported Duty of Candour cases for the year, as it appears that more cases have triggered a Duty of Candour matter but were not treated as such. **(Matter Arising 6)**

2.24 The WG statutory guidance requires the Health Board to produce an annual report in relation to the Duty, which is to be published at the end of October each year, in line with the 'Putting Things Right' annual report. As such, at the time of our fieldwork, the Health Board's first annual report in relation to the Duty was being prepared.

2.25 The Duty is embedded within the incident management process, so lessons learnt are recorded and disseminated as part of this process. Our testing has confirmed

that for all cases in our sample, the lessons learned sections in Datix had been appropriately completed.

Conclusion:

2.26 Since the Duty of Candour was launched an established reporting and monitoring routine has been established. However, our testing has identified some instances where the information is not complete or accurate for some elements of the data. We have provided **Reasonable Assurance** against this objective.

# Appendix A: Management Action Plan

| **Matter Arising 1: Duty of Candour awareness training** (Operation) | **Potential Impact** |
|---|---|
| NHS staff should have an awareness of the Duty of Candour and understand the requirements of the Act. At the time the Duty came into effect, an all-Wales e-learning module was made available to staff via ESR. Staff were made aware of the training module when it was launched, but we have not seen further communication to encourage participation. We also note that there is no reference or link to the training module on the Duty of Candour intranet pages.<br><br>The Health Board has not mandated completion of the training and to date there does not appear to have been any monitoring of uptake. Our review of data provided by the Learning & Development team identified that 434 staff enrolled on the on-line course between March 2023 and September 2024. Most have started to view the course content, but only 145 have completed the course. | Incorrect application of the Duty of Candour. |

| | **Recommendations** | **Priority** |
|---|---|---|
| 1 | Information and a link to the ESR Duty of Candour training module should be included on the Duty of Candour intranet pages.<br><br>Consideration should be given to identifying those staff that would most benefit from attending Duty of Candour training and direct communications to encourage participation.<br><br>Periodic monitoring on training uptake should take place. If necessary, reminders about the duty and the availability of training should be issued via Health Board wide communication channels. | **Low** |

| | **Agreed Management Action** | **Target Date** | **Responsible Officer** |
|---|---|---|---|
| 1 | a) Duty of Candour Intranet pages to be updated to include links to training programmes.<br>b) Consideration of Duty of Candour training to be included in training plan for implementation of revised Putting Things Right regulations. | 31.03.25<br><br>31.10.25 | Head of Concerns & Business Intelligence<br><br>Assistant Director for Quality & Safety /Head of Concerns and Business Intelligence |

| **Matter Arising 2: Amendments to the assessment of level of harm** (Operation) | **Potential Impact** |
|---|---|
| We obtained a report from the Datix system showing the changes in harm level between the reporter's initial assessment, the manager's triaged assessment, and the post investigation review assessment. The report contained 528 incidents from 2023/24.<br><br>Following the manager assessment, 261/528 cases had their harm level reduced to none or low, meaning they did not trigger the Duty of Candour at that time. However, following completion of the incident investigation, all 261 cases had the harm level increased back up to moderate or above. We acknowledge that the manager level of harm assessment is based on the limited information they have at that time, whereas the final level of harm assessment is based on information following investigation. However, as all 261 cases where the harm level was lowered at management review stage, were then increased, would suggest further guidance or training may be needed. | Duty of Candour not recognised and acted up where inaccurate harm assessments are made. |

| **Recommendations** | | **Priority** |
|---|---|---|
| 2.1a<br><br>2.1b | Regular analysis of data on the variations in harm levels at the various stages in the incident process should be undertaken to look for any trends or patterns. For example, if the under or overstating of harm levels is predominately linked to certain care groups or departments.<br><br>Training should be provided in relation to assessing the level of harm, with a focus on those areas where analysis may have shown higher numbers of variations. | **Medium** |
| 2.2 | To encourage a consistent and more accurate assessment of harm levels at the various incident stages, information and guidance should be incorporated into any operating procedures that are developed. (see Matter Arising 3) | |

| **Agreed Management Action** | | **Target Date** | **Responsible Officer** |
|---|---|---|---|
| 2.1a | Monthly assessment of variations in harm levels to be undertaken and feedback provided monthly Care Group reports | 30.06.25 | Head of Concerns & Business Intelligence |

| | | | |
|---|---|---|---|
| 2.1b | Training in relation to assessment of harm to be included in training programme for implementation of revised Putting Things Right Regulations. | 31.10.25 | Assistant Director of Quality & Safety / Head of Concerns & Business Intelligence |
| 2.2 | The Incident Management Framework to be updated to include information and guidance in relation to harm assessment and its application to Duty of Candour. | 31.05.25 | Head of Concerns & Business Intelligence |

| **Matter Arising 3: Completion of Datix records** (Operation) | **Potential Impact** |
|---|---|
| A report from the Datix system for the period April to end July 2024 records 8,080 incidents. Our review of the data identified instances where information relevant to the Duty of Candour process had not been input.<br><br>The manager's assessment of the level of harm, takes place following the reporter assessment of harm, and is required to determine if a Duty of Candour matter has been triggered. Our analysis of the 8,080 incidents in the report identified that:<br><br>• For 1,239 incidents the manager harm assessment was not recorded, and of these 35% had already been closed or were awaiting closure within Datix.<br><br>• Of the incidents closed or awaiting closure, 42 had been initially assessed by the reporter as having a harm level of 'moderate or above', indicating a Duty of Candour may have triggered. In addition, the question on whether 'healthcare was a factor in the patient suffering harm', had also not been answered meaning that these incidents may not have been considered for Duty of Candour despite the initial reporter assessment meeting the threshold.<br><br>• For 308 incidents the managers assessment of harm was recorded as 'moderate or above'. However, in 123 of these incidents the healthcare factor question had not been completed, meaning a Duty of Candour matter had not been triggered. We tested a sample of 15 of these cases, five should have triggered a Duty of Candour as a 'yes' answer had been input against the previously used question relating to nursing care being a factor.<br><br>• For 50 incidents a Duty of Candour matter was triggered as the manager harm assessment had been recorded as 'moderate or above' and healthcare had been a determining factor in the patient suffering harm. However, no information was recorded in the 'date became aware' field in 22/50 (44%) of cases, which is a criteria for identifying Duty of Candour matters in some Datix reports. (see matter arising 6)<br><br>We understand that the Workstream forms set up within Datix Cymru had mandated fields that would prevent a case being closed if key information was missing. However, it appears that some users within the Health Board were not using the approved form. This has allowed the mandatory controls in-built not to be completed. As such, information in relation to key stages can be left unpopulated, meaning incidents can be closed without answers to the Duty of Candour trigger questions being completed, or with key information missing where a Duty of Candour matter has been triggered. | Failure to properly identify and act upon Duty of Candour cases.<br><br>Failure to declare Duty of Candour incidents correctly and within timescales. |

| | | |
|---|---|---|
| Furthermore, there are no supporting operating procedures or guidance notes to aid staff on matters such as how to interpret key dates including 'date first became aware a DOC was triggered', or the capturing of information in Datix. | | |
| **Recommendations** | | **Priority** |
| 3.1a<br>3.1b | Detailed operating procedures should be developed to aid staff in ensuring the correct application of the Duty of Candour and the capture of essential information within the Datix system.<br>Once produced, the procedures should be made accessible to staff via the Duty of Candour intranet pages. | **High** |
| 3.2 | A review of the current forms used within Datix Cymru by the Health Board should take place with a view to reinstating the workstream approved form in the system that have mandatory elements in-built and prevent fields being left unpopulated. | **High** |

| **Agreed Management Action** | | **Target Date** | **Responsible Officer** |
|---|---|---|---|
| 3.1a | The Incident Management Framework to be updated to include flow charts as appendices to support the implementation of Duty of Candour and accurate completion of Datix Cymru. | 31.05.25 | Head of Concerns & Business Intelligence |
| 3.1b | The Incident Management Framework Health Board Intranet Pages to be updated to include all supporting documentation relating to the implementation of Duty of Candour and the accurate completion of Datix. | 31.05.25 | Head of Concerns & Business Intelligence |
| 3.2 | Review of Datix Cymru forms allocated to be undertaken and updated as required. | 30.04.25 | Head of Concerns & Business Intelligence |

| **Matter Arising 4: Following the Duty of Candour process** (Operation) | **Potential Impact** |
|---|---|
| The WG statutory guidance states that on first becoming aware that a Duty of Candour is triggered, the patient or person acting on their behalf should be notified 'in person' (telephone, video call, face to face) and an initial apology and explanation provided. This should be followed up with a written notification within five working days. Reference is then made to the 'Putting Things Right' (PTR) guidance and the need for a final letter to be sent within 30 working days, (upon completion of the investigation). The Datix Cymru system has been set up to capture this information. We undertook testing in relation to a sample of 24 cases where the 'date became aware' field had been populated, meaning a Duty of Candour matter had been triggered. We identified:<br>• In two cases, the date the initial letter was sent was not captured and we could not see a copy of the letter saved to Datix.<br>Where date information was captured, there were only eight cases where the initial letter was sent within the target 5-working days after the initial notification. However, our review of the data suggests staff are not clear on the date to be recorded in this field. In many cases other dates such as when the final letter was sent, or the case closed date had been input in this field.<br>• The system requires the manual calculation and input of a date 30-working days after the initial written notification. This is the target date for the final response letter to be sent. 7 cases had no date captured of when the final letter was due to be sent by. Of the closed cases, only two were sent within the 30-day target.<br>We also noted some cases where the 'sent date' in Datix was not accurate when compared to the date recorded on the final letter. Again, it appears there is a confusion as to what information is required. | Failure to comply with requirements and timescales set out in the statutory guidance.<br>Inaccurate reporting where data is incomplete or incorrectly captured. |

| | **Recommendations** | **Priority** |
|---|---|---|
| 4.1 | As part of the development of an SOP to provide clarity to staff on the capture of information, staff should be remined of the importance of comprehensively and accurately completing the required fields in Datix and saving copies of relevant documents to the Datix record.<br>Staff should also be remined of the timeframes of when key letters should be issued. (Though we appreciate achievement of the 30-day timeframe in complex investigations is difficult). | **Medium** |

| | Agreed Management Action | Target Date | Responsible Officer |
|---|---|---|---|
| 4.1 | The Incident Management Framework to be updated to include flow charts as appendices to support the implementation of Duty of Candour and accurate completion of Datix Cymru. | 31.05.25 | Head of Concerns & Business Intelligence |

| **Matter Arising 5: Complex case guidance** (Design) | | | **Potential Impact** |
|---|---|---|---|
| During our testing we identified a small number of cases that involved other health boards or trusts. In such cases, determination of who is responsible for the incident can delay the actions required under the Duty of Candour. The WG statutory guidance includes a chapter on complex cases including where more than one NHS body is involved, or the NHS and other organisations. However, in the absence of detailed guidance notes or operating procedures, it is not clear to staff the process that should be followed. | | | Failure to declare candour correctly and within timescales. |
| **Recommendations** | | | **Priority** |
| 5.1 | The Health Board should consult with the Candour network to ensure a consistent and unified approach to dealing with complex cases involving other health boards or trusts is set out and prevent possible delays. | | **Low** |
| **Agreed Management Action** | | **Target Date** | **Responsible Officer** |
| 5.1 | Consult with Duty of Candour Network to identify best practice for management of complex cases and incorporate into Standard Operating Procedure. | 30.06.25 | Assistant Director of Quality & Safety / Head of Concerns & Business Intelligence |

| **Matter Arising 6: Accuracy of data used for monitoring** (Operation) | **Potential Impact** |
|---|---|
| Our testing has identified instances where data is not captured consistently within Datix Cymru. As such, there is a risk that Datix reports used for monitoring are inaccurate and incomplete. For example, if reports on the number of Duty of Candour cases are generated using 'date became aware', this is a risk of under-reporting. It appears that the standard reports built into the system have not been utilised and as alternative reports have been put in place, this creates the risk of inconsistency.<br><br>Furthermore, an all-Wales Datix update in April 2024 may also be having an impact on the accuracy of the number of 2023/24 cases being reported. The system update saw the addition of a key question relating to whether the healthcare provided was a factor in the patient suffering harm. This question was also retrospectively added to cases already captured in Datix Cymru, and an automatic answer of 'yes' applied in cases where the manager's level of harm assessment was moderate or above.<br><br>As part of the update, a validation exercise should have been carried out by the Health Board to identify any records where healthcare was not actually a factor. This exercise does not appear to have been carried out and has resulted in records being closed with a harm grading of moderate or above and no rationale in place while the Duty of Candour does not apply. | Inaccurate reporting of Duty of Candour cases. |

| **Recommendations** | | **Priority** |
|---|---|---|
| 6.1 | The Health Board should ensure the reports it utilises for monitoring of Duty of Candour are in line with the standard reports produced by the OfW Central Team. | **Medium** |
| 6.2 | The Health Board should undertake a review of 2023/2024 data to validate all matters which are closed with a harm grading of moderate or greater. Assistance for this task can be obtained from the OfW Central Team.<br><br>A regular review/audit of closed records should be undertaken to identify which have a closed status, a harm grading of moderate or greater and insufficient clarification regarding Duty of Candour status. | **Medium** |

| | Agreed Management Action | Target Date | Responsible Officer |
|---|---|---|---|
| 6.1 | Review all reports produced in relation to Duty of Candour are in line with Once for Wales templates and reports. | 31.03.25 | Head of Concerns & Business Intelligence |
| 6.2 | Review of 2023 / 2024 data to be completed and learning identified to inform improvement action.<br><br>Weekly review of closed records to be implemented and monitored via the weekly Quality & Safety data meeting. | 31.03.25 | Head of Concerns & Business Intelligence |

# 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.<br>**Low impact** on residual risk exposure. |
| | **Reasonable assurance** | Some matters require management attention in control design or compliance.<br>**Low to moderate impact** on residual risk exposure until resolved. |
| | **Limited assurance** | More significant matters require management attention.<br>**Moderate impact** on residual risk exposure until resolved. |
| | **Unsatisfactory assurance** | Action is required to address the whole control framework in this area.<br>**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.<br>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.<br>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.<br>Some risk to achievement of a system objective. | Within one month* |
| Low | Potential to enhance system design to improve efficiency or effectiveness of controls.<br>Generally issues of good practice for management consideration. | Within three months* |

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

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

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

# Cancer Tracking Process

## Final Internal Audit Report

## 2024/25

## Cwm Taf Morgannwg University Health Board

Reasonable Assurance

**Contents**


Executive Summary .....1
Findings & Agreed Action Plan .....3
Appendix A .....13


| | |
|---|---|
| **Review Reference** | CTM-2425-02 |
| **Fieldwork** | December 2025 – March 2025 |
| **Executive Sign Off** | 2 May 2025 |
| **Audit Committee** | May 2025 |
| **Executive Lead** | Gethin Hughes, Chief Operating Officer |
| **Audit Team** | Paul Dalton, Head of Internal Audit |
| | Emma Samways, Deputy Head of Internal Audit |

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

# Executive Summary

## Purpose

Our audit review of the cancer tracking process has been undertaken in line with the 2024/25 internal audit plan for Cwm Taf Morgannwg University Health Board (the 'Health Board').

The Welsh Government (WG) quality statement for cancer describes what good cancer services for Wales should look like. One of its most important features is the introduction of the Suspected Cancer Pathway (SCP) and the underpinning Welsh Cancer Network's Nationally Optimised Pathways (NOP) for different cancer types.

The SCP was introduced in all health boards from June 2019, and is a WG target for diagnosing cancer and starting more timely treatment. The NOPs are a set of standardised care pathways for certain types of cancer. The NOPs are 'timed' pathways of care that describe how organisations can achieve the NHS delivery target for the SCP that is set out in the NHS Wales Performance Framework 2024/25.

Cancer services improvement is a key workstream that features within the Health Board's Integrated Medium-Term Plan as part of its planned care recovery and improvement programme. The Health Board's cancer performance, in relation to the SCP, is reported within its integrated performance report.

We focused on the effectiveness of the structures and processes in place to provide sustainable cancer services that deliver the SCP and adherence to the NOPs for gynaecology and urology, with consideration to how the Multi-Disciplinary Teams (MDT) are functioning.

## Overview

We have concluded reasonable assurance on this area and have highlighted a number of matters which require management attention. These are:

- Health Board's visibility of and ability to track all patients entering a suspected cancer pathway is subject to risk from human and technological error.
- A number of the standard operating procedures and guidance documents used by the Cancer Services Unit (CSU) team have passed their review date.
- Findings identified that there is a need to maintain better training records for cancer trackers and MDT coordinators.
- Continued high operational demand and resource constraints are adding pressures and strains to workloads of CSU staff resulting in backlogs and inability to perform quality assurance work such as validation checks.
- The terms of reference for a number of governance groups are out of date and attendance at the Cancer Performance Group needs to improve.
- Whilst there are robust arrangements in place to monitor performance against the SCP, further work is required to scrutinise and review cancer delivery performance against the NOPs.
- Whilst a number of cancer performance metrics have been agreed for presentation to the Productivity, Improvement and Transformation Board, realistic targets need to be set.

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

## Scope & Assurance Summary

| | Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.) | Related Findings | Assurance |
|---|---|---|---|
| 1 | The Health Board has a structure to support the delivery of cancer services, which includes clearly defined roles and responsibilities, guidance and training across the cancer team, service areas and MDTs. | 1, 2, 3 and 4 | **Limited** |
| 2 | Appropriate governance arrangements have been established which provide effective oversight of cancer services, ensuring that they are subject to effective scrutiny and review. | 5 | **Reasonable** |
| 3 | Urology and gynaecology service areas have approved performance and improvement trajectories for cancer services including detailed actions plans where required, ensuring effective implementation and adherence to optimal clinical pathways. | 6 | **Reasonable** |
| 4 | The Health Board has developed appropriate metrics to capture the performance of cancer services and the reporting of measures, such as the number of patients entering a single cancer pathway. | 7 | **Reasonable** |
| 5 | The deliverables for suspected cancer pathways are regularly monitored, with assurance provided to the Board and appropriate groups, and where performance issues are encountered, appropriate rectifying action is undertaken. | - | **Substantial** |

### Management Actions

| 1 | 6 |
|---|---|
| High Priority | Medium Priority |

### Themes

### Risk Types

Quality or Safety Issues

Legal & Regulatory Non-Compliance

Public Perception & Reputational Risk

Choose an item.

# Findings & Agreed Action Plan

| **Objective 1:** The Health Board has a structure to support the delivery of cancer services, which includes clearly defined roles and responsibilities, guidance and training across the cancer team, service areas and multi-disciplinary teams (MDT). | **Limited** |
|---|---|

**Overview / Summary of Observations**

The Cancer Services Unit (CSU) team is centralised within the Health Board and is part of the planned care portfolio of operations. The team is not patient facing but is responsible for overseeing and scrutinising the system-wide management of cancer patients from the point of suspicion, through to initial treatment. They provide support to staff working within departments and the multi-disciplinary teams in relation to managing patients with suspected or confirmed cancer and yet to start treatment cancer pathways.

Our fieldwork has identified a number of issues which impact the CSU team's ability to provide effective and efficient guidance and support to departments:

- We saw that there are standard operating procedures (SOPs) and guidance documents in place to guide CSU staff, but a number of the procedures have passed their review date.
- There is an approach for training new staff, but our testing found that training records for cancer tracker and MDT coordinator staff were not up to date.
- In some areas, we saw evidence of high operational demand and high staff turnover, which may have an adverse impact on CSU staff workload. For example, we saw instances of backlogs and reduced capacity to undertake quality assurance work such as validation checks of the data input on the cancer tracker and providing breach report data to departments. This has resulted in incorrect reporting figures to Welsh Government in January 2025.
- Our discussions with management identified their concerns on the suitability of the IT infrastructure in place to support cancer service delivery.

| | Key Findings | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 1 | **Visibility of Suspected Cancer Pathway (SCP) patients by CSU**<br><br>Our discussions with management highlighted their concerns on the appropriateness and suitability of the IT infrastructure in place to support cancer service delivery. These discussions identified matters relating to:<br><br><u>Data collection</u><br><br>Cancer Service Information Assistants ('cancer trackers') have access to a number of internal and external databases and are responsible for checking these each day for new suspected or confirmed cancer patients. This can mean checking up to ten systems and databases per patient.<br><br>The cancer trackers are only able to identify patients if the patient has been flagged as 'Urgent Suspected Cancer' (USC) at referral stage. As such, the visibility of USC patients relies heavily on system-wide data | Treatment delays, leading to patient harm /poor patient experience. | **Agreed Action:**<br><br>A system-wide project should be undertaken with the aim of improving integrity/quality for Suspected Cancer Pathway data.<br><br>Management should undertake a technology gap analysis of the current IT Infrastructure and its ability to support the cancer delivery remit and share the findings of the analysis with DHCW.<br><br>**Expected Evidence of Implementation:**<br><br>Improvement plan for refining and improving the quality of the SCP cancer data set. |

| | | | |
|---|---|---|---|
| | integrity. We understand from discussions with the cancer services supervisors that flags are not always applied consistently when referrals are made, so the CSU team maybe unaware of a patient until the patient is already on their pathway.<br><br><u>Maintaining the cancer tracker database</u><br><br>The cancer service information assistants/MDT co-ordinators are responsible for manually populating and updating the cancer tracking module of the Welsh Patient Administration System (WPAS) with the patient information collected from the various systems.<br><br>At the time of our fieldwork, there were 15 cancer trackers in the CSU team, many of which are part time. There can be up to 2,500 suspected or confirmed cancer patient records on the cancer tracker, so maintaining the tracker database for the CSU team may be a time consuming and labour-intensive task with an increased risk of human error.<br><br>We note that the Health Board operates two versions of the cancer tracker module. One across the Health Board and a second at the Princess of Wales (PoW) Hospital. The PoW WPAS system is hosted by Swansea Bay UHB and is a legacy system that existed before the transfer of PoW from Abertawe Bro Morgannwg to the Health Board in 2019. We understand that the merger of both WPAS systems will happen in May 2025. | **Medium Priority** | **Officer:** Cancer Improvement Manager<br><br>**Target Implementation Date:** 31st July 2025 |
| | **Theme:** Information, Data Quality & Data Accuracy | Control Design | |
| 2 | **Out of date standard operating procedures and guidance**<br><br>There are a number of Standard Operating Procedures (SOPs) and guidance documents that are out of date:<br><br>• The Health Board's SOP for 'Delivering Cancer Waiting Times' refers to Welsh Health Circular 2021/001 which has been superseded by WHC (2023) 025 (Guidelines for managing patients on the suspected cancer pathway).<br><br>• The 'Cancer Patient Escalation Policy' was due for review in April 2022.<br><br>• 'Upgrade and downgrade of SCP Patients' guidance was due for review in June 2024.<br><br>• SOP for 'emailing internal consultant to consultant referral letters' was due for review in August 2024.<br><br>• SOP for reporting cancer patient breaches does not have a version control date so we are unclear if it needs to be reviewed. | There is a risk that the Health Board will not be able to provide effective, high quality and sustainable cancer services.<br><br>**Medium Priority** | **Agreed Action:**<br><br>Standard operating procedures and guidance to be reviewed and updated.<br><br>**Expected Evidence of Implementation:**<br><br>Up to date SOPs and guidance<br><br>**Officer:** Senior Cancer Manager<br><br>**Target Implementation Date:** 31st July 2025 |

| | | | |
|---|---|---|---|
| | **Theme:** Policies & Procedures | Control Operation | |
| 3 | **Training records**<br><br><u>Training and development arrangements</u><br><br>Cancer services supervisors are responsible for planning, supervising and undertaking the necessary training for new and existing staff within the CSU. Training consists of new starters in the Cancer Service Information Assistant/MDT coordinator roles shadowing experienced colleagues in their roles until deemed competent by their cancer services supervisor.<br><br>We note that supplementary training guidance is in place and training logs should be kept documenting the competency sign off process. However, our review of the training logs found that they had not been updated since 2021. | The issues may hinder the ability to identify and evaluate the skill and competence gaps within the teams resulting in ineffective and inefficient planning and provision of training and development for existing staff. | **Agreed Action:**<br><br>Training records for cancer trackers and MDT coordinators be kept up to date<br><br>**Expected Evidence of Implementation:**<br><br>Completed Departmental Induction/Training checklists for all new staff. |
| | | **Medium Priority** | **Officer:** Senior Cancer Manager /Cancer Services supervisors<br><br>**Target Implementation Date:** 30th June 2025 |
| | **Theme:** Training & Development | Control Design | |
| 4 | **Validation and breach reporting backlogs**<br><br><u>Month-end validation</u><br><br>At the end of each month, Cancer Services Supervisors undertake a validation exercise of the cancer tracking database to ensure that the correct information has been captured such as the initial point of suspicion, the treatment date, and treatment type. Accuracy of data in these fields is important as they are used for calculating breaches to the SCP timescales. At the time of our fieldwork in February, the January data should have been validated. Whilst Prince Charles Hospital (PCH) and Princess of Wales (PoW) data for the two departments that we sampled confirmed they were up to date, our testing found that the Royal Glamorgan Hospital (RGH) validation data for urology and gynaecology was last fully undertaken in November 2024. The validation work for December 2024 and January 2025 was only partially completed.<br><br><u>Breach reports</u><br><br>Cancer Services Supervisors create a monthly summary report of the validated records of confirmed and treated cancer pathways that have breached the SCP target. These reports are then issued to managers within departments for information so that lessons can be learnt.<br><br>At the time of our review not all breach reports had been undertaken for the latest available and validated data (up to end of January 2025): | There is a risk that the Health Board will not be able to provide effective, high quality and sustainable cancer services. | **Agreed Action:**<br><br>Arrangements be put in place to ensure that validation and breach reports backlogs are addressed and in future, are undertaken in a timely manner.<br><br>**Expected Evidence of Implementation:**<br><br>Up to date validation records and breach reports |
| | | **High Priority** | **Officer:** Cancer Improvement Manager<br><br>**Target Implementation Date:** 31st May 2025 |

| | | | |
|---|---|---|---|
| | • PoW – the last breach reports urology and gynaecology were issued for data up to the end of October 2024. There is a backlog for all breaches that have occurred since November 2024.<br>• PCH and RGH – up to date on gynaecology breach reports, but the last urology breach reports were issued for data up to the end of November 2024. There is a backlog of urology breaches that have occurred since December 2024.<br><br>The findings were acknowledged by the cancer services supervisors, and we were informed that the backlogs to validation and breach reports have arisen as a result of capacity constraints within the teams.<br><br>Each month Breach numbers are reported Welsh Government. The data reported to Welsh Government for January 2025 appears incorrect as the Health Board reported a 100% completion of breach reports, but the backlog identified above suggests that this would not be accurate. | | |
| | **Theme:** Lessons Learnt | Control Operation | |

| **Objective 2:** Appropriate governance arrangements have been established which provide effective oversight of cancer services, ensuring that they are subject to effective scrutiny and review. | **Reasonable** |
|---|---|

**Overview / Summary of Observations**

Cancer service delivery is an intrinsic element of the Health Board's strategic plan. The associated risks are recorded in the Board Assurance Framework (BAF) and the Organisational Risk Register (ORR), which are appropriately reviewed within the Health Board. Cancer service delivery is a key theme of the planned care programme of work. The recently formed Productivity Innovation and Transformation (PIT) programme board meets monthly and monitors performance against the key themes of the planned care programme. Our review of the PIT programme board minutes confirmed that cancer metrics are discussed, and actions are agreed to improve performance trajectories.

In addition to the PIT programme board, which has a wider remit than cancer, the following governance structure is in place in relation to cancer services delivery:

- The Health Board's Board and its committees receive the integrated performance dashboard, which includes cancer delivery performance information against the SCP.
- Cancer Board – An executive decision-making group for overseeing and delivering strategic leadership of cancer service delivery.
- Cancer Performance Group – a steering group reporting into the Cancer Board on operational delivery of strategic objectives. We note that the attendees of the group are largely similar to those that attend the Cancer Board.
- Cancer performance meeting - Reviews and discusses cancer performance data for each department in more detail.

Escalation arrangements are in place between the CSU team and departments. Our review of the arrangements confirmed that these are operating in line with the escalation policy to ensure that 'slow moving' confirmed or suspected cancer patients, are identified and action is taken.

We reviewed the system for overseeing and scrutinising cancer delivery, which appears appropriate. However, we identified some matters, that need to be addressed.

| | Key Findings | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 5 | **Governance arrangements**<br>Our review of the governance arrangements identified some matters to be addressed. These are:<br>• The terms of reference (ToR) for the Cancer Board was scheduled for a review in August 2024, but this has not happened.<br>• The Cancer Performance Group ToR also needs to be reviewed as it was scheduled for review in February 2024. This was planned for the January 2025 meeting but this meeting did not go ahead as it was not quorate. | There is a risk that the Health Board will not be able to provide effective, high quality and sustainable cancer services. | **Agreed Action:**<br>Decision be made on the relevance and necessity of the Cancer Performance Group given that it has not met for over a year.<br>Terms of reference for the Cancer Board and Cancer Performance Group be reviewed and updated.<br>Action log for the weekly cancer performance meeting be kept up to date including adequate narrative for closed/completed actions. |

| | | | |
|---|---|---|---|
| | • The Cancer Performance Group should meet each quarter, at the time of our fieldwork it had last met in April 2024, and as such the last three meetings had been cancelled. We understand one meeting was stood down due to quoracy and another due to the Princess of Wales roof critical incident. We note that actions that would have been addressed through this group have been delegated to individuals by the Cancer Board.<br>• The action log for the weekly cancer performance meeting is not adequately updated, often lacking narrative to substantiate the closure and completion of actions. | **Medium Priority** | **Expected Evidence of Implementation:**<br>Revised terms of reference and up to date action log.<br><br>**Officer:** Clinical Director of Cancer Services and Deputy Medical Director for Acute Services<br>**Target Implementation Date:** 31st July 2025 |
| | **Theme:** Governance | Control Operation | |

| **Objective 3:** Urology and gynaecology service areas have approved performance and improvement trajectories for cancer services including detailed actions plans where required, ensuring effective implementation and adherence to optimal clinical pathways. | **Reasonable** |
|---|---|

**Overview / Summary of Observations**

A weekly cancer performance meeting is held, which is attended by senior operational management from the planned care programme and staff from the CSU and departments. The meeting is operational in nature and used to review and discuss current cancer service performance, and for setting improvement trajectories for each department. At the time of our review, the 2025/26 improvement and performance trajectories for urology and gynaecology had been approved by the Chief Operating Officer.

Our review of the performance information discussed at the weekly cancer performance meetings during January and February 2025 confirmed that agreed performance and improvement trajectories were appropriate, allowing the identification of pathway bottlenecks, capacity issues, and constraints. These plans are monitored at the respective urology and gynaecology service improvement groups, both of which feed into the wider PIT board.

At a more granular level, the CSU team have day to day engagement with relevant department staff to discuss patients that are on a suspected or confirmed cancer pathway and are awaiting treatment. Actions are agreed locally to progress and escalate matters as relevant.

We note that the performance monitoring arrangements that are currently in place do not consider departmental pathway compliance/adherence with the gynaecology/urology NOP guidance.

| | Key Findings | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 6 | **National Optimal Pathways**<br>The cancer pathways for gynaecology and urology are complex and may require a number of additional clinical and diagnostic steps before the patient can be treated.<br>Cancer performance data and improvement trajectories are discussed and analysed at the weekly performance meetings. The datasets focus on the SCP standard. Cancer service delivery performance is not measured against NOPs guidance, which was released by the Welsh Cancer Network, as it is not mandatory. As such, there is limited information to ensure departments adhere to the specific NOP. | There is a risk that the Health Board will not be able to provide effective, high quality and sustainable cancer services. | **Agreed Action:**<br>Cancer Services Unit, in collaboration with the leads of the Service Improvement Groups (SIG) undertake a self-assessment against the National Optimal Pathways to inform a cancer improvement plan.<br>**Expected Evidence of Implementation:**<br>Cancer improvement plan |
| | | **Medium Priority** | **Officer:** Cancer Improvement Manager and Service Improvement Group lead**s**<br>**Target Implementation Date:** 31st July 2025 |
| | **Theme:** Performance Monitoring | Control Design | |

| **Objective 4:** The Health Board has developed appropriate metrics to capture the performance of cancer services and the reporting of measures, such as the number of patients entering a single cancer pathway. | **Reasonable** |
|---|---|

**Overview / Summary of Observations**

In addition to the WG mandated performance metric SCP 62-day and 104-day targets, other appropriate metrics have been developed that capture the performance of cancer services. We saw evidence of the following metrics being monitored at the following forums:

Cancer Board (quarterly)

- Number of days patients have to wait for a first outpatient appointment.
- Percentage of patients whose diagnosis is 'downgraded' within the first 28 days of suspicion. Downgrades refer to those patients that are initially suspected of having a cancer diagnosis, but are subsequently downgraded following clinical/diagnostic confirmation of a non-malignancy.
- SCP performance by department (current performance vs improvement trajectory).
- Backlogs of cases which have breached the SCP targets of 62 days and 104 days between first point of suspicion and initial cancer treatment.

Productivity, Improvement and Transformation Board (monthly)

- SCP compliance.
- Compliance with the 10 day first contact, which aims to reach out to the patient within first ten days of a USC referral.
- Compliance with the 28 day diagnostic testing from the original point of suspicion.
- 62 day and 104 day SCP patients backlog.
- Downgrade rate.

Cancer Performance meeting (weekly)

- Number of patients booked with a first outpatients' appointment (FOPA) within 14 days or less, between 15 to 28 days, more than 28 days from the initial date of suspicion.
- Median wait for first outpatients' appointment from initial date of suspicion (target is 10 days).
- Percentage of patients booked a FOPA within the first 2 weeks (target 85%).
- Patients that have not been booked a FOPA when initial date of suspicion was in the last 5 days, between 6-9 days, and more than 10 days (target within 10 days).
- Numbers of patients where a treatment date has been booked and whether this treatment date results in a breach against the 62 days (SCP target).

| Key Findings | | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 7 | **Lack of targets for cancer performance metrics reported to the productivity, improvement and transformation group**<br><br>Cancer performance metrics are presented monthly at the PIT programme board. For metrics that have been identified by WG targets have been set. However, our review of the report presented at the March 2025 meeting identified that, whilst metrics are reported, the column in relation to the targets for each metric remains blank as targets for Health Board level cancer performance metrics are yet to be agreed. | There is a risk that the Health Board will not be able to provide effective, high quality and sustainable cancer services. | **Agreed Action:**<br><br>Targets be agreed for the cancer performance metrics being reported to the productivity, improvement and transformation group. |
| | | | **Expected Evidence of Implementation:**<br><br>Agreed targets for cancer performance metrics |
| | | **Medium Priority** | **Officer**: Clinical Director for Cancer Services/Cancer Improvement Manag**er** |
| | **Theme:** Performance Monitoring | Control Design | **Target Implementation Date:** 31st July 2025 |

| **Objective 5:** The deliverables for suspected cancer pathways are regularly monitored, with assurance provided to the Board and appropriate groups, and where performance issues are encountered, appropriate rectifying action is undertaken. | **Substantial** |
|---|---|

**Overview / Summary of Observations**

Internal reporting

In addition to the internal governance structures/groups identified above, which regularly review and monitor cancer services performance, we also note that the integrated performance report is presented to the Board every other month. The data within the report provides assurance on the following SCP performance measures, which also includes: performance comparison with other health boards; actions taken with indication of when improvement is anticipated; and main areas of risk.

The overall SCP compliance during January 2025 was 61.9%, against a WG expectation of 70% of patients to be treated within 62 days by March 2025. While five departments had individually reached the target of 70% for this period, urology or gynaecology stood at 45.2% and 33.3% respectively.

We understand that delays at various stages of the pathway are a significant factor in not achieving the overall compliance target. We note that 26% of patients experience delays at first outpatient appointment stage, and 49% experience delays at diagnostic stage. While diagnostic delays remain in radiology, endoscopy and pathology, action taken to improve the trajectories against the SCP compliance target include:

- continued rollout of digital vetting;
- continuing outsourcing of pathology;
- mobile endoscopy units on Royal Glamorgan from early March 2025 to increase endoscopy capacity; and
- an increased focus on the time taken for patients to have their first appointments through a capacity review, booking analysis and standing item at the weekly cancer performance meeting.

External reporting

Health boards submit monthly cancer performance data to WG. The data is collated and published by DHCW via an All-Wales dashboard and is accessible by the public. We reviewed the monthly cancer performance reports issued to WG for November and December 2024 and note that appropriate cancer service deliverable updates were provided.

We note that at the time of our audit, the Health Board's cancer delivery arrangements had been de-escalated from Level 4 to Level 3 targeted intervention by WG.

# Appendix A

## Assurance Opinion

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

## Prioritisation of Findings

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

## Disclaimer

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

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

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

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

## Public Sector Internal Audit Standards

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

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

# Follow-up: 4-hour Emergency Department Performance

# Final Internal Audit Report

March 2025

Cwm Taf Morgannwg University Health Board

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

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

# Contents

Executive Summary ..... 3
1. Introduction ..... 4
2. Findings ..... 4
Appendix A: Management Action Plan ..... 6
Appendix B: Assurance opinion and action plan risk rating ..... 15

| | |
|---|---|
| Review reference: | CTM-2425-28 |
| Report status: | Final |
| Fieldwork commencement: | 3 December 2024 |
| Fieldwork completion: | 7 February 2025 |
| Draft report issued: | 18 February 2025 |
| Management response received: | 25 March 2025 |
| Final report issued: | 27 March 2025 |
| Auditors: | Emma Samways, Deputy Head of Internal Audit<br>Liz Vincent, Principal Internal Auditor |
| Executive sign-off: | Gethin Hughes, Chief Operating Officer<br>Sarah James, Deputy Chief Operating Officer |
| Distribution: | Sarah Follows, Service Director, Unscheduled Care<br>Lee Collins, Directorate Manager, Emergency and Acute Medicine<br>Ruth Morrissey – Deputy Directorate Manager, Emergency and Acute Medicine |
| 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, Risk and Assurance 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**

The overall objective of the audit was to provide the Health Board with assurance regarding the implementation of the agreed management actions from the '4-hour ED Performance' review that was reported as part of our 2023/24 work programme.

**Overview of findings**

Our previous report had six matters arising of which four were 'High' priority and two were 'Medium' priority. Of these, two are now closed and four remain open with a 'Medium' priority rating.

Management have undertaken work to:

- Better use the Welsh Patient Administration System (WPAS) to track the patient journey through Emergency Departments (ED).
- Create a tracker Standard Operating Procedure (SOP) for use across sites to ensure consistency.
- Update the casualty 'CAS' cards, though there is less requirement on their use in relation to capturing times and breach reasons, as information is now input directly into WPAS.
- Undertaking routine monitoring that is also at a site-specific level.

Further work is needed in relation to:

- Ensuring relevant staff are trained on the new approach and its supporting SOP.
- The development of an SOP to set out a consistent approach to validation work.
- Once the new approach is embedded, analyse data gathered in relation to breach reasons to identify where improvements can be made.

## Follow-up Report Classification

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

## Progress Summary[1]

| | Previous Matters Arising | Previous Priority Rating | Direction of Travel | Current Priority Rating |
|---|---|---|---|---|
| 1 | Lack of standardised operating procedures | High | | Closed |
| 2 | CAS card completion | High | | Closed |
| 3 | Training | High | | Medium |
| 4 | Accuracy and consistency of capturing information | High | | Medium |
| 5 | Validating data and adjustments | Medium | | Medium |
| 6 | Monitoring and Reporting | Medium | | Medium |

[1]The 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 '4-hour Emergency Department Performance' was completed in line with the 2024/25 Internal Audit Plan for Cwm Taf Morgannwg University Health Board (the 'Health Board'). The opinion provided through this review will inform the Head of Internal Audit's Annual Opinion.

1.2 Our original 'limited' assurance report was finalised in February 2024 and made four high and two medium priority recommendations. Management responses to address the matters arising were provided and recorded on the Audit and Risk Committee Internal Audit tracker.

1.3 The Lead Executive Director for this review is the Chief Operating Officer.

1.4 The associated risks considered in our original review were as follows:

- Inaccurate reporting within the Health Board and to Welsh Government if correct processes are not followed.
- Where data is inaccurate, areas of poor performance may not be properly identified, and corrective action not taken.
- Exposure to reputational issues for the Health Board, should reported data be found to be inaccurate or incomplete.

# 2. Findings

2.1 While there were six overarching matters arising, five of the matters arising had a number of parts, meaning that there were 15 recommendations to follow up.

| Original Priority Rating | Number of Recommendations | Implemented / Obsolete (Closed - No Further Action Required) | Action Ongoing (Further Action Required) | Not implemented (Further Action Required) |
|---|---|---|---|---|
| High | 5 | 3 | 1 | 1 |
| Medium | 9 | 5 | - | 4 |
| Low | 1 | 1 | - | - |
| **Total** | **15** | **9** | **1** | **5** |

2.2 Full details of 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:

- All Emergency Departments (ED) moving to a new method of using the WPAS to track patients. This new method allows for consistency across all sites, effective monitoring of patients' clinical journeys and removing the need to separately record and manage breach exclusions.
- To encourage consistency a Tracker Standard Operating Procedure (SOP) has been developed to support the change in approach and is being implemented across all three Health Board sites.
- During the development of the Tracker SOP, management undertook an examination of the 'breach reason' codes, resulting in the creation of a standard set of codes, which are outlined in the SOP.
- A new casualty 'CAS' card has been developed and is to be implemented across all sites by May 2025. Key date and time information will be recorded on the cards. However, the updated tracker process means this information, as well as the breach reason codes, will also be directly recorded in the WPAS. As such, the CAS cards are no longer the primary source for capturing time and reason codes.
- Management has undertaken a data cleansing exercise at Princess of Wales (PoW) to allow validation activity to focus on recent cases.
- Weekly meetings for the Senior Management Team at PoW have been re-established. These meetings have been replicated at Royal Glamorgan Hospital (RGH) and Prince Charles Hospital (PCH), with both the Deputy Clinical Service Group Manager and the Directorate Manager for Emergency and Acute Medicine in attendance. In addition, we saw evidence that key action plans are in place, with senior management actively monitoring the 4-hour performance during the meetings.
- A weekly performance trajectory report is produced, which breaks down the ED national targets by acute site. The report identifies the number of 4-hour breaches over the previous six weeks.

2.4 The actions listed above have either resulted in the recommendations being categorised as 'implemented' or 'partially implemented'. Two of the four matters arising originally categorised as High priority are now closed, with the remaining two reassessed to a Medium priority.

# Appendix A: Management Action Plan

| **Previous Matter Arising 3: Training** (Operation) | | |
|---|---|---|
| Original Recommendation 3.1 | | Original Priority |
| Acknowledging that two versions of WPAS are in use by the Health Board, where possible a consistent approach to WPAS training should be in place for staff across the sites to ensure data capture is consistent.<br>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. | | **High** |
| Management Response | Target Date | Responsible Officer |
| Ensure standardised approach to training across all EDs, monitor through Directorate Performance Meetings. | June 2024 | Lee Collins<br>Directorate Manager, Emergency and Acute Medicine |
| **Current findings** | | **Residual Risk** |
| Some training was conducted during a stakeholder meeting at the end of January 2025. The sessions had representation from WPAS, nursing, clinical, and administrative departments, and covered the implementation of the new SOP, including the changes in breach code reporting, and the implementation of WPAS tracking.<br>However, it is unclear whether all relevant staff were present, and if all those who will be using the system have received adequate training aligned to the new procedures. Additionally, given recent staff turnover, refresher training will also be necessary.<br>**Conclusion:** We consider this recommendation to be partially implemented. | | Inaccurate reporting within the Health Board and to Welsh Government if correct processes are not followed. |
| **New Recommendation** | | **Priority** |
| 1.1 New and existing staff who are required to capture patient information in the updated WPAS tracker should be provided with training in relation to the WPAS and the new Standard Operating Procedures (SOPs). To ensure | | **Medium** |

| | | | |
|---|---|---|---|
| | staff understand the importance of accurate data capture, the training should incorporate an overview of the rationale for capturing information. | | |
| **Management Response** | | **Target Date** | **Responsible Officer** |
| 1.1 | Since April 2024 the WPAS team has worked closely with the 3 EDs across the sites to review and standardise all of the codes and drop down options available in WPAS to enable standardised breach reporting and as preparation for the merger of POW WPAS over to CTM and to ensure comparable data is available moving forward. This work has now been completed.<br>The existing training SOPs are in the process of being updated – Date for completion 30 April 2025.<br>Roll out training programme 1 May 2025 to align with the WPAS POW merger on 4 May 2025. | 14 May 2025 | Lee Collins - Directorate Manager, Emergency and Acute Medicine |

| **Previous Matter Arising 4: Accuracy and consistency in capturing information** (Operation) | | |
|---|---|---|
| Original Recommendation 4.2 | | Original Priority |
| The 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. | | **Medium** |
| Management Response | Target Date | Responsible Officer |
| Undertake review of treatment complete time and implement consistent definition on all sites.<br>Ensure breach exemption codes applied consistently, develop SOP and monitor through Directorate Performance Meetings. | June 2024 | Lee Collins<br>Directorate Manager, Emergency and Acute Medicine |
| **Current findings** | | **Residual Risk** |
| During our initial audit, the 'treatment complete' time was interpreted differently at each site. The new tracking system captures timestamps for the patient journey making the 'treatment complete' time recorded on the CAS card no longer relevant when applying breach exemption codes. However, the new CAS card has retained a section for recording 'treatment complete' time, highlighting the need for a clear understanding and a standardised approach to ensure consistency across sites. The new Tracker SOP provides no information in relation to this matter.<br>**Conclusion:** We consider this recommendation to be not implemented. | | Where data is inaccurate, areas of poor performance may not be properly identified, and corrective action taken. |

| **New Recommendation** | | **Priority** |
|---|---|---|
| 2.1 | The criteria for determining the treatment complete time should be reviewed with a view to having a consistent definition in place across all sites. The agreed approach should be captured in a SOP. | **Medium** |

| Management Response | | Target Date | Responsible Officer |
|---|---|---|---|
| 2.1 | The new sample card and standardisation of drop downs undertaken will ensure accurate data capture moving forward with a standardise approach and understanding of the data requirement / meaning being in place across CTM.<br><br>The definitions on when and how this should be captured will be written into the updated SOP and will be discussed with staff during the training roll out. | 14 May 2025 | Matt Jones – Clinical Systems Manager |

| **Previous Matter Arising 5: Validating data and adjustments** (Operation) | | | |
|---|---|---|---|
| Original Recommendations | | | Original Priority |
| 5.1 | A 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 | | **Medium** |
| 5.2 | Further work should be undertaken to ensure that those cases adjusted as part of the retrospective validation process are being correctly captured and reported.<br>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. | | **High** |
| 5.3 | A 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. | | **Medium** |
| Management Response | | Target Date | Responsible Officer |
| 5.1 | Following implementation of the standardised patient tracking and breach recording, monthly audit meetings will be arranged and will feed into existing Directorate Performance review meetings.<br>Data to be presented in the monthly performance meetings as part of the core data set – Action Neil Poulton and Ruth Morrissey<br>WPAS will be able to provide audit information that enable us to see who made changes to the breach reasons etc. Information to run monthly reports where subsequent changes have been made to breach codes give us an audit of who made changes to the records.<br>Longer term, Informatics will develop the power BI breach app to have a built-in checking system to flag user issues – App launch date TBC | June 2025 | Lee Collins<br>Directorate Manager, Emergency and Acute Medicine |
| 5.2 | Undertake regular 'snapshot' audits to ensure validation is correctly captured and monitor through Directorate Performance reviews. | | |

| | | | |
|---|---|---|---|
| 5.3 | Review validation approaches across all EDs and implement a standardise approach to reporting. | | |

| Current findings | Residual Risk |
|---|---|
| Management planned to develop a spreadsheet setting out details of the adjustments made during the validation process. The intention was to share the spreadsheet information with senior nurses across all three acute sites to help identify training needs. However, we saw no evidence that this process has been put in place.<br><br>During our fieldwork management expressed increased confidence in the system and the accuracy of reporting to Welsh Government. Furthermore, it is expected that the introduction of the new tracker system will decrease the number of validations needed. However, we saw no evidence to demonstrate that regular 'snapshot' audits have been undertaken.<br><br>We saw evidence that management had asked staff at each site regarding their understanding of the validation process and their respective procedures. This dialogue highlighted those inconsistencies in approach remained. While we acknowledge that minor adjustments to the validation process may occur with the introduction of the new tracker system, work to instigate a single approach to validation is still required.<br><br>**Conclusion:** We consider this matter arising to be not implemented. | Where data is inaccurate, areas of poor performance may not be properly identified, and corrective action taken. |

| New Recommendations | | Priority |
|---|---|---|
| 3.1 | A detailed record of any adjustments made following validation should be maintained, including the individual who initially entered the data and the specific error that was amended. This information should be utilised to determine the training needs of the staff. | **Medium** |
| 3.2 | Snapshot audits should be undertaken as intended to verify that the data submitted to WG aligns with the number of breaches documented in the post-validation figures. | **Medium** |
| 3.3 | A SOP in relation to the validation process should be developed to accurately reflect the recent changes in the process to ensure a consistent approach is in place across all sites. The SOP should include details of the snapshot audits process for verify data submitted to WG. | **Medium** |

| Management Response | | Target Date | Responsible Officer |
|---|---|---|---|
| 3.1 | WPAS team to run weekly report from system to identify where an adjustment(s) have been to a patients breach outcome.<br>Plan to make automatically available the ED power BI app. | April 2025<br>Q4 | Lee Collins - Directorate Manager, Emergency and Acute Medicine |
| 3.2 | Informatics to run monthly reports as part of the submission to WG. | June 2025 | Lee Collins - Directorate Manager, Emergency and Acute Medicine |
| 3.3 | Standardised SOP to be develop for each site that includes breach data validation process. | May 2025 | Lee Collins - Directorate Manager, Emergency and Acute Medicine |

| **Previous Matter Arising 6: Monitoring and Reporting** (Operation) | | |
|---|---|---|
| Original Recommendation 6.4 | | Original Priority |
| Consideration 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'.<br>Analysis of the breach reason codes, should be undertaken with the aim of better understanding the causes of patients exceeding the 4-hour target. | | **Medium** |
| Management Response | Target Date | Responsible Officer |
| Develop a more detailed report to include analysis of breach codes | June 2024 | Lee Collins<br>Directorate Manager, Emergency and Acute Medicine |
| **Current findings** | | **Residual Risk** |
| Until the new tracker process is fully implemented, and the new codes are established within the CTM WPAS, more detailed analysis of the breach reason codes cannot be performed to gain a clearer understanding of the factors contributing to patients exceeding the 4-hour target.<br>**Conclusion:** We consider this matter arising to be not implemented. | | Where data is inaccurate, areas of poor performance may not be properly identified, and corrective action taken. |

| **New Recommendation** | | **Priority** |
|---|---|---|
| 4.1 | Consideration 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'.<br>Analysis of the breach reason codes, should be undertaken with the aim of better understanding the causes of patients exceeding the 4-hour target. | **Medium** |

| Management Response | | Target Date | Responsible Officer |
|---|---|---|---|
| 4.1 | Plan to recruit Patient Flow Coordinators to support real time data capture on WPAS. Until recruited on each site, the patient pathway information will be updated by PFCs (PCH x 2 WTE, RGH 1 WTE) consultants and NIC. Implementation date for patient tracking on WPAS as above – 14th May 2025.<br><br>Snapshot audits to be undertaken against breach outcomes and patient notes during May – Action for Band 7 Ops Managers weekly commencing after rollout.<br><br>Longer term, plan to introduce as part of the data set in the ED power BI app – Action ED clinical lead, Informatics and Directorate. | End May 2025 | Lee Collins - Directorate Manager, Emergency and Acute Medicine |

# 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.<br>**Low impact** on residual risk exposure.<br>**Follow up:** All recommendations implemented and operating as expected |
| | **Reasonable assurance** | Some matters require management attention in control design or compliance.<br>**Low to moderate impact** on residual risk exposure until resolved.<br>**Follow up:** All high priority recommendations implemented and progress on the medium and low priority recommendations. |
| | **Limited assurance** | More significant matters require management attention.<br>**Moderate impact** on residual risk exposure until resolved.<br>**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.<br>**High impact** on residual risk exposure until resolved.<br>**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.<br>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.<br>Some risk to achievement of a system objective. | Within one month* |
| Low | Potential to enhance system design to improve efficiency or effectiveness of controls.<br>Generally issues of good practice for management consideration. | Within three months* |

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

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

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

# Service User Experience

## Final Internal Audit Report

## 2024/25

## Cwm Taf Morgannwg University Health Board

Substantial Assurance

**Contents**


Executive Summary .....1
Findings & Agreed Action Plan .....3
Appendix A .....6


| | |
|---|---|
| **Review Reference** | CTM-2425-13 |
| **Fieldwork** | February to April 2025 |
| **Executive Sign Off** | 09 May 2025 |
| **Audit Committee** | May 2025 |
| **Executive Lead** | Greg Dix, Executive Director of Nursing, Midwifery & Patient Care |
| **Audit Team** | Paul Dalton, Head of Internal Audit |
| | Emma Samways, Deputy Head of Internal Audit |

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

# Executive Summary

## Purpose

Our review of service user experience has been undertaken in line with the 2024/25 Internal Audit Plan for the Cwm Taf Morgannwg University Health Board ('CTMUHB' or the 'Health Board').

Service users have the right to experience respectful and professional care, in a considerate and supportive environment, where their privacy is protected, and dignity maintained. A high-quality experience should be fundamental, underpinned by appropriate standards, whatever and wherever the setting of care and treatment.

The Welsh Government framework for assuring service user experience was first introduced in 2013 and then updated in 2015. It describes the evidence based key determinants of a good service user experience, identifies the key attributes, and uses of a range of feedback methods. The Framework was further updated in 2018 to reflect a set of eleven validated questions to be used by all NHS Wales organisations to obtain real time feedback.

The Health Board currently uses the CIVICA system for service users to feedback on their experience via a Short Messaging Service (SMS), text service, paper, and quick reader (QR) codes, while generating reports from the data provided.

During 2024, CTMUHB participated in the national procurement exercise for a new Patient Reported Outcome Measures (PROMs) digital system to meet the national PROMs Standard Operating Model (PSOM) guidance, and procured a system called 'Promptly'. Implementation is currently underway, and work is being undertaken to migrate service user data collected as Patient Reported Experience Measures (PREMs – linked to healthcare interventions) and 'Have Your Say' (completed by anyone interacting with the Health Board) to the Promptly system, supporting the vision of one integrated system which will enable the use of patient experience data in person with patients, as well as supporting aggregated analysis and improvement action.

## Overview

We have concluded substantial assurance on this area. The matter requiring management attention relates to:

- The identification and analysis of the effects of under-representation of certain patient groups in service user feedback processes.

Full details of the matter arising are detailed within the Findings & Agreed Action Plan. We also identified the following opportunities for enhancement that do not impact the overall opinion and are highlighted for management information:

- Due to delays in the publication of the Welsh Government's service user experience framework, production of a patient experience strategy has been postponed. The framework was released in April 2025 as our fieldwork concluded. This now enables the Health Board to progress with drafting its strategy.
- 'Have Your Say', PROM and PREM surveys are not available in languages other than English and Welsh, although a multi-lingual functionality can be incorporated into the Promptly system, and translations efforts are ongoing. Progress in relation to the publication of surveys in alternative languages should continue to be monitored.

## Scope & Assurance Summary

| Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.) | | Related Findings | Assurance |
|---|---|---|---|
| 1 | The Health Board has a patient experience strategy/ plan in place detailing its commitment and approach to listening and learning from patient's experience. | - | **Reasonable** |
| 2 | Appropriate mechanisms and resources (including the use of technology and Patient Advice and Liaison Service (PALS) officers), are in place for the collation and analysis of patient feedback. | 1 | **Reasonable** |
| 3 | Feedback is used to inform and drive improvement throughout the Health Board, with evidence of action taken to address identified issues and share good practice. | - | **Substantial** |
| 4 | Patient experience is monitored and reported to the Board (or an appropriate committee of the Board), to provide assurance that the key components of the service user experience are being assessed, and that action is taken to deliver improvements. | - | **Substantial** |

### Management Actions

| - | 1 |
|---|---|
| High Priority | Medium Priority |

### Themes

- Information, Data Quality & Data Accuracy

### Risk Types

Quality or Safety Issues

# Findings & Agreed Action Plan

| **Objective 1:** The Health Board has a patient experience strategy/ plan in place detailing its commitment and approach to listening and learning from patient's experience. | **Reasonable** |
|---|---|

The Health Board is in the process of developing a patient experience strategy. However, production of the document had been paused as the Health Board waits for the Welsh Government (WG) to release the people's experience toolkit, which includes an updated service user experience framework. During our fieldwork, the framework was released by WG and we understand that work in relation to the strategy has now resumed.

We established that although work on the strategy document is ongoing, activities and initiatives detailed in the planning document are already being acted upon.

The various approaches taken by the Health Board to capture service user experience and listening and learning, are referenced in the strategy planning document. We understand that these areas will be more detailed in the final strategy document.

| **Objective 2:** Appropriate mechanisms and resources (including the use of technology and Patient Advice and Liaison Service (PALS) officers), are in place for the collation and analysis of patient feedback. | **Reasonable** |
|---|---|

Several feedback mechanisms are in operation throughout the Health Board and incorporate various innovations to ensure feedback is sought from as many service users as possible. For example, the 'Have Your Say' survey is available to all service users in multiple formats, PREMs are incorporated into clinical processes, and patient engagement with these surveys is strongly encouraged. PREM SMS surveys are also used. Robust procedures exist to ensure the accuracy of data collected via the feedback systems.

We saw that significant effort is made to promote inclusivity in the feedback processes and to ensure feedback is obtained from a diverse range of service users. The Patient Experience and Value-Based Health Care (VBHC) teams work independently and collaboratively on initiatives intended to address health inequalities within specific groups of service users.

We saw evidence that a proactive approach is taken to obtaining feedback, and a comprehensive Patient Advice and Liaison Service (PALS) provides individualised assistance to service users when required. Resources have been enhanced as PALS officers now operate from all three of the main Health Board sites. Their presence ensures that individuals belonging to potentially under-represented groups are given the opportunity to provide feedback on a more equal basis and mitigates some of the risks surrounding non-response bias that are inherent to feedback processes.

However, we note that the Health Board does not identify and evaluate potential sources of bias in the patient feedback mechanisms, or under-representation in the feedback results. As such, no work has been done to quantify or explain the effects that bias and under-representation could have on the feedback data.

| | Key Findings | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 1 | **Bias and under-representation**<br><br>Processes are in place to ensure feedback mechanisms are made available to all service users on an equal basis and incorporate inclusivity. A wide range of targeted engagement activities are supported by the People's Experience and Value Based Healthcare teams. The specific needs of groups that are identified as potentially being vulnerable to experiencing access or engagement issues with Health Board services are being addressed by this work.<br><br>Notwithstanding these efforts, systems to identify and quantify under-represented groups in service user feedback data are yet to be established. | Harm to patients where issues are not identified in underrepresented groups. | **Suggested Action:** Feedback data analysis processes will be revised and refined in order to incorporate procedures to assess the potential effects of under-representation and bias in feedback results.<br><br>Observations derived from the operation of these procedures will be utilised in efforts to reduce bias and under-representation where possible.<br><br>Furthermore, information on this will be disseminated to managers, and included in the narrative of feedback reports in order to provide additional context to the data contained therein.<br><br>**Expected Evidence of Implementation:** Analysis results. Demographics data reports. |
| | | **Medium Priority** | **Responsible Officers:** Denise Lowry Head of VBHC and Jenny Oliver Head of People's Experience<br><br>**Target Implementation Date:** 29 December 2025 |
| | **Theme:** Information, Data Quality & Data Accuracy | Control Design | |

| **Objective 3:** Feedback is used to inform and drive improvement throughout the Health Board, with evidence of action taken to address identified issues and share good practice. | **Substantial** |
|---|---|

Management reporting arrangements in relation to patient feedback and the activities of the People's Experience and VBHC teams appear to be well established and operating effectively.

There are various means by which feedback themes and trends are identified. The same categories of themes are used across the different feedback systems to allow data to be combined and be more meaningful. Common themes are then identified and reported upon with trends in themes included in management reports. We saw evidence that suitable processes were in place to ensure remedial actions are implemented in response to themes and trends in patient feedback.

Mechanisms have been implemented to ensure actions are taken in response to individual instances of feedback where appropriate. Responses may be directly co-ordinated by the PALS team or reported to management by various means which include the People's Experience Forum and the care group Quality, Safety, Risk and Experience group meetings.

The work of the People's Experience and VBHC teams contribute to the Health Board's compliance with the Duty of Quality standards. Particular emphasis is placed on the work of the People's Experience team in the Health Board's most recent Annual Duty of Quality Report.

| **Objective 4:** Patient experience is monitored and reported to the Board (or an appropriate Committee of the Board), to provide assurance that the key components of the service user experience are being assessed, and that action is taken to deliver improvements. | **Substantial** |
|---|---|

Appropriate management and reporting arrangements in relation to patient experience and associated feedback processes have been established, and monitoring processes are in place.

The Health Board's Quality, Safety and Experience (QSE) Committee provides oversight of patient feedback systems, and some information relating to the activities of the VBHC team are reported to the Strategic Development Committee.

Regular 'People's Experience Activity Reports' are presented to each QSE Committee meeting, which provide a summary of the Health Board's activities in relation to patient feedback. We also saw additional information presented via the individual care group highlight reports that are reported to the QSE Committee.

Performance monitoring processes are incorporated into patient feedback systems. Performance information is reported through various channels to stakeholders across the Health Board, and externally where required.

# Appendix A

## Assurance Opinion

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

## Prioritisation of Findings

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

## Disclaimer

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

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

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

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

## Public Sector Internal Audit Standards

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

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

# New Care Group Model

## Final Internal Audit Report

## 2024/25

## Cwm Taf Morgannwg University Health Board

Reasonable Assurance

**Contents**


Executive Summary .....1
Findings & Agreed Action Plan .....3
Appendix A .....7


| | |
|---|---|
| Review Reference | CTM-2425-01 |
| Fieldwork | March - April 2025 |
| Executive Sign Off | 12 May 2025 |
| Audit Committee | May 2025 |
| Executive Lead | Gethin Hughes, Chief Operating Officer |
| Audit Team | Paul Dalton, Head of Internal Audit |
| | Emma Samways, Deputy Head of Internal Audit |

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

# Executive Summary

## Purpose

Our audit focused on the operating structures that have been put in place within the Planned Care, Unscheduled Care and Mental Health & Learning Disabilities Care Groups. We assessed the impact of those structures on ensuring that appropriate governance arrangements are in place.

## Overview

In 2022 the Health Board launched the care group model, which saw the organisation transition from three Integrated Locality Groups (ILGs) to six care groups. The core design principal was to ensure services are managed to be more focused and specialised, delivering across the whole of the Health Board. Phase one of the move was completed by autumn 2022. This saw the establishment of the triumvirate senior leadership teams for each care group. Phase two of the transition saw the creation and movement of the directorates that made up each care group and the leadership and management structures to support the care groups.

Whilst the care groups operate across the Health Board, site-based hospital leadership teams remain in place at each of the acute District General Hospitals (DGH). Their role involves supporting care groups to achieve and deliver their services.

We noted that the implementation of Care Groups was viewed positively by all that we interviewed as part of this review, and that the management and staffing structures are operating largely as intended. The procedures for ensuring effective governance and performance reporting in the three Care Groups that we reviewed appear reasonable, although the systems and approach are more immature in the Mental Health and Learning Disabilities Care Group due to the relatively recent appointment of the Service Director. Although each of the Care Groups were already effectively monitoring key areas of concern (e.g. performance, quality, finance), or at least had plans to do so, there are variations in approach between the Care Groups and we have suggested that the Health Board consider imposing a minimum data requirement to provide assurance that these areas will continue to be effectively covered.

We have concluded reasonable assurance on this area. Full details of matters arising are detailed within the Findings & Agreed Action Plan.

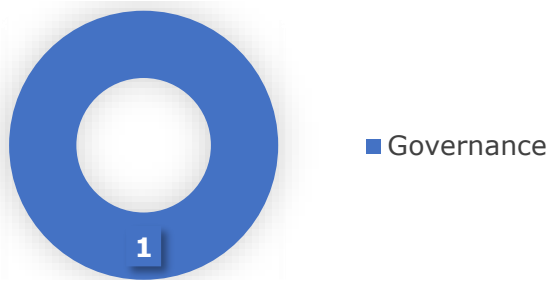
## Scope & Assurance Summary

| | Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.) | Related Findings | Assurance |
|---|---|---|---|
| 1 | The staffing model and lines of operational and professional responsibility have been consistently and effectively established and are operating as intended. | - | **Substantial** |
| 2 | Management structures within Care Groups align with the scheme of delegation and facilitate effective performance and decision-making. | - | **Reasonable** |
| 3 | The relationship and reporting lines between Care Group Management and Hospital and other site management have been clearly established. | - | **Reasonable** |
| 4 | Consistent and appropriate governance arrangements have been established within Care Groups for managing and monitoring risks, quality and performance. | - | **Reasonable** |
| 5 | Any issues arising in Directorates are escalated promptly and appropriately to Care Group Management. | - | **Reasonable** |
| 6 | There is appropriate support provided to Care Groups from the COO Business Office. | - | **Reasonable** |

## Management Actions

| 0 | 1 |
|---|---|
| High Priority | Medium Priority |

## Themes




## Risk Types

Financial Loss

Legal & Regulatory Non-Compliance

# Findings & Agreed Action Plan

| **Objective 1:** The staffing model and lines of operational and professional responsibility have been consistently and effectively established and are operating as intended. | **Substantial** |
|---|---|

### Overview / Summary of Observations

The staffing model has largely been set up in accordance with that planned under the Phase Two Organisational Change Programme. This is predicated on ensuring that each of the directorates will comprise of a leadership team that will be multi-professional. This introduces a new approach in the Care Groups to directorate leadership and reflects the importance of working collaboratively to ensure equity of service delivery for the population served by the Health Board.

There are some differences in approach due to the nature of the services being provided (e.g. Mental Health and Learning Disabilities having a quad structure with a Clinical Director in Psychology/Psychology leads in addition to the standard triumvirate of the Service Director/Directorate Manager, Medical Director/Clinical Director and Nurse Director/Lead Nurse). The Unscheduled Care Group also includes two Governance Leads which are not present in the structures of either the Planned Care Group or Mental Health & Learning Disabilities, but which is an accurate reflection of the structure set out in the OCP Phase Two document. We understand that these posts were already in place and the nature of services provided by Unscheduled Care justifies their existence. It is also evident that the degree of business and administrative support available to each Care Group may differ as they have been left to procure this independently.

| **Objective 2:** Management structures within Care Groups align with the scheme of delegation and facilitate effective performance and decision-making. | **Reasonable** |
|---|---|

### Overview / Summary of Observations

Management structures are operating as was documented in the OCP Phase Two report dated October 2023. There have however been some changes in the intervening period. Initially, Unscheduled Care initially had two medical directors in post, but this has now reverted to a single post with a deputy in support. The Mental Health and Learning Disabilities Care Group now comprises an additional directorate to compliment the three clinical directorates. This is the Business, Strategy, Commissioning and Improvement Directorate which was referred to as a group in the OCP document that would support the three directorates. We understand that the reason for this is that there are a number of tasks (e.g. administration of patient records, commissioning and performance reporting) which for other care groups is undertaken corporately, but for Mental Health and Learning Disabilities is undertaken within the Directorate. Our discussion with Health Board management on this issue has identified that there may be elements of duplication of activity under the current arrangements that could be more effectively streamlined, and we understand that this issue will be considered by the Health Board. For this reason we have not raised a separate finding for this issue.

| **Objective 3:** The relationship and reporting lines between Care Group Management and Hospital and other site management have been clearly established. | **Reasonable** |
|---|---|

## Overview / Summary of Observations

Although the Care Group model is predicated on a portfolio approach, arrangements remain for site leadership, with clear roles and responsibilities. The Organisational Change Programme for Phase Two dated October 2023 states that:

*At each of our Acute DGH Hospitals, a triumvirate leadership team will be established comprising of Hospital General Manager, Head of Nursing and Hospital Medical Lead. These lead roles will work in partnership taking joint accountability for the management and leadership of the Hospital Site, including delivery of safe and high-quality clinical care and the best possible patient experience. This Hospital Leadership Team will support the Care Group Directors to achieve and deliver all local and national performance targets and standards e.g. waiting times, productivity targets and activity levels, within budget and resource availability.*

Of the three Care Groups included for review as part of this audit, there are very few issues for the Mental Health and Learning Disabilities Care Group as their services are largely community rather than hospital based. We did not identify any particular issues in the Planned Care Group other than a matrix-based approach was required to ensure that issues could be managed from both a Care Group and a locality perspective when required.

Our discussion with senior management in the Unscheduled Care Group highlighted their concerns over the nursing arrangements in that there is no direct accountability from the Hospital Heads of Nursing on each hospital site to the Director of Nursing for Unscheduled Care. This apparently limits the authority of the Care Group Triumvirate in respect of nursing and results in separate conversations having to be undertaken for each site rather than being able to have one conversation covering the whole Health Board from an Unscheduled Care Nursing perspective. We understand that the Care Group is seeking to address this issue over the coming months.

As the matter raised above is already being taken forward, we have not raised a formal finding but have attributed a reasonable rating to this objective.

| **Objective 4:** Consistent and appropriate governance arrangements have been established within Care Groups for managing and monitoring risks, quality and performance. | **Reasonable** |
|---|---|

## Overview / Summary of Observations

The arrangements for each of the three Care Groups that we reviewed are as follows:

**Planned Care** - There is a fortnightly Senior Leadership Team which includes the triumvirate, the Directorate Leads, and representatives from Finance, Workforce, Planning, Project Management and Procurement. In the intervening weeks, the triumvirate meet with the finance and workforce leads, but not currently the Directorate Leads. However, this is likely to change shortly as it has become apparent that their presence would be helpful in these meetings. There is also a monthly Executive Finance meeting with the Finance Lead and the Executive Finance Team, and a bi-monthly Quality & Safety meeting within the Care Group. Meetings have formal agenda and papers and either minutes or an action log are produced following the meeting.

**Unscheduled Care** – There is a weekly Senior Management Team meeting with business partners (e.g. from finance, workforce etc) and a bi-monthly Quality Safety and Experience meeting for the whole Care Group. Meetings have formal agendas and meetings are recorded.

**Mental Health and Learning Disabilities -** The arrangements within the Care Group are currently subject to review following the relatively recent appointment of the Service Director in November 2024. The proposed governance structures include regular Senior Leadership meetings and a number of Boards which replicate the Health Board structures – these are an Operational Management Board, an Improving Care Board and bi-monthly Quality, Safety and Experience meetings. Meetings that pre-date the Service Director, and which for the time being are still held, are the People, Planning, Performance and Finance meeting, and a Quality, Safety, Risk and Experience meeting.

All of the three Care Groups that we reviewed therefore have governance structures in place to ensure that risks, quality and performance are regularly monitored and managed. However, there are some differences in approach and also in the maturity of structures and processes. Whilst procedures are relatively established in Planned Care and Unscheduled Care, the arrangements in Mental Health and Learning Disabilities are more immature due to the relatively recent appointment of the Service Director in November 2024, following a gap of several months where no Service Director was in post. However, there are clear plans in place within the Care Group to implement formal structures that largely replicate the overall Health Board approach in managing risk, quality and performance.

| | Key Findings | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 1 | Each of the Care Groups are either already monitoring in key areas such as performance, quality and finance, or had plans to do so. However, there is a lack of overall guidance/instruction to clarify what the minimum governance arrangements should be within Care Groups and as such we evidenced variations in approach. | The Care Groups may not continue to cover all key areas of governance if there is no guidance on what is required. | **Agreed Action:**<br>The Health Board will establish the minimum data requirements / governance arrangements that each Care Group should have in place to ensure assurance on key areas such as finance, quality and performance continue to be effectively monitored within each Care Group. |
| | | | **Expected Evidence of Implementation:**<br>Guidance for Care Groups |
| | | **Medium Priority** | **Officer: Sarah James/Julie Denley /Sarah Livingstone** |
| | **Theme:** Governance | Control Design | **Target Date: April 2026** |

| **Objective 5:** Any issues arising in Directorates are escalated promptly and appropriately to Care Group Management. | **Reasonable** |
|---|---|

### Overview / Summary of Observations

The arrangements for each of the three Care Groups are as follows:

**Planned Care** - Each of the three Directorates has a monthly Operational Assurance & Business meeting with the Senior Leadership Team. This involves submission of a standard slide pack by the Directorate which covers key performance indicators, quality and risk information. There is then a fortnightly Senior Leadership Team which includes the triumvirate, the Directorate Leads (going forward), and representatives from Finance, Workforce, Planning, Project Management and Procurement.

**Unscheduled Care** – Monthly Performance and Assurance Groups are held with each of the three Directorates. These include relatively standard agendas which include Quality, Performance, Finance and Risk updates. A finance review is also held monthly with each Directorate.

**Mental Health and Learning Disabilities –** As stated before governance arrangements are subject to review and revision and the plan is to have monthly Integrated Performance meetings with each of the Directorates.

All Care Groups that we reviewed have appropriate formal procedures in place (supplemented by regular informal meetings and engagement) to ensure that issues noted in the Directorate can be escalated promptly if necessary to Care Group management. As previously noted, arrangements in the Mental Health and Learning Disabilities Care Group are less mature due to the recent appointment of the Service Director, but governance arrangements are currently being revised and enhanced. For this reason, we have attributed reasonable assurance to this objective.

| **Objective 6:** There is appropriate support provided to Care Groups from the COO Business Office. | **Reasonable** |
|---|---|

### Overview / Summary of Observations

The role of the Chief Operating Officer Business Office, and particularly the relationship with the Care Groups, is still relatively immature as both the Business Office and the Care Group governance structures and management arrangements bed down. From the Care Group perspective, the role of the COO Business Office is seen less as a support function and more as a holding to account mechanism to ensure that key information is flowing up from the Care Groups on a timely and accurate basis to the COO. There are no major concerns from the Business Office at the current time and work continues to help streamline and refine the processes to support information flows for key meetings and governance requirements. Management acknowledge that substantial information is currently requested from the Care Groups, but it is hoped that as the approach and structures mature, there will be more opportunity to support the Care Groups in sharing good practice and learning.

Although we are not raising a finding for this objective, we have again attributed reasonable assurance in recognition of the further work that is being undertaken to improve current practices and procedures.

# Appendix A

## Assurance Opinion

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

## Prioritisation of Findings

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

## Disclaimer

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

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

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

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

## Public Sector Internal Audit Standards

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

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

# Prince Charles Hospital – Key Project Objectives

# Final Internal Audit Report

## 2024/25

## Cwm Taf Morgannwg University Health Board

Reasonable Assurance

**Contents**


Executive Summary .....1
Findings & Agreed Action Plan .....2
Appendix A.....10


| | |
|---|---|
| Review Reference | CTM-SSU-2425-18 |
| Fieldwork | January – February 2025 |
| Executive Sign Off | 13 May 2025 |
| Audit Committee | May 2025 |
| Executive Lead | Sally May, Executive Director of Finance |
| Audit Team | Huw Richards, Deputy Director Specialist Services Unit<br>Murray Gard, Audit Manager |

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

# Executive Summary

## Purpose

This audit was commissioned in accordance with the Integrated Audit Assurance Plan for this project. The objective of this audit was to review the performance of the Prince Charles Hospital (PCH) Redevelopment Programme against the key performance objectives of time, cost and quality.

## Overview

Based on the findings of the audit, **reasonable assurance** has been determined in respect of this discrete area. The audit identified a strong control environment in operation and the Health Board was taking proactive steps to mitigate risk.

Overall, the programme had been delayed by approximately 11 weeks, mainly due to additional asbestos remediation and the Health Board's request to expand the Intensive Therapy Unit (ITU). Given the length of the construction programme (294 weeks) and intrusive nature of the works, this is not considered unreasonable.

The cost position faces significant pressure, with a projected overspend of £4.6m (representing a 2.1% difference to the original budget) at the time of concluding audit fieldwork. Key contributing factors include inflation, Value Added Tax (VAT) recovery rates, asbestos remediation, and the robustness of the provisional sum estimates provided within the Full Business Case. The Health Board had proactively identified potential offsets that could reduce the forecast overspend to approximately £1.8m (representing a 0.8% difference to the original budget) with potentially further gainshare to be realised on sections 4 & 5 of the programme (being progressed). Additionally, the Health Board had maintained transparent communication with the Welsh Government through dashboard reports and Capital Resource Meetings (CRMs) regarding the potential overspend.

The forecasted overspend presents a potential adverse impact to the Health Board finances, or an opportunity cost should discretionary capital be required to address any variance. However, the cost assurance remains at a reasonable level, largely due to the robust controls implemented within the Project Team and the transparent reporting structures in place.

In terms of quality, positive progress has previously been reported on all prior audit recommendations for this project including recommendations into the role of the Supervisor and management of quality, which demonstrated management commitment to learning lessons and continuous improvement through the delivery programme.

A small number of areas require management attention to improve controls and consistency. Details of these matters arising are within the Findings & Agreed Action Plan.

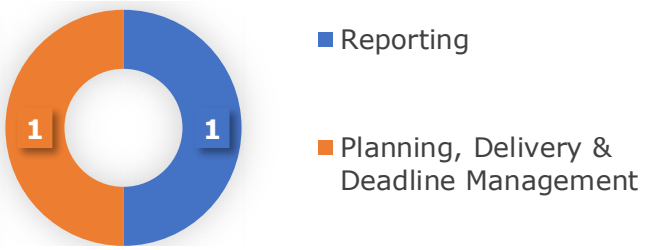
## Scope & Assurance Summary

| | Objectives | Related Findings | Assurance |
|---|---|---|---|
| 1 | Time - Evaluate the project's adherence to established timelines and milestones. Ensuring that key dependencies and the critical path have been identified and is routinely monitored. To identify any key risks to the delivery programme. This will include an assessment of any delays to date. | 1 | **Reasonable** |
| 2 | Cost - Assess the adequacy of financial management arrangements and reporting to ensure that costs are managed within agreed budgets – including the cost impact of any changes to the original requirements. | 2,3 | **Reasonable** |
| 3 | Quality - Assess the extent to which project deliverables (both products and services) meet or exceed predetermined standards and/or requirements. | - | **Substantial** |

### Management Actions

| - | 2 |
|---|---|
| High Priority | Medium Priority |

### Themes



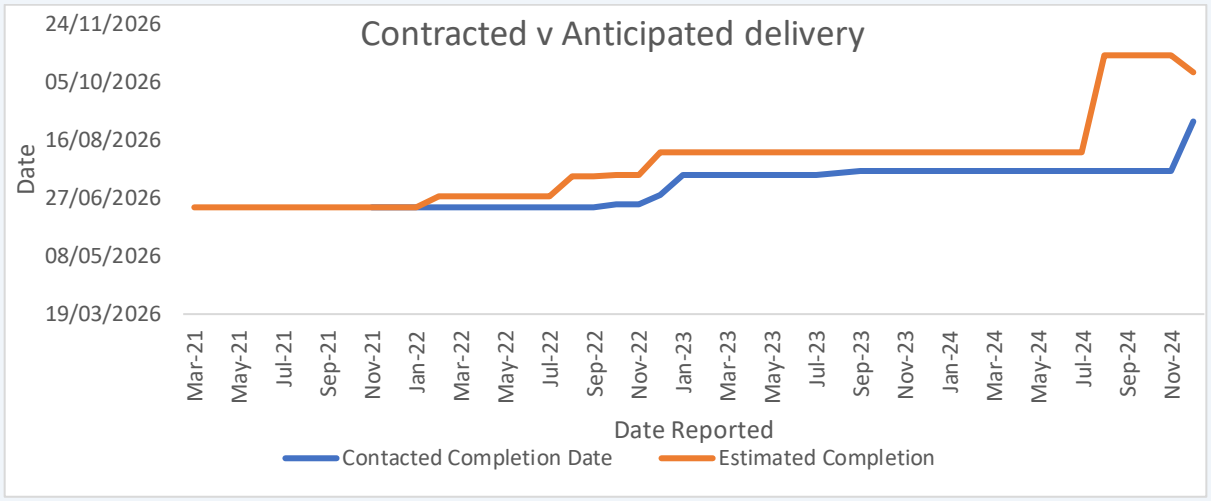

### Risk Types

Public Perception & Reputational Risk

## Key Project Objectives - At a Glance:

Time (see objective 1 below)– An assessment of the movement in both the Supply Chain Partner's (SCP's) anticipated completion date and the contractual completion date outlines the following:

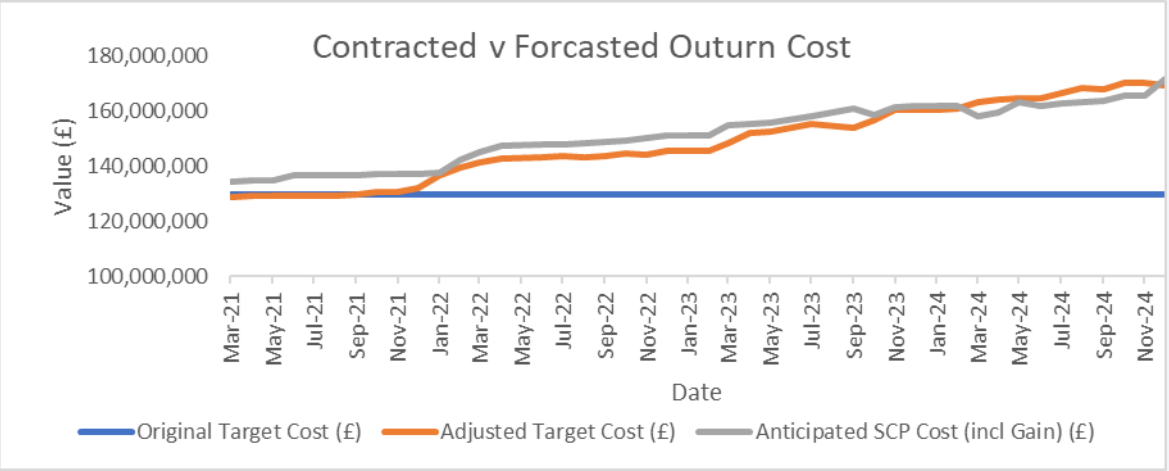
| Section | Contract Completion | Original Completion |
|---|---|---|
| 1 | Complete 8th April 2022 | |
| 2 | Complete 6th December 2022 | |
| 3 | Complete 16th September 2024 | |
| 4 | 5th May 2026 | 24th April 2026 |
| 5 | **1st September 2026** | **19th June 2026** |
| 6 | Complete 21st March 2022 | |




*Note the Supply Chaim Partner had built in a Time risk allowance at zero cost to the contract of 6 weeks.

Cost (see objective 2 below) - The overall target cost and Supply Chain Partner forecast outturn cost was reported as follows:

| Item | Cost |
|---|---|
| Current approved budget | £220.276m |
| Forecasted Spend | £224.876m |
| **Forecasted Overspend** | **£4.6m** |
| *Potential Offsets* | |
| VAT Recovery on inflation | £632k |
| VAT Recovery on Phase 1B | £777k |
| Vat reclaims on project | £1.402m |
| Section 4 & 5 Gainshare (Remaining unagreed) | Can not be currently assessed. |
| Total Potential Offset | £2.810m |
| **Residual Funding Shortfall** | **£1.8m** |



# Findings & Agreed Action Plan

| **Objective 1:** Time | **Reasonable** |
|---|---|

**Overview / Summary of Observations**

Since the commencement of the project in November 2020, the overall programme delivery had experienced extensions. Initially, the planned completion date was set for 22nd June 2026. However, this had been extended to 1st September 2026, reflecting an overall delay of approximately 11 weeks. This revised completion date accounts for changes instructed by the Health Board and other circumstances and challenges encountered throughout the course of the project delivery programme.

The main drivers contributing to the extended timeline were primarily additional asbestos remediation work and changes to the scope associated with the extension of the ITU.

The project risk register outlined various risks associated with the project. One specific item, T6 (risk score of 16), addressed the inability to meet the Fire Enforcement Notice timescales (EN79/10), indicating the significant impact it could have on the project if not managed properly. To manage this risk, several mitigating actions have been put in place. One key action was the annual on-site review with the South Wales Fire and Rescue Service (SWFRS) that was last undertaken on the 31st of July 2024, resulting in a positive outcome, where SWFRS confirmed that an extension of time to the Enforcement Notice (EN79/10) had been granted.

| | Key Findings | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 1 | **Delay Reporting**<br><br>Delays to the programme were reported via monthly progress reports to the Project Board, but the details of delays beyond 20th July 2026 (latest delays reviewed by internal audit), extending to the new contract completion date of 1st September 2026, were not documented. These delays were attributed to the expansion of the ITU that was still in dispute at the time of reporting. This dispute had previously been considered at the SCP performance audit report submitted to the Audit Committee in February 2025. To enhance transparency and accountability, the rationale for these and any further extensions should be clearly documented, along with any relevant approvals, ensuring a comprehensive record of adjustments. | A lack of clear documentation and approval for timeline extensions may lead to misalignment among stakeholders and accountability issues. | **Agreed Action:**<br><br>Implemented since audit fieldwork - An updated Project Managers report has been provided to the Project Board outlining the rationale for stated delays.<br><br>**Expected Evidence of Implementation:**<br><br>N/A – Implemented since audit fieldwork. |

| | | | |
|---|---|---|---|
| | | **Medium Priority** | **Officer: N/A – Implemented since audit fieldwork.** |
| | **Theme:** Reporting | Control Operation | **Date: N/A – Implemented since audit fieldwork.** |

## **Objective 2:** Cost — **Reasonable**

### Overview / Summary of Observations

The scheme's approved budget remained at £220.276m as of January 2025, with a reported estimated outturn cost of £224.876m. Consequently, the forecast overspends had risen to approximately £4.6m, an increase of circa £900k compared to the previous audit.

Key contributory elements to the current cost pressure included the following:

| Item | Original Allowance (£) | Actual/ forecast Expenditure (£) | Difference (£) |
|---|---|---|---|
| Inflation | 22,925,761 | 29,806,789 | 6,881,028 |
| Asbestos | 1,583,750 | 5,047,556 | 3,463,806 |
| Provisional Sums (Cumulative) | 11,660,000 | 14,185,134 | 2,525,134 |
| **Total** | **36,169,511** | **49,039,479** | **12,869,968** |

It is recognised the inflationary impact are outside the direct control of the Health Board and similarly the asbestos issues may only be identified once works progress in associated areas.

To mitigate the forecast, overspend the Health Board had:

- Obtained Welsh government approval to utilise banked gain shares.
- Resubmitting a VAT reclaim to HMRC on 19/11/24 for £780,000 and analysing further offsets.

In addition, changes in personnel within the Cost Advisors team requested by the Health Board had enhanced the reliability of expenditure forecast.

The Health Board's current actions to manage the forecast overspend, have effectively reduced the forecast overspend to present a potential £1.8m funding shortfall. Further mitigation may arise from gain shares on sections 4 and 5, dependent on the SCP's performance.

In additional to the potential £1.8m shortfall the contingency balance (as at January 2025) was £733,000, with an average £75,000 monthly run rate. With the programme 70% complete and 93% contingency spent, remaining costed high-risk items identified within the project risk register of £1,417,596 creates an additional total potential shortfall of £684,596. This excludes medium/low risks and potential project changes outside the risk register that could emerge during the remaining construction programme.

The forecast overspend could pose significant challenges for the project (and the wider Health Board), including:

1. Increased Financial Pressure: The existing shortfall and limited contingency funds may increase financial pressure on the wider Health Board e.g. requiring reallocation of discretionary funds or seeking additional funding from Welsh Government.
2. Higher Risk Appetite: Reduced contingency reserves might mean less flexibility to address unforeseen costs in later stages, increasing project risks.

| Key Findings | | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 2 | **Contingency and Cashflow Monitoring**<br><br>As of January 2025, remaining contingency balance was £733,000 (approx. 7%) of the approved £11,111,000. The programme was 70% complete, with 93% of the contingency expended.<br><br>A risk review in November 2024 identified total potential risks of £7,401,375 (High Medium and Low categorised risks). High risks totalled £1,417,596. Accordingly, the remaining contingency may be insufficient to address materialising risk through to project completion.<br><br>The Health Board proactively analysed contingency expenditure and risks (as of January 2025), which resulted in an outturn shortfall of £1.8m; if assumption around VAT reclaim (see key finding 1) were realised.<br><br>However, the review did not specify potential timescales for any additional funding requirements or sources (e.g., discretionary allocations, Welsh Government applications etc). Management should review and regularly report to the Project Board the anticipated commitments on the contingency. | Financial instability, potentially causing delays in completion or requiring additional funding. | **Agreed Action:**<br><br>Noted and agreed to review and report regularly to the Project Board.<br><br>**Expected Evidence of Implementation:**<br><br>To be incorporated in the Project Managers monthly report and in dialogue with Welsh Government Capital Review Meetings. |
| | | **Medium Priority** | **Officer:** Responsible Officer – Prince Charles Hospital Construction Programme |
| | **Theme:** Planning, Delivery & Deadline Management | Control Operation | **Date:** July 2025 |

| **Objective 3:** Quality | **Substantial** |
|---|---|

**Overview / Summary of Observations**

The audit confirmed that robust systems were in place to ensure the quality of works and that issues were identified and reported to the Project Board. Positive progress had been made on addressing previously agreed audit recommendations; with substantial assurance being achieved at the Validation of Management Actions report submitted to the Audit Committee in September 2024.

Due to the nature of the project, the contract was split into 6 sections of construction (with the target cost split by section). Regular reporting (monthly) was observed to the Project Board, in respect of the handover of areas/sections. Fifteen areas had been handed over between April – December 2024 with documentation provided that identified a positive trend in the number of defects/observations, within these areas as noted below:

| | September 24 | October 24 | November 24 | December 24 |
|---|---|---|---|---|
| Total Defects in Areas Handed Over | 152 | 48 | 39 | 25 |
| Total Phase 2 Defects Overdue | 148 | 69 | 53 | 33 |

Although the trend was positive there remained several defects not being rectified by the due date. This was raised as part of the SCP Performance audit report submitted to the Audit Committee in February 2025 with associated recommendations. To avoid duplication no further recommendation has been raised as part of this review.

# Appendix A

## Assurance Opinion

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

## Prioritisation of Findings

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

## Disclaimer

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

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

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

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

## Public Sector Internal Audit Standards

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

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

# Follow-up: Arrangements for Financial Savings

# Final Internal Audit Report

May 2025

Cwm Taf Morgannwg University Health Board

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

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

# Contents

Executive Summary ..... 4
1. Introduction ..... 5
2. Findings ..... 5
Appendix A: Management Action Plan ..... 7
Appendix B: Assurance opinion and action plan risk rating ..... 12

| | |
|---|---|
| Review reference: | CTM-2425-31 |
| Report status: | Final |
| Fieldwork commencement: | February 2025 |
| Fieldwork completion: | April 2025 |
| Draft report issued: | May 2025 |
| Management response received: | May 2025 |
| Final report issued: | May 2025 |
| Auditors: | Emma Samways – Deputy Head of Internal Audit<br>Andrea Calise – Audit Manager |
| Executive sign-off: | Gethin Hughes – Chief Operating Officer |
| Distribution: | Sarah James – Deputy Chief Operating Officer<br>Sarah Follows – Service Director, Unscheduled Care<br>Clare Williams – Service Director, Mental Health & Learning Disabilities<br>Mike Dickie – Head of Change Hub |
| Committee: | Audit, Risk and Assurance 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, Risk and Assurance 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 2023/24 Arrangements for Financial Savings review.

**Overview of findings**

Of the three high priority matters originally raised, two have been closed, and the third matter remains open.

The key matter we have raised within this report relates to:

- Project planning (control) documentation for the saving schemes identified by care groups still needs to be progressed.

## Follow-up Report Classification

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

## Progress Summary[1]

| Previous Matters Arising | | Previous Priority Rating | Direction of Travel | Current Priority Rating |
|---|---|---|---|---|
| 1 | Savings Gap | High | ⇧ | Closed |
| 2 | Guidance documentation | High | ⇧ | Closed |
| 3 | Control documentation | High | ⇔ | High |

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

# 1. Introduction

1.1 Our follow-up review of 'Arrangements for Financial Savings' audit has been completed in line with the 2024/25 Internal Audit Plan for Cwm Taf Morgannwg University Health Board (the 'Health Board').

1.2 Our original audit report was finalised in November 2023. We issued three audit opinions relating to centralised processes, care group processes, and enabling schemes. This follow up review will focus on the care group processes, for which we issued a limited assurance opinion. Our testing has revisited the areas of focus from our original review, namely the Unscheduled Care (USC) and Mental Health & Learning Disabilities (MH&LD) care groups.

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:

- Insufficient savings schemes identified by care groups, so savings targets are not achieved.
- Identified schemes are not properly assessed and planned, risk and quality impact assessments are not undertaken, resulting in schemes providing their desired outcomes.

# 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 | 3 | 2 | - | 1 |
| Medium | - | - | - | - |
| Low | - | - | - | - |
| **Total** | **3** | **2** | **-** | **1** |

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

2.3 The actions documented in appendix A have resulted in two recommendations being closed as implemented. Where action is ongoing, if applicable, we have re-assessed the priority rating.

# Appendix A: Management Action Plan

| **Previous Matter Arising 2.1: Savings scheme assessments** (Design) | | |
|---|---|---|
| **Original Recommendation** | | **Original Priority** |
| Work by Care Groups and their finance support officers should continue in an attempt to close the gap between the savings targets and identified schemes. | | **High** |
| **Original Management Response** | **Original Target Date** | **Original Responsible Officer** |
| <u>Mental Health</u><br>This happens on an ongoing basis.<br><u>Unscheduled Care</u><br>As referenced in the report, there is active engagement between the Care Group and CSGs with the Finance team to progress saving schemes.<br>We do not propose changing this approach. The hope is that with the conclusion of the organisational change process and staff appointed to permanent roles and fewer management gaps, there will be capacity to focus on service transformation and release of savings.<br>To M06 savings of £3.8m savings are forecast against the 2.6% improvement target and 1% stretch (£5.1m). Unfortunately, wider service pressures have driven increased spend elsewhere which has prevented the same level of progress towards the control total. | Ongoing to year end<br><br>Ongoing to year end | Elaine Lorton - Service Director MH & LD<br><br>Sarah Follows - Director of Operations |
| **Current findings** | | **Residual Risk** |
| Our follow up work confirmed that both care groups (MH&LD and USC) have robust arrangements in place for managing the financial position and outlook, which includes close monitoring of financial savings against targets set at the start of 2024/25. Our review of the savings and financial position identified that both care groups made progress closing the gap between the savings targets set at the start of 2024/25 and the identified savings schemes. At the start of | | Identified schemes are not properly assessed and planned, risk and quality impact assessments are not undertaken, |

| | |
|---|---|
| 2024/25 the USC care group identified green and amber schemes with a value that exceeded their savings target, and the MH&LD care group identified schemes that amounted to 84% of their target for 2024/25.<br><br>**Conclusion:** While we consider this matter, in relation to identifying schemes in line with targets to be **closed**, we note that challenges throughout the year, such as the major incident with the roof at the Princess of Wales hospital, and the change to the classification of some savings schemes during the year, has meant that a number of identified schemes have not progress as intended and large gaps between targets and actual savings remained for both care groups.<br><br>See also matter arising 2.2b where we established there has been a lack of control documentation for 2024/25 schemes, which may also be a contributory factor in the limited success of some schemes. | resulting in schemes not achieving their desired outcomes. |

| **Previous Matter Arising 2.2a: Savings scheme assessments** (Design) | | |
|---|---|---|
| **Original Recommendation** | | **Original Priority** |
| Guidance should be in place in relation project plans for identified savings schemes, including when consideration should be given to developing a detailed PID for a scheme. Guidance should also include details in relation to producing quality impact assessment and risk assessment for identified schemes. | | **High** |
| **Original Management Response** | **Original Target Date** | **Original Responsible Officer** |
| Agreed. The guidance is already in place will be updated and will set out the documentation requirements and resource assessments etc for savings schemes, which will vary depending on the size of the schemes. This will be in place ready for 24/25 planning. | Mid-January 2024 | Mike Dickie - Head of Change Hub |
| **Current findings** | | **Residual Risk** |
| The Project Management Office (PMO) released Operational Savings Plan Guidance in February 2024 across the Health Board. We confirmed that this guidance sets out the required control documentation to be completed for identified savings schemes. Depending on the size of the scheme the required documentation may include a business case, Project Initiation Document, risk register and communication plan. The guidance does not provide criteria for determining the size of the scheme; however, we understand previous attempts to set criteria became too prescriptive and complex.<br><br>All schemes require an initial Quality Impact Assessment to be completed, with more detailed assessments for those schemes that score above 12 in the initial assessment.<br><br>**Conclusion:** We consider this matter arising to be **implemented**, though note matter arising 2.2b where we established there has been a lack of control documentation completion for 2024/25 schemes. | | Identified schemes are not properly assessed and planned, risk and quality impact assessments are not undertaken, resulting in schemes not achieving their desired outcomes. |

| **Previous Matter Arising 2.2b: Savings scheme assessments** (Design) | | |
|---|---|---|
| **Original Recommendation** | | **Original Priority** |
| Before a savings scheme starts and depending on size, a project plan should be put in place and a quality impact assessment and risk assessment should be undertaken, together with an assessment of the resources that may be required to deliver the anticipated savings. | | **High** |
| **Original Management Response** | **Original Target Date** | **Original Responsible Officer** |
| Agreed. The guidance is already in place will be updated and will set out the documentation requirements and resource assessments etc for savings schemes, which will vary depending on the size of the schemes. This will be in place ready for 24/25 planning. | Mid-January 2024 | Mike Dickie - Head of Change Hub |
| **Current findings** | | **Residual Risk** |
| We were unable to obtain control documentation for savings schemes identified for both the USC and the MH&LD care groups. Our discussions with the Service Director for USC care group and with the Directorate Manager for the MH&LD confirmed that the administration of control documentation for savings schemes is an area that needs to be improved, and we understand that it will be an area of focus in 2025/26. Greater clarity on the documentation required should aid this.<br>**Conclusion:** We consider this matter arising to be **not implemented.** | | Identified schemes are not properly assessed and planned, risk and quality impact assessments are not undertaken, resulting in schemes not achieving their desired outcomes. |
| **New Recommendation** | | **Priority** |
| 1 Before a savings scheme starts and depending on size, relevant control documentation including a project plan should be put in place and a quality impact assessment and risk assessment should be undertaken, together with an assessment of the resources that may be required to deliver the anticipated savings. | | **High** |

| | Management Response | Target Date | Responsible Officer |
|---|---|---|---|
| 1 | We will advise all care groups that the relevant documentation should be used for all the savings schemes identified. An email will be circulated from the COO office advising Care groups. | May 2025 | Sarah James Deputy COO Acute Services & Julie Denley Deputy COO Mental Health, Primary Care and Community Services |

# 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.<br>**Low impact** on residual risk exposure.<br>**Follow up:** All recommendations implemented and operating as expected |
| | **Reasonable assurance** | Some matters require management attention in control design or compliance.<br>**Low to moderate impact** on residual risk exposure until resolved.<br>**Follow up:** All high priority recommendations implemented and progress on the medium and low priority recommendations. |
| | **Limited assurance** | More significant matters require management attention.<br>**Moderate impact** on residual risk exposure until resolved.<br>**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.<br>**High impact** on residual risk exposure until resolved.<br>**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.<br>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.<br>Some risk to achievement of a system objective. | Within one month* |
| Low | Potential to enhance system design to improve efficiency or effectiveness of controls.<br>Generally issues of good practice for management consideration. | Within three months* |

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

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

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

# New Personal Development Review (PDR) process

# Final Internal Audit Report

## 2024/25

## Cwm Taf Morgannwg University Health Board

Reasonable Assurance

**Contents**


Executive Summary .....1
Findings & Agreed Action Plan .....3
Appendix A .....10


| | |
|---|---|
| **Review Reference** | CTM-2425-15 |
| **Fieldwork** | November 2024 – April 2025 |
| **Executive Sign Off** | 14 May 2025 |
| **Audit Committee** | May 2025 |
| **Executive Lead** | Hywel Daniel, Executive Director for People |
| **Audit Team** | Paul Dalton, Head of Internal Audit |
| | Emma Samways, Deputy Head of Internal Audit |

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

# Executive Summary

## Purpose

In February 2022 Cwm Taf Morgannwg University Health Board (the 'Health Board') introduced a new approach to its Personal Development Review (PDR) process, called 'Your Conversation'. The new approach uses a condensed, values-based format with the aim of facilitating meaningful conversations about personal and professional development. Staff are also required to complete a 'staying well' plan ahead of their PDR meeting, providing an important space for staff to discuss their wellbeing alongside their development.

One of the themes of the Quadruple Aim, set out in the Welsh Government's 'A Healthier Wales' document, relates to 'a motivated and sustainable workforce'. A target in relation to PDRs has been set, whereby 85% of staff should have had a PDR review in the previous 12 months. As at April 2025, the Health Board reported that this had been achieved for 68% of staff.

Our review has looked at the Health Board's arrangements in relation to the new PDR process and to aid the achievement of the 85% Welsh Government target.

## Overview

We have concluded reasonable assurance for this area and identified the following matters requiring management attention:

- Limited formal evaluation following implementation of the new PDR process to demonstrate recommendations for improvements have been captured and acted upon.
- A lack of understanding by line managers on the PDR process to be followed for new starters, and how this PDR information should be captured.
- Non-achievement of the WG 85% compliance target, with some departments having higher levels of PDRs that are more than a year old, or where staff have never had a PDR.

Full details of the above key findings are detailed within the Findings & Agreed Action Plan below. We also identified the following opportunity for enhancement that does not impact the overall opinion and is highlighted for management information:

- A peer review or sample check of completed PDRs would enable the quality of completion to be assessed and ensure completion of the staying well plan element of the PDR.
- Where new projects or initiatives are to take place, documentation should be in place setting out the setting out the purpose, the desired outcomes and any or metrics to measure to determine success.
- The data presented to the Health Board committees is not always clear or comprehensive, for example the overall compliance rate is often not reported.

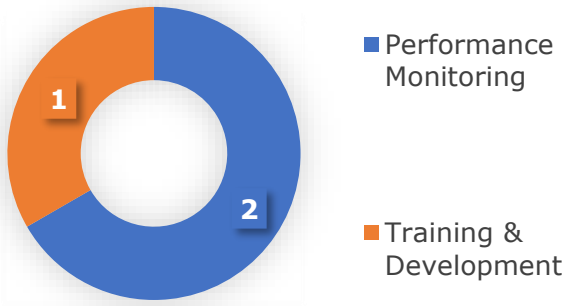
## Scope & Assurance Summary

| | Objectives | Related Findings | Assurance |
|---|---|---|---|
| 1 | The Health Board identified the desired outcomes of the revised PDR process to allow effectiveness to be monitored. | 1 | **Reasonable** |
| 2 | Appropriate guidance, support and training is available to managers to allow them to conduct meaningful PDR meetings. | - | **Substantial** |
| 3 | PDRs are appropriately undertaken and can demonstrate managers are engaging with staff about their development and wellbeing. They are carried out in line with set timeframes, are captured appropriately, and are logged in ESR in a timely manner. | 2,3 | **Reasonable** |
| 4 | Monitoring and reporting of compliance rates takes place at appropriate levels within the organisation. | - | **Substantial** |

### Management Actions

| - | 3 |
|---|---|
| High Priority | Medium Priority |

### Themes




### Risk Types

Quality or Safety Issues

Public Perception & Reputational Risk

# Findings & Agreed Action Plan

| **Objective 1: The Health Board identified the desired outcomes of the revised PDR process to allow effectiveness to be monitored.** | **Reasonable** |
|---|---|

**Overview / Summary of Observations**

In February 2022 the Health Board introduced a new approach to its PDR process, called 'Your Conversation'. While we did not see documentation relating to the proposed changes, we understand that the implied intent was to simplify the PDR process, reduce the amount of paperwork and combine development and wellbeing objectives and key HR process, such as pay progression. In turn, it was anticipated the revised approach would result in increased PDR completion rates. To achieve these outcomes the new approach uses a condensed, values-based format with the aim of facilitating meaningful conversations with staff about their personal and professional development objectives as well as a touchpoint on their wellbeing.

Since the launch of the new PDR process the Health Board has adopted one metric to measure desired outcomes, namely the WG PDR target of 85% compliance. Before the new process was introduced the PDR compliance rate for the Health Board was 55%. By April 2025 this had risen to 68%. The increase in compliance demonstrates more PDRs are taking place, with personal and professional objectives being set, which in turn should contribute to WG's aim of a 'motivated and sustainable workforce'.

Despite there not being any documented objectives or desired outcomes from introducing the new process, in September 2022 an evaluation report was produced to reflect on achievements of the new process. The report also contained a number of recommendations for action and indicated quarterly evaluation reports would be prepared to report on the ongoing achievements of the new process and in implementing the identified actions.

| | Key Findings | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 1 | **Monitoring effectiveness**<br><br>In September 2022 an evaluation report was published to reflect on the impact the new PDR process. The report contains data showing the increase in compliance rate month by month and qualitative feedback findings. It also sets out challenges and barriers that have been identified through the feedback process and corresponding recommendations to address these.<br><br>The evaluation report was to be updated quarterly, to capture the positive impact the new process was having and to update on the actions undertaken against identified recommendations. We understand that whilst work will have taken place to address the recommendations, no further evaluation reports have been produced.<br><br>We have also seen quarterly Learning and Development highlight reports which set out a number of actions in relation to | Inability to determine if the revised process has achieved any desired outcomes.<br><br>Actions not taken to further improve processes if desired outcomes are not captured. | **Agreed Action:**<br><br>1) Develop briefing report to go to Care Group performance meetings via Heads and Deputy Heads of People, to gain further insight and monitor continued effectiveness of PDR process. Compliance reports will remain part of this briefing, but additional data and discussion points will build more holistic picture of PDR impact.<br>2) Compile summative report capturing feedback from the above briefing alongside evaluation data to date and findings of the internal audit, to set out rationale and details for improvements to the PDR process and associated documentation. Also include compliance rates for those areas targeted as part of the detailed briefing reports. |

| | | | |
|---|---|---|---|
| | wider projects that the team are working on. One element does relate to the PDR process and the feedback, as such this may be a more appropriate platform to capture actions and progress against them. | | **Expected Evidence of Implementation:**<br>• Delivery of briefing and summative report.<br>• Increased evaluative data, as captured within summative report.<br>• Positive feedback from staff as a result of enhanced engagement from Care Group leadership teams. |
| | | **Medium Priority** | **Officer:** George Shouler, Deputy Head of Organisational Development and Inclusion |
| | **Theme:** Performance Monitoring | Control Design | **Target Implementation Date:**<br>1) 31/07/2025<br>2) 31/10/2025 |

| Objective 2: Appropriate guidance, support and training is available to managers to allow them to conduct meaningful PDR meetings. | Substantial |
|---|---|

**Overview / Summary of Observations**

The L&D team have ensured appropriate guidance and support is available to managers and staff to allow them to conduct and participate in meaningful PDR meetings. The Health Board's intranet pages contain a copy of the 'Your Conversation' form for managers and staff to download and use. There are also links to a reviewer's guide, wellbeing plans, pay progression information, declaration of interest form, sample questions guide and a guide to updating ESR.

Training information is available and can be accessed both online and in person. This includes a 15-minute video aimed at managers and supervisors, to guide them through the 'Your Conversation' process. Completion of this module is not mandatory and is accessed via the intranet. Guidance on the PDR process is also included as part of the corporate induction and for those staff participating in leadership and management training. Furthermore, for those areas identified by the L&D team as having low PDR compliance, the Learning and Development Lead will undertake targeted training sessions with managers.

During our interviews with a sample of managers across the organisation, all expressed the view that the support and information provided by Learning and Development is good.

| Objective 3: PDRs are appropriately undertaken and can demonstrate managers are engaging with staff about their development and wellbeing. They are carried out in line with set timeframes, are captured appropriately, and are logged in ESR in a timely manner. | Reasonable |
|---|---|

**Overview / Summary of Observations**

We interviewed a sample of managers from across the organisation and found that all had an awareness of the revised PDR process. All had a good approach for undertaking annual PDRs with their staff. Where PDR commitments were not met, this was largely attributed to work pressures for both managers and staff: meaning PDR meetings could get moved back beyond due dates. Our interviews identified that some managers experienced difficulties engaging with staff who are at the top of their pay band and see less value in the PDR process.

The Health Board's 'Reviewer Guidance' sets out the expected timeframes for new starter PDRs. From our discussion with a number of managers who have had recent new starters, we noted that not all were aware of the expected timeframes or the need to capture early PDRs in ESR.

Our analysis of January 2025 PDR compliance data has identified that while most had an appropriate PDR, 23% of staff had their last PDR more than a year ago, and a further 10% (excluding new starters) do not appear to have ever had a PDR, some of which have worked for the Health Board for many years.

The Health Board does not have a centralised process to assess the quality of PDRs. We have seen this considered at other Health Boards.

| Key Findings | | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 2 | **Completion of PDRs for new starters**<br><br>The Health Board's PDR reviewer guidance suggests that new starters, in the first year of being in post, should have three PDRs are undertaken and recorded in ESR. These are a baseline PDR at induction, an interim PDR at three months, and the annual PDR. We acknowledge that the guidance says these are suggested PDR intervals and only the annual PDR is mandatory.<br><br>Our discussions with managers of a sample of new starters identified that the PDR process for new starters was not done consistently: Often the initial PDR was completed within the first few months of employment. There did not appear to be an understating of the Health Board's desire for baseline PDR and then three-month interim PDRs. We also note that recording the initial PDR in ESR was not consistently done. | Low staff engagement and morale if the PDR process is not undertaken. | **Agreed Action:**<br><br>1) Embed further guidance into key People documents and training: induction, Managing Staff Wellbeing training, PDR paperwork, potential new monthly 'Key People Messages' briefing note. |
| | | | **Expected Evidence of Implementation:**<br><br>• Process and guidance more visible.<br>• Improvement in compliance, particularly in-year for new starters. |
| | | **Medium Priority** | **Officer:** George Shouler, Deputy Head of Organisational Development and Inclusion |
| | **Theme:** Performance Monitoring | Control Design | **Target Implementation Date:** 31/10/2025 |

3 **Timely completion of PDRs**

We obtained data of the PDRs recorded in ESR from January 2025 and identified that of the 12,032 staff listed:

- 1,252 (10.4%) have never had a PDR recorded in ESR (excludes new starters who were not yet due a PDR).
- 2,808 (23.3%) had their last PDR more than a year ago.

Our analysis identified the three service groups with the highest proportion of their staff with an out of date or no PDR:

| Service Group | No. of staff in Service Group | No. and % of staff with PDR > 12mths ago | No. and % of staff never had PDR |
|---|---|---|---|
| Facilities | 1076 | 295 / 27% | 128 / 12% |
| Anaesthetics, Critical Care, Theatres, T&O | 940 | 259 / 28% | 72 / 8% |
| Obstetrics, Gynaecology & Sexual Health | 559 | 191 / 34% | 50 / 9% |

Collectively these three service areas account for 25% of all out of date or no PDRs.

We undertook additional analysis on the Facilities data and identified that a number of supervisors have in excess of 50 staff and manage the PDR process effectively. Whereas other

Low staff engagement and morale if the PDR process is not undertaken.

**Agreed Action:**

1) As part of briefing set out in Objective 1, include Care Group and Directorate level data on staff that have never had a PDR, which can then be targeted via Care Group leadership teams.

**Expected Evidence of Implementation:**

- Delivery of briefing report.
- Care Group and Directorate access to more detailed reports.
- Improvement in compliance, particularly in worst-performing areas.

| | | | |
|---|---|---|---|
| | supervisors with similar numbers of staff and those with far few staff were not managing this process as effectively.<br><br>We note that no specific monitoring is undertaken in relation to staff that have never had a PDR logged in ESR.<br><br>Furthermore, through our meetings with managers, we understand that some experience difficulties in getting engagement with staff who are at the top of their pay band and see little value in the PDR process. | **Medium Priority** | **Officer:** George Shouler, Deputy Head of Organisational Development and Inclusion<br><br>**Target Implementation Date:**<br><br>31/07/2025 for publishing briefing report.<br><br>31/10/2025 for monitoring compliance. |
| | **Theme:** Training & Development | Control Design | |

| Objective 4: Monitoring and reporting of compliance rates takes place at appropriate levels within the organisation. | Substantial |
|---|---|

**Overview / Summary of Observations**

Our review established that reporting of compliance takes place at various levels within the organisation. Managers record completed PDRs in ESR, and these form the primary database from which a hierarchy of reports can be accessed. The L&D team produce monthly compliance reports at a health board, care group and directorate level. The directorate and care group reports are shared with managers by email. However, managers also have access to run their own reports via ESR. We also established that the L&D team issue targeted reports to areas identified as having low compliance. The reports are then used by the care group leadership teams and their respective Head of People during senior leadership team meetings.

Regular updates on PDR compliance levels were provided to the former People and Culture Committee as part of the workforce metrics report, and to the Board as part of the integrated performance dashboard. We identified that the infographics being used are not as comprehensive as they could be, as they did not display the Health Board's overall compliance rate and had errors in description titles. This has been fed back to management.

# Appendix A

## Assurance Opinion

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

## Prioritisation of Findings

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

## Disclaimer

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

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

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

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

## Public Sector Internal Audit Standards

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

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

# Electronic Whiteboards

## Final Internal Audit Report

## 2024/25

## Cwm Taf Morgannwg University Health Board

Reasonable Assurance

**Contents**


Executive Summary .....1
Findings & Agreed Action Plan .....3
Appendix A .....14


| | |
|---|---|
| **Review Reference** | CTM-2425-11 |
| **Fieldwork** | February – April 2025 |
| **Executive Sign Off** | 15 May 2025 |
| **Audit Committee** | May 2025 |
| **Executive Lead** | Gethin Hughes – Chief Operating Officer |
| | Julie Denley, Deputy Chief Operating Officer – Mental Health, Primary Care and Community Services. |
| **Audit Team** | Paul Dalton, Head of Internal Audit |
| | Emma Samways, Deputy Head of Internal Audit |

# Executive Summary

## Purpose

Our audit review of Electronic White Boards (EWB) was completed as part of our 2024/25 Internal Audit work for Cwm Taf Morgannwg University Health Board (the 'Health Board').

## Overview

The EWB system was implemented across a number of health board service areas in January 2023. The EWBs are designed to be used in conjunction with the Health Board's 'Optimal Patient Flow Framework' and information should be routinely captured in the EWB system as part of daily 'Board Round', and during day-to-day ward activities to aid decision-making regarding patient flow and discharge planning. In-built to the system are a number of forms such as the Electronic Transfer of Care (e-TOC), which are essential documents to be completed for referrals into the Discharge to Recover then Assess pathway (D2RA). This digital system replaces traditional paper-based whiteboards and should provide real-time, at-a-glance information about patients.

Access to the system requires a Nadex login, which is necessary to access the whiteboard and associated forms. The system is accessible by partners in local authorities, enabling real-time input of information and centralising data into a dashboard for comprehensive oversight of patient flow throughout the Cwm Taf Morgannwg region.

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

- The rollout of optimise training has been limited due to the resources available to deliver it.
- Training and guidance materials are not complete or accessible to all relevant staff.
- There was a lack of controls and guidance around the use of generic logins for updating elements of the EWB system.
- There appears to be insufficient monitoring of accounts held by local authority staff.
- Use of the EWB system was variable across the nine wards that we visited.
- Error logs are currently not used to identify recurring mistakes.
- Wards are not using the EWB system to run reports and few are aware of the Power BI Discharge App.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

- The Health Board should consider replicating the practices implemented by the patient flow nurse at Prince Charles Hospital to help with patient flow.

## Scope & Assurance Summary

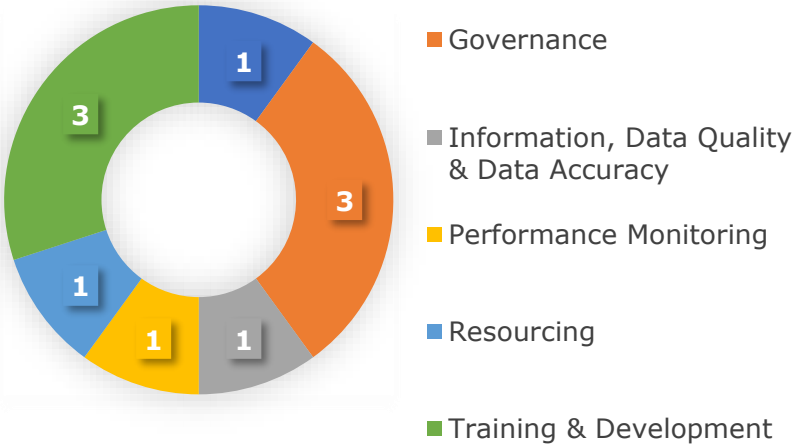
| Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.) | | Related Findings | Assurance |
|---|---|---|---|
| 1 | Training, guidance and support is available to staff using the system and is appropriately resourced. | 1,2, 3 | **Limited** |
| 2 | Appropriate access controls have been set up within the system. | 4,5 | **Reasonable** |
| 3 | All relevant wards and departments are using the system, with feedback sought from areas failing to fully engage with the system. | 6,7 | **Reasonable** |
| 4 | The system has been built to capture all required information to comply with National Discharge Guidance and the information captured in the system is done so in a timely manner and is complete and accurate. | 8, 9 | **Limited** |
| 5 | The reporting tools available within the system are effectively used at ward, site and Health Board level to manage services and make decisions. | 10 | **Reasonable** |

### Management Actions

**2** High Priority

**8** Medium Priority

### Themes




### Risk Types

Financial Loss

Quality or Safety Issues

Legal & Regulatory Non-Compliance

# Findings & Agreed Action Plan

| **Objective 1:** Training, guidance and support is available to staff using the system and is appropriately resourced. | **Limited** |
|---|---|

**Overview / Summary of Observations**

Electronic whiteboards (EWBs) form one element of the 'Optimise' initiative, which focuses on adding value to patient flow and ensuring the Health Board is working to achieve national discharge guidance. Since implementation in 2023, EWBs have be rolled out to the majority of wards across all three main hospital sites and the community hospitals.

There is one Optimise nurse lead in post, who provides Optimise training sessions for staff, and is supported by a programme manager. While there have been training workshops at Royal Glamorgan Hospital (RGH) and the Princess of Wales (PoW) hospital, there are yet to be any held at Prince Charles Hospital (PCH), although specific EWB online training is available to staff. We visited nine wards across health board sites and the community hospitals and found that varying levels of training had been received by staff.

The nurse lead also undertakes clinical duties. This limited resource has had an impact on the ability to roll out training, produce and update guidance documents and develop the Optimise SharePoint pages. Recently, non-recurrent funding has been allocated for two staff to join the team on a secondment basis. Operational support is provided to Ward Staff by the D2RA Hub, which assists in troubleshooting, and offers guidance in relation to the discharge policy.

| | Key Findings | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 1 | **Rollout of Optimise training**<br>We identified that where workshops are yet to be held, or where ward managers have not attended a session, there was less engagement with the EWB system.<br>We were unable to determine how many staff are yet to be trained on the Optimise initiative.<br>We understand there are plans to undertake additional EWB training sessions via Teams; to set up an EWB Teams channel to act as a community of support for staff and to have EWB drop sessions on-site. However, the current resource constraints, have meant these training initiatives have not progressed. | Inappropriate, inefficient or inconsistent use of the system impacting on patient flow, delayed discharges and inaccurate reporting. | **Agreed Action:**<br>*Ongoing roll out of Optimise training workshops will continue.*<br>*Additional training sessions via Teams.* |
| | | | **Expected Evidence of Implementation:**<br>*Optimise training roll out programme and support programme* |
| | | **Medium Priority** | **Officer:**<br>**Target Implementation Date:** |
| | **Theme:** Training & Development | Control Operation | |

| | | | |
|---|---|---|---|
| 2 | **Training and guidance materials**<br><br>Detailed Optimise presentation slides, covering the use of EWBs are used during the training workshops. However, the presentation or accompanying notes are not made available for staff to refer to at a later date.<br><br>There are three EWB user guides in place. One for acute wards, AMU, and community hospitals. Our review identified:<br><br>• Whilst some variation in the guides may be necessary due to the differing service area needs, all differed in content and layout. For example, the icons representing access to the different elements of the EWB system varied across each of the user guides.<br><br>• Whilst each appeared to cover each screen within the system, they were not comprehensive and did not provide a clear step-by-step guide. For example, they do not indicate which are the essential fields for completion, such as the 'Assessment Fit' date, nor do they provide a clear definition of descriptions of field to ensure consistency. Additionally, key timeframes for completion of data with the EWBs are not outlined within the guidance.<br><br>• None of the guides had links to key guidance documents such as the Optimal Patient Flow Framework, Hospital Discharge Policy, E-TOC user guide, SDN user guide, or D2RA Pathways.<br><br>• Our testing identified occasions when there are issues with data transfer from WPAS, which is the source of information for EWBs. However, there is no reference in the guides to WPAS, meaning staff use judgement to resolve issues. Similarly, the guides contain no information for staff to deal with patients who have not been properly discharged or transferred from the emergency department or another ward. | Inappropriate, inefficient or inconsistent use of the system impacting on patient flow, delayed discharges and inaccurate reporting. | **Agreed Action:**<br><br>*Detailed training materials, including comprehensive user guides and step-by-step processes for using EWB will be developed and distributed. These materials will be made available online for broader distribution to ensure all staff have access to the necessary documentation.*<br><br>*The need for three distinct user guides will be evaluated, given that the primary processes are fundamentally similar. Creating a single user guide, which highlights any exceptions, would require less effort than maintaining multiple guides.*<br><br>**Expected Evidence of Implementation:**<br><br>*Updated user guides and training materials made available to staff.* |
| | **Theme:** Training & Development | Control Operation | **High Priority**<br><br>**Officer:**<br><br>**Target Implementation Date:** |
| 3 | **Communication and access to information**<br><br>An Optimise SharePoint page is available via the Health Board's intranet. This features a YouTube video introducing Optimise in the Health Board. The page also has a number of sections relating to discharge planning, guidance and the EWBs, | Inappropriate, inefficient or inconsistent use of the system impacting on patient | **Agreed Action:**<br><br>*The Optimise SharePoint homepage will be reviewed and updated to include working links to all relevant information in relation to the Optimise work programme including Electronic White Boards. Links to the user guides will be included to provide* |

| | | | |
|---|---|---|---|
| | However, only the D2RA section has content and there are no links to the EWB user guides.<br><br>An updated version of the EWB software is shortly due to be released. We understand that the release and subsequent system changes will be communicated through emails and notifications on the Optimise SharePoint Page. However, of the nine ward managers visited, only five were aware of the existence of the Optimise SharePoint Page.<br><br>We understand that the lead nurse plans to develop the SharePoint page to incorporate up to date guidance and training, but that delivery of training is the priority. | flow, delayed discharges and inaccurate reporting. | *users with necessary resources. Staff will be made aware of the Optimise SharePoint Page and its functionalities.*<br><br>**Expected Evidence of Implementation:**<br><br>*Updated Optimise SharePoint page with links to key documents and guides.* |
| | | **Medium Priority** | **Officer:**<br><br>**Target Implementation Date:** |
| | **Theme:** Resourcing | Control Design | |

| **Objective 2:** Appropriate access controls have been set up within the system. | **Reasonable** |
|---|---|

## Overview / Summary of Observations

During our visit to nine wards, we confirmed that nearly all staff had individual access to EWB via their Nadex log in. Each ward has a primary monitor set up to display the 'schematic' view of the ward, showing the bed usage and key details of each patient, similar to the physical whiteboards.

A generic ward account is in place, replacing the need for staff to log out and log back in each time they entered information, as this could impede their ability to record data efficiently, making the information needed readily available and easy to update, in the same way as physical whiteboards. The majority of users, but especially ward clerks, update the schematic view, while ward managers and the nurse in charge generally update the 'list' view where more detailed patient notes on the discharge plan are captured. However, this is not restricted and whilst there are audit logs within the system capturing activity by user, the use of the generic accounts prevents activity being attributed on one individual.

Access to information is not restricted by ward or department as everyone who has access to the EWB system can view all information. This was an intentional decision made with the support of the Information Governance team. Teams such as therapies, pharmacy and social workers operate across various locations, therefore full access is necessary for continuity of patient care. Similarly, while a staff member on one ward does not necessarily need access to another ward's data, restricting access could impede the ability to follow patient journeys if they move between wards.

We understand that the Health Board has given consideration to the implications of sharing data with the relevant Local Authorities (LA) and a Joint Data Controller Agreement (JDCA) is in place setting out the responsibilities of all parties. Access to the EWB system is granted to number of LA staff and we saw evidence that it is in line with the JDCA. We also confirmed that all LA employees had signed an honorary contract with the Health Board.

LA user accounts are periodically reviewed to identify and disable licences for accounts that have not be active for 90 days or more. Whilst we were able to obtain a copy of the most recent check carried out in April 2025, there did not appear to be a consistent approach to disabling accounts.

| | Key Findings | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 4 | **Generic log in**<br><br>A ward generic log-in is mainly used for primary monitors on the wards where the 'schematic' view of the ward can be seen, like the previous physical whiteboards. As the system has developed, more patient information is being entered into the discharge plan page within the 'list' view section of the system. However, the use of a generic log-in means all staff can update all sections of the system without a clear audit log of who made changes. | Inappropriate access or inaccurate updates or to patient information that can not be traced to system users. | **Agreed Action:**<br><br>*Guidance on the use of generic logins will be established and incorporated into the user guide and training materials. Amendments made within the 'list' view will be carried out by staff using their own Nadex identification to ensure an audit trail of the changes.*<br><br>*Explore possibility of stopping access to list view with generic logon.* |
| | | | **Expected Evidence of Implementation:**<br><br>*Restrictions within EWB of where generic logins can be used.* |
| | | **Medium Priority** | **Officer:** |
| | **Theme:** Governance | Control Operation | **Target Implementation Date:** |

| | | | |
|---|---|---|---|
| 5 | **Periodic review of LA users**<br><br>The April 2025 LA user report lists 62 individuals and when they last logged into the Citrix platform (required to access EWB externally) and the EWB system. We identified inconsistencies with the disabling of accounts of staff who last logged in over 90 days ago; some accounts have been disabled while others remain enabled. | Inappropriate access to patient information. Financial loss if more licences are in use than required. | **Agreed Action:**<br><br>*An agreed schedule for reviewing the licences and accounts of Local Authority users will be put in place. Consistent parameters will be established for disabling the accounts of those that have not logged into the system for set periods of time. Once adjustments are made to accounts, a new report will be run to confirm the changes.* |
| | | | **Expected Evidence of Implementation:**<br><br>*Local Authority user reports run and actioned on a regular basis.* |
| | | **Medium Priority** | **Officer:** |
| | **Theme:** Governance | Control Operation | **Target Implementation Date:** |

| **Objective 3:** All relevant wards and departments are using the system, with feedback sought from areas failing to fully engage with the system. | **Reasonable** |
|---|---|

**Overview / Summary of Observations**

We visited nine wards and the degree to which the system is being used varied across the wards. Four wards appeared to be fully engaged with the process. We understand that one further ward tries but struggles to update the system as frequently as required due to staff capacity. In contrast, we visited one ward where there was limited engagement with the system and staff continued to use a physical whiteboard. We also visited Acute Medical Units (AMU) or Surgical Assessment Units (SAU) who naturally have a higher turnover of patients and as such experience difficulties in capturing all of the information required in the EWB system in a timely manner. We understand that these wards with a high turnover of patients were advised by management that completion of the, more detailed, 'list view' information was not a requirement, although some are now trying to use it.

We note that the current training demands has meant that proactive work with wards that are not currently engaging with the system is limited.

| | Key Findings | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 6 | **Lack of engagement with the EWB**<br><br>From our visits to a sample of nine wards we identified five wards where the EWB is not used as expected. We note:<br><br>• Ward 4 PoW - Medical staff have requested that the physical whiteboard remains in use. As such, the large EWB screen is not used (nor is it in a practical location), and there is limited engagement with the EWB system.<br><br>• Ward 6 PCH and Wards 4 & 9 RGH (AMUs & SAU) – All have a quick turnaround of patients so experience difficulties in maintaining timely patient information. Whilst all use the 'schematic view', only recently have the wards in RGH started to use the 'list view' element of the system following previous instructions not to use it. Ward 6 PCH do try to use 'list view' but they do not consistently use it. Our testing reported under objective 4 highlighted that data relating to discharge planning is not completed for patients on these wards.<br><br>• Ward C3 YCR – We understand that staff capacity issues means that the daily updates of the 'list view' is not always maintained and ward staff are not regularly allocating icons against their patients in the 'schematic view'.<br><br>• A number of wards were not using the 'patient comments' field. This field allows general notes to be added by ward staff and provides a place for social workers and therapists to give brief updates. | Inefficiencies where paper based, or alternative systems continue to be used.<br><br>Inability to use the EWB system for central monitoring and reporting if ward fail to input key data.<br><br>**Medium Priority** | **Agreed Action:**<br><br>*Those wards not engaging with the system will be contacted to establish the barriers for non-use of the EWB. Support and additional training will be provided to the ward staff and medical team to elevate any concerns around the EWB system.*<br><br>*Discussions will also take place regarding the placement of the EWB screen to ensure it is functional and easily accessible for staff to use.*<br><br>*Strategies to simplify the maintenance of the 'list view, and discharge processes will be developed for wards with a quick turnaround of patients.*<br><br>*Clear guidelines and training will be provided to ensure the consistent use of the 'list view' and 'patient comments'. Any previous misinformation will be addressed, and ongoing support will be provided to ensure the effective utilisation of these tools.*<br><br>**Expected Evidence of Implementation:**<br><br>*Greater engagement with the EWB system by all wards.*<br><br>**Officer:**<br><br>**Target Implementation Date:** |

| | | | |
|---|---|---|---|
| | **Theme:** Communication & Engagement | Control Operation | |
| 7 | **Displaying patient names on the EWB**<br><br>The primary EWB screen displayed the patient's name for all of the wards that we visited. The 'Hide Names' tab was not used when staff were away from the EWB, and some ward managers were unaware of how to use this function. | Patient identifiable information not held securely and viewed inappropriately. | **Agreed Action:**<br><br>*The mandatory use of the 'Hide Names' tab will be implemented. All staff members will be trained on the importance of using the 'Hide Names' tab when they are away from the primary EWB screed. This will help protect patient privacy and comply with GDPR regulations.*<br><br>*This will also be included in the User Guide and the training materials.* |
| | | | **Expected Evidence of Implementation:**<br><br>*Updated user guide and training materials.*<br><br>*Staff aware of the 'Hide Names' functionality.* |
| | | **Medium Priority** | **Officer:**<br><br>**Target Implementation Date:** |
| | **Theme:** Governance | Control Operation | |

| **Objective 4:** The system has been built to capture all required information to comply with National Discharge Guidance and the information captured in the system is done so in a timely manner and is complete and accurate. | **Limited** |
|---|---|

## Overview / Summary of Observations

The EWB system receives patient information from the two WPAS systems used in the Health Board. Our testing has identified there can be delays in EWB updating with patient records especially for patients on the Swansea Bay version of WPAS. We understand that the imminent move to a single Health Board wide WPAS will help resolve this issue.

The system is split into two sections. The 'schematic view' where data is normally input by nurses or ward clerks during patient admission and updated during board round. The 'list view' section is designed to focus on the discharge planning for each patient and is normally updated by ward managers or the nurse in charge.

Within the 'list view', users can edit each patient's discharge planning tab. A number of key fields should be completed to aid discharge planning and ensure compliance with the WG guidance. Fields to be completed include: 'Red2Green' (R2G) status, indicating if an intervention has taken place that day to support the patient journey; an Estimated Date of Discharge (EDD) should be captured within 24hours of admission, unless a patient is deemed not medically fit; the Assessment Fit Date (AFD), the date a patient was deemed medically fit for assessment; Clinically Optimised for Discharge / Transfer (COFD/T) date, ideally patients should be discharged / transferred within 48 hours of their COFD/T date; the patient pathway in line with the 'Discharge to Recover then Assess' (D2RA) model and an Electronic Transfer of Care (ETOC) form for those on pathways 1-3.

The staff members we met recognised the significance of accurate data entry, particularly concerning D2RA pathways and R2G metrics, which can impact patient care if recorded incorrectly. However, our overarching testing in relation to the nine wards that we visited and more detailed testing on a sample of patients from the wards identified a number of instances where data had not been input in a timely manner and was therefore incomplete or inaccurate. This was more prevalent in the wards with high patient turnover and the ward not using the system. We also note that generally the system is not updated over the weekends, with some exceptions depending on staff availability.

Error logs are not used to identify recurring mistakes although introducing these would be beneficial.

| | Key Findings | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 8 | **Data accuracy and completeness**<br><br>We reviewed the data captured in 'list view' for 223 patients across the nine wards that we visited. We also tested the information captured on the 'discharge planning tab' for a sample of 26 patients from those wards using the tab. We identified a number of instances where the data was incomplete or not captured in a timely manner.<br><br>***R2G status***<br><br>At five wards, all 114 patients were categorised as 'red'. Whilst some patients may correctly have a red status, we would not expect all on a ward to be red, suggesting that their status has not been correctly updated that day.<br><br>***EDD*** | The discharge of patients is delayed if key information is not captured and then acted upon. This may have an impact on quality of patient health if they remain in hospital longer than needed, and impact the ability to treat other patients if beds are not available. | **Agreed Action:**<br><br>Comprehensive instructions and detailed explanations for each section of the discharge planning tab will be provided within the user guide and accompanying training materials. The information will be updated to explain to staff the importance of accurate reporting to facilitate patient flow. The guides will contain key definitions and criteria for staff to follow. |

This information was not complete at any of the wards that we visited.

Patient testing: 17/26 did not have an EDD assigned within 24 hours. However, as seven had no AFD date recorded, we were unable tell if the missing EDD information is due to the patient not yet being fit enough to establish an EDD.

Furthermore, 3/26 patients had EDD dates that had passed, and 13/23 patients had EDD dates that had passed before revised dates were allocated. EDD dates should be updated before they pass.

***COFD***

Ward testing: 4/9 wards had little, or no information recorded in the COFD field. These being the AMU and SAU wards and ward 4 POW. 3/5 wards still had 100% of their patients on the ward 48hours after their COFD date. We acknowledge that this is not necessarily an indication that the ward has not followed due process in a timely manner, but may be due to a lack of beds in community hospitals or care homes for patients to move to.

Patient testing: 17/26 were COFD but remained on the ward. However, seven of those had either the wrong criteria to reside recorded or had conflicting information between the criteria to reside, their pathway and their R2G status.

8/19 patients who had a COFD and AFD, the date was the same. This should not be the case, as the date a patient is deemed as fit for assessment should not also be the date they are deemed fit for discharge.

***D2RA Pathways & ETOC***

Ward testing results: 59 out of 223 patients lacked a pathway or were marked as 'not yet decided'. Among the 58 patients on pathways 1-3 requiring ETOCs, only 24 had them completed. Most completed forms were for pathway 3, involving the most complex cases. ETOC forms were not consistently completed for pathways 1-2.

We understand that version three of EWB is under development and will include conditions that prevents contradictory information being entered. However, the update will not incorporate the use of mandatory fields that prevents users from proceeding without completing required information.

**High Priority**

**Expected Evidence of Implementation:**

**Officer:**

**Target Implementation Date:**

| | | | |
|---|---|---|---|
| | **Theme:** Information, Data Quality & Data Accuracy | Control Operation | |
| 9 | **Managing errors**<br><br>The system has the ability to run error logs but understand this functionality is not being used.<br><br>Our testing and discussions with ward staff identified that E-TOC forms are often returned to wards after they are submitted due to errors in the information contained on them. For example, no next of kin data included. We did not see evidence of analysis of frequent errors which would identify trends so that training needs could be identified, or the e-TOC guidance updated. | | **Agreed Action:**<br><br>The use of the error logs will be explored as a means to identify training needs and enhance guidance documents.<br><br>Ongoing errors with e-TOC form completion will be reviewed with the view to ensuring there is clear guidance expected information and how to complete the forms. |
| | | | **Expected Evidence of Implementation:** |
| | | **Medium Priority** | **Officer:**<br><br>**Target Implementation Date:** |
| | **Theme:** Training & Development | Control Design | |

| **Objective 5:** The reporting tools available within the system are effectively used at ward, site and Health Board level to manage services and make decisions. | **Reasonable** |
|---|---|

### Overview / Summary of Observations

A Power BI Discharge App has been developed to allow reports to be generated from the data captured in the EWB system. We understand that the system data is used for reporting and decision-making purposes at a Health Board level, to support national requirements and the monthly submission to NHS Executives. As not all wards are using the system additional data needs to be gathered to ensure completeness, which can be time consuming.

The D2RA Hub, which is a central point in managing the discharge process, have access to a suite of reports they can run via the app to help with service improvement and decision-making. We understand reports can be generated on matters such as patients with a length of stay of over 100 days and patients who are clinically optimised for discharge and have an outstanding e-TOC form. We understand that the Hub's use of the app and the available reports will be explored further in our forthcoming 'Discharge Planning' audit review.

While all wards also have access to the app to enable them to run reports as required, our fieldwork identified that there was limited knowledge and little use of the app at ward level.

We note that the patient flow lead nurse at PCH actively uses the Power BI Discharge App to run daily reports, for example, of patients who are clinically optimised with an expected discharge date (EDD) for the following day. This helps ensure that transport and other arrangements have been made to prevent delays. Through this process, lapsed EDDs, where the patient is still on the ward, will be identified and the nurse will engage with the ward to amend the EDD. Additionally, the patient flow lead nurse's team visits the wards during Board Rounds to assist with patient flow.

| | Key Findings | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 10 | **Using the EWB to run reports**<br><br>Our fieldwork identified that the available resources to run reports from the EWB system are not being fully used. In some cases this staff were unaware of the capability to generate reports from the system, the types of data accessible, and the Power BI Discharge App.<br><br>Additionally, the user guides and training materials do not include instructions on how to generate these reports or describe the different types of available reports. For example, the Patient list COFD that identifies outstanding e-TOCs could be run daily by the wards instead of relying on ad-hoc reports from the D2RA Hub. | | **Agreed Action:**<br><br>Staff will receive guidance on how to generate reports from the system, and how to use the Power BI Discharge App. This procedure, along with the variety of available reports and explanation of the advantages of utilising them will be thoroughly outlined in the EWB User Guide. |
| | | | **Expected Evidence of Implementation:** |
| | | **Medium Priority** | **Officer:** |
| | **Theme:** Performance Monitoring | Control Operation | **Target Implementation Date:** |

# Appendix A

## Assurance Opinion

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

## Prioritisation of Findings

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

## Disclaimer

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

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

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

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

## Public Sector Internal Audit Standards

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

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