

Agenda

12:30 - 12:35 1. PRELIMINARY MATTERS
5 min

1.1. Welcome and Introductions

Discussion Patsy Roseblade, Committee Chair

1.2. Apologies for Absence

Information Patsy Roseblade, Committee Chair

1.3. Declarations of Interest

Information Patsy Roseblade, Committee Chair

12:35 - 12:35 2. CONSENT AGENDA BUSINESS
0 min

Discussion Patsy Roseblade, Committee Chair

The Committee Chair will ask if there are any items from the Consent Agenda (item 6) that Committee Members wish to bring forward to the Main Agenda for discussion.

12:35 - 12:45 3. PRELIMINARY BOARD MATTERS
10 min

3.1. Action Log

Discussion Patsy Roseblade, Committee Chair

📄 3.1 Action Log ARAC 19th May 2026.pdf (21 pages)

3.2. Matters Arising not contained within the Action Log

Discussion Patsy Roseblade, Committee Chair

12:45 - 14:00 4. STRATEGIC PILLAR: INSPIRING PEOPLE
75 min

4.1. Losses & Special Payments Report

Discussion Sally May, Executive Director of Finance

📄 4.1 Losses & Special Payments Report ARAC 19.5.26.pdf (11 pages)

4.2. Procurement & Scheme of Delegation Report

Discussion Sally May, Executive Director of Finance

📄 4.2 Proc SoD Report Q4 2025_26 ARAC 19.5.26.pdf (10 pages)

4.3. Post Payment Verification End of Year Report 2025-26

Discussion *Sally May, Executive Director of Finance*

-  4.3 PPV End of Year 25-26 ARAC 19 May 2026.pdf (5 pages)
-  4.3a PPV End of Year 25-26 ARAC 19 May 2026.pdf (5 pages)

4.4. Local Counter Fraud Report

Discussion *Neil Jones, Local Counter Fraud Specialist*

-  4.4 Local Counter Fraud Report ARAC 19 May 2026.pdf (3 pages)
-  4.4.a Local CF Update Report ARAC 19 May 26.pdf (3 pages)
-  4.4b App CF Benchmark Report.pdf (4 pages)

4.5. Local Counter Fraud Annual Report 2025-26

-  4.5 Counter Fraud Annual Report 2025-26.pdf (3 pages)
-  4.5a Counter Fraud Annual Report 2025-26.pdf (20 pages)

4.6. Local Counter Fraud Functional Standard Return 2025-26

-  4.6 CF Functional Standard Return 2025-26.pdf (3 pages)
-  4.6a CF Functional Standard Report 2025_2026.pdf (24 pages)

4.7. Local Counter Fraud Work Plan 2026-27

-  4.7 Counter Fraud Work Plan 2026-27 (2).pdf (3 pages)
-  4.7a Counter Fraud Work Plan 2026-27.pdf (14 pages)

4.8. Speaking Up Safely Update

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

-  4.8 Speaking up Safely ARAC 19 May 2026.pdf (8 pages)
-  4.8a Annex 1 Speaking Up Safely IA Report ARAC 19 May 2026.pdf (11 pages)

4.9. Declarations of Gifts, Hospitality & Sponsorship - Annual Report

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

-  4.9 DOI and GHS Cover Report ARAC 19 May 2026.pdf (4 pages)
-  4.9a App 1 DOI Register 25&26 Board and Non Board.pdf (13 pages)
-  4.9b App 2 Register of Gifts Hospitality and Sponsorship 2025-2026.pdf (1 pages)

4.10. COMFORT BREAK - 10 Minutes

14:00 - 15:10
70 min

5. STRATEGIC PILLAR: IMPROVING CARE

5.1. Board Assurance Framework

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

-  5.1a Board Assurance Framework ARAC 19 May 2026.pdf (4 pages)
-  5.1b Board Assurance Framework ARAC 19 May 2026.pdf (74 pages)

5.2. Organisational Risk Register

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

-  5.2a Org Risk Register ARAC 19 May 2026.pdf (9 pages)
-  5.2b Org Risk Register Summary ARAC 19 May 2026.pdf (6 pages)
-  5.2c Org Risk Register ARAC 19 May 2026.pdf (7 pages)

5.3. Audit Recommendations Tracker

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

-  7.1a Cover Paper - Audit Tracker - ARAC May 26.pdf (8 pages)
-  7.1.b AMaT Audit Recommendations Tracker_ARAC 19.05.2026_FINAL.pdf (8 pages)
-  7.1.c AMaT Audit Recommendations Tracker_ARAC 19.05.2026_OVERDUE.pdf (11 pages)

5.4. NWSSP Internal Audit Progress Report

Discussion *Paul Dalton, Head of Internal Audit*

-  5.4 CTM -Progress report ARAC 19 May 2026.pdf (13 pages)

5.5. Internal Audit Review Reports

Please note that the Substantial, Reasonable and Final Follow Up Reports are contained within the supporting documents folder

5.5.1. IA Review - Savings Centrally Led Programmes

Discussion *Internal Audit*

-  5.5.1 Savings Final Internal Audit Report.pdf (12 pages)

5.6. NWSSP Internal Audit Plan 2026-27

Discussion *Paul Dalton, Head of Internal Audit*

-  5.6 CTM - Internal Audit Plan 2026-27.pdf (25 pages)

5.6.1. NWJCC Internal Audit Plan 2026-27

Discussion *Paul Dalton, Head of Internal Audit*

-  5.6.1 JCC IA Plan ARAC 19 May 2026.pdf (4 pages)

5.7. Audit Wales Progress Report

Discussion *Nathan Couch, Audit Wales Performance Lead*

-  5.7 Audit Wales Progress Report ARAC 19.05.26.pdf (11 pages)

5.8. Audit Wales Report - Digital Transformation

Discussion *Nathan Couch, Audit Wales Performance Lead*

-  5.8 AW Digital Transform ARAC 19.5.26.pdf (35 pages)

5.9. Audit Wales - Audit Plan 2026

Discussion *Nathan Couch, Audit Wales Performance Lead*

-  5.9 AW 2026 Audit Plan ARAC 19 May 26.pdf (25 pages)

5.10. Clinical Audit Update Report

Discussion *Dom Hurford, Medical Director*

-  5.10 Clinical Audit Report ARAC 19.5.26.pdf (8 pages)

15:10 - 15:15

5 min

6. CONSENT AGENDA

6.1. Items for Approval

6.1.1. Unconfirmed Minutes of the Meeting held on 3 February 2026

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

 6.1.1 Unconfirmed Mins 3.2.26 ARAC 19.5.26.pdf (12 pages)

6.1.2. Unconfirmed In Committee Minutes of the Meeting held on 3 February 2026

Discussion Gareth Watts, Director of Governance/Board Secretary

 6.1.2 Unconfirmed Mins IC 3.2.26 ARAC 19.5.26.pdf (3 pages)

6.2. Items for Noting

6.2.1. Audit Wales Annual Report 2025

Information Nathan Couch, Audit Wales Performance Lead

 6.2.1 CTMUHB Annual Audit Summary 2025 ARAC 19 May 2026.pdf (16 pages)

6.2.2. Audit Wales Structured Assessment

Information Nathan Couch, Audit Wales Performance Lead

 6.2.2a CTMUHB 2025 SA Final Report ARAC 19 May 2026.pdf (42 pages)

 6.2.2b CTM SA 2025 - Management Response Form Final ARAC 19 May 2026.pdf (4 pages)

6.2.3. Outcome of the Committee Referral to Quality, Safety & Experience Committee re: Audit Wales Eye Care Services Report

Information Gareth Watts, Director of Corporate Governance/Board Secretary

 6.2.3 Outcome of Cmt Ref to QSEC ARAC 19.5.26.pdf (4 pages)

 6.2.3a App 1 Planned Care Highlight Report QSEC 24 March 2026.pdf (8 pages)

 6.2.3b App 2 Audit Wales Eye Care Review Mgt Response.pdf (10 pages)

6.2.4. Committee Annual Cycle of Business 2026

Information Gareth Watts, Director of Governance/Board Secretary

 6.2.5 Annual Cycle of Business ARAC 19.5.26.pdf (4 pages)

 6.2.5a Annual Cycle of Business ARAC 2026 V5.pdf (8 pages)

6.2.5. Committee Forward Work Plan - Non Routine Business

Information Gareth Watts, Director of Corporate Governance/Board Secretary

 6.2.6 Forward Work Plan ARAC 19 May 2026.pdf (5 pages)

15:15 - 15:20

5 min

7. CLOSE OUT BUSINESS

7.1. Any Other Urgent Business

Discussion Patsy Roseblade, Committee Chair

7.2. Committee Highlight Report to Board

Discussion Patsy Roseblade, Committee Chair

7.3. How did we do in this meeting?

Discussion Patsy Roseblade, Committee Chair

Is there anything we could do more or less of?

Have we managed our time well and allowed open and balanced discussion?

Have we considered our values and acted in a way that supports embedding our values across CTM? Have we maintained a strategic focus?

Have we received sufficient assurance from a range of sources?

Has our discussion allowed us to better understand the risks that we are managing that may affect the achievement of our strategic goals?

15:20 - 15:25 8. PRIVATE/CLOSED SESSION BUSINESS

5 min

Information Patsy Roseblade, Committee Chair

- CTM Draft Annual Report 2025-26
- CTM Draft Annual Accounts 2025-26
- Audit Wales - Audit of the Financial Statements - Verbal Update
- CTM Audit Enquiries Letter
- Organisational Risk Register - Business Sensitive Risks
- Financial Control Procedures - Medical Variable Pay - Summary of Authorised Breaches
- Local Counter Fraud Report (Individual Cases)

15:25 - 15:30 9. DATE AND TIME OF NEXT MEETING - 24 JUNE 2026 AT 10:00 AM - TO APPROVE THE ANNUAL ACCOUNTS AND ANNUAL ACCOUNTABILITY REPORT

5 min

Information Patsy Roseblade, Committee Chair

Audit Risk & Assurance Committee - Action Log (as at 20.01.26)									
Name of Meeting: Audit Risk & Assurance Committee									
Committee Chair: Patsy Roseblade									
Date of meeting the action originated from	Minute Item Ref	Minute Ref Page Number	Item 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 2026	3,1	3	Action log	To schedule a further update on the Forward Plan for JAG Accreditation for 6-9 months' time	Head of Corporate Governance & Board Business	Director of Corporate Governance/ Board Secretary	nov-26	Propose to Close	Added to Forward Work Plan for November 2026 meeting.
Audit Risk & Assurance Committee - February 2026	4,1	3	Organisational Risk Register	To review the reporting format for emerging risks.	Director of Corporate Governance / Board Secretary	Director of Corporate Governance/ Board Secretary	mai-26	Open	In progress - the risk register has recently been updated following previous ARAC feedback and the next action to take this forward re emerging risks will be considered over the coming months
Audit Risk & Assurance Committee - February 2026	4,2	3	Response to the updated HM Treasury Audit & Risk Assurance Committee Handbook	Further action required for: - Item 2.1.3, concerning meetings between the Chair and the Director of Finance, it was noted that it does not reflect current practice and that this section be reworded to align with the process already in place. - The proposed changes to the ARAC Terms of Reference relating to Speaking Up Safely, noting that amendments are required to ensure clarity of role, and outline governance responsibilities. - The proposed self-assessment process and the need to streamline and review the intended target audience, agreeing that the current version is overly detailed.	Director of Corporate Governance / Board Secretary	Director of Corporate Governance/ Board Secretary	mai-26	Open	In progress: - Item 2.1.3, concerning meetings between the Chair and the Director of Finance - we will maintain the process which is currently in place - The proposed changes to the ARAC Terms of Reference relating to Speaking Up Safely, noting that amendments are required to ensure clarity of role, and outline governance responsibilities - further clarity in the SUS process - The proposed self-assessment process and the need to streamline and review the intended target audience, agreeing that the current version is overly detailed - we will issue an effectiveness review tailored to CTM needs in the summer.
Audit Risk & Assurance Committee - February 2026	5,1	5	Losses and Special Payments Report	To explore where thematic/clinical trends behind claims should be reported into Committee Chair and Director of Corporate Governance to discuss with Chair of Quality & Safety Committee (or Quality Lead) how to ensure themes (e.g., obstetrics, high cost cases) are reviewed at the appropriate Committee to ensure operational learning is not lost and that ARAC continues to receive assurance on the financial process.	Director of Corporate Governance / Board Secretary	Director of Corporate Governance/ Board Secretary	mai-26	Open	In Progress -this will be reviewed in conjunction with the output of the Committees' annual effectiveness reviews to agree a way forward.
Audit Risk & Assurance Committee - February 2026	5,2	5	Procurement and Scheme of Delegation report	To include a brief narrative summary in future procurement reports explaining why each of the top suppliers appears on the retrospective receipting list, the current actions being taken, and levels of progress.	Director of Finance	Director of Finance	mai-26	Propose to close	Requested to be included for future reports.
Audit Risk & Assurance Committee - February 2026	6,1	6	Local Counter Fraud Report	To highlight the discrepancies relating to training attendance figures with the Counter Fraud Team and seek clarification.	Director of Finance	Director of Finance	mai-26	Propose to Close	The issue has been highlighted to Local Counter Fraud Services
Audit Risk & Assurance Committee - February 2026	7,1	6	Audit Recommendation Tracker	The latest Healthcare Inspectorate Wales (HIW) position was reported to the Committee on 20 January 2026, and queried whether this date should actually be 2025. G Watts agreed to check the date and amend the tracker if incorrect.	Director of Corporate Governance / Board Secretary	Director of Corporate Governance/ Board Secretary	mai-26	Propose to Close	Complete - The date 20 January 2026 is correct but the Committee to which it is referring is the Quality, Safety and Experience Committee - so the information went to that committee first before being considered by the Audit Risk and Assurance Committee.

Audit Risk & Assurance Committee - February 2026	7,2	7	NWSSP Internal Audit Progress Report	To take the Committee's concerns back to the Executive Leadership Group, highlighting the need for improved timeliness from audited departments and raise concerns in relation to low turnaround figures with Operational Leads.	Director of Corporate Governance / Board Secretary	Director of Corporate Governance/ Board Secretary	mai-26	Open	Details have been fed back to ELG - improvements are noted in the Audit Tracker but will keep the action open as this will be an on-going issue until its finally resolved.
Audit Risk & Assurance Committee - February 2026	7.2.3	8	Response to Critical Incident - Final	To clarify with the Executive Lead whether the longer-term business continuity and emergency planning issues should sit with Audit Risk & Assurance Committee (ARAC), Operational Delivery Committee (ODC), or Strategic Development Committee (SDC).	Director of Corporate Governance / Board Secretary	Director of Corporate Governance/ Board Secretary	mai-26	Propose to Close	Complete - business continuity both current and preparedness for the future is covered off at ODC.
Audit Risk & Assurance Committee - February 2026	7.2.5	8	Discharge Planning - Final	It was agreed there was an issue when an internally developed "Transfer Portal" became unusable after the developer had left . To discuss governance arrangements with the Executive Director in relation to preventing unsupported systems from being developed in the future.	Director of Corporate Governance / Board Secretary	Director of Corporate Governance/ Board Secretary	mai-26	Propose to Close	Complete - the plan is to stand down the unsupported systems and use alternative systems - it is agreed that unsupported systems should not be developed and only corporately approved systems will be used in undertaking HB processes any new approved systems will require appropriate sign off.
Audit Risk & Assurance Committee - February 2026	7.3.1	10	Audit Wales Review - Eye Care Services	To make a formal cross Committee referral of the concerns raised in the Audit Wales Eye Care Services report to QSEC.	Head of Corporate Governance & Board Business	Director of Corporate Governance/ Board Secretary	mai-26	Propose to Close	Referral was received at Quality, Safety & Experience Committee and the response is on the Agenda for the May 2026 meeting.
Audit Risk & Assurance Committee - February 2026	7,5	10	JAG Accreditations Update	To revise the recommendation within the report.	Chief Operating Officer	Chief Operating Officer	mai-26	Propose to Close	Recommendation was reviewed and updated.
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	nov-25	Propose to Close	Outcome report received by the Committee at the November 2025 meeting. Action following meeting was O James to circulate the redress threshold email, (which has been completed) clarify the impact of local redress management and invite someone from Patient, Care & Safety to the next meeting. This has been completed
Audit Risk & Assurance Committee - November 2025	2.1 & 8.2.1	2	Outcome of the Committee Referral to Quality, Safety & Experience Committee	To review the statement in the report regarding increased thresholds for redress cases to £50k outside of the meeting.	Head of Corporate Finance	Director of Finance	feb-26	Propose to Close	An update was provided at the February 2026 meeting

Audit Risk & Assurance Committee - November 2025	4,1	3	Organisational Risk Register	To provide an update on 6372 - Cost escalation risk – Microsoft Enterprise Agreement renewal.	Director of Corporate Governance / Board Secretary	Director of Digital	feb-26	Open	Update to risk reported in December - Negotiations with Microsoft continue. They are proposing three differing profile types. Profile 1 covers Frontline worker, those that share a device on wards etc. Profile 2 is for Advanced Clinical Users that want to use dedicated devices with additional functionality. Profile 3 Is for Information workers that need full M365 functionality. There is also an offer of CoPilot licensing and Power Platform licensing. The detail is still being worked through. The initial costs look high with a potential for CTM costs to go up between £1-1.5m per year. Negotiations are looking to reduce that big step up in costs. Update for May ARAC 2026 Following further all Wales negotiation and detailed internal analysis, a preferred renewal approach has been identified. An approval paper was presented to the Executive Management Board on 23 February 2026, recommending the commencement of a new all Wales Microsoft Enterprise Agreement from 1 July 2026 for a minimum five year term. The recommended option mitigates the previously reported £1–£1.5m per annum cost risk through licence optimisation, refined user profiling, and improved commercial terms. While Year 1 costs increase compared to the current EA, financial modelling demonstrates cost avoidance from Year 2 onwards and savings over five years when compared to extending the current agreement into its final year and subsequently transitioning to standard pricing via the Crown Commercial Services Strategic Partnership Arrangement (2024). CTMUHB licence volumes have been minimised and aligned to active workforce data to avoid over licensing. Subject to final confirmation by the all Wales EA Project Board, and the release of the All Wales Business Case and Commitment to Participate documentation, the risk exposure has reduced but remains under active management until the new agreement is formally executed.
Audit Risk & Assurance Committee - November 2025	4,1	3	Organisational Risk Register	Discussions to be held offline on the usefulness of the heat map, narrative context and trend analysis improvements.	Director of Corporate Governance / Board Secretary	Director of Corporate Governance/ Board Secretary	feb-26	Propose to Close	Complete - but will keep under review the heat up has been updated following ARAC feedback to provide more context in movement of risks etc
Audit Risk & Assurance Committee - November 2025	7,1	7	Audit Recommendations Tracker	To check with the team on the numbers listed on the pie chart includes the 39 recommendations proposed for closure.	Director of Corporate Governance / Board Secretary	Director of Corporate Governance/ Board Secretary	feb-26	Propose to Close	Complete - Clarified that the number of recommendations noted as proposed for closure means those recommendations approved for closure by Execs but which have not yet gone to ARAC - if no further questions at ARAC those recommendations then move into the closed columns.
Audit Risk & Assurance Committee - 14 August 2025	6,1	7	Local Counter Fraud Report	Local Counter Fraud Team explore the possibility of mandating Counter Fraud Training requirements for the Health Board to improve learning in this area and advised the team to contact G Watts for advice and signposting.	Local Counter Fraud Specialist	Local Counter Fraud Specialist	nov-25	Open	In progress pending discussions

Audit Risk & Assurance Committee - November 2025	4,3	4	Data Lapses Report	To provide an update on whether the master patient index incident had led to data breaches outside of the meeting	Director of Digital	Director of Digital	feb-26	Closed at 3rd Feb' 2026
Audit Risk & Assurance Committee - November 2025	4,4	5	Declarations of Interests and Gifts, Hospitality and Sponsorship Report	To amend the detail listed in relation to P. Daniels.	Director of Corporate Governance/ Board Secretary	Director of Corporate Governance/ Board Secretary	feb-26	Closed at 3rd Feb' 2026
Audit Risk & Assurance Committee - November 2025	5,3	6	Post Payment Verification Mid-Year Report	To reformat the report for future meetings.	Corporate Governance Manager	Director of Finance	feb-26	Closed at 3rd Feb' 2026
Audit Risk & Assurance Committee - November 2025	2,1	2	Consent Agenda Business	Governance Team to liaise with the Chief Operating Officer regarding a date to receive the JAG accreditation update.	Corporate Governance Manager	Director of Corporate Governance/ Board Secretary	feb-26	Closed at 3rd Feb' 2026
Audit Risk & Assurance Committee - November 2025	3,1	3	Action Log	To reformat the Action Log in a landscape format for future meetings.	Corporate Governance Manager	Director of Corporate Governance/ Board Secretary	feb-26	Closed at 3rd Feb' 2026
Audit Risk & Assurance Committee - 14 August 2025	7.3.4	10	IA Review – Decarbonisation – Follow Up	Executive Director of Strategy & Transformation and Executive Director of Finance to meet Head of Internal Audit to review recommendations 4.1 and 4.2.	Executive Director of Strategy & Transformation Executive Director of Finance Head of Internal Audit	Executive Director of Strategy & Transformation Executive Director of Finance	nov-25	Closed

				Head of Internal Audit to set out the approach to follow up reviews within the next Internal Audit Progress Report update to the November meeting.	Head of Internal Audit	Head of Internal Audit	nov-25	Closed
Audit Risk & Assurance Committee - 14 August 2025	7,5	12	Audit Wales Review – Tackling the Planned Care Challenges	A focus for the Strategic Development Committee is how the Health Board compares service transformation with short term improvements and that sustainable transformation should be the focus.	Chair of the Strategic Development Committee Executive Director of Strategy & Transformation	Executive Director of Strategy & Transformation	nov-25	Closed
								Closed
Audit Risk & Assurance Committee - 14 August 2025	7.3.1	9	IA Review - End of Life Care Management	Revisit the audit review and recommendations with relevant Executive Leads and if there were any changes needed to the recommendations and management responses these would return to the Committee following engagement and agreement with Internal Audit Colleagues. Explore the risk around training identified within the audit review and report back to the next Strategic Development Committee.	Executive Director of Strategy & Transformation	Executive Director of Strategy & Transformation	nov-25	Closed
Audit Risk & Assurance Committee - 14 August 2025	5,2	5	Procurements and Scheme of Delegation Report	Future updates to FCPs to include a detailed appendix to the report which outlines the amendments made to the documents.	Head of Corporate Finance	Executive Director of Finance	nov-25	Closed
Audit Risk & Assurance Committee - 14 August 2025	5,1	4	Losses and Special Payments Report	To provide an update as to whether there has been an increase in Clinical Negligence claims following the introduction of the Duty of Candour.	Deputy Executive Director of Nursing	Executive Director of Nursing	nov-25	Closed
Audit Risk & Assurance Committee - 14 August 2025	4,2	3	Interim Amendments to the Model Standing Financial Instructions (SFIs) Chapter 11 for Local Health Boards	Future updates to the Standing Orders and Standing Financial Instructions to provide a summary paragraph so any amendments are specified and clearly visible to the reader.	Corporate Governance Team	Director of Corporate Governance/ Board Secretary	nov-25	Closed

Audit Risk & Assurance Committee - 14 August 2025	4,1	3	Organisational Risk Register	The September iteration of the Organisational Risk Register to capture an update on the "Lack of Resuscitaire in Princess of Wales Hospital Emergency Department" (Datix Risk ID 6152).	Assistant Director of Governance & Risk	Director of Corporate Governance/ Board Secretary	nov-25	Closed
	4,2	3	Interim Amendments to the Model Standing Financial Instructions (SFIs) Chapter 11 for Local Health Boards	Future updates to the Standing Orders and Standing Financial Instructions to provide a summary paragraph so any amendments are specified and clearly visible to the reader.	Corporate Governance Team	Director of Corporate Governance/ Board Secretary	nov-25	Closed

Audit Risk & Assurance Committee - 14 August 2025	4,1	3	Organisational Risk Register	The September iteration of the Organisational Risk Register to capture an update on the "Lack of Resuscitaire in Princess of Wales Hospital Emergency Department" (Datix Risk ID 6152).	Assistant Director of Governance & Risk	Director of Corporate Governance/ Board Secretary	nov-25	Closed

Audit Risk & Assurance Committee - 14 August 2025	4,1	3	Organisational Risk Register	The September iteration of the Organisational Risk Register to capture an update on the "Lack of Resuscitaire in Princess of Wales Hospital Emergency Department" (Datix Risk ID 6152).	Assistant Director of Governance & Risk	Director of Corporate Governance/ Board Secretary	nov-25	Closed
Audit Risk & Assurance Committee - 14 August 2025	3,1	3	Action Log	Risk relating to Paediatric Dentistry - a report had been received by Quality, Safety & Experience Committee and it was suggested that this report could be share as a cross report between the two Committees.	Director of Corporate Governance/ Board Secretary	Director of Corporate Governance/ Board Secretary	45870	Closed
Audit Risk & Assurance Committee - 14 August 2025	4,3	4	Organisational Risk Register	To provide further assurance on clarity and mitigations of risk 5671 - Cross Health Board Data Sharing	Director of Corporate Governance/ Board Secretary	Director of Corporate Governance/ Board Secretary	45870	Closed
Audit, Risk & Assurance Committee - May 2025	5,1	5	Losses and Special Payments Report	To receive an update on penalties for late submitted evidence	Deputy Director of Nursing & Midwifery	Director of Nursing & Midwifery	45870	Closed
Audit, Risk & Assurance Committee - May 2025	7,3	8	NWSSP Internal Audit Services Annual Audit Plan 2025-26	To review the Executive Lead for the Medical Annual Leave and Rostering	Head of Internal Audit	Head of Internal Audit	45870	Closed

Audit, Risk & Assurance Committee - May 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	45870	Closed
Audit, Risk & Assurance Committee - May 2025	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	45689	Closed
Audit Risk & Assurance Committee - February 2025	5,2	7	Audit Recommendations Tracker	To include the feedback received for the next iteration of the Tracker	Director of Corporate Governance/Board Secretary	Director of Corporate Governance/Board Secretary	45689	Closed
Audit & Risk Committee December 2024	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	45778	Closed

Audit & Risk Committee December 2024	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	45778	Closed
Audit Risk & Assurance Committee - February 2025	5.4.2	46002	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	45778	Closed
Audit Risk & Assurance Committee - February 2025	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	45689	Closed
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	45778	Closed
Audit & Risk Committee December 2024	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	45778	Closed

Audit Risk & Assurance Committee - February 2025	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	45627	Closed
Audit Risk & Assurance Committee - February 2025	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	45689	Closed
Audit & Risk Closed In Committee October 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	45689	Closed
Audit & Risk Committee December 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	45627	Closed

Audit & Risk Committee December 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	45627	Closed

There have been no reported issues as a result of the master patient index incident.

Detail has been amended
Report has been formatted as requested.
On Agenda for February 26 meeting
Report has been formatted as requested.
Following discussion outside of the Committee with Internal Audit Colleagues and the Executive Director of Strategy & Transformation and the Executive Director of Finance the management response action has been reframed to the satisfaction of all concerned and amended report received. The new wording is captured in the Audit Tracker Report received at this meeting.

An explanatory paragraph has been added to the Internal Audit Progress report for the November meeting of the Committee.
A meeting has been arranged between the SDC Chair and the Executive Director of Strategy & Transformation for the 17 November 2025

Audit outcomes reviewed and confirmed as achievable with colleagues

A number of FCPs will be presented at the November 2025 ARAC meeting, attached to that is going to be an appendix outlining the amendments to each FCP.
Data has been reviewed and a response sent via email on 06.11.25
This has been noted for future updates. The report was also updated ahead of submission to the Board in September to address the feedback received at the Committee.

This risk will now not be escalated to the Organisational Risk Register as the risk score has been significantly reduced as the Resuscitaire equipment for the Emergency Department has been received and was being put together by the Electro-Biomedical Engineering (EBME) department. The interim arrangements regarding the Resuscitaire from maternity scheduled to cease at the end of September allowing for training on the new Resuscitaire equipment.

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Report was shared via email to the Committee on the 30.7.25
Update was shared via email to the Committee 23.05.25
Penalties for Late Submitted Evidence Update report scheduled for the August meeting at agenda item 5.3.
Report was reviewed outside of meeting and amended to reflect the Executive Leads as the Medical Director & Executive Director for People

Included as an update in the In Committee session on the 14 August at Agenda item 2.2.
Latest update captured on the Organisational Risk Register for July 2025. See agenda item 4.1b. This risk is monitored via the following assuring Committees - Operational Delivery Committee and Quality, Safety & Experience Committee.
The actions from the last meeting will be built into the improvement programme for the development of the Audit Tracker
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.

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.
Received at the Health Board Meeting 27.03.25
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.
Report to be brought to May 2025 meeting to include coloured text to highlight last updates.
Primary Care review in progress. Update to be brought to May 2025 meeting as part of the Local Counter Fraud Report

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/
Nothing to flag within papers for this meeting. Noted for future drafting.
Table has an additional column to highlight actions since last report. Happy to review formatting for future meetings if Committee would prefer different style.
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

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

Audit, Risk & Assurance Committee

Losses & Special Payments 1st March 2026 to 31st March 2026

Eitem yr Agenda / Agenda Item	4.1
Dyddiad y Cyfarfod / Date of Meeting:	19/05/2026
Statws Cyhoeddi / Publication Status:	Open/Public.
	Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	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
Diben yr Adroddiad / Report Purpose:	For Noting
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	For Noting
Cyd-destun Strategol: <i>Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol</i> Strategic Context: <i>This report aligns to the following Strategic Pillars</i>	Not applicable
	If more than one applies please list below:
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol <i>(Cyfeiriad blaenoriaeth berthnasol)</i> Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan <i>(Reference relevant priority)</i>	Not applicable

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio:

Dechreuwch drwy **grynhai'r wybodaeth bwysicaf yn fyr**. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn:

Executive Summary of what the report is describing:



Start by **summarising briefly** the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:

Beth (*crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati*)

What (*summary of current position / issue & why it matters and evidence to support that position etc*)

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 2026 to 31 March 2026, as required by the Standing Financial Instruction.

Felly, beth (*darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain*)

So, what (*provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these*)

The losses and special payments recorded during this period totalled £8,324k, with the majority of this comprising of payments in respect of Clinical Negligence, Redress and Personal Injury.

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.

The total recovered from Welsh Risk Pool during the period is £4,338k, giving a net cash in position for the period of £3,986k. The significant reimbursements of claims, especially on medical negligence has decreased the amount owed by Welsh Risk Pool and therefore the debtor balance we are anticipating. At 31st March the amount paid but not yet received from Welsh Risk Pool is £29.7m.

This is £11.5m higher than it was at the end of the 2024/25 financial year and will have a detrimental impact on cash flow if it is not reimbursed by the end of this financial year.

It is important that there is timely recovery of payments of claims from WRP, including interim reimbursements where appropriate.

Beth Nesaf (*crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud*)

What Next (*summary of intended action and benefits supporting the*

This report is backwards looking, but it is important to note the trend of increasing numbers of live cases and the value of claims which have been paid but not yet reimbursed by Welsh Risk Pool.



choices and
recommendation(s)being
made)

Argymhelliad (*Wedi'i gysylltu â'r
adran "Beth Nesaf" uchod*).

Recommendation (Linked to the
"What Next" section above).

The Committee is asked to note the report.

1. Background / Context

- 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 2026 to 31 March 2026, 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. Strategic Insights

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

1. Losses and Special Payments recorded during period

- 2.3 The losses and special payments recorded during this period totalled £8,324k, 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 £4,338k, giving a net cash in position for the period of £3,986k. The significant reimbursements of claims, especially on medical negligence has decreased the amount owed by Welsh Risk Pool and therefore the debtor balance we are anticipating. At 31st March the amount paid but not yet received from Welsh Risk Pool is £29.7m.

2.6 This is £11.5m higher than it was at the end of the 2024/25 financial year and will have a detrimental impact on cash flow if it is not reimbursed by the end of this financial year.

2.7 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.

	01.01.26 - 31.03.26 £000	Previous Periods	Total 25-26 £000
Medical Negligence Claims	3,880	21,270	25,150
Medical Negligence Costs	2,703	3,812	6,515
Medical Negligence Defence Fees	334	1,219	1,553
Medical Negligence Totals	6,917	26,301	33,218
Redress Medical Negligence Claims	287	59	346
Redress Medical Negligence Costs	23	17	40
Redress Medical Negligence Defence Fees	9	9	18
Redress Medical Negligence Totals	319	85	404
GP Indemnity Claims	300	73	373
GP Indemnity Costs	61	101	162
GP Indemnity Defence Fees	8	22	30
GP Indemnity Totals	369	196	565
Personal Injury Claims	46	73	119
Personal Injury Costs	29	262	291
Personal Injury Defence Fees	131	191	322
Personal Injury Totals	206	526	732
Permanent Injury Benefit	263	466	729
Permanent Injury Benefit Totals	263	466	729
Other:			
Ex-Gratia	6	46	52
Debt Write Off	2	14	16
WRP Penalty Charge	0	0	0
Ombudsman	0	4	4
Employment Matter/Other	242	0	242
Other Totals	250	64	314
TOTAL	8,324	27,638	35,962
Recovered from Welsh Risk Pool	(4,338)	(16,909)	(21,247)
Net Cash Write-Off/(Recovery)	3,986	10,729	14,715

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 meetings, the WRP committee approved the payment of a further £4,338k of claims (40 claims), this was paid in February and March. 2 further claims reviewed by the committee were deferred, and another 17 claims were deferred until further information was received.

2. Provision as at 31 March 2026

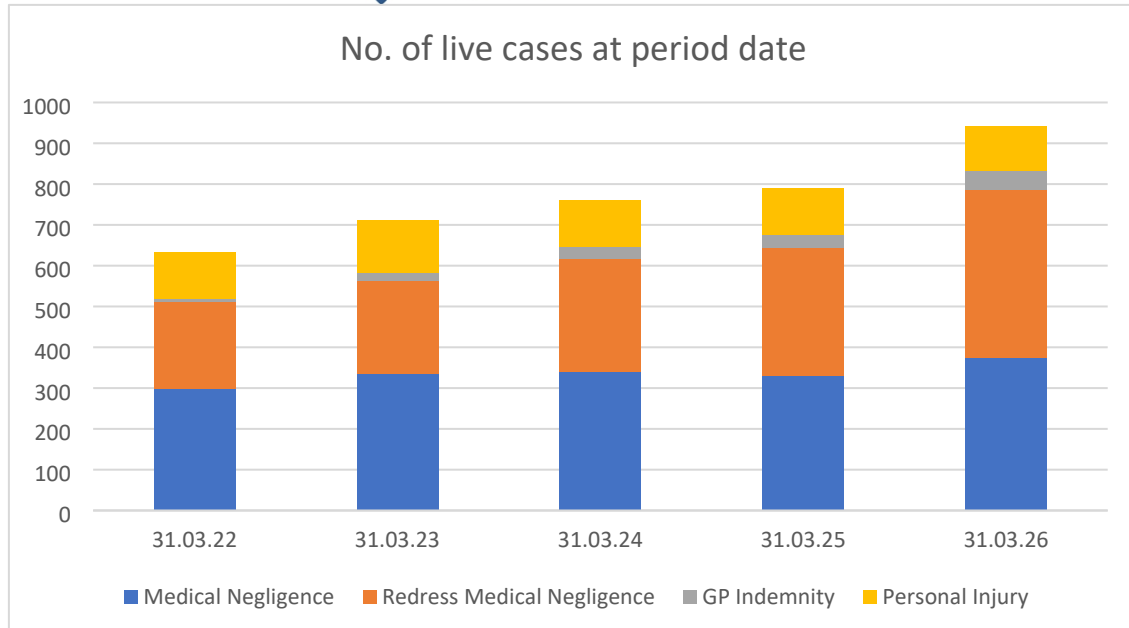
- 2.9 A provision reflecting the estimated value of the claim will be made on the balance sheet as a claim is deemed probable. There will also be an estimate for the value recoverable from Welsh Risk Pool, leading to a net provision value on the balance sheet.
- 2.10 The table below shows the provision 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 decreased by £1,690k since 31 March 2025, this is mainly due to a decrease in value of medical negligence claims.

- 2.12 The net provision at the end of 31st March 2026 was £22,981k which is £3,202k lower than the previous reported period. This is due to the large claims that were paid for medical negligence claims that have been reimbursed by WRP.

	31.03.26	31.03.25	31.03.24	31.03.23	31.03.22
	£000	£000	£000	£000	£000
	Cumulative	Cumulative	Cumulative	Cumulative	Cumulative
Medical Negligence claims/costs	133,219	136,729	94,478	72,198	65,127
Redress Medical Negligence claims/costs	1,082	490	372	385	235
GP Indemnity (Note 1)	2,240	1,670	612	0	0
Personal Injury claims/costs	2,393	1,734	917	701	611
TOTAL CLAIMS/COSTS PROVISION	138,933	140,623	96,379	73,284	65,973
Recoverable from Welsh Risk Pool	(165,890)	(156,234)	(106,450)	(83,623)	(93,074)
NET CLAIMS / COSTS PROVISION	(26,957)	(15,611)	(10,071)	(10,339)	(27,101)
Permanent Injury Benefit	3,976	3,707	3,755	4,077	6,201
NET PROVISION inc Perm Injury Ben.	(22,981)	(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. The rate of new cases being opened in 2025/26 has been relatively in line with previous years. However, the rate of cases being closed has been slower due to awaiting WRP reimbursement prior to full case closure. This is reflected in the number of live cases for the period to 31st March 2026 versus prior years.



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
	31.03.26
	£000
Medical Negligence claims/costs	29,709
Redress Medical Negligence claims/costs	993
GP Indemnity	1,135
Personal Injury claims/costs	1,392
Recoverable from Welsh Risk Pool	(30,903)
Net claim expenditure (Note 1)	2,326
Permanent Injury Benefit	997
Other	315
Total Net expenditure	3,638

Note 1: The annual budget for net claim expenditure for 2025-26 is £2,019k, actual expenditure for the year is £2,341k, therefore showing an overspend of £321k. It is important to note that these costs can fluctuate during the year.

WRP Risk Sharing Agreement

- 2.16 The Audit, Risk & Assurance 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 As previously reported for 2025/26 WRP are reporting a risk of significant overspend of based on the risk sharing agreement, during Month 8 Welsh Government have confirmed funding support up to the forecast will be released any remaining risk beyond the forecast is to be funded by organisations.

3. Risks and Opportunities

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

4. Compliance and Governance

- 4.1 This report satisfies the requirements of the Standing Financial Instructions.
- 4.2 The Committee is asked to note the increased value of claims paid but not yet reimbursed from Welsh Risk Pool.

5. Conclusion

- 5.1 The Audit, Risk & Assurance Committee is requested to:
- **NOTE** the losses and special payments made for the period 1 January 2026 to 31 March 2026.
 - **NOTE** the key risks for escalation on the increasing net provision value.

- **NOTE** the amount of claims that have been paid out but we are awaiting reimbursement from Welsh Risk Pool is now £29.7m at the end of March.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd <i>(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)</i> Link to Strategic Risk(s) on the Board Assurance Framework (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Strategic Risk 9
	If more than one applies please list below:

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable
	If more than one applies please list below:

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Whole-Systems Perspective
	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:

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg <i>(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhwch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)</i>	Outcome for Equality (delete as appropriate): NEUTRAL	If no, please select a reason below. Choose an item. Named Executive/Board member sign off for no EWLIA completion:
	Summary of impact:	
Equality & Welsh Language Impact Assessment Outcome <i>(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)</i>	Outcome for Welsh Language (delete as appropriate): NEUTRAL	
	Summary of impact:	
Canlyniad Asesiad Effaith Ansawdd	The majority of losses and special payments are as a result of things going wrong and where	



(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)

Quality Impact Assessment Outcome

(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)

quality, safety or patient experience may therefore have been compromised.

Details of medical negligence and personal injury claims are provided quarterly to the Concerns (Claims) Scrutiny Panel who subsequently reports to the Quality, Safety & Risk Committee

Cyfreithiol / Legal

Yes

Losses provided for are informed by legal advice where appropriate based on probability of a successful claim

Enw da / Reputational

Yes (include further detail below)

As noted within Quality Impact Assessment section above, reputational risk is managed via the reporting hierarchy.

Effaith Adnoddau

(Pobl /Ariannol) /

Resource Impact

(People / Financial)

Yes (include further detail below)

The report highlights the resource impact of losses both in expenditure and cash terms. It also highlights the level of provision within the balance sheet for potential future payments.

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

WRP

NWSSP

VER

DEL

GMPI

Welsh Risk Pool

NHS Wales Shared Services Partnership

Voluntary Early Release

Departmental Expenditure Limit

General Medical Practice Indemnity



Agenda Item

4.2

Audit, Risk & Assurance Committee

Procurement & Scheme of Delegation Update

Dyddiad y Cyfarfod / Date of Meeting	19/05/2026
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Owen James - Head of Corporate Finance
Cyflwynydd yr Adroddiad / Report Presenter	Sally May – Executive Director of Finance
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
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
- i) File Note Process

This report provides details of any such transactions within the period 01.01.26 to 31.03.26

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 2025-26.

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. Procurement Matters

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

There were no such engagements or contracts entered into during the period 01 January 2026 to 31 March 2026

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

Standing Financial Instructions require four competitive tenders for supplies of goods and services over £25,000 up to the prevailing Public Procurement threshold and five competitive tenders above Public Procurement 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 provide details of such actions during the period 01 January 2026 to 31 March 2026

Table A – Single Tender Actions

None for Q4 2025/26

Table B - Single Tender Actions - Retrospective CTM

None for Q4 2025/26

c) Summary of contracts awarded between £500,000 and £1 million

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 Government Commercial Agency (formerly Crown Commercial Services).

None for Q4 2025/26

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

None for Q4 2025/26

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.

None for Q4 2025/26

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	Department	Retro Orders	Comment
BOC Ltd	55510 PCH PHARMACY	101	Gases
	559163_PONTYPRIDD_DENTAL	8	
	533002_RESPIRATORY & SLEEP PHYSIOLOGY	3	
	534131_POW DERMATOLOGY UNIT (WARD 17)	3	
	559152_KH Admin Blk2	1	
St David Recruitment Services Ltd	559157_H and N RGH Directorate Office	26	Recruitment
	533890_RGH PATHOLOGY	25	
	533870_RGH SURG OFFI	14	



	533063_UROLOGY DEPT TREATMENT CENTRE RGH	10	
	533359_POW SURG UROLOGY	7	
	555156 PCH EEG	6	
	532994_PLANNED CARE - RM36	3	
	555079 PCH C.P.U.	3	
	533888_RGH RADIOLOGY	1	
	534133_MSK OFFICES (SITE SECRETARY) OLD POST GRAD	1	
Cardiff & Vale University Local Health Board	533958_RGH ADULT MHU	23	Various
	555127 PCH WM and CHD	5	
	559157_H and N RGH Directorate Office	3	
	533872_RGH MED OFFI	3	
	555156 PCH EEG	2	
	544036_LLW OP DEPT	2	
	533360_POW DERMATOLOGY	1	
	533888_RGH RADIOLOGY	1	
	533934_RGH PHARMACY	1	
	535043_YMH PLANNING	1	
	559152_KH Admin Blk2	1	

Top 3 Receipting Areas	Count of Inv Num	Total
533862_RGH THEATRE	73	£85,087.96
533944_RGH ENG'ING	68	£233,092.79
534112_POW MAIN THEATRE	59	£94,766.16

g) Consultancy Contracts

None for Q4 2025/26

h) File Notes (retrospective)

Below is a table detailing File Notes that have been completed between 01 January 2026 to 31 March 2026.

File Note reference number	Department	Value of PO (ex VAT)	Supplier
CTM-FN-006	Estates	£ 45,310.00	Morris Churchfield

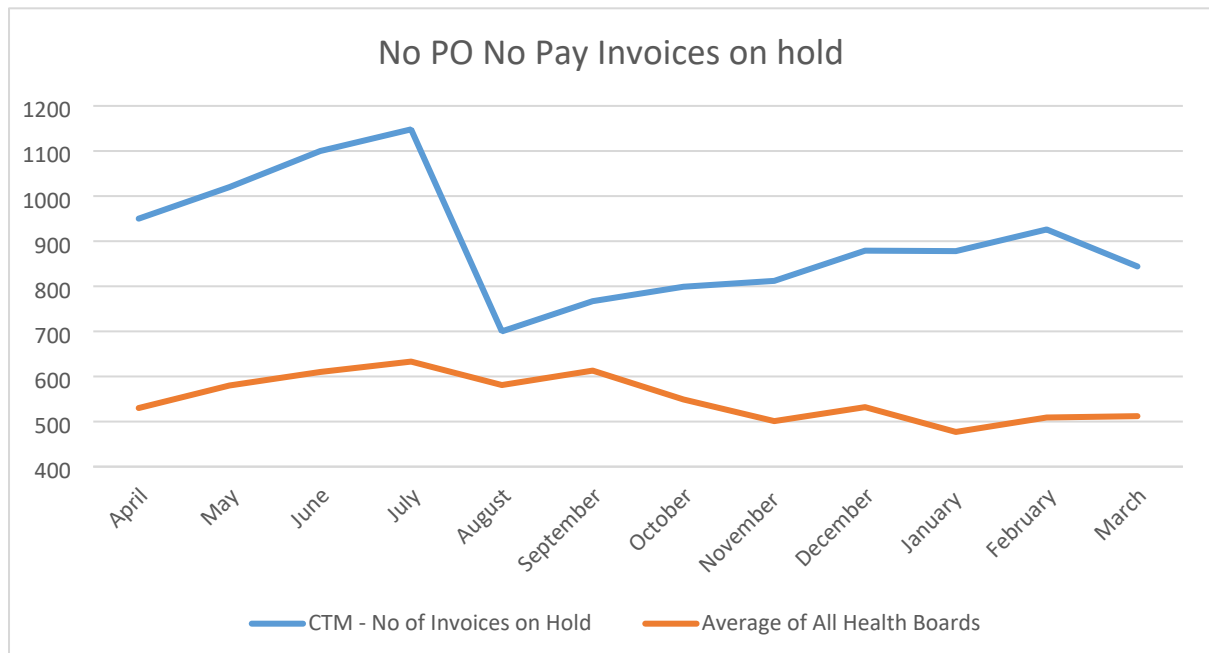


CTM-FN-007	Digital & Data	£ 11,802.00	MultiTone via Softcat
CTM-FN-008	Radiology	£ 15,600.00	Jennie Reeves Radiographers Agency
CTM-FN-009	People Directorate	£ 13,715.00	Silvermaple
~~CTM-FN-010~~	<i>Cancelled</i>		
CTM-FN-011	Estates	£ 5,530.35	Mitie
CTM-FN-012	Primary Care	£ 10,780.18	OmniceLL LTD
~~CTM-FN-013~~	<i>Cancelled</i>		
CTM-FN-014	Dermatology	£ 22,115.71	Synnovis
CTM-FN-015	Medical records	£ 59,000.00	Just Wales Ltd
CTM-FN-016	Facilities	£ 10,500.00	DeterTech UK Limited
CTM-FN-017	General Surgery	£ 12,000.00	Hays
CTM-FN-018	Facilities	£ 150,000.00	Blue Arrow
CTM-FN-019	Estates	£ 11,252.00	Eastwood Park Ltd
CTM-FN-020	Facilities	£ 19,250.00	Castell Howell Foods Ltd
CTM-FN-021	Neurodiversity	£ 15,000.00	Beam Up Ltd
CTM-FN-022	People Directorate	£ 9,640.00	Silvermaple
CTM-FN-023	Haematology	£ 12,326.99	Benson Viscometers
CTM-FN-024	Mental Health	£ 9,000.00	Pamova
CTM-FN-025	Medical Office	£ 7,254.00	Swanton Care & Community Ltd
CTM-FN-026	Labour Ward	£ 7,527.97	Gettinge Ltd
CTM-FN-027	H&N Directorate	£ 9,837.26	St David Recruitment
CTM-FN-028	Major Works	£ 39,900.25	Socotec Asbestos Limited
CTM-FN-029	PCH THERAP	£ 13,500.00	Corporate Research Forum Ltd
CTM-FN-030	PCC	£ 421,000.00	Abergarw Care Home

i) 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 continues to have a higher number of invoices on hold due to No PO than the average across Welsh Health Boards. However, in August the number of No PO No Pay holds fell significantly from nearly 1,200 to 700, before increasing again in subsequent periods. The top three suppliers—Konica Minolta Business Solutions, Oxford Immunotec Ltd and JLA Ltd—account for 20% of all No PO No Pay holds, totalling 178 invoices. Procurement and Finance are working with suppliers and departments to resolve these issues and process payments where appropriate, including raising POs to clear outstanding invoices and introducing arrangements such as call-off orders to help prevent future holds.

2.1 Purchase to Pay (P2P)

The PSPP figures are reported to the end of 31st March 2026.

The Health Board has met its 95% target of paying non-NHS invoices within 30 days to Month 12 2025-26 achieving 95.6% (value 92.3%). This means the Health Board achieved the target of 95% for the year to date.

	0 - 30 Days		Total		%	
	Number	Value	Number	Value	Number	Value
Apr-25	23,349	48,613,792	24,243	52,792,910	96.31%	92.08%
May-25	21,336	48,846,593	22,188	50,835,517	96.16%	96.09%



Jun-25	20,173	46,562,058	21,139	49,596,993	95.43%	93.88%
Jul-25	22,139	51,418,725	23,270	54,118,296	95.14%	95.01%
Aug-25	22,125	21,528,540	22,842	23,221,715	96.86%	92.71%
Sep-25	21,784	19,157,285	22,538	20,159,890	96.65%	95.03%
Oct-25	22,749	29,802,407	24,140	33,441,590	94.24%	89.12%
Nov-25	19,094	19,398,530	19,840	20,246,401	96.24%	95.81%
Dec-25	19,993	25,607,761	20,888	28,805,298	95.72%	88.90%
Jan-26	18,545	24,815,979	19,819	30,333,789	93.57%	93.01%
Feb-26	18,887	22,197,717	19,826	24,499,515	95.26%	94.21%
Mar-26	18,753	22,933,467	19,598	24,658,787	95.69%	95.43%
YTD	248,927	380,882,854	260,331	412,709,830	95.62%	95.17%

The NHS invoice position continues to be challenging and shows a position of 74.3% (number) and 97.5% (value) of invoices were paid within 30 days to Month 12 2025-26. Velindre NHS Trust have recently piloted an Invoice Exception Approval workflow where invoices which are on the No PO No Pay exception list such as NHS Wales invoices can be approved in line with the approval hierarchy directly to the approver without need for PO. This could be an option to approve NHS Wales invoices in a timely manner. The Head of Corporate Finance is currently reviewing the process and engaging with appropriate stakeholders to understand whether this could be a viable option to implement in CTM. This could improve the timely payment of NHS Wales invoices going forward.

2.2 Scheme of Delegation (SoD) and Financial Control Procedures (FCPs)

There are no changes to SoD or FCPs in this report.

3. Key Risks / Matters for Escalation

No matters for escalation



4. Assessment

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

Impact Assessment		
Ansawdd Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality Have you undertaken a Quality Impact Assessment Screening?	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? / Equality and Welsh Language Have you undertaken an Equality and Welsh Language Impact Assessment Screening?	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: Not applicable



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

5. Recommendation

5.1 **NOTE** the position on procurement matters for the period 01.01.2026 to 31.03.2026;

NOTE the update regarding Purchase to Pay and achievement of PSPP target up to Month 12 of 2025/26



Agenda Item

4.3

Audit, Risk & Assurance Committee

Post Payment Verification End of Year Report 1st April 2025 – 31st
March 2026

Dyddiad y Cyfarfod / Date of Meeting	19/05/2026
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Amanda Legge – All Wales Post Payment Verification Manager
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	(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	

1. Situation /Background

The Audit and Risk Assurance Committee is asked to take assurance from the contents of this report. It highlights Post Payment Verification (PPV) progress and how practices have been performing over the current cycle. It compares the overall performance of the Health Board (HB) 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).

At mid-year and end of financial year, the PPV Manager will prepare a report for Health Board audit committees to outline how practices have been performing and highlighting PPV progress.

The report is being produced for the Committee to review and seek assurance that the Post Payment Verification cycle is being managed appropriately. 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 specification and relevant legislation

2. Specific Matters for Consideration

The following key points should be noted:

General Medical Services (GMS): We progressed well this year with our GMS routine visits and all are either closed or in progress by the end of this financial year.

Beginning 2026/2027 we will be concentrating the first quarter on GMS visits only and incorporating both revisits and the practice routine visit. This is part of our ongoing recovery plan. Some vaccination claims are now being claimed on the Welsh Immunisation System (WIS) and due to PPV highlighting the issues we found whilst conducting our verification checks, new internal process changes have been implemented to stop the duplicate vaccination payments prior to payment and not post payment, which is beneficial to everyone.

General Ophthalmic Services (GOS): The visit plans for GOS 2025-2026 progressed better than the last few years, based on the team having the ability to carry out remote access on more contractors who have transferred to electronic patient records. We have had to still carry out elements of physical visits too, as not all contractors are electronic.

In 2025/2026, we verified claims for an additional 2 services, which were the WGOS 4 (Glaucoma and Medical Retina) and Independent Prescribing Optometry Service 5 urgent claims (IPOS5). These checks have been going well with learning shared with our contractors and our teams.

General Pharmacy Services (GPS): In 2025-2026, the PPV team undertook checks on the Collaborative Working Scheme along with the Quality and Safety Scheme which we conduct remotely by verifying the data we hold against the evidence that we request from the contractors. This again has been positive for all HB, PPV team and contractor learning.

Additional Service: The team progressed well with its quarterly dispensing data checks and has introduced a robust service moving forward into the new financial year, which resulted in future financial recoveries. The results for the two dispensing practices in Cwm Taf Morgannwg University Health Board have been added to PPV reports.

The PPV team also manages the Waste Management Audit programme on behalf of the Health Boards, offering advice and support to General Practitioners and Community Pharmacies in respect of Waste Management alongside the clinical waste self-assessments required to be completed by our contractors every three years. We will incorporate our GOS contractors into our clinical waste process in the next financial year.

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.

The team is also continuing to investigate other avenues for savings from the provision of Clinical Waste services. The team also arrange bi-monthly National GMS, GOS Working Group 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 requirements continue to be delivered to Health Boards and contractors, whenever needed and we also facilitate one-on-one training requirements when requested, particularly for new practice staff within the Primary Care setting.

We currently have our data analysts looking at producing some PPV dashboards with information for submission to future committee meetings.

3. Key Risks / Matters for Escalation

There are no options included in this report. The report is for assurance and will only detail specific risks if any, and provides the narrative for what PPV, Primary Care, Finance and Counter Fraud consider to be the best approach to support practices in improving their claiming process.



4. Assessment

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

Impact Assessment		
Ansawdd Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality Have you undertaken a Quality Impact Assessment Screening?	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? / Equality and Welsh Language Have you undertaken an Equality and Welsh Language Impact Assessment Screening?	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below:



	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

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 for 2026-2027 and enhance future financial reports.

Audit Report - 1st April 2025 to 31st March 2026 = Cwm Taf Morgannwg University Health Board												
General Medical Services (GMS)	CTMHB							ALL WALES				
	Visit Type	HB Annual Visits Due	No. In progress/completed	No. Recoveries	Value of recoveries	Value of Duplicate Recoveries	Total Recoveries	All Wales Visits Due	All Wales No. in progress/completed	All Wales Value of Recoveries	All Wales Value of Duplicate Recoveries	All Wales Total Recoveries
GMS 2024 - 2025	Combined		32				£18 912,31		197			£251 104,95
GMS 2025-2026	Routine	13	13	236	£8 112,84	£23 223,24	£31 336,08	103	102	£80 912,90	£72 691,84	£153 604,74
	Revisit	13	7	236	£3 457,82	£549,21	£4 007,03	148	54	£37 048,01	£5 736,38	£42 784,39
	TOTAL	26	20	472	£11 570,66	£23 772,45	£35 343,11	251	156	£117 960,91	£78 428,22	£196 389,13
General Ophthalmic Services (GOS)	CTMHB					ALL WALES						
	Visit Type	Annual Visits Planned	No. In progress/Completed	No. Recoveries	Value of recoveries	All Wales visits due	All Wales No. in progress/completed	All Wales Value of Recoveries				
GOS 2024-2025	Combined		11		£1 349,54		100	£16 316,67				
GOS 2025-2026	Routine	19	19	47	£1 209,17	168	127	£12 939,39				
	Revisit	0	0	0	£0,00	11	9	£583,84				
	TOTAL	19	19	47	£1 209,17	179	136	£13 523,23				
General Pharmacy Services (GPS)	CTMHB					ALL WALES						
	Visit Type	Annual Visits Planned	No. In progress/completed	No. Recoveries	Value of recoveries	All Wales visits due	All Wales No. in progress/completed	No. Recoveries	All Wales Value of Recoveries			
GPS 2024 - 2025	Combined	32	32		£2 436,00		238		£48 153,27			
GPS 2025 - 2026	Routine	38	23	4 pending	£2 318,20	232	200	Pending	Pending			
	TOTAL	38										
New Recovery process												
	Quarter Period	Amount of Dispensing GP Practices	Value of Recoveries	All Wales Dispensing GP Practices	All Wales Value of Recoveries							
DISPENSING 2025-2026	Quarter 4 2024/25 (Jan to Mar 2025)	2	£217,42	64	£24 444,29							
Dispensing GP practices should not dispense to patients who live within 1.6 kms / 1 mile from a Local Community Pharmacy												

GMS Summary									
PRACTICE	Routine or Revisit	Overall Sample size	Claim errors	Error % recovery	Value of recovery	Value of Duplicate recovery	Total recovery	Breakdown of Recovery	Advisory Notes
Practice 1	Revisit	833	79	9,48 %	£883,16	£61,71	£944,87	Contraceptives, Immunisations	• The planned visits were sent to the HB for 2025/26 Visit Plan. These are subject to change due to ad hoc visits or closures/mergers. • All closed visit files have been authorised by the Health Board
Practice 2	Revisit	283	0	0,00 %	£0,00	£0,00	£0,00	All claims verified.	
Practice 3	Revisit	814	74	9,09 %	£1 647,00	£0,00	£1 647,00	Homes and	
Practice 3	Routine	273	5	1,83 %	£85,40	£746,64	£832,04	ptives, Immunisations, Minor Surgery,	
Practice 4	Revisit	38	0	0,00 %	£0,00	£0,00	£0,00	All claims verified.	
Practice 5	Revisit	283	20	7,07 %	£560,06	£420,00	£980,06	tions, DOAC/D OAR,	
Practice 6	Revisit	1248	56	4,49 %	£157,60	£0,00	£157,60	OAR and Wound Care	
Practice 7	Revisit	115	7	6,09 %	£210,00	£0,00	£210,00	DOAR/D OAR	
Practice 8	Routine	337	26	7,72 %	£682,57	£328,74	£1 011,31	Denosumab, Flu, Learning Disabilities	

Practice 9	Routine	269	15	5,58 %	£521,49	£20,06	£541,55	INR, Care Homes, Denosumab, Immunisations, Near	GMS team with any concerns/issues being addressed. • The duplicate amount of recovery is due to the practice submitting certain additional claims for the same patient more than once. This is a new audit check by PPV and feedback and
Practice 10	Routine	388	27	6,96 %	£1 171,11	£2 580,62	£3 751,73	Contraceptives, Denosumab,	
Practice 11	Routine	434	21	4,84 %	£906,38	£3 255,81	£4 162,19	INR, Care Homes, Immunisations, Minor Surgery, Care	
Practice 12	Routine	229	4	1,75 %	£188,96	£30,09	£219,05	Homes, Denosumab, DOAC/D	
Practice 13	Routine	349	22	6,30 %	£936,67	£14 922,92	£15 859,59	Homes, Contraceptives, Gonador	
Practice 14	Routine	471	25	5,31 %	£500,59	£177,70	£678,29	Disabilities, Minor Surgery,	
Practice 15	Routine	301	15	4,98 %	£1 234,39	£795,26	£2 029,65	Diasbilities,	
Practice 16	Routine	343	17	8,75 %	£362,52	£19,32	£381,84	Duplicate	
Practice 17	Routine	296	0	0,00 %	£0,00	£20,06	£20,06		

Practice 18	Routine	600	11	1,83 %	£165,00	£253,74	£418,74	Homes, DOAC/D OAR,	lessons learnt are being
Practice 19	Routine	450	45	10,00 %	£1 358,76	£139,78	£1 498,54	ptives, Flu, Homeles	

GOS Summary

PRACTICE	Routine or Revisit	Overall Sample size	Claim errors	Error % recovery	Value of recovery	Breakdo wn of Recoveri es and	visory Notes
Practice 1	Routine	103	5	4,85 %	£225,31	GOS 4W and	The planned visits were sent to the HB for 2025/26 Visit Plan. Numbers are subject to
Practice 2	Routine	103	0	0,00 %	£0,00	All claims	
Practice 3	Routine	103	2	1,94 %	£32,37	GOS 3W and GOS	
Practice 4	Routine	103	5	4,85 %	£71,48	GOS 3W	
Practice 5	Routine	103	4	3,88 %	£101,17	GOS 4W	
Practice 6	Routine	103	0	0,00 %	£0,00	All claims	
Practice 7	Routine	103	2	1,94 %	£64,37	GOS 3W and GOS	
Practice 8	Routine	103	11	10,68 %	£262,56	GOS	
Practice 9	Routine	103	0	0,00 %	£0,00	All claims	
Practice 10	Routine	103	2	1,94 %	£20,17	claims.Cl aim	
Practice 11	Routine	103	2	1,94 %	£64,25	GOS 4W and	
Practice 12	Routine	103	0	0,00 %	£0,00	All claims	
Practice 13	Routine	103	4	5,48 %	£64,74	GOS 4W	
Practice 14	Routine	103	7	6,80 %	£170,00	GOS 3W and	
Practice 15	Routine	103	0	0,00 %	£0,00	All claims	

Practice 16	Routine	103	1	0,97 %	£42,71
Practice 17	Routine	103	1	0,97 %	£45,02
Practice 18	Routine	103	1	0,97 %	£45,02

GOS 4W claim.
WGOS 2 claim.
WGOS 2 claim.

GPS Summary

PRACTICE	In progress	Closed	Value of recovery
Practice 1		Y	
Practice 2		Y	
Practice 3		Y	
Practice 4		Y	
Practice 5		Y	£584,68
Practice 6		Y	£642,50
Practice 7		Y	£877,02
Practice 8		Y	£214,00
Practice 9		Y	
Practice 10		Y	
Practice 11		Y	
Practice 12		Y	
Practice 13	Y		
Practice 14	Y		
Practice 15	Y		
Practice 16	Y		
Practice 17	Y		
Practice 18	Y		
Practice 19	Y		
Practice 20	Y		
Practice 21	Y		
Practice 22	Y		
Practice 23	Y		

Advisory Notes

Awaiting further evidence for practice 13 to 23.
Out of 38 planned visits 15 have been postponed due to change of ownership.
All Wales recoveries



Agenda Item

4.4

Audit, Risk & Assurance Committee

Local Counter Fraud Update Report

Dyddiad y Cyfarfod / Date of Meeting	19/05/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Robert Neil Jones, Interim Head of Local Counter Fraud Services
Cyflwynydd yr Adroddiad / Report Presenter	Robert Neil Jones, Interim 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.
- 2.2 The detail on the Investigations are being taken at the (CLOSED) In Committee meeting of the Committee due to potentially identifiable information

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



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

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

5. Recommendation

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

6. Next Steps

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



Cwm Taf Morgannwg University Health Board

Audit, Risk & Assurance Committee – 19th May 2026

Counter Fraud Progress Report

Robert Neil Jones
Interim Head of Local Counter Fraud Services

1. INTRODUCTION

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

2. BACKGROUND

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

3. RESOURCE UTILISATION

AREA OF WORK	Planned Days	Days to Date
Strategic Governance		
Ensuring that anti-crime measures are embedded at all levels across the organisation	48	4
Inform and Involve		
Identifying the risks and consequences of crime against the NHS, and raising awareness of these risks amongst NHS staff, stakeholders, and the public.	100	2
Prevent and Deter		
Discouraging those who may want to commit crimes against the NHS and ensure that such opportunities are minimised.	143	3
Hold to Account		
Detecting and investigating crime, prosecuting those who have committed crimes and seeking redress as a result.	290	28
TOTAL	581	37

4. STRATEGIC GOVERNANCE

The Counter Fraud Annual Report 2025/26 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 are looking to drive participation in both online and face-to-face fraud awareness training. The Team are utilising the use of the Employee Engagement Platform – Viva Engage to build a fraud awareness culture within the Health Board. In addition, the Team is developing the use of AI to produce updated counter fraud literature, which include court case updates and scam awareness articles for release to staff and members of the public.

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 area of fraud risk has increased since the introduction of remote working opportunities following the Covid pandemic. A full progress report will be presented to a future Committee meeting for review.

7. HOLD TO ACCOUNT

The status of the LCFS investigative caseload is summarised in Appendix 2 to this report. Case information presented is split by between those cases which are currently open and under active investigation by the LCFS; contained in the Open Cases table. The Pending Cases table reflects those cases where active investigation by the LCFS has concluded, however the case must remain open due to other outstanding actions from third parties such as (but not limited to) disciplinary, professional body enquiries, financial recoveries. A table of Closed Cases is also presented to review outcomes of investigations.

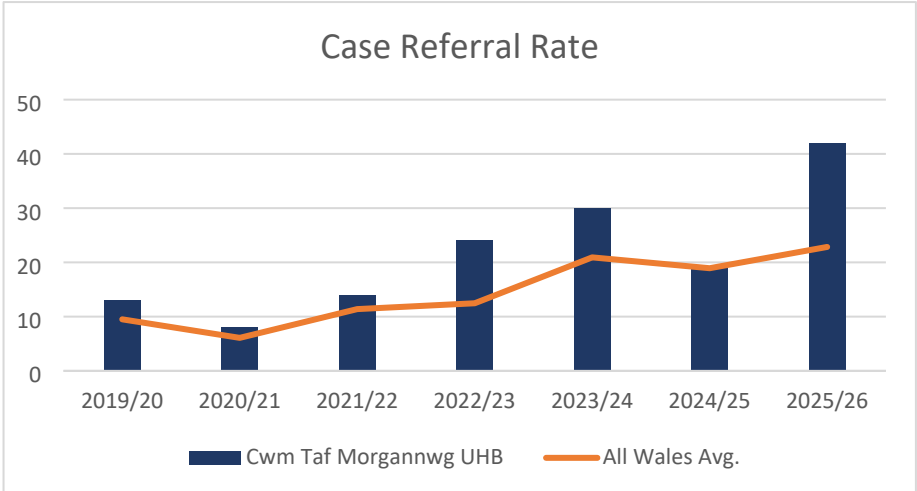


Item 4.4b – Appendix 2

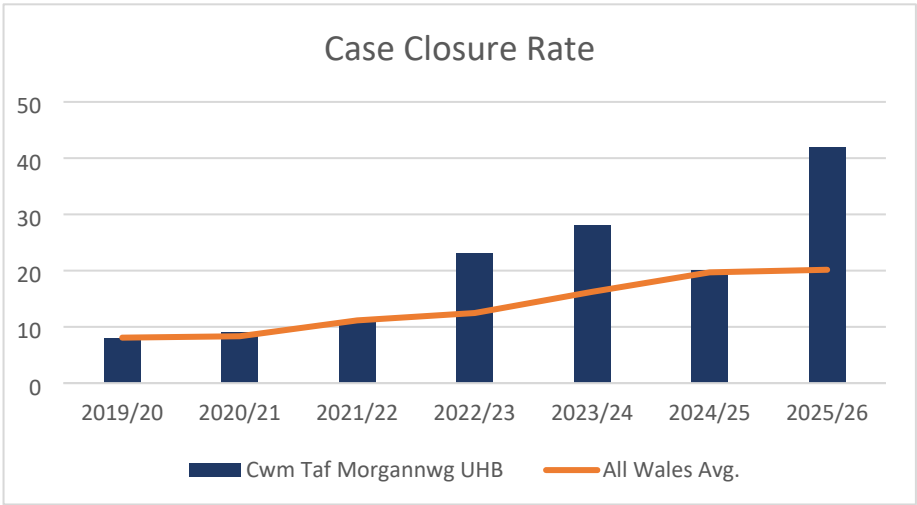
Counter Fraud Benchmark Report

Counter Fraud Benchmarking Statistics – 2025/26

Case Referral Rate	Cwm Taf Morgannwg UHB	All Wales Avg.
2021/22	12	11.4
2022/23	29	12.5
2023/24	17	20.9
2024/25	31	18.9
2025/26	42	22.8



Case Closure Rate	Cwm Taf Morgannwg UHB	All Wales Avg.
2021/22	10	11.2
2022/23	24	12.5
2023/24	13	16.2
2024/25	30	19.7
2025/26	42	20.2

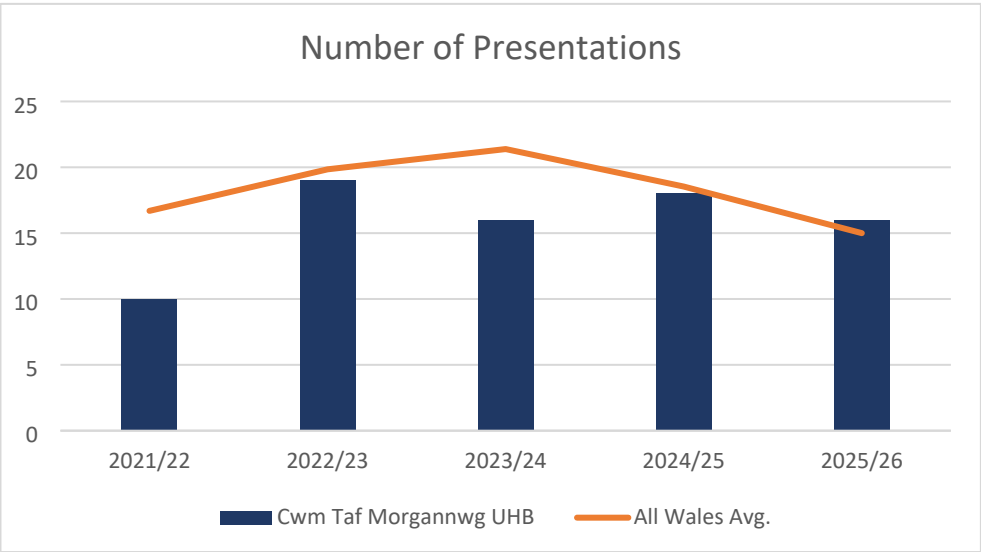


Counter Fraud Benchmarking Statistics – 2025/26

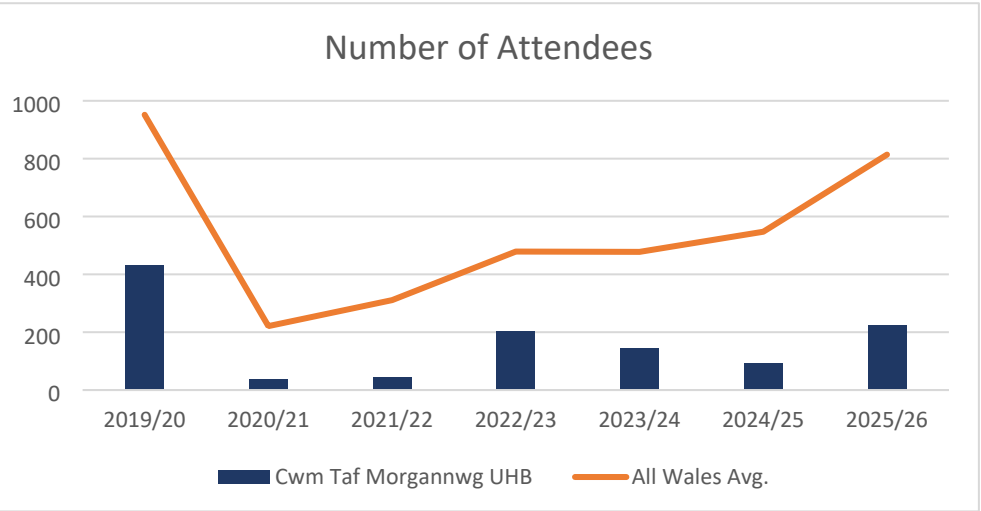
Investigation Progression Rate	Cases Open at Start of FY	Referrals Received	Cases Closed	Total Cases Open End of Period
2020/21	50	11	32	29
2021/22	33	12	10	35
2022/23	24	29	24	29
2023/24	20	17	13	24
2024/25	22	31	30	23
2025/26	20	42	42	20

Counter Fraud Benchmarking Statistics – 2025/26

Number of Presentations	Cwm Taf Morgannwg UHB	All Wales Avg.
2021/22	10	17
2022/23	19	20
2023/24	16	21
2024/25	18	19
2025/26	16	15



Number of Attendees	Cwm Taf Morgannwg UHB	All Wales Avg.
2021/22	45	311
2022/23	204	479
2023/24	143	478
2024/25	91	547
2025/26	223	814





Agenda Item

4.5

Audit, Risk & Assurance Committee

Counter Fraud Annual Report 2025/26

Dyddiad y Cyfarfod / Date of Meeting	19/05/2026
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Robert Neil Jones, Interim Head of Local Counter Fraud Services
Cyflwynydd yr Adroddiad / Report Presenter	Robert Neil Jones, Interim 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 the counter fraud activity in 2025/26 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 (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	Not Applicable
	If more than one applies please list below:
Dolen i Feysydd Ansawdd	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 Cydraddoldeb a'r Gymraeg? / Equality and Welsh Language Have you undertaken an Equality and Welsh Language Impact Assessment Screening?	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below:
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	

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 2025/26

May 2026

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1. Introduction

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

The Counter Fraud Work Plan for 2025/26 was approved by the Audit Committee in March 2025 and identified a total resource of 581 days for the year. The Counter Fraud Team delivered 452 days of counter fraud activity. The under delivery of days was due to long term sickness absence within the Team.

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 2025/26 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 2025/26 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 2026/27 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

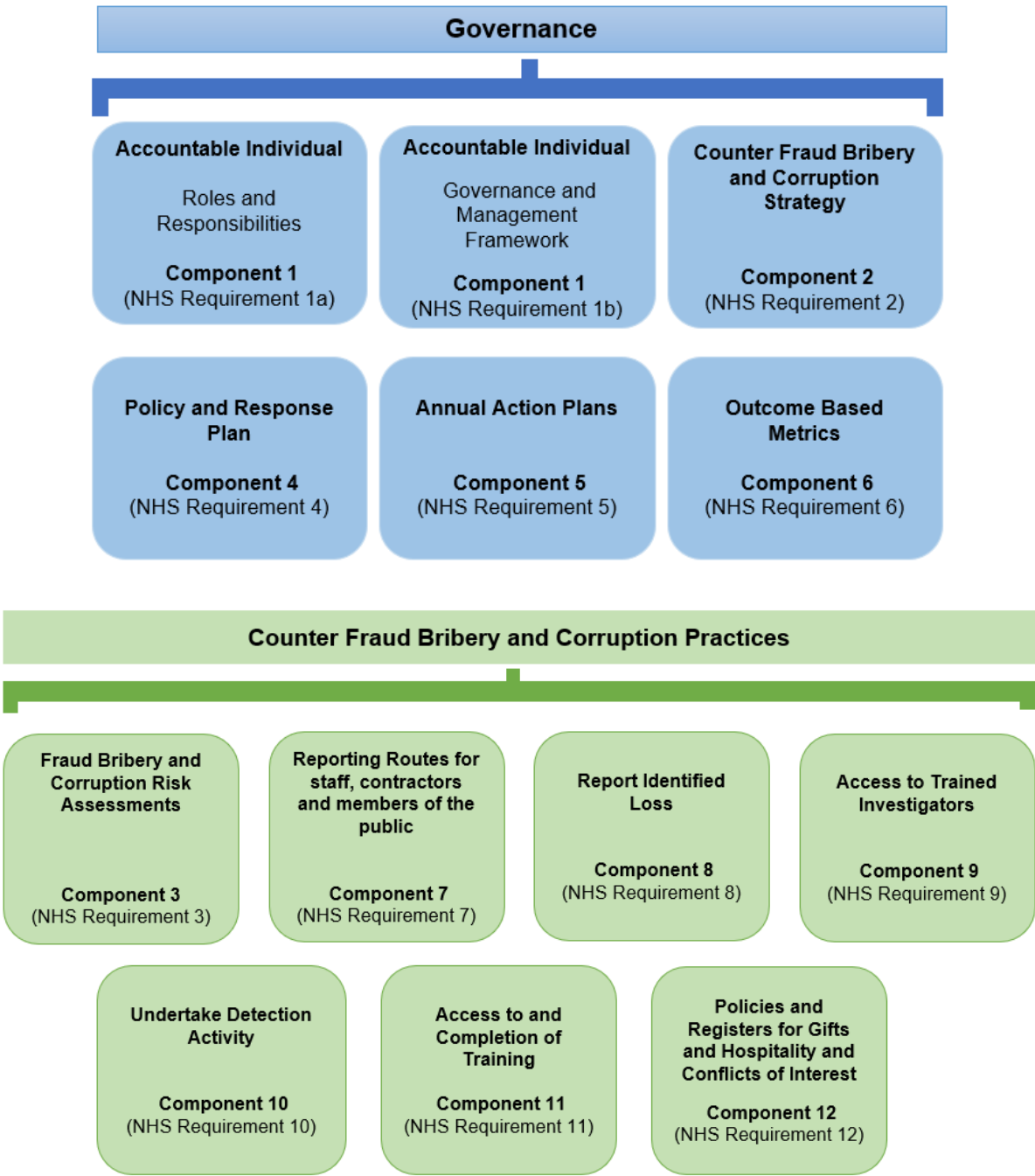
I declare that the counter fraud, bribery and corruption work carried out during 2025/26 has been self-reviewed against the Functional Standard Requirements relating fraud, bribery and corruption and Service Condition 24 of the NHS Standard Contract, and that the above rating has been achieved.

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 activities 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		2025 Rating	2026 Rating	Current Position
Component 1 Accountable individual	NHS Requirement 1A	This relates to the role of the accountable board member and their responsibility for the strategic management of, and support for, counter fraud, bribery and corruption work, including timely reporting and accurate notification of nominations to the NHSCFA.	GREEN	GREEN	The Director of Finance is responsible for the strategic management and support of counter fraud work. A good level of support and assistance is given to the Counter Fraud Team in the discharge of responsibilities by the Director of Finance and the wider Finance Directorate. The Health Board's Audit Committee receive regular reports of Counter Fraud activity throughout the year which includes quarterly benchmarking reports. The Audit Committee receive and approve the Health Board's Counter Fraud Annual Report and Workplan. All Counter Fraud submissions to the Audit Committee are sponsored and supported by the Director of Finance.
	NHS Requirement 1B	This relates to the work of the organisations board / governing body in gaining assurance	GREEN	GREEN	The Audit Committee receives an Annual Report written in line with NHSCFA guidance using the

Function Standard Component	NHS Requirement		2025 Rating	2026 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. The Director of Corporate Governance has been nominated as the Fraud Champion supported by the Assistant Director of Governance and Risk. Support around the implementation of fraud risk recording via DATIX, furthering counter fraud awareness at induction under Corporate Governance input, and supporting work around Standards of Behaviour Policy fraud proofing.
Component 2 Counter fraud bribery and corruption strategy	NHS Requirement 2	This Component relates to the organisations overarching 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. 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

Function Standard Component	NHS Requirement		2025 Rating	2026 Rating	Current Position
					by Director of Finance and Audit Committee and progress is tracked via regular reporting and attendance at Audit Committee.
Component 4 Policy and response plan	NHS Requirement 4	This Component relates to the organisations counter fraud, bribery and corruption policy and response plan and its alignment to the NHSCFA strategic guidance.	GREEN	GREEN	The Health Board has a Counter Fraud Policy & Response Plan in place. The Policy is reviewed to ensure that it remains current. Issues relating to bribery and fraud are also referenced within the Standards of Behaviour Policy.
Component 5 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. 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		2025 Rating	2026 Rating	Current Position
					overall resource availability.
Component 6 Outcome based metrics	NHS Requirement 6	This Component relates to how the organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance	GREEN	GREEN	All Wales Performance statistics are collated on a quarterly basis and shared between Health Boards and Welsh Government. Statistics are utilised to examine performance between NHS Wales organisations. Benchmarking undertaken on an organisational level against previous years and against other NHS Wales Organisations. Reports on performance and benchmarking are shared with the Audit Committee to scrutinise. Clue3 includes recording and reporting mechanisms 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		2025 Rating	2026 Rating	Current Position
Component 3 Fraud bribery and corruption risk assessment	NHS Requirement 3	This Component relates to the local risk assessments undertaken in line with Government Counter Fraud Profession methodology to identify fraud, bribery and corruption risks, and how the organisations counter fraud, bribery and corruption provision is proportionate to the level of risk identified.	GREEN	GREEN	Comprehensive risk assessments are carried out in line with the GCFP methodology and recording aligns to the Health Board's Risk Management Policy. The annual counter fraud work is informed by these risk assessments. NHS CFA issued national fraud risks guidance containing 129 fraud risk descriptors across the entirety of business areas the NHS engages in. These risks have been concatenated into core risk areas for review locally. Work since introduction of this Component has been to map fraud risk descriptors to core risk assessments, development of a fraud risk profile around core risk areas, implementation of managing fraud risk via DATIX, implement sufficient scanning techniques and processes to ensure all emerging fraud risk is captured and reviewed against existing fraud risk assessments.
Component 7 Reporting routes for staff, contractors	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		2025 Rating	2026 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. The Counter Fraud Team have regularly received contact from individuals raising concerns resulting in the commencement of 42 new investigations in 2025/26.

Function Standard Component	NHS Requirement		2025 Rating	2026 Rating	Current Position
Component 8 Report identified loss	NHS Requirement 8	This Component relates to the organisations use of the approved NHS fraud case management system to record all allegation and investigative activity. Including all outcomes, recoveries and system weaknesses identified during the course of investigations and/or proactive prevention and detection exercise.	GREEN	GREEN	The Health Board fully utilises the Clue case management system to record and report identified loss. The system includes opportunity to record all investigaiton materials, local proactive exercises and operational statistical information. Statistics are collated and submitted on a quarterly basis to Counter Fraud Service Wales and an All Wales Operational Performance report produced. A benchmarking report utilising this information is presented to Audit Committee on a quarterly basis.
Component 9 Access to trained investigators	NHS Requirement 9	This Component relates to the accredited Local Counter Fraud Specialist (LCFS) at the organisation, and details of the continuous professional development undertaken. All LCFS undertaking counter fraud activity at the organisation must be nominated with the NHSCFA.	GREEN	GREEN	Local Counter Fraud Services for the Health Board are provided by Swansea Bay UHB under a Service Level Agreement. The service is delivered by qualified, nominated and accredited LCFS, who conduct the full range of anti-fraud, bribery and corruption work on behalf of the organisation. The LCFS attend all necessary training and continuous professional development events as required to appropriately fulfil their

Function Standard Component	NHS Requirement		2025 Rating	2026 Rating	Current Position
					role on an ongoing basis.
Component 10 Undertake detection activity	NHS Requirement 10	This Component relates to the proactive work completed to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and the work undertaken in response.	GREEN	GREEN	LCFS review Final Internal and External Audit reports and meet with the Head of Internal Audit to share details on identified risk. This would include instances where data mining or sampling has highlighted outliers or concerns. A PPV programme is undertaken in respect of GPs, Opticians and Pharmacies, with final reports received by the LCFS. Meetings are held with the PPV Manager. The HB also participates in the NFI process. Risk assessments are considered as part of this work and completed where necessary.
Component 11 Access to and completion of training	NHS Requirement 11	This Component relates to the programme of work undertaken at the organisation to raise awareness of fraud, bribery and corruption and to create a counter fraud, bribery and corruption culture among all staff. The effectiveness of the awareness programme is measured.	GREEN	GREEN	The Health Board has an ongoing programme of work to raise awareness of economic crime issues amongst all staff, using a range of methods including virtually delivered presentations and e-learning package availability. This is supported by newsletters and intranet pages alongside the regular release of counter

Function Standard Component	NHS Requirement		2025 Rating	2026 Rating	Current Position
					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.
Component 12 Policies and registers for gifts and hospitality and Conflicts of Interest	NHS Requirement 12	This Component requires the organisation to have in place policies and registers for gifts and hospitality and conflicts of interest that reference the requirements of the Bribery Act 2010 that are communicated to all staff. The effectiveness of which is regularly tested.	GREEN	GREEN	The HB has a Standards of Behaviour Policy in place, which has incorporated declarations of interest, gifts, hospitality and sponsorship. The Policy also includes reference to fraud, bribery and corruption and the requirements of the Bribery Act 2010, and is available to all staff via the intranet. It is also promoted during fraud awareness presentations.

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	212
Reactive work	240
Total days used	452

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	74,846
Reactive costs	84,731
Total costs	159,577

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	Robert Neil Jones
Supporting LCFS	Alison Williams
Supporting LCFS	Olivia Fabian

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	42
Cases Closed or Transferred during period	42
Cases Ongoing	13*

* 1 Investigation transferred to CFS Wales

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	42
Investigations closed during the most recent financial year	42
Investigations open as at 31/03/2026	13

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	6
Number of new FRAs recorded in line with the organisations risk management policy	6

Local Proactive Exercises	Number
Number of LPEs conducted during the year	2
Number of LPEs recorded on the NHS CFA Case management system as per component 8	2
Number of LPEs concluded during the year	0

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	3
Civil applied and recorded during this financial year	2
Criminal applied and recorded during this financial year	0
Total Sanctions	5

Redress Imposed	Total Amount £
Fraud identified	£10,973
Fraud Loss Identified	£10,973
Fraud Prevented	£286
Fraud Recovered	£10,973
Non-Fraud Loss	£189
Non-Fraud Recovery	£189



Agenda Item

4.6

Audit, Risk & Assurance Committee

Counter Fraud Functional Standard Return 2025/26

Dyddiad y Cyfarfod / Date of Meeting	19/05/2026
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Robert Neil Jones, Interim Head of Local Counter Fraud Services
Cyflwynydd yr Adroddiad / Report Presenter	Robert Neil Jones, Interim 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 the counter fraud activity in 2025/26 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 (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Enablers of Quality (<i>Duty of Quality Statutory Guidance (gov.wales)</i>)	Not Applicable
	If more than one applies please list below:
Dolen i Feysydd Ansawdd (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Domains of Quality	Not Applicable
	If more than one applies please list below:



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

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

5. Recommendation

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

6. Next Steps

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



Counter Fraud Authority

Counter Fraud Functional Standard Return (2025/2026)

**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 Annual operational budget of the ICB	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 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	Robert Neil Jones
Email of the Local Counter Fraud Specialist	neil.jones7@wales.nhs.uk
Name of the counter fraud supplier organisation (including in-house)	Other Swansea Bay University Health Board
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)	212
Reactive days used (Maximum 3 digits)	240
Total days used for counter fraud work	452
Cost of counter fraud staffing per financial year - Proactive	74846.00
Cost of counter fraud staffing per financial year - Reactive	84731.00
Total costs for counter fraud work	159577.00

Reactive information	
Number of allegations received and recorded as an investigation during the most recent financial year	42
Number of allegations received during the most recent financial year and recorded as an investigation on the case management system	42
Rationale for any discrepancy between case management system investigations received and expected	N/A
Number of investigations recorded and closed during the most recent financial year	42
Number of investigations closed during the most recent financial year as recorded on the case management system	44
Rationale for any discrepancy between case management system investigations closed and expected	Two cases investigated by CFS (Wales)
Number of investigations open as at 31 /03/2026	13
Number of investigations open as at 31 /03/2026 as recorded on the case management system	16
Rationale for any discrepancy between case management system investigations open as of 31/03/2026 and expected	Two ongoing CFS(Wales) investigations
Amount of fraud losses identified and recorded during the most recent financial year	10973.00
Amount of fraud losses recovered and recorded during the most recent financial year	10973.00

Counter Fraud Functional Standard Return (2025/2026)

Amount of fraud losses prevented from reactive work and recorded during the most recent financial year	286.00
Number of criminal sanctions applied and recorded during the year	0
Number of civil sanctions applied and recorded during the year	2
Number of disciplinary sanctions applied and recorded during the year	3

Proactive information

Number of proactive exercises conducted and recorded during the most recent financial year	2
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	5884.00
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.

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:

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 42 new investigations in 2025/26.

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 Clue3 Case Management System to record and report identified loss. The system includes opportunity to record all investigation 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 University Health Board 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.

10: Undertake detection activity

NHS Requirement 10:

The organisation undertakes proactive work to detect fraud using relevant information, intelligence and fraud risk assessments to identify anomalies that may be indicative of fraud, bribery and corruption. Proactive detection activity includes local proactive exercises (LPE) in high fraud risk areas, based on the organisation’s fraud risk assessment and participation in national exercises co-ordinated by the NHSCFA. Other proactive activity that are not LPEs include taking action in response to Fraud Prevention Notices (FPN) or IBURNS. Findings of this proactive work are evaluated and where appropriate used to develop improvements to prevent and deter fraud, bribery and corruption as well inform the organisation’s fraud risk assessment. Instances of suspected fraud, bribery and corruption identified through the proactive work are subject to appropriate investigation. 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 intelligence reports and loss measurement exercises. Key findings from proactive work 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 Health Board also participates in the NFI process. Risk assessments are considered as part of this work and completed where necessary.

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 improving. Work has been undertaken including risk based training resulting from proactive work, embedding of short form 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 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 improving. 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.

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 chapter 11 of the NHS Audit Committee Handbook, I confirm that the information contained in this self review 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

4.7

Audit Risk & Assurance Committee

Counter Fraud Work Plan 2026/27

Dyddiad y Cyfarfod / Date of Meeting	19/05/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Robert Neil Jones, Interim Head of Local Counter Fraud Services
Cyflwynydd yr Adroddiad / Report Presenter	Robert Neil Jones, Interim 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 (Duty of Quality Statutory Guidance (gov.wales))	Not Applicable
	If more than one applies please list below:



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

5. Recommendation

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

6. Next Steps

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



Counter Fraud Work Plan 2026/27

Robert Neil Jones
Head of Counter Fraud Services

May 2026

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.

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 Review and maintain materials and media used. Evaluate presentations, collate results, and amend presentations as a result of the feedback received. Report outcomes to the Director of Finance.	GovS 013 component 11	Throughout the Year
I&I.2	Undertake 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: Counter Fraud, Bribery and Corruption Policy and Response Plan; Fraud, Bribery and Corruption incident reporting routes; and Policy and procedures relating to Conflicts of Interests, Gifts and Hospitality and Bribery Act.	GovS 013 Components 4, 7 and 12	Throughout the Year



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.

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

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

TASK/OBJECTIVE		RISK/FPN/STANDARD	PROPOSED DELIVERY
P&D.1	Review key organisational policies, procedures and documents, to ensure that they are adequately robust to counter fraud. The communication of revised policies, procedures and documents as appropriate, emphasising the organisational commitment to countering fraud.	GovS 013 component 3 GovS 013 component 10	As Appropriate
P&D.2	Carry out risk analysis in line with Government Counter Fraud Profession (GCFP) fraud risk assessment methodology. Record and manage assessed risk in line with the Health Board's Risk Management policy and include on the risk registers where appropriate.	GovS 013 component 3	Throughout the Year
P&D.3	Utilise DATIX for recording of risk assessment work to effectively manage, evaluate, evidence and measure the effectiveness of counter fraud work in mitigating and reducing fraud risk or expenditure and influencing of policy and procedure aimed at reducing fraud.	GovS 013 component 2 GovS 013 component 3 GovS 013 component 5	Throughout the Year
P&D.4	Review existing fraud risk assessments with Risk Owners before recording on DATIX for ongoing management.	GovS 013 component 2 GovS 013 component 3 GovS 013 component 5	Throughout the Year

PREVENT AND DETER

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

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

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

TASK/OBJECTIVE		RISK/FPN/STANDARD	PROPOSED DELIVERY
P&D.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	Q2
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	Q3
P&D.7	Review Recruitment Fraud Risk Assessment and undertake Local Proactive Exercise aimed at policy compliance measurement.	GovS 013 component 3 GovS 013 component 10	Q2
P&D.8	Review and update information sharing protocols currently in place. Review and refresh protocols with People Services	Service level	Q1
P&D.9	Regular meetings with the Head of Internal Audit (NWSSP Audit & Assurance)	Service level	Throughout the Year
P&D.10	Record and respond to ad-hoc requests for assistance received.	Service level	Throughout the Year

PREVENT AND DETER

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

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

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

TASK/OBJECTIVE		RISK/FPN/STANDARD	PROPOSED DELIVERY
P&D.11	Action Fraud Prevention Notices issued by NHS Counter Fraud Authority and/or Counter Fraud Services Wales as and where appropriate.	GovS 013 component 3	As Appropriate
P&D.12	Issue of fraud alerts to all appropriate staff.	GovS 013 component 11	As Appropriate
P&D.13	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.14	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.15	Participate in thematic fraud risk evaluation exercises as instructed by the NHS Counter Fraud Authority.	GovS 013 component 10	As Required



PREVENT AND DETER

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

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

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

TASK/OBJECTIVE		RISK/FPN/STANDARD	PROPOSED DELIVERY
P&D.16	Conduct proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption. Results of this work are evaluated and where appropriate feed into improvements to prevent and deter fraud, bribery and corruption in line.	GovS 013 component 10	Throughout the Year
P&D.17	Membership of Local Intelligence Network and attendance at meetings.	Service level	As Required
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.

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

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

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

COUNTER FRAUD WORK PLAN 2025/26



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

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.

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

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

TASK/OBJECTIVE			PROPOSED DELIVERY
SG.1	Attendance at all Fraud Forum meetings held by CFS Wales.	Service Level	As Required
SG.2	Completion and agreement of the annual work plan with Director of Finance.	GovS 013 component 2	Q4
SG.3	Completion and agreement of the annual report with Director of Finance.	GovS 013 component 5	Q1
SG.4	Regular meetings/liaison with Director of Finance.	GovS 013 component 1	Throughout the Year
SG.5	Preparation for and attendance at Audit Committee meetings.	GovS 013 component 1	As Required
SG.6	Full participation in the quality assurance process as directed by NHS Counter Fraud Authority	Service Level	Q4 and As Required
SG.7	Undertake additional training as required by the Health Board or NHS Counter Fraud Authority.	Service Level	As Required

STRATEGIC GOVERNANCE

A member of the executive board or equivalent body is accountable for provision of strategic management of all counter fraud, bribery and corruption work within the organisation.

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

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

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

SUMMARY TOTALS

	STRATEGIC AREA OF ACTIVITY	RESOURCE ALLOCATED (in days)
A	INFORM AND INVOLVE	100
B	PREVENT AND DETER	143
C	HOLD TO ACCOUNT	290
D	STRATEGIC GOVERNANCE	48
	TOTAL	581



Agenda Item

4.8

Audit, Risk & Assurance Committee

Speaking up Safely Update

Dyddiad y Cyfarfod / Date of Meeting	19/05/2026
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Gareth Watts, Director of Corporate Governance/Board Secretary
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	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 / Forum Individuals	Date	Outcome
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	

1. Situation / Background

- 1.1 The purpose of this report is to provide the Audit, Risk & Assurance Committee (ARAC) with an assurance-focused assessment of Speaking Up Safely arrangements, responding directly to the questions set out in the Audit and Risk Assurance Handbook as reported to the Committee at its February 2026 meeting.
- 1.2 The report draws together triangulated sources of assurance, including policy alignment, internal audit review, operational system evidence and governance oversight in line with the expectations of the February 2026 HM Treasury Audit & Risk Assurance Committee Handbook.
- 1.3 Additionally, results from the 2025 Staff Survey have also been considered as an additional source of assurance.

2. Specific Matters for Consideration

- 2.1 Speaking Up Safely is a nationally mandated requirement under the Welsh Government NHS Wales Speaking Up Safely Framework. The Framework places clear expectations on NHS Boards to ensure that staff can raise concerns safely, confidentially and without fear of detriment, supported by effective governance arrangements and independent assurance.
- 2.2 Cwm Taf Morgannwg University Health Board has progressively strengthened its Speaking Up Safely arrangements since local adoption of the framework. ARAC has requested clarity on how assurance is obtained against key elements of these arrangements. This report addresses that requirement.
- 2.3 Annexed to this report is the Internal Audit Report (**Annex 1**) recently completed on Speaking up Safely which is an important source of assurance for the Committee.

3. Assurance Against Speaking up Safely Questions

- 3.1 As I reported to the Committee in February, the Audit and Risk Assurance Handbook suggests that in seeking assurance on this area of activity the Committee would need to assure themselves in respect of the five questions below:
- 3.2 *i) Are there appropriate and effective Speaking Up Safely practices in place?*
 - Speaking Up Safely arrangements are aligned to the Welsh Government framework and have been progressively strengthened since adoption. Current practices include clear executive ownership,

an independent Guardian model and a dedicated confidential reporting system.

- Internal Audit has reviewed both the design and early operation of these arrangements, providing reasonable assurance overall while identifying areas requiring further maturity.

ARAC assurance position:

- Appropriate and effective Speaking Up Safely practices are in place and operating. Arrangements are sufficiently established, with further embedding and maturity required.

3.3 *ii) Do these provide suitable channels for staff and others to raise their concerns?*

- Multiple channels are available for raising concerns, including direct access to Speaking Up Safely Guardians and named or anonymous reporting via the Work in Confidence digital platform. These routes are articulated in guidance and operational in practice.
- Internal Audit has confirmed that reporting routes are identifiable, accessible and functioning.

ARAC assurance position:

- Suitable and accessible channels exist, including anonymous reporting routes, and are operating in practice.

3.4 *iii) Do the policies appropriately cover confidentiality and anonymity?*

- Speaking Up Safely guidance explicitly addresses confidentiality, anonymity and protection from detriment. These principles are reinforced operationally through system design, with access to reported concerns restricted to authorised Guardians and in the Work in Confidence platform.
- Internal Audit testing has confirmed that confidentiality and access controls are in place.

ARAC assurance position:

Policies and systems appropriately address confidentiality and anonymity, with safeguards independently tested.

3.5 *iv) Are staff offered appropriate support and provided with suitable and timely feedback?*

- The Guardian model is intended to provide independent support to individuals raising concerns. The reporting platform enables secure, two-way communication, including anonymised feedback where required.
- Internal Audit has identified that the consistency and visibility of feedback represents an area for further development, and actions are in place to strengthen these arrangements

ARAC assurance position:

- Partial assurance. Support and feedback mechanisms exist and are operating, but consistency and maturity of feedback remain development areas.

3.6 v) Are concerns raised dealt with properly and reported to senior management?

- Concerns raised are logged, tracked and managed within the Work in Confidence system, providing an auditable record. Governance arrangements allow for appropriate escalation of themes and issues to senior management while preserving confidentiality.
- Internal Audit has identified maturity of reporting and thematic oversight as an area requiring further development.

ARAC assurance position:

Assurance can be taken that concerns are managed within defined processes and governance structures, with reporting arrangements continuing to mature.

4. Workforce Evidence – NHS Wales Staff Survey

- 4.1 Assurance is further supported by evidence from the NHS Wales Staff Survey, which provides an independent indicator of staff confidence and organisational culture.
- 4.2 The 2025 Staff Survey shows improvement in areas directly relevant to Speaking Up Safely, including the “Raising concerns” sub-theme, which increased from 56% in 2024 to 62.2% in 2025, and question-level improvements relating to staff feeling safe to speak up and report concerns. The survey also reports a strengthening reporting culture, including an increase in staff feeling encouraged to report incidents (+3.8%).

- 4.3 While improvement is evident, survey commentary continues to highlight the importance of visible action and timely feedback following concerns raised, reinforcing the need for continued focus on embedding and consistency.

5. Key Risks / Matters for ARAC Consideration

- 5.1 Speaking Up Safely arrangements are in place and operating, but assurance remains at an early stage of maturity, with further embedding required to evidence consistent lived experience across the organisation.
- 5.2 Staff Survey improvement is encouraging but fragile; confidence is highly dependent on timely action and visible feedback, and gains may not be sustained if this is inconsistent.
- 5.3 At this early stage, of the new arrangements, the Committee also needs to consider that there is a risk that assurance primarily focuses on controls and case handling rather than demonstrable organisational learning, thematic insight and visible system level change, which are essential to long term trust and Board assurance.

6. Overall Assurance Position

- 6.1 Assurance over Speaking Up Safely is derived from a triangulated range of evidence, including nationally aligned policy and guidance, independent Internal Audit review, operational system evidence from Work in Confidence, governance oversight, and independent workforce insight from the NHS Wales Staff Survey.
- 6.2 Internal Audit has provided independent assurance that Speaking Up Safely arrangements are appropriately designed and operating, confirming the existence of multiple reporting routes, effective confidentiality controls and defined governance oversight, while identifying areas where arrangements continue to mature. Operational evidence from the Work in Confidence platform demonstrates that concerns can be raised and managed confidentially in practice, rather than relying solely on documented processes.
- 6.3 This assurance is strengthened by workforce evidence from the NHS Wales Staff Survey, which provides an independent indicator of staff confidence and organisational culture. The 2025 Staff Survey shows improvement in areas directly relevant to Speaking Up Safely, including an increase in the "Raising concerns" sub-theme to 62.2%, alongside question-level improvements relating to staff feeling safe to speak up and report concerns. The survey also reports a strengthening reporting culture, including an increase in staff feeling encouraged to report incidents (+3.8%).

- 6.4 Taken together, the triangulated evidence indicates that Speaking Up Safely arrangements are in place, operating and increasingly embedded. However, the workforce survey and Internal Audit findings both reinforce that confidence remains closely linked to the visibility of action and timeliness of feedback following concerns raised. As such, while the Committee can take sufficient assurance at this stage, continued focus is required to strengthen consistency, feedback and reporting maturity as arrangements continue to embed.

7. Next Steps

- 7.1 An annual update on assurance will be provided to the Committee year on year.
- 7.2 Going forward those risks identified in Section 5 can be mitigated through continued triangulation of assurance (Internal Audit, workforce evidence and qualitative insight), focused scrutiny of feedback and learning arrangements, and ongoing oversight as Speaking Up Safely arrangements mature.

8. Recommendation

- 8.1 The Audit, Risk & Assurance Committee is requested to:
- **Note** the assurance provided against the SUS Questions; and
 - **Confirm** that it is content with triangulated approach to assurance over Speaking Up Safely provided this year and to receive further reports, annually going forward.



Assessment

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

Impact Assessment		
Ansawdd Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality Have you undertaken a Quality Impact Assessment Screening?	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: No impact on Quality for this paper
Cydraddoldeb a'r Gymraeg Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? / Equality and Welsh Language	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: N/for this paper but wider consideration on the ability for staff to raise concerns



<i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	through the medium of Welsh is being actively explored and considered.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	Yes (Include further detail below) The organisation needs to ensure it has effective and for purpose Speaking up Safely arrangements.	
Effaith Adnoddau <i>(Pobl / Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

Speaking Up Safely

Final Internal Audit Report

2025/26

Cwm Taf Morgannwg University Health Board



Reasonable Assurance

Contents

Executive Summary	1
Findings & Agreed Action Plan	3
Appendix A	10

Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

CTM-2526-06

February - March 2026

May 2026

May 2026

Gareth Watts, Director of Governance

Paul Dalton, Head of Internal Audit

Emma Samways, Deputy Head of Internal Audit

Executive Summary

Purpose

Our review of the arrangements for implementing the Welsh Government’s Speaking up Safely (SuS) framework was undertaken in line with the 2025/26 Internal Audit Plan for Cwm Taf Morgannwg University Health Board (‘the Health Board’). We sought to provide assurance on how effectively the Health Board has implemented the SuS framework, focusing on governance, culture, training, and monitoring arrangements for speaking up safely concerns that have been raised.

Overview

The framework was issued by Welsh Government in September 2023 and states that ‘organisations, departments and teams are required to follow in order to establish and sustain a culture where no individual will suffer victimisation or detrimental treatment as a result of speaking up, and where organisations learn and improve as a result of listening and responding to concerns raised’.

Having effective arrangements which enable staff to speak up (also referred to as ‘raising a concern’) helps to protect patients, the public and the NHS workforce, as well as helping to improve the population’s experience of healthcare.

We have concluded reasonable assurance on this area. The key matters requiring management attention are:

- Further work to raise SuS awareness.
- Minimal uptake of the ESR SuS training modules for staff and management.
- Absence of reporting arrangements for SuS case activity and outcomes.

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 process for staff to raise concerns is clearly documented and subject to regular review.	-	Substantial
2	Arrangements are in place to raise staff awareness of the process for speaking up safely, ensuring they can do so with confidence and that they will be supported and not suffer detriment as a result. The process for managing concerns raised is adhered to.	1	Reasonable
3	Designated contacts, responsible for the handling of staff concerns are aware of their responsibilities and have received training to deal appropriately with concerns.	2	Reasonable
4	Regular updates are provided to the Board or relevant committee on the implementation of the Welsh Government framework and any lessons learnt to date are shared.	3	Reasonable

Management Actions

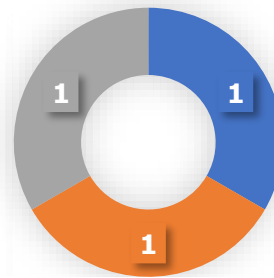


High Priority



Medium Priority

Themes



■ Communication & Engagement

■ Reporting

■ Training and Development

Risk Types

Quality or Safety Issues

Public Perception & Reputational Risk

Choose an item.

Choose an item.

Findings & Agreed Action Plan

Objective 1: The process for staff to raise concerns is clearly documented and subject to regular review.

Substantial

Overview / Summary of Observations

The Health Board has produced its own Speaking Up Safely (SuS) guidance that is available in both English and Welsh. Our review confirmed that it outlines the process staff should follow to raise a concern. The content of the guidance aligns to the key requirements and timescales set out in the Welsh Government (WG) SuS framework. The guidance was recently updated to include information on the 'Work in Confidence' SuS reporting platform (the App), which went live in November 2025. The platform is a digital, and anonymous two-way communication system designed for staff to raise concerns, share ideas, or provide feedback. It allows employees to engage with dedicated responders, such as SuS guardians, while keeping their identity hidden if they choose to do so. The role of the nominated Executive SuS lead, line managers and all members of staff are also set out in the guidance.

The Health Board's dedicated SuS team was established in November 2025. The team facilitated the implementation of the recently launched Work in Confidence SUS reporting platform. They have also been involved in the development of the SuS SharePoint site where the Health Board's guidance and the WG SuS framework can be found. The guidance is also available to staff via the Health Board's internet.

Overview / Summary of Observations

SuS was introduced in October 2023, supported by initial awareness activities, such as staff wide emails, which were led by the communications team. Prior to the launch of the App there was a dedicated telephone hotline for staff to raise concerns, although we note only a small number of calls were received. However, we understand that staff may have raised their concerns through alternative routes such as speaking directly with line managers, trade unions, or the People Team.

A revised approach to SuS was launched in July 2025 leading up to the launch of the 'Work in Confidence' App in Nov 2025. The roll out of the revised approach was supported by a communications and implementation plan.

While the SuS Guardians and the SuS team helped raise awareness of SuS by presenting at various staff forums, not all teams took up the offer of direct engagement.

There is a dedicated SuS SharePoint page, but data indicates a low number of views. We also note that SuS awareness does not form part of the staff induction process, but we understand that work is ongoing to address this.

There are multiple routes for staff to report a concern, which are described on the SharePoint site, within SuS guidance and on posters and promotional materials. Staff can report anonymously through the 'Work in Confidence' App, which can be accessed via a website or QR code. SuS guardians that speak directly to a staff member or receive a concern via email log these in the 'Work in Confidence' platform. Access to the App is restricted to the SuS guardians ensuring confidentiality.

Between November 2025 and March 2026, 14 concerns were recorded in the 'Work in Confidence' platform. Our testing of a sample of cases confirmed timely acknowledgment, ongoing communication with the reporting individual and appropriate case closure, in line with SuS guidance and the Welsh Government framework.

Key Findings		Risk & Impact	Agreed Management Action
1	<u>SuS awareness</u> The SUS SharePoint site is the primary source of SuS information and signposts staff to the 'Work in Confidence' reporting platform. However, since the launch of the platform in November 2025 to February 2026, the site has only had 124 views. The staff induction process does not include information on SuS. During October and November 2025 departments were contacted and offered SuS awareness sessions. There was limited uptake and at the time of the audit the team had not followed up on the offers.	Poor practice not being challenged due to staff being aware how to raise a concern.	Agreed Action: Further periodic communications exercises will be undertaken to raise awareness of the SUS SharePoint site, its content, and the Work in Confidence SUS reporting platform. Work has been undertaken to include relevant SUS information into the staff induction package. This should be completed in the coming weeks. The SUS team will actively target those teams who have not taken up the offer of SUS awareness training / sessions. The SUS team also recognise the importance of face-to-face interactions and reaching all areas of the Health Board which is why it is developed an engagement plan and has begun to spread

			the message in a pro-active way and will continue this important work into future years. Expected Evidence of Implementation: The Team to utilise a Speaking Up Safely action plan, which will evidence the work undertaken as above. Further promotion will be visible for staff and copies of this can be provided to demonstrate work undertaken. Continue to complete SUS Team engagement log, saved on Teams channel, to document activity; awareness sessions delivered and those offered.
		Medium Priority	
Theme: Communication & Engagement	Control Operation		Officer: Rachel Breen (Speaking Up Safely Administrator), Leanne Holborn, Natasha Williams, Ruth May, Jane Canning (SUS Guardians). Target Implementation Date: September 2026. (End of Q2).

Overview / Summary of Observations

There are four SuS guardians which provide advocacy and promote a culture for staff to feel safe and supported to speak up about concerns, without fear of reprisal. The guardians provide coverage across the Health Board and are not dedicated to sites or directorates. The 'Work in Confidence' platform identifies where the SuS Guardians are based which allows staff to decide which guardian to communicate with. The guardians have been trained in relation to their roles and a 'Guardian Framework' has been drafted to provide further guidance on their roles and responsibilities.

The SuS guardians, SuS team and Director of Corporate Governance meet each monthly to discuss matters such as open cases, closed cases, system functionality and raising awareness work.

Staff and people who manage staff all have a SuS responsibility. There are training modules within ESR to support staff in relation to their responsibilities. The three modules available are: 'Speak Up' – core training for all workers; 'Listen Up' – training for all managers; and 'Follow Up' – for senior managers. However, completion rates across the modules are low and the courses are not promoted on the SuS SharePoint site. In addition, the Health Board is offering a new training course, 'How to be an active bystander: Speaking Up Safely at Work', launching via MS Teams, which all staff can access. Communications issued in mid-March 2026 promoted the content and availability of this course.

Strategic oversight is provided by an Executive Champion (Director of Governance) and an Independent Member Champion, whose roles are outlined on the SuS SharePoint site.

Key Findings		Risk & Impact	Agreed Management Action
2	<u>SuS training for staff and managers</u> Three non-mandatory ESR modules provide SuS training for staff and managers. The completion rate data extracted from ESR for each course since the SuS launch in October 2023 to March 2026 shows: • 49 - Speak Up (for all staff); • 8 - Listen Up (for managers); and • 2 - Follow Up (for senior managers). We found that the three ESR modules are not referenced on the SUS SharePoint site, nor included in awareness activities delivered since November 2025.	Concerns are not reported, documented, investigated, acted upon or appropriately.	Agreed Action: The three ESR SUS modules will be promoted and signposted on the resources section of the SUS SharePoint site, and further promotion of these will be undertaken to ensure that as many Health Board staff and managers undertaken an appropriate level of SUS training. We are aware of a new All Wales Speaking Up Safely module, which is due to be released at a later date. When this is made available to staff, we will review what is most suitable to advertise to staff to complete, and update resources as appropriate. We will request updated ESR data every 6 months, to monitor the uptake of these modules, in conjunction with our further promotion of them. Expected Evidence of Implementation:

			Module information on the SharePoint page, as well as additional email communications to all staff. ESR data which would show an increase in completion of ESR modules, particularly 'Speak up'.
		Medium Priority	Officer: Rachel Breen (Speaking Up Safely Administrator) Target Implementation Date: May 2026 (To update SharePoint, and further email comms)
	Theme: Training & Development	Control Operation	September 2026, and then every 6 months after, to look at ESR module completion data.

Overview / Summary of Observations

We have seen historic reporting to committees of the Board relating to SuS implementation and have been provided with information in relation to verbal updates to Board members post implementation on the progress of embedding SuS across the organisation. To date, there have not been regular update reports on SuS activity. We understand that due to the low number of cases recorded in the 'Work in Confidence' platform since its launch in November 2025, and the low number of previously reported cases, the SuS team have been unable to analyse the data to identify themes or trends. We understand it is management's intention to review data from the 'Work in Confidence' platform after quarter one of 2026/27, with outcomes to be reported to the Operational Delivery Committee.

Whilst there has not been any formal reporting, we are aware that cases are discussed during the monthly meetings held between the SuS team and the guardians and Director of Corporate Governance, allowing the identification of potential trends. The guardians also share their experiences with one another to allow lessons and best practice to be shared.

The WG Framework encourages organisations to embed speaking up as a 'cultural gateway' for all types of concerns. We are aware that staff concerns are also raised directly with the People Team or may be referred onto the People Team if not resolved by the guardians. As such, there are several ways of raising a concern, but these are not aggregated to form an overall view of concerns across the Health Board. This hinders monitoring and reporting of trends or themes, and the feeding back of lessons learned to services.

Key Findings	Risk & Impact	Agreed Management Action
3 <u>Reporting of SuS Activity</u> No formal SuS reporting has been undertaken as management decided to allow a sufficient volume of concerns to accumulate during the initial six months following the launch of the 'Work in Confidence' platform. Going forward, the team intend to analyse data for the period November 2025 to June 2026 and report to the Operational Delivery Committee in summer 2026. Thereafter, reporting is intended to be on a bi-annual basis. However, it is our understanding that only data captured in the 'Work in Confidence' platform will be analysed. This may mean information arising from cases raised directly with the People Team will not be considered to aid the identification of wider themes and trends emerging from SUS and People team cases. There is no mechanism to capture staff feedback on their experience of the SuS process following case closure. Though we understand this is something the team plan to introduce. Such insight would support continuous improvement and inform the development of the service.	The Board may not be aware of serious concerns relating to the organisation. Common themes or trends go undetected.	Agreed Action: Reporting arrangements for SuS case activity and outcomes covering the period of November 2025 to June 2026 will be implemented and provided to the Operational Delivery Committee (ODC) in June/July 2026, and thereafter to ODC on a bi-annual basis. The concerns raised through the numerous channels in place within the Health Board will be reported and discussed together to allow better oversight of themes and trends across the organisation. A quality survey to capture staff experience and opinions relating to the SuS process and the advice/help provided will be offered to individuals upon case closure, which we will launch in November 2026. We were advised to begin using surveys etc., after 10-12 months of launching, giving suitable time for the SuS process to bed, which is important to note. Expected Evidence of Implementation:

			Suitable reporting provided to ODC as required. Survey data to be collated following case/conversation closures. This data needs to be meaningful and useful. Identify any emerging themes and trends, which the Health Board needs to act on / inform future learning.
	Theme: Reporting	Medium Priority Control Operation	Officer: Gareth Watts, (Director of Governance), Hannah Williams, (Assistant Director of Leadership & Culture) Amadu Jalloh, (Head of People Policy and Compliance), Rachel Breen, (Speaking Up Safely Administrator) Target Implementation Date: July 26 (ODC reporting). November 26 (Survey/Feedback launch to individuals).

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

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

Disclaimer

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

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

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.





Agenda Item

4.9

Audit, Risk & Assurance Committee

Declarations of Interest & Gifts, Hospitality and Sponsorship Register

Dyddiad y Cyfarfod / Date of Meeting	19/05/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Emma Walters, Head of Corporate Governance & Board Business
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance/Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Executive Leadership Group	11/05/2026	<i>PENDING</i>

Acronyms / Glossary of Terms	

1. Situation /Background

- 1.1 In accordance with the requirements of the Health Board's Standing Orders and Standards of Good Governance & Probity, 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 the Health Board. This report has also been considered by the Executive Leadership Group prior to the Committee.

2. Specific Matters for Consideration

- 2.1 The form in the Standards of Good Governance & Probity 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 June 2025, all Board Members were formally asked to review and update, where appropriate, their declarations for the new financial year 2025-2026. A response from all Board Members was received and is captured in Appendix 1. A further update was sought from Board Members in November 2025 and again in March 2026 asking them to revisit their declarations to ensure it remains up to date, 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 2025 to 1187 members of staff, which included all Consultants, Very Senior Managers and Staff at Band 8a and over). 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 2026 for the 2026-2027 reporting period.
- 2.4 As at 31 March 2026 there have been:
- 30 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".
 - 250 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 10 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 is a further one

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



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

5. Recommendation

- 5.1 The Audit, Risk & Assurance 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 is published on the Health Boards public facing website available here: [Register of Interests, Gifts, Hospitality and Sponsorship - Cwm Taf Morgannwg University Health Board](#) .

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
New Appointment	Neil Mesher	Independent Member	27.3.2025	Director, Mesher Consulting Ltd	From November 2023	Present	Financial
				NED, Life Science hub Wales Ltd	From September 2023	Present	Financial
				NED, MyHealthChecked plc	From 2004	des-25	Financial
				Director, Little Court Fram Res Co Lrd	From 2004	Present	Benefits in Kind
				Advisor, Ibex AI Ltd	From December 2023	Present	Financial
				Chair Tandridge Village Hall Management Co.	From 2022	Present	Nil
				Wife, Director Mesher Consulting Ltd	From December 2023	Present	Financial
PD email 5.6.2025	Philip Daniels	Executive Director of Public Health	5.6.2025	Chair of the Faculty of Public Health (FPH) in Wales	From 2022	Present	Nil
				Board Member / Trustee of UK FPH	From 2022	Present	Nil
				Wife: Artistic Director / Coach / Founder of the Performance Centres Ltd.	From 2008	Present	Nil
				Chair of CTM Area Planning Board	From 2023	Present	Nil
Yes - via email 9.6.2025	Jonathan Morgan	Independent Member - Chair	23.6.2025	Trustee and Director of NHS Confederation	apr-24	Present	Travel expenses reimbursed.
				Director of Insight Wales Consulting Limited	2012	Present	No financial benefits or benefits in kind
				100% Share Ownership of Insight Wales Consulting Limited	2012	Present	Dividend
				Associate Consultant with Practice Solutions Limited	aug-11	Present	Fees for work undertaken.
				Independent Member on the Hendre Limited Board	des-24	Present	Remunerated
Yes via email 9.9.2025				Director of Yellow Wales (Added Sept 25)	aug-25	Present	No financial benefits or
Yes via email 9.9.2025				Director of Hafod Resources Limited (Added Sept 25)	sep-25	Present	benefits in kind
				Wife employed as a Welsh Government Lawyer and First Tier Tribunal Judge	2010	Present	Salaried.
Yes - via email 9.6.2025	Kath Palmer	Vice Chair	1.7.2025	Natural Resources Wales – Board member and Chair of Audit, Risk and Assurance Committee.	feb-23	31-mai-25	Remunerated
				Trustee of Crisis (national homelessness charity) and chair of the client services governance committee.	des-22	Present	Expenses paid
				Board Member (Crisis Trustee) for Pathway UK (Subsidiary of Crisis)	08-jul-24	Present	Expenses paid
Yes - via email 9.6.2025	Helen Lentle	Independent Member (Legal)	3.7.2025	Trustee CISWO (the Coal Industry Social Welfare Organisation)	sep-22	Present	Voluntary Role
				Trustee - Dyslecsia Cymru / Wales Dyslexia Charity	sep-22	feb-26	Voluntary Role
Yes - via email 9.6.2025	Dilys Jouvenat	Independent Member (Third Sector)	12.6.2025	Trustee at South East Wales Citizens Advice	mai-22	Present	Nil
				Trustee at Interlink	nov-22	Present	Nil
				Trustee Rhondda Cynon Taff Citizens Advice	nov-23	Present	Nil
				Trustee of the Cymru Older Peoples Alliance (COPA)	sep-24	Present	Nil
Yes - via email 9.6.2025	Rachel Rowlands	Independent Member (Community)	24.6.2025	Age Connect Morgannwg (Appointed as CEO in 2005 and then appointed as Company Secretary in December 2021)	2005	29-aug-25	Salaried
				Age Connects Britain Ltd (dormant – due to resign) Company No 07801698	24.07.2014	Present	Nil
				Member, Care & Repair Cymru	2008	Present	Nil
				Member, Cynon Taf Community Housing Association	2007	Present	Nil
				Member, Cym Taf Care & Repair	2007	Present	Nil

				Age Connect Wales Charity Trustee	2017	29-aug-25	Nil
				Director of Community Housing at Trivallis	sep-25	Ongoing	Salaried
Yes - via email 9.6.2025	Hayley Proctor	Independent Member (Trade Union)	12.6.2025	Sister: civil servant of WG - Head of Pharmacy and Prescribing, Primary and Community Care Division	2019	Present	Salaried Position
Yes - via email 9.6.2025	Patsy Roseblade	Independent Member (Finance / Audit)	10.6.2025	Nil Interests Declared	Not applicable	Not applicable	Not applicable
Yes - via email 9.6.2025	Carolyn Donoghue	Independent Member (University)	18.6.2025	Independent Member of the Board of Governors - University West of England	2021	Present	No financial benefits or benefits in kind
				Senior Professional Fellow - Cardiff University	2020	Present	No financial benefits or benefits in kind
				Member of Health and Care Research Wales Advisory Board	mai-24	Present	No financial benefits or benefits in kind
				Trustee Staple Hill Community Hub	20-mar-25	20-mar-28	No financial benefits or benefits in kind
				Son employed as a Business Development Manager at Seating Matters	Not stated	Present	Not Stated
Yes - via email 9.6.2025	Geraint Hopkins	Independent Member (Local Authority)	12.6.2025	Clerk to Llantrisant Community Council	okt-21	Present	Remunerated
				Elected Member, Rhondda Cynon Taff County Borough Council	2006	Present	Remunerated
		Independent Member (Digital Vacancy)					
Yes - via email 9.6.2025	Paul Mears	Chief Executive	9.6.2025	Member of the Advisory Board, Awen Cultural Trust Nil interests declared as at November 2025.	sep-22	Present	Nil
Yes - via email 9.6.2025	Gethin Hughes	Chief Operating Officer	9.6.2025	Nil Interests Declared	Not applicable	Not applicable	Not applicable
Yes - via email 9.6.2025	Sally May	Executive Director of Finance	9.6.2025	Cousin—Director of DECIPHER / Professor in Social Interventions and Health at Cardiff University	Not known	Ongoing	Salaried Position
				Cousin - Regional Sales Manager at South West Arthrex Ltd.	Not known	Ongoing	Salaried Position
				Cousin - Partner in Knight Frank Project and Building Consultancy	Not known	Ongoing	Salaried Position
				Daughter - Clinical Operations Manager at InHealth	01-apr-25	Ongoing	Salaried Position
Yes via email 9.6.2025	Dom Hurford	Executive Medical Director	9.6.2025	Nil Interests Declared	Not applicable	Not applicable	Not applicable
Yes via email 9.6.2025	Greg Dix	Executive Director of Nursing / Deputy CEO	17.7.2025	Trustee - Royal College of Nursing Foundation	sep-21	Present	Voluntary - Travel and Accommodation Paid for by the Charity
				Visiting Professor at the University of South Wales	2020	Present	Nil
Yes via email 9.6.2025	Hywel Daniel	Executive Director for People	30.06.2025	Nil Interests Declared	Not applicable	Not applicable	Not applicable
Yes via email 9.6.2025	Lauren Edwards	Executive Director of AHPs and HS	9.6.2025	Trustee and Director of Royal College of Speech and Language Therapists	08-nov-23	Present	Nil.
				Visiting Professor at the University of South Wales	01-okt-27	Present	Nil.
Yes via email 9.6.2025	Claire Thompson	Executive Director of Strategy & Transformation (From 9 June 2025)	11.6.2025	Parent Governor at Writhlington School, Knobsbury Lane, Writhlington, Radstock, BA3 3NQ	sep-24	mar-26	Nil
Yes via email 9.6.2025	Victoria Oxley	Interim Executive Director of Strategy & Transformation (Up until 8 June 2025)	8.6.2025	Nil Interests Declared	Not applicable	Not applicable	Not applicable
Yes via email 9.6.2025	Stuart Morris	Director of Digital	9.6.2025	Nil Interests Declared	Not applicable	Not applicable	Not applicable

Board Members Declaration of Interest 2025-2026

Yes via email 9.6.2025	Simon Blackburn	Director of Communications, Engagement and Fundraising	26.6.2025	Nil Interests Declared	Not applicable	Not applicable	Not applicable
Yes via email 9.6.2025	Gareth Watts	Director of Corporate Governance / Board Secretary	11.6.2025	Board Member of Coleg Gwent (Further Education College)	2015	31.12.2025	Nil
				Member of the Joint Audit Committee of Gwent Police and Crime Commissioner for Gwent	2022	31.03.2025	Daily rate for meeting attendance and preparation
				Chair of the Joint Audit Committee of the Office of the Policy and Crime Commissioner for Gwent and Gwent Police	mar-25	Present	Daily rate for meeting attendance and preparation
Yes via email 9.6.2025	Cllr Paul Deenik	ABM - Chair of the Stakeholder Reference Group	24.6.2025	Chair, Ynysawdre Community Council	feb-23	Present	Minimum Expenses
				Councillor, St Bride's Minor Community Council	okt-24	Present	Minimum Expenses
Yes via email 9.6.2025	Lisa Curtis-Jones	ABM - Director of Social Services	24.6.2025	Director of Social Services-Merthyr Tydfil	apr-15	Present	Remunerated
Yes via email 9.6.2025	Sally Bolt	ABM - Chair of the Clinical Advisory Group	9.6.2025	Nil Interests Declared	Not applicable	Not applicable	Not applicable
New Appointment	Kathy Mason	Independent Member - Digital	27.8.2025	Director and Company Secretary. Libero MC Ltd (Co number: 04973190)	feb-24	Present	Interest on Director's Loans. Dividends
				Trustee. Challenge Wales (sail Training for Young People in Wales) Charity number: 1111859	nov-24	Present	None
				Non Exec Director. Topp Pro Cycling Ltd Co number: 15090381	mar-24	Present	None
				Senior Associate. In-form Solutions Limited (https://www.in-formsolutions.com/)	Consultancy fees earned and invoiced by assignment		
				Husband Director and founder Libero MC Ltd			
				Son Founder and Owner, Topp Pro Cycling Ltd			
Added to Board as Interim Executive Director of Nursing from October 2025. Substantive from February 2026	Richard Hughes	Executive Director of Nursing	5.6.2025	Chair for Mind Aberystwyth (Ceredigion) - 4 year term from 2025	2025	Present	Nil
				Trustee for Marmalade Trust	2022	Present	Nil
				Chair for Strategic Nursing Workforce Implementation Board on behalf of HEIW	mai-25	Present	Nil
				Chair for Welsh Nursing & Midwifery Committee, independent and statutory committee advising the Chief Nursing officer and Ministers in Wales.	jun-25	Present	Nil

Date Approved	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
09.04.2025	Peer Mentor		Second employment as a receptionist in a private chiropractic clinic	Since August 2024	Paid employment part time wage	Not applicable	
24.04.2025	Clinical Lead and Teacher Practitioner Pharmacist	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
02.05.2025	IBD Pharmacist	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
06.05.2025	Clinical Pharmacist - IBD	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
07.05.2025	Primary Care Estate Manager	Primary & Community Care Group	Nil return	Not applicable	Not applicable	Not applicable	
07.05.2025	Consultant Child and Adolescent Psychiatrist	CAMHS	1. Director of my own company A HASSAN LTD. Do private assessments and consultations 2. Husband is a Partner in the above company A Hassan LTD.	1. Since 12 May 2022	1. Financial	Not applicable	
08.05.2025	Principal Occupational Therapist - Adult Mental Health	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
09.05.2025	Staff Nurse	Primary & Community Care Group	Nil return	Not applicable	Not applicable	Not applicable	
13.05.2025	Interim Clinical Director for Allied Health Professionals	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
14.5.2025	Consultant Clinical Psychologist	Mental Health & Learning Disabilities	Individual is owner of RFPsychology Ltd and provides assessments of young people for court, family proceedings and Local Authorities. There is occasional consultation work following these assessment. From the commencement of this post I will not see children or families from the Cwm Taf Morgannwg area	Since May 2020	Paid for reports and consultation work.	Manager confirmed no potential conflict of interest. Individual confirmed they do not see children or families from the CTM area.	
21.05.2025	Physiotherapist	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
22.05.2025	Rotational Physiotherapist	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
28.05.2025	Principal Pharmacist MH	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
04.06.2025	MSK Clinical Specialist Physio	Diagnostics, Therapies, Pharmacy & Specialties	Started private evening clinic for joint/soft tissue corticosteroid injections Performance Physiotherapy Ltd in Pontypridd	May 2025 to present	Monthly invoice sent to practice	Not applicable	
05.06.2025	Deputy Director of Allied Health Professions and Health Sciences / Clinical Director of Health Sciences	Allied Health Professions	Nil return	Not applicable	Not applicable	Not applicable	
05.06.2025	Consultant in Public Health	Public Health	Nil return	Not applicable	Not applicable	Not applicable	
05.06.2025	Dental Director Primary Care and Communities	Primary & Community Care Group	1. Director Birchgood Ltd – provision of private dental services outside of HB area 2. Landlord – Cefn Coed Dental Practice Buildings- provision of contract undertaken by an independent company. 3. Trustee – Gateway Church Cwmru	1. 2010-to date 2. 2015-to date 3. 2016-to date	1. Not applicable 2. No financial involvement or ties to the contract. Only rental income on two buildings 3. Not applicable	Not applicable	
05.06.2025	Consultant Anaesthetist	Planned Care	Nil return	Not applicable	Not applicable	Not applicable	
05.06.2025	Senior Nurse	Unscheduled Care	Nil return	Not applicable	Not applicable	Not applicable	
05.06.2025	Head of Operational Estates	Estates	Nil return	Not applicable	Not applicable	Not applicable	
05.06.2025	Head if Orthoptic Services	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
05.06.2025	Consultant Oral & Maxillofacial Consultant	Planned Care	Nil return	Not applicable	Not applicable	Not applicable	
05.06.2025	Consultant Anaesthetist	Planned Care	Nil return	Not applicable	Not applicable	Not applicable	
05.06.2025	Consultant Surgeon	Planned Care	Nil return	Not applicable	Not applicable	Not applicable	
05.06.2025	Principal Psychologist	Diagnostics, Therapies, Pharmacy & Specialties	Works as a private Psychotherapist	14 years	None	Not applicable	
05.06.2025	Clinical Director/Consultant Dermatologist	Planned Care	1.DIRECTOR: ANTANA KAMHAT LTD (spouse is also a Director) 2.DIRECTOR: KAMATH DERMATOLOGY LTD (spouse is also a Director) 3. CARDIFF MULTISPECIALITY LTD 4. Dermatology Meeting attendance sponsored by Sanofi London 5. Dermatology meeting attendance sponsored by Novartis London	1. SINCE JAN 2021 2. SINCE JUNE 2020 3. SINCE NOV 2022	1. Rental Income from BTL Properties 2. Private Practice Income 3. Private Clinic for Multispecialty Medical Services	Not applicable	
05.06.2025	Head of Charity & Income Generation	Communications	Nil return	Not applicable	Not applicable	Not applicable	
05.06.2025	Consultant	Mental Health & Learning Disabilities	Nil return	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
05.06.2025	Head of Patient Flow	Unscheduled Care	Nil return	Not applicable	Not applicable	Not applicable	
05.06.2025	Consultant in Public Health	Public Health	1. Advanced Paramedic Practitioner (Welsh Ambulance Services NHS Trust) . 2. Bank Paramedic (South Western Ambulance Services NHFST and South Central Ambulance Service NHFST) 3. Senior Lecturer (University of the West of England)	1. Ongoing Ongoing Ongoing	2. 3. 1. Salaried Salaried Salaried	2. 3. Not applicable	
05.06.2025	Head of Assets, Governance & Technical Services	Estates	Nil return	Not applicable	Not applicable	Not applicable	
05.06.2025	Consultant Anaesthetist	Planned Care	Nil return	Not applicable	Not applicable	Not applicable	
05.06.2025	Advanced Nurse Practitioner	Unscheduled Care	Nil return	Not applicable	Not applicable	Not applicable	
05.06.2025	Head of Adult Speech & Language Therapy	Diagnostics, Therapies, Pharmacy & Specialties	Yoga teacher training currently	January 2025 - February 2026	Nil payments taken currently but will likely charge a nominal amount for classes once qualified in 2026	Not applicable	
05.06.2025	Deputy Head of People for Planned Care & DTPS	People Services	Nil return	Not applicable	Not applicable	Not applicable	
05.06.2025	Assistant Head of Estates	Estates	Nil return	Not applicable	Not applicable	Not applicable	
05.06.2025	Head of Children's Speech and Language Therapy	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	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
05.06.2025	Head of Commissioning	Planning & Performance	Nil return	Not applicable	Not applicable	Not applicable	
05.06.2025	Senior Estates Manager	Estates	Nil return	Not applicable	Not applicable	Not applicable	
05.06.2025	Consultant Neonatologist	Children & Families	Honorary Senior Lecturer Cardiff University year 4 medical students in placement at CTM		feb-17 : Monthly Honorarium	Not applicable	
05.06.2025	Programme Director PCH	Estates	Nil return	Not applicable	Not applicable	Not applicable	
05.06.2025	Principal Audiologist	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
05.06.2025	Consultant in Public Health	Public Health	Nil return	Not applicable	Not applicable	Not applicable	
05.06.2025	Principal Occupational Therapist for POW	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
05.06.2025	Deputy Head of Pharmacy	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
05.06.2025	Assistant Director (Operational Support) & HTA Designated Individual	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	

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05.06.2025	Deputy Director of Planning (Primary Care)	Primary & Community Care Group	Nil return	Not applicable	Not applicable	Not applicable	
05.06.2025	Deputy Director Commissioning & Engagement	Joint Commissioning Committee	Voluntary Member of Swansea University's Industry Panel in the School of Media	Since 2021	Not applicable	Not applicable	
06.06.2025	Deputy Head of Service, Nutrition & Dietetics	Diagnostics, Therapies, Pharmacy & Specialties	Spouse is Director of Nursing and AHP's in Velindre NHS Trust	Not applicable	Not applicable	Not applicable	
06.06.2025	Director of Midwifery & Nursing	Children & Families	Spouse is the Director of Workforce at NWSSP	Not applicable	Not applicable	Not applicable	
06.06.2025	Consultant Physician	Unscheduled Care	Nil return	Not applicable	Not applicable	Not applicable	
06.06.2025	Professional Manager, Paediatric Physiotherapy	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
06.06.2025	Clinical Lead Paediatric Physiotherapist	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
06.06.2025	Haematology Service Manager	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
06.06.2025	Community Dietetic Professional Manager	Diagnostics, Therapies, Pharmacy & Specialties	Historical honorarium via malnutrition pathway for work undertaken (funded by Nutricia) and conference sponsorship from both Abbott and Fresenius Kabi. Nil recent sponsorship.	Not applicable	Not applicable	Not applicable	
06.06.2025	Consultant	Diagnostics, Therapies, Pharmacy & Specialties	ERH PATH LTD Private limited company Nature of business: specialists medical practice activities	Incorporated May 2022	Director (ad hoc payments)	Not applicable	
06.06.2025	Consultant Psychiatry	Mental Health & Learning Disabilities	Nil return	Not applicable	Not applicable	Not applicable	
06.06.2025	LHP Infrastructure Programme Director	Executive Team	Nil return	Not applicable	Not applicable	Not applicable	
06.06.2025	Consultant	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
06.06.2025	Consultant Physiotherapist	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
06.06.2025	Clinical Scientist - Cardiology	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
06.06.2025	Head of Audiology	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
06.06.2025	principle pharmacist aseptic services	Pharmacy	Nil return	Not applicable	Not applicable	Not applicable	
06.06.2025	Consultant ENT	Rhondda Taf Ely Integrated Locality Group	Nil return	Not applicable	Not applicable	Not applicable	
06.06.2025	Assistant Director of Evidence Evaluation and Effectiveness	Joint Commissioning Committee	1. Bank position in TriTech, Hywel Dda University Health Board 2. Associate Editor, BMJ Leader 3.Trustee, UK Research & Development Forum 4. Honorary Senior Lecturer, Swansea University 5. Brother is Senior Programme Manager in Becton Dickinson 6. Brother has shares in BD 7.Doctoral Candidate (DBA, VBHC) in Swansea University	1. Since 2023 2.Since 2023 3.Since 2024 4.Since 2018 5.Since 2015 6. Since 2015 7.Since 2024	1. Financial 2.Fiancial 3.Benefits in kind 4.Benefits in kind 5. Financial Transaction 6. Financial Transaction 7.N/A	Not applicable	
06.06.2025	Consultant Ophthalmologist	Planned Care	1. Director Optimal Eye Care Ltd. Limited company 10555090 2. Educational grant for study and conference from Bayer and Roche 3. Private practice at Spire Cardiff and Nuffield Hospitals	1. 7 Years 2. 3 years 3. 27 years	1. Company Shareholder 2.£12428.07 including event registration and travel and professional fees. 3.	Not Applicable	
06.06.2025	Consultant Radiologist	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
06.06.2025	Consultant in emergency medicine	Unscheduled Care	Nil return	Not applicable	Not applicable	Not applicable	
06.06.2025	Head of Commissioning - Ambulance Services and 111/Interim Assistant Committee Secretary	Joint Commissioning Committee	Spouse is NWSSP Principal Internal Auditor currently seconded to NWSSP Corporate Governance Department	Ongoing	Not applicable	Not applicable	
07.06.2025	Directorate Manager	Primary & Community Care Group	Nil return	Not applicable	Not applicable	Not applicable	
07.06.2025	Clinical Director for Primary Care	Primary & Community Care Group	1. Clinical Director for Primary Care, Aneurin Bevan University Health Board 2. Sessional GP Locum	1. June 2024 to present October 2022 to present	2. 1. Employed role (0.4 WTE) 2. Self Employment	Not applicable	
08.06.2025	Consultant Dermatologist	Planned Care	1. Director in Cutis Consulting Limited Spouse is Director in Cutis Consulting Limited	1. Since Nov 2014 Since March 2019	2. 1. Ltd Company through which I conduct my Private Practice	Not applicable	

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08.06.2025	Deputy Director of Strategy and Transformation	Planning & Performance	Nil return	Not applicable	Not applicable	Not applicable	
08.06.2025	Dental & Maxillofacial Laboratory Manager	Planned Care	Nil return	Not applicable	Not applicable	Not applicable	
09.06.2025	Chief Pharmacist for Primary Care and Medicines Optimisation	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
09.06.2025	Consultant Radiologist	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
09.06.2025	Director of Nursing Primary Care and Localities	Primary & Community Care Group	Nil return	Not applicable	Not applicable	Not applicable	
09.06.2025	Lead Pharmacist and Non-Medical Prescriber for the Neurodevelopmental Service	Children & Families	Nil return	Not applicable	Not applicable	Not applicable	
09.06.2025	Principal Psychologist	Mental Health & Learning Disabilities	Nil return	Not applicable	Not applicable	Not applicable	
09.06.2025	Locum Consultant Radiologist	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
09.06.2025	Consultant	Children & Families	Nil return	Not applicable	Not applicable	Not applicable	
09.06.2025	Clinical Pharmacist - Rheumatology	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
09.06.2025	Assistant Director - Children & Families and DTPS. Formerly Hospital General Manager POW.	Children & Families	Nil return	Not applicable	Not applicable	Not applicable	
09.06.2025	Consultant Emergency Department	Unscheduled Care	Nil return	Not applicable	Not applicable	Not applicable	
09.06.2025	Assistant Director of Governance & Risk	Corporate Governance	Spouse is co-owner of Emrys Darts Limited.	Since June 2025	Not applicable	Not applicable	
10.06.2025	Consultant Physician	Unscheduled Care	Nil return	Not applicable	Not applicable	Not applicable	
10.06.2025	ACSP Programme Director	Strategy & Transformation	Nil return	Not applicable	Not applicable	Not applicable	
10.06.2025	Senior Clinical Psychologist	Older Adult Mental Health	Nil return	Not applicable	Not applicable	Not applicable	
10.06.2025	Senior Fire Advisor	Estates & Capital	Nil return	Not applicable	Not applicable	Not applicable	
10.06.2025	Consultant Clinical Psychologist and Clinical Lead for Multi-Disciplinary Therapies,	Mental Health & Learning Disabilities	Nil return	Not applicable	Not applicable	Not applicable	
10.06.2025	Head of People Policy and Compliance	People Services	Nil return	Not applicable	Not applicable	Not applicable	
10.06.2025	Consultant	Planned Care	1. COMMITTEE SECRETARY FOR WELSH HOSPITALS DENTAL SPECIALITIES 2. HONARARY LECTURER - CARDIFF DENTAL SCHOOL	1. Ongoing since approximately 2018 2. Approximately 2023	1. Nil 2. Nil	Not applicable	
10.06.2025	Pharmacist High Cost Medicines	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
10.06.2025	Consultant in Acute Medicine	Unscheduled Care	Nil return	Not applicable	Not applicable	Not applicable	
10.06.2025	Consultant Podiatrist	Diagnostics, Therapies, Pharmacy & Specialties	1. Director of Theatre Soar (Arts Centre) , Merthyr Tydfil 2. Private Practice Delivered out of KHHP paying CTM for room usage	1. 10 Months 2. Over 2 years	1. None 2. Yes financial transactions	Not applicable	
10.06.2025	Stroke Consultant	Unscheduled Care	Nil return	Not applicable	Not applicable	Not applicable	
10.06.2025	Consultant Radiologist	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
11.06.2025	Assistant Director of Finance	Finance	Nil return	Not applicable	Not applicable	Not applicable	
11.06.2025	Service Director	Primary & Community Care Group	Nil return	Not applicable	Not applicable	Not applicable	
11.06.2025	Deputy Director of Pharmacy and Medicines Management	Diagnostics, Therapies, Pharmacy & Specialties	1. Trustee and Treasurer Hands up for Downs Registered Charity (CIO) 2. Vice Chair Welsh Pharmaceutical Committee (Statutory Ministerial Advisory Committee.WGL	1. 2016 - Present 2. 2018 - present	1. No Financial Transactions or Benefits in Kind at all as Voluntary work 2. None	Not applicable	
11.06.2025	Senior Finance Manager	Finance	Nil return	Not applicable	Not applicable	Not applicable	
11.06.2025	Senior Nurse Surgery	Planned Care	Nil return	Not applicable	Not applicable	Not applicable	
11.06.2025	Assistant Director - Capital and Estates	Estates	Nil return	Not applicable	Not applicable	Not applicable	
12.06.2025	Consultant Old Age Psychiatrist & Clinical Director	Mental Health & Learning Disabilities	Nil return	Not applicable	Not applicable	Not applicable	
12.06.2025	Consultant Psychiatrist	Mental Health & Learning Disabilities	Nil return	Not applicable	Not applicable	Not applicable	
12.06.2025	Speech and Language Therapy Professional Manager	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
12.06.2025	Advanced Pharmacist - formulary and Interface	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
12.06.2025	Senior Nurse Complex Care	Primary & Community Care Group	Nil return	Not applicable	Not applicable	Not applicable	
12.06.2025	Lead Nurse Children & Young People	Children & Families	Nil return	Not applicable	Not applicable	Not applicable	
12.06.2025	Consultant Clinical Psychologist	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
13.06.2025	Consultant Urologist and Clinical Director Urology	Planned Care	1. Director of Appanna Healthcare Ltd 2. Spouse is Director of Appanna Healthcare Ltd	Ongoing	Yes financial transactions	Not applicable	
13.06.2025	Chief Paediatric Audiologist	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
13.06.2025	Senior Advanced Clinical Practitioner	Primary & Community Care Group	Nil return	Not applicable	Not applicable	Not applicable	

Date Approved	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
16.06.2025	Consultant Upper GI Surgeon	Planned Care	Chughtai Surgery Limited (for private practice, one person in company i.e. myself)	Since January 2024	Private practice – Clinics at Nuffield Health Cardiff Bay and Vale of Glamorgan, St Joseph Hospital Newport and Oak tree Clinic Cardiff.	Not applicable	
16.06.2025	Consultant Pathologist	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
16.06.2025	Consultant General Surgeon	Planned Care	Nil return	Not applicable	Not applicable	Not applicable	
17.06.2025	Principal Occupational Therapist	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
17.06.2025	Consultant Clinical Psychology	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
17.06.2025	Emergency Medicine Consultant	Unscheduled Care	Nil return	Not applicable	Not applicable	Not applicable	
17.06.2025	Deputy Assistant Medical Director for Education	Medical Director Function	Also hold the role of Faculty Lead with HEIW	Since November 2023	Salary attached to role	Not applicable	
17.06.2025	Locum Consultant Psychiatrist	Mental Health & Learning Disabilities	Nil return	Not applicable	Not applicable	Not applicable	
17.06.2025	MH&LD AMH Acute Service Manager	Mental Health & Learning Disabilities	Nil return	Not applicable	Not applicable	Not applicable	
18.06.2025	Weight Management Service Professional Manager	Diagnostics, Therapies, Pharmacy & Specialties	Partner employed by NHS supplier "The Owl Centre"	Started employment July 2023	Receives salary	Not applicable	
18.06.2025	Consultant	Planned Care	Nil return	Not applicable	Not applicable	Not applicable	
18.06.2025	Deputy Director of Commissioning for Ambulance Services and 111	Joint Commissioning Committee	Nil return	Not applicable	Not applicable	Not applicable	
19.06.2025	Professional Manager SLT	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
19.06.2025	Head of Speech & Language Therapy	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
20.06.2025	Care Group Nurse Director	Mental Health & Learning Disabilities	Nil return	Not applicable	Not applicable	Not applicable	
23.06.2025	Clinical Lead ACP Frailty	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
26.06.2025	Consultant	General Surgery	Nil return	Not applicable	Not applicable	Not applicable	
26.06.2025	Cluster Pharmacist	Pharmacy	Author and freelance writer for Lingo360 (Welsh learner's magazine), Cjp and Bylines Cymru.	Not applicable	Not applicable	Not applicable	
26.06.2025	Consultant Dermatologist	Planned Care	1. Sponsorship received by Almirall pharmaceutical to attend the EADV conference in Amsterdam in September 2024 2. I hold the title of Honorary lecturer for Cardiff University. Title awarded in recognition of medical student teaching and training of students rotating through Princess of Wales Hospital Dermatology.	1. 25th - 28th September 2024 Ongoing	2. 1. Sponsorship for conference fees, travel and hotel and dinner 2. No financial reward	Not applicable	
29.06.2025	Directorate Manager, Prison Healthcare	Primary & Community Care Group	Nil return	Not applicable	Not applicable	Not applicable	
30.06.2025	Medical Secretary	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
30.06.2025	Head of Digital Service Management	ICT	Nil return	Not applicable	Not applicable	Not applicable	
30.06.2025	Advanced Nurse Practitioner	Children & Families	Director of JCDC properties ltd. Property investment company	Since February 2025	Money from personal re finance of residential and buy to let mortgage transferred from personal accounts to business account.	Not applicable	
30.06.2025	Consultant Cardiologist	Unscheduled Care	1. Trustee for Swansea Chinese Christian Church 2. Received funding from pharmaceutical company to attend meeting (hotel, transportation, course fee) Honorarium for giving talks and producing teaching materials for pharmaceutical companies and HEIW. Pharmaceutical companies bring lunch to support departmental meeting and Bridgend Cardiac Study Day. Joint working between pharmaceutical company and health board to fund nurses /pharmacists to improve heart failure care in the locality. 3. Hold Honorary Lecturer Post with Cardiff University Medical School)	1. Since 2012 Since 2015 2016	2. 1. Nil Yes 3. Since from HEIWs	2. 1 PA	Not applicable
01.07.2025	Support Manager - GSGI	Planned Care	Nil return	Not applicable	Not applicable	Not applicable	
01.07.2025	Consultant	Planned Care	1. SPECIALIST IN PRIVATE PRACTICE AT SOUTH WALES SPECIALIST ORAL SURGERY AND DENTAL IMPLANT CENTRE 2. PREVIOUS HONONARY CONTRACT (LECTURER) WITH CARDIFF UNIVERSITY (not renewed 2025).	1. Since April 2024 Prior to April 2025	2. 1. Patients for private patients None	2. Not applicable	
01.07.2025	Consultant ENT	Planned Care	1. Director of Vale ENT Ltd (private ENT services provider) 2. QI Course Director for the Royal College of Surgeons of Edinburgh 3. Spouse is a co-Director of Vale ENT Ltd 4. NB TALGITS Trial closed recruitment March 2025 5. I am an Honorary Senior Lecturer for Cardiff University. I was recruited by CTMUHB Education department to organise delivery of PoWH Phase 1 (Years 1 & 2) medical student education in POWH	1. Vale ENT Ltd since 2018. RCSEd QI Director since 2018 3. Since 2018 N/A Since 2022	2. 1. Vale ENT Ltd has been dormant since 2020 (covid pandemic) but I hope to restart an ENT private clinic service this year. 2. RCSEd will cover my travel / accommodation expenses when I organise / attend the annual QI Symposium. 3. £500 annual dividend and some paid employment 4. N/A 5. Once session per week paid		
02.07.2025	Consultant	Gastroenterology	Nil return	Not applicable	Not applicable	Not applicable	

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Date Approved	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken	In Year Amendments
18.08.2025	Prescribing Support Dietitian	Primary & Community Care Group	Nutricia - to work as a consultant at training session in London.	One day - 15th October 2025	Hotel accommodation and payment	Existing governance safeguards within Dietetics and Medicines Management are sufficient. No further action required.	
18.08.2025	Rotational Physiotherapist	Primary & Community Care Group	Club physio for Rhiwbina RFC. Due to start August 2025	August 2025 - February 2026	Paid per session - irregular shifts	Not applicable	
18.08.2025	Occupational Therapist	Primary & Community Care Group	I will be undertaking occasional, low-volume expert witness work. For Jill Ferrie & Associates Ltd. I will ensure there is no overlap between my NHS work and any expert witness cases, and no conflicts of interest will arise. I have private indemnity insurance cover.	Commencing 28 August 2025	None		
18.08.2025	Clinical Psychologist	Mental Health & Learning Disabilities	Nil return	Not applicable	Not applicable	Not applicable	
19.08.2025	NICE Co-ordinator	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
20.08.2025	Physiotherapist	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
08.09.2025	Assistant Director of Claims and Complaints	Patient Care & Safety	Volunteer for Women's Aid on various projects. SWAN project etc.	Approximately 12 months and ongoing	No financial benefits or benefits in kind	Not applicable	
9.09.2025	Head of Innovation	Patient Care & Safety	Director GALLOWAVE LTD (15815356)	July 2024 - Present	None	Management action agreed - 1.Adhere to all relevant CTM policies and procedures 2.Do not undertake commercial activity with CTMUHB where a conflict of interest could be said to exist.....	
			Ely Vale Innovations LTD (16563357)	July 2025-Present	None	Management action agreed - 1.Adhere to all relevant CTM policies and procedures 2.Do not undertake commercial activity with CTMUHB where a conflict of interest could be said to exist.....	
			Spouse - Director/Chief Financial Officer HEALTH ECONOMICS AND OUTCOMES RESEARCH LTD (07532879)	December 2023-to date	None	N/A	
09.09.2025	Senior Nurse	Primary & Community Care Group	Nil return	Not applicable	Not applicable	Not applicable	
09.09.2025	Senior Nurse	Primary & Community Care Group	Nil return	Not applicable	Not applicable	Not applicable	
10.09.2025	Senior Nurse Palliative Care	Primary & Community Care Group	Nil return	Not applicable	Not applicable	Not applicable	
12.09.2025	Principal Clinical Psychologist	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
12.09.2025	Physiotherapist	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
15.09.2025	Service Project Manager, Capital Planning	Estates Directorate	Nil return	Not applicable	Not applicable	Not applicable	
15.09.2025	Senior Nurse	Primary & Community Care Group	Nil return	Not applicable	Not applicable	Not applicable	
23.09.2025	Highly Specialist Weight Management Dietitian	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
25.09.2025	Dietetic Assistant Practitioner	Diagnostics, Therapies, Pharmacy & Specialties	Part time work (less than 20hrs a month) as a personal assistant in care for a young adult with disability	Once a month over the weekend	Paid at hourly rate for time	Not applicable	
3.10.2025	Primary Care Pharmacist	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
7.10.2025	Highly Specialist Diabetes Dietitian	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
8.10.2025	Prescribing Advisor Pharmacist	Diagnostics, Therapies, Pharmacy & Specialties	Work for Tarian Group GP practice as a practice pharmacist helping deliver GMS services 3 days per week in the same area that I work for the health board for my prescribing advisor role	Ongoing	Not applicable	Not applicable	
17.10.2025	Principal Public Health Practitioner	Public Health	Director in a limited company - Molomix Bioscience Limited	2020-Present	No contractual or financial relationship with CTMUHB or other NHS bodies.	Management action discussions have been held to manage any potential conflicts of interest and this is detailed on the Declaration of Interest Form (available upon request).	
			Director in Morgannwg Investments	2024-Present	No contractual or financial relationship with CTMUHB or other NHS bodies.		
			Shares in limited company - Molomix Bioscience Limited	2021-Present	No contractual or financial relationship with CTMUHB or other NHS bodies.		
			Shares in limited company- SIGENEX	2021-Present	No contractual or financial relationship with CTMUHB or other NHS bodies.		
			Shares in limited company Morgannwg Investments	2021-Present	No contractual or financial relationship with CTMUHB or other NHS bodies.		
17.10.2025	Community Dietetic Professional Manager	Diagnostics, Therapies, Pharmacy & Specialties	1. Historical funding from Abbott and Fresenius Kabi to attend conferences (BAPEN 2019, ESPEN 2020). 2. Travel, subsistence and attendance at Nutricia Frailty Expert Day in Utrecht, Netherlands 3. Role on the Consensus Panel for the Malnutrition Pathway for COPD 3rd Edition via Hilary Franklin Healthcare Communications on behalf of the Malnutrition Pathway panel funded by an unrestricted educational grant from Nutricia.	1. Historical funding 2019/2020 2. October 2025 2022 - 2023	2. 1. £260.15 travel (Abbott 2019), £100 conference fee (Fresenius Kabi 2020) 3. 2. Travel and Subsistence for 2 days in Netherlands 3. £250 honoraria (Nutricia Educational Grant)		
20.10.2025	Speech and Language Therapist	Children & Families	Nil return	Not applicable	Not applicable	Not applicable	
22.10.2025	Consultant Radiographer	Diagnostics, Therapies, Pharmacy & Specialties	Providing Radiology Reporting for DMC Radiology Reporting	Commenced October 2025	Self Employed hours outside of NHS contracted hours	Not applicable	

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23.10.2025	Prescribing Support Dietitian	Primary & Community Care Group	Nil return	Not applicable	Not applicable	Not applicable	
30.10.2025	Pharmacist	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
30.10.2025	B4 PAP	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
4.11.2025	Neuro rehab seconded physiotherapist	Diagnostics, Therapies, Pharmacy & Specialties	Bank Physiotherapist at Nuffield health the vale hospital	From October 2025	Paid employment	Management has advised staff member to take personal responsibility of ensuring she has adequate rest time in between her full time CTM role, plus out of hours On Call commitments plus this additional bank work at the weekends in accordance to Working Time Directive 2003 "At least 24 hours of rest in a 7-day period."	
6.11.2025	GTAP, Falls Prevention Service	Diagnostics, Therapies, Pharmacy & Specialties	Working with charitable/voluntary sports teams and organisations outside of my role within the NHS. Secondary income as self-employment working privately within the sports sector.	Have been self employed for over 10 years	Self employed income and voluntary opportunities	Not applicable	
13.11.2025	Assistant Mental Health Act Administrator	Mental Health & Learning Disabilities	Nil return	Not applicable	Not applicable	Not applicable	
14.11.2025	Bank Physiotherapy Assistant	Public Health	Nil return	Not applicable	Not applicable	Not applicable	
20.11.2025	Acute Stroke Physiotherapist	Diagnostics, Therapies, Pharmacy & Specialties	Nuffield health - bank inpatient physiotherapist	2023 - present	Per shift payment, monthly basis	Staff member to ensure she has adequate rest periods between working in both settings/shifts in accordance with working time directive	
20.11.2025	Occupational Therapist	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
25.11.2025	Physiotherapy Assistant Practitioner	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	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
27.11.2025	Administrator	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
2.12.2025	Clinical Specialist Physiotherapist	Diagnostics, Therapies, Pharmacy & Specialties	1. Member of Central Beacons Mountain Rescue Team 2. Husband - Member of Central Beacons Mountain Rescue 3. Brother in Law works for Welsh Government	1. 2007 - present 2004 - present 2020 - present	2. Not applicable 3.	Not applicable	
8.12.2025	Neuro Op Team lead	Diagnostics, Therapies, Pharmacy & Specialties	Spouse works at Cardiff & Vale UHB	Not applicable	Not applicable	Not applicable	
9.12.2025	Physiotherapy Team Leader	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
9.12.2025	Therapies Administrative Support Officer	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
11.12.2025	Rotational Physiotherapist	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
12.12.2025	Directorate Lead Consultant Clinical Psychologist (CYP services)	Mental Health & Learning Disabilities	I provide clinical supervision to other clinical psychologists in an independent capacity. At present I supervise just one clinical psychologist for one hour every 2 months. This psychologist works for CAVUHB. It is not in my CTMUHB job role to clinically supervise any psychologists working for other health boards and therefore there is no conflict of interests in my view.	Started in 2022 – On going	Charge per hour – paid by CAVUHB	Not applicable	
16.12.2025	Neonatal Practise Development Nurse	Children & Families	Nil return	Not applicable	Not applicable	Not applicable	
23.12.2025	Physiotherapist	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
6.01.2026	Energy Support Officer	Estates	Nil return	Not applicable	Not applicable	Not applicable	
07.01.2026	Advanced Primary Care Pharmacist	Diagnostics, Therapies, Pharmacy & Specialties	1) Royal Pharmaceutical Society - East Wales Ambassador 2) Cardiff University - guest speaker for MH diploma talk once a year 3) Partner is a community pharmacist within CTM (Georgetown Pharmacy)	1. Since 2022 2. Since 2025 Since 2018	3. 1. Voluntary role - payment of £75 if support with any in-person activities 2. One off payment per session 3. Not applicable	Staff member works in a separate locality and sector to her fiancé, so their roles don't directly influence each other. The RPS role doesn't conflict or influence staff members post substantive post	
08.01.2026	Pharmacist	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
08.01.2026	Speech & Language Therapist	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
23.01.2026	Senior Pharmacy Technician	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
12.03.2026	Clinical Psychologist	Diagnostics, Therapies, Pharmacy & Specialties	1. Private Psychology work - developing and providing resources, workshops, and webinars for beauty professionals. Running workshops on wellbeing and self-care for the general public. 2. Developing an app-based course for children and young people with persistent pain, with the PAIND app and team. Currently on hold.	1. Since February 2026 Since September 2025	2. 1. Financial transactions 2. Financial transactions	Not applicable	
18.03.2026	Clinical Lead Physiotherapist. Adulthood Strategy Clinical Director	Diagnostics, Therapies, Pharmacy & Specialties	Fitness professional completing exercise classes at Fitness Gym, Ystrad Mynach outside of working hours	Since March 2026	Payment for classes delivered	Not applicable	
24.03.2026	Clinical Psychologist	Mental Health & Learning Disabilities	Nil return	Not applicable	Not applicable	Not applicable	
24.03.2026	Physiotherapist	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	Not applicable	Not applicable	Not applicable	
24.03.2026	Physiotherapist	Diagnostics, Therapies, Pharmacy & Specialties	Nil return	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
11.04.2025	11.04.2025	Acute Oncology CNS	Relative of patient	11.04.2025	Theatre voucher tickets given to staff member by a patient's relative as a thank you for the care and support provided during their relatives care at RGH. Value of voucher £50. Following advice given by Head of Charities and Income Generation, the donor is happy for the gift to be donated to Y Bwthyn for fundraising.	Gift
18.07.2025	30.07.2025	Chief Executive	HLTH	16.06.2025	HLTH Europe Conference 16TH - 18TH June 2025 Travel - £110.48 Accommodation - £384.34 (being repaid by organisers) Free admission to conference as I was a speaker	Hospitality
19.09.2025	23.09.2025	Director of Digital	Microsoft	24.09.2025	Llantrisant Health Park Digital - Workshop, National Imaging Academy of Wales, Pencoed – Hosted by Microsoft. Meals & Refreshments £350.00	Hospitality
09.09.2025	29.09.2025	Principal Pharmacist Haematology	Pharmaceutical Representatives	29.09.2025	Sponsorship to attend British Oncology Pharmacy Association (BOPA) 28th Annual Conference at ICC Belfast including transport, accommodation and conference fees 3-5 October 2025 £976.00	Hospitality/Sponso rship
	11.09.2025	Directorate Manager, Pathology	HBSUK	11.09.2025	HBSUK provided Dictaphones and tapes for insourcing activity in relation to the National Outpatient Programme for use in Princess of Wales and Royal Glamorgan Hospitals. Total value £3380.34.	Gift
10.09.2025	13.10.2025	Practice Development Nurse	Pharmaceutical Representatives	24.09.2025	Reps will be hosting stalls at the Practice Nurse Forum. The reps named in the section below will be charged £350 for the opportunity to have a stall at the event. They will not approach the attendees but if the Practice Nurses visit the stalls, they can give information about their products to them. They leave the event during the educational presentations but some return during any breaks for networking purposes. The monies raised by charging the reps for hosting these stalls off sets the cost of room hire and refreshments. (Idorsia/Exeltis)	Hospitality
05.02.2026	10.02.2026	Practice Development Nurse	Pharmaceutical Representatives	10.03.2026	Reps will be hosting stalls at the Practice Nurse Cancer Care Study Day at Pontypridd Rugby Club The reps named in the section below will be charged £350 for the opportunity to have a stall at the event. They will not approach the attendees but if the Practice Nurses visit the stalls, they can	Hospitality
21.03.2026	29.04.2026	Consultant Physician	Idorsia UK	07.05.2025	Honorarium of £1700 received for talk preparation and talks given for Idorsia on Insomnia at an evening event in London held on 7 May 2025. The honoraria received will be donated to the Royal Glamorgan Hospital Respiratory Endowment Fund.	Honoraria
21.03.2026	29.04.2026	Consultant Physician	Chiesi Ltd	14.04.2026	Honorarium of £500 received for providing a talk for primary care on “COPD the (Important) Basics” at an event in Cardiff on 14 April 2026. The honoraria received will be donated to the Royal Glamorgan Hospital Respiratory Endowment Fund.	Honoraria
27.04.2026	30.04.2026	Practice Development Nurse	Pharmaceutical Representatives	21.05.2026	Reps will be hosting stalls at the Practice Nurse Forum Celebration of International Nurses Day at Heronston Hotel, Bridgend The reps named in the section below will be charged £350 for the opportunity to have a stall at the event. They will not approach the attendees but if the Practice Nurses visit the stalls, they can	Hospitality



Agenda Item

5.1

Audit, Risk & Assurance Committee

BOARD ASSURANCE FRAMEWORK REPORT

Dyddiad y Cyfarfod / Date of Meeting	19/05/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Emma Walters, Head of Corporate Governance & Board Business
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance / Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	Endorse for Board Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Strategic Risk Owner updates	April 2026/May 2026	Reviewed and signed Off
Executive Leadership Group	11 May 2026	Risks reviewed and management sign off received.

Acronyms / Glossary of Terms	
BAF	Board Assurance Framework
ELG	Executive Leadership Group



1. Situation /Background

- 1.1 It is good practice for the Health Board to have a Board Assurance Framework (BAF) that clearly sets out the risks, actions and relevant sources of internal and external assurances to provide a clear picture of the 'health' of the organisation and the high level risks threatening delivery of the Board's strategic goals.

2. Specific Matters for Consideration

- 2.1 The BAF has been developed to ensure it appropriately reflects;
- the four strategic goals of the Health Board;
 - assurance reporting that supports a streamlined and effective committee and reporting structure;
 - a robust mechanism that reaches into each of the Care Groups and central functions to provide assurance on performance, quality and resources across the breadth of the integrated Health Board;
 - international best practice; and
 - the management of board meetings and agendas to be focussed equally on Oversight, Insight and Foresight i.e. balancing the governance of immediate operational priorities with the need to focus on long-term strategic planning.
- 2.2 The Organisational Risk Register is received in its entirety by the Audit, Risk & Assurance Committee and the assigned risks to the other Board Committees as appropriate.

3. Key Risks / Matters for Escalation

- 3.1 Please refer to Appendix 1 which outlines the key risks for discussion and review. Amendments have been highlighted in red. In summary:
- No new risks were added this period.
 - No risks were proposed for closure this period.
 - There were no changes to risk scores this period.

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: Sustaining Our Future
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Ageing Well
	If more than one applies please list below: Dying Well, Growing Well, Living Well, Starting Well 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))	Leadership If more than one applies please list below: Culture and Valuing People, Data to knowledge, Learning, Improving and Research, Whole- system Perspective
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))	Effective If more than one applies please list below: Efficient, Equitable, Person Centred, Timely, Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	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:	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):	If no, please include rationale below: Not required for the organisational Risk Register. Individual risks may have been subject to an Impact Assessment.
Cyfreithiol / Legal	Yes (Include further detail below)	
	See detail captured for each risk	
Enw da / Reputational	Yes (Include further detail below)	
	See detail captured for each risk	
Effaith Adnoddau (Pobl /Ariannol) / Resource Impact (People / Financial)	Yes (Include further detail below)	
	See detail captured for each risk	

5. Recommendation

5.1 The Audit, Risk & Assurance Committee is asked to:

- **Endorse for Board Approval the amendments** made to the existing risks and confirm that the updates provide adequate assurance and reflect recent discussions.

CTMUHB - BOARD ASSURANCE FRAMEWORK REPORT

Section 1 – Summary

Risk no	Strategic Goal	Strategic / Principal Risk	Lead(s) for this risk	Assurance committee	Current score	Scoring Trajectory	Risk Treatment
1.	Improving Care, Sustaining our Future  Click Here for Risk 1a Click Here for Risk 1b	a) Enough capacity to meet elective demand	Chief Operating Officer	Quality, Safety & Experience Committee and Operational Delivery Committee	16 (C4XL4)	No change to risk scores this period. ↔	Treat with elements that are being Tolerated due to the pace in being able to mitigate the risk.
		b) Enough capacity to meet emergency demand			20 (C4xL5)	No change to risk scores this period. ↔	Treat with elements that are being Tolerated due to the pace in being able to mitigate the risk.
2.	Improving Care, Sustaining our Future  Click Here for Risk 2	Ability to deliver improvements which transform care and enhance outcomes	Executive Director of Nursing / Executive Medical Director	Quality, Safety & Experience Committee and Operational Delivery Committee	16 (C4XL4)	No change to risk scores this period. ↔	Treat
3.	Sustaining our Future, Improving Care and Inspiring People  Click Here for Risk 3	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 and Operational Delivery Committee	16 (C4XL4)	No change to risk scores this period. ↔	Treat
4.	Creating Health, Sustaining our Future  Click Here for Risk 4	Effective Community and Partner Engagement in service changes and developments	Director of Communication, Engagement & Fundraising	Strategic Development Committee	16 (C4XL4)	No change to risk scores this period. ↔	Treat with elements that are being Tolerated due to the pace in being able to mitigate the risk.
5.	Improving Care, Sustaining our Future  Click Here for Risk 5	Delivery of a digital and information infrastructure to support organisational transformation	Director of Digital	Operational Delivery Committee and Strategic Development Committee	16 (C4XL4)	No change to risk scores this period. ↔	Treat
6.	Improving Care, Sustaining our Future  Click Here for Risk 6	Ability to maintain a safe and fit for purpose estate infrastructure	Executive Director of Finance	Operational Delivery Committee	16 (C4XL4)	No change to risk scores this period. ↔	Treat with elements that are being Tolerated due to the pace in being able to mitigate the risk.
7.	Sustaining our Future, Creating Health  Click Here for Risk 7	Fulfilling our Environmental and Social Duties and ambitions	Executive Director of Strategy & Transformation	Strategic Development Committee	16 (C4XL4)	No change to risk scores this period. ↔	Treat with elements that are being Tolerated due to the pace in being able to mitigate the risk.
8.	Creating Health, Sustaining our Future  Click Here for Risk 8	Prevention and early Intervention to support Healthy Life Expectancy	Executive Director of Public Health	Strategic Development Committee	20 (C5xL4)	No change to risk scores this period. ↔	Treat
9.	Sustaining our Future  Click Here for Risk 9	Failure to deliver a sustainable plan and manage revenue resources within the Revenue Resource limits set by Welsh Government (WG)	Executive Director of Finance	Operational Delivery Committee	20 (C4xL5)	No change to risk scores this period	Treat
10.	Sustaining our Future, Improving Care  Click Here for Risk 10	Ability to develop a fit for the future estate to reflect our future clinical service model	Executive Director of Finance	Strategic Development Committee	16 (C4XL4)	No change to risk scores this period. ↔	Treat with elements that are being Tolerated due to the pace in being able to mitigate the risk.
11.	Creating Health, Sustaining our Future, Improving Care  Click Here for Risk 11	Delivery of an Integrated Care Model	Chief Operating Officer	Strategic Development Committee	16 (C4xL4)	No change to risk scores this period. ↔	Treat

Section 2 Strategic Risk Heat Map

Current risk scores in **black**

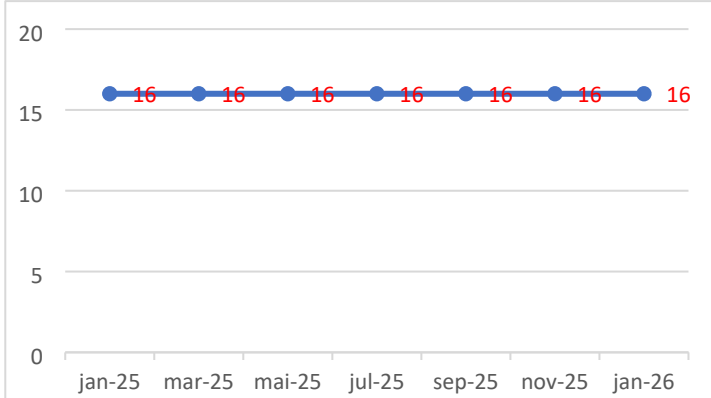
Target risk scores in *grey italic*

Consequence	5				8	
	4		3,4,6,7,8,10	1a,1b,2,5,11,9	1a,2,3,4,5,6,7,10,11	1b, 9
	3					
	2					
	1					
CxL		1	2	3	4	5
		Likelihood				

SECTION 3 – STRATEGIC RISKS

Strategic Goal(s):  Improving Care - Delivering safe and compassionate care - Developing new models of care - Digital transformation for patients and staff - Ensuring timely access to care  Sustaining Our Future - Becoming a green organisation - Ensuring our Services financial sustainability Embedding value-based healthcare - Ensuring our estate is fit for the future			Risk score 16
Strategic Risk: Enough capacity to meet elective demand - (Risk No.1a)			
If the Health Board is unable to meet demands for services at all points in the patient journey.		Then its ability to provide high quality and affordable care and to meet access targets will be reduced	Resulting in avoidable harm to patients, poor patient experience, diminished staff morale, and loss of trust and confidence from the wider community, ongoing overspends.

Risk Lead	- Chief Operating Officer - Executive Director of Strategy & Transformation	Assurance committee	- Quality, Safety & Experience Committee - Operational Delivery Committee (Performance Targets)

	Consequence	Likelihood	Score	Risk Score Trend this Period:
Initial	4	5	20	No change to risk scores this period.
Current	4	4	16	
Target	4	3	12	
Risk Appetite	Cautious (<i>quality and safety; trust and confidence; legal and regulatory</i>)			Risk Score Trajectory
				
Rationale for assessment of risk score: <i>Including where risk score remains unchanged and for any changes</i>				- End of year RTT >104 weeks was 98 patients with all these in Orthopaedics - Progress is maintained in all areas with HBS outpatient programme delivering 0 patients >52 weeks. - Cancer SCP maintained >63% and the service received automatic de-escalation to level 1 routine monitoring. With CTMUHB maintaining the position in Wales for 4 months. - National orthopaedic Cement supply issue has delayed the orthopaedic recovery plan by approximately 2.5 weeks. - Progress made in theatre start times and in outpatient SOS and PIFU rates. - Insourcing support for weekend elective Orthopaedics commenced on 13th December at Princess of Wales hospital. Contract for an additional 240 cases to be completed by end of March 2026. - HBSUK continues to have significant reduction on Waiting list each week. Total waiting list has decreased by >12,000 since June 2025. - Progress made on >104 week. All specialities aim to maintain <104 weeks with the exception of Orthopaedics.

	• Vascular short-term issue. This is being resolved via implementation of the network criteria. • The Vascular Network INNU process has been adopted by CTMUHB. • Regional Outpatient Insourcing commenced at CTMUHB on 6th September 2025. Aiming to reduce Outpatient waiting times across all specialities • The Orthopaedic Elective unit commenced at the Princess of Wales Hospital from 1st September 2025. 3 dedicated operating theatres for Arthroplasty with a protected Ward of 28 beds. • All Cataract surgery was consolidated to the Princess of Wales Eye Unit on 1st September 2025. Focusing on standardisation and delivery of HVLC. • Regional Cataract Plan continues through Q2-Q4 to reduce Cataracts waits further. • ~~4 theatres across CTMUHB (RGH) will be moved to Vanguard in November.~~ • Endoscopy recovery plan commencing August to December 2025. • PIT Board refocussed on delivery of key actions for each group, with focus of all specialities on PIFU and SOS. • ~~4 Mobile theatres opened Mid-April and closed in August 2025.~~ • ~~2 Prince Charles Hospital (PCH) theatres opened end of April 2025~~ • ~~1 Theatre and Ward at PCH dedicated to Orthopaedic Inpatient surgery from May – July 2025~~ • ~~Critical incident declared at Princess of Wales (POW) on 9th October 2024 due to the roof integrity issues with immediate impact on clinical pathways, bed capacity, all theatre elective capacity (inc. cardiac) and trauma capacity~~ • ~~There has been continuous planning on clinical pathways and diversion of emergency intakes, which again has impacted on the capacity and resilience across the full CTMUHB system.~~ • ~~There had been a requirement to deescalate and close 190 inpatient beds on the POW site. With re-provision of the capacity across CTMUHB acute and community.~~ • ~~There has also been significant reallocation of internal capacity at POW and Royal Glamorgan Hospital (RGH) to respond to the critical incident.~~ • ~~Planning continues recovery phase following critical incident with the impact not yet quantified.~~ • There has been continuous improvement against trajectories for elective demand for a range of services including Mental Health and Learning Disabilities. • The financial and economic challenges faced by the third sector and local authority partners has an impact on the Health Boards ability to mitigate this risk, as capacity cannot be protected. • The large-scale capital programme at PCH will temporarily reduce the number of operating theatres by 2. An ongoing work programme continues to review options to mitigate this. • ~~The current Fire enforcement notice at Princess of Wales hospital will be completed as part of the Critical incident response and reduce the number of operating theatres until early summer 2025. Plans are ongoing for the temporary location of the theatres.~~ • Workforce recruitment continues across the care group to enable a sustainable capacity model. There continues to be a reduction of ADH and WLI activity attributed to standardisation of pay. • Regional working continues and the positive and negative impact of this will be continuously reviewed. It is anticipated that the risk score may remain quite stagnant as the pace of improvement is constrained by the incident, workforce, financial and environmental constraints on the service. Advancements have been made in achieving elective targets and implementing a comprehensive system approach to capacity management through improved system flow, but the Health Board continues to face routine operational pressures, especially during peak periods, that constrain elective capacity. These challenges necessitate regular monitoring and ongoing continuous improvement efforts to address rising demand.
Risk Treatment Assessment <i>i.e. Treat, Tolerate, Transfer etc.</i>	It is recognised that there is an element of tolerating this risk in terms of the pace in being able to mitigate it. There are, however, ongoing risk treatment activity outlined in the mitigating actions section.

Current Control Measures

Productivity, improvement and transformation programme (PIT)

- Increase Planned Care Capacity
- Transform the way Planned Care is delivered
- Prioritise both diagnosis and treatment
- Provide better information and support to patients

Progress has been made against these four commitments; however, patients are still waiting too long for both diagnosis and treatment, and there is now a national requirement to outline how the waiting times for elective treatment in Wales will further improve.

In addition to setting up the National Six Goals programme for Urgent & Emergency Care, Welsh Government have now outlined the national direction for Planned Care, with health boards expected to deliver against key objectives aligned to national policy. This is an opportunity to radically transform the way services are both designed and delivered, ensuring the best possible outcomes can be achieved, maximising sustainable throughput, with an emphasis on improving productivity and efficiency within the envelope of existing resource.

The key areas for improvement each Health board are expected to incorporate into their improvement programme are:

1. Effective Waiting List Management Systems: clear national pathways; focused treat in turn; effective booking processes; robust demand management
2. Outpatient & Preoperative Modernisation: utilisation of SOS and PIFU; additional advice & guidance services; virtual preoperative clinics
3. Theatre Capacity: reduction of fallow lists; efficient scheduling; increased utilisation; improved productivity
4. gGiRFT & Clinical Implementation Networks: identifying opportunities for full implementation of high volume, low complexity; adopting procedure time best practice; maximising day case surgery
5. Diagnostics: regional and community diagnostic centres; straight to test pathways; diagnostic pathway best practice

All areas of the programme will focus on the following crosscutting themes:

1. Increased efficiency: streamlining processes to reduce waiting times, eliminate unnecessary delays, and ensure all services are delivered in a cost-effective manner.
2. Enhanced Quality of Care: ensuring our patients receive the right care at the right time, by sharing best practices, standardising procedures, and improving coordination between services.
3. Optimised resource utilisation: making better use of the available resource, including staff, equipment, and facilities, to ensure maximum productivity and minimal waste.
4. Improved Patient Outcomes: focusing on patient-centred care to improve outcomes, satisfaction, and overall experience, whilst ensuring our care is well-co-ordinated and effectively managed.
5. Reduction of Variability: minimising variations in clinical practices and outcomes by implementing evidence-based guidelines and protocols, delivering consistent and high-quality care.
6. Data utilisation: using our data and intelligence to pinpoint areas for improvement, regularly monitor key performance matrix and empowering data-driven decision-making to drive continuous improvement
7. Support Workforce Development: training our staff to develop the right skills and knowledge to help implement and sustain necessary changes and create the environment for effective cross-sector working.

All elective care services will hold a monthly Service Improvement Group.

Planned Care Recovery Programme

- Enhanced monitoring process for Cancer Services –weekly focussed meetings
- Llantrisant Health Park site plans under development
- Clinical Services Plan Group being established
- Speciality Specific and Cancer Improvement Trajectories Completed.

Current Control Measures Cont.

IMTP – investment agreed by Board.

Specific Improvement Groups/Boards

- PIT programme
- Planned Care recovery
- Service Improvement Groups
- Cross Cutting Improvement Groups – Theatre, Pre assessment, Diagnostics, Outpatients and therapies.

All updates feed into the Improving Care Board.

Annual Planning Process

Recovery Planning post critical incident at POW.

Lessons learnt from Winter Planning process - currently being analysed from a lesson learnt perspective.

Partnership Leadership Team established with Local Authority and NHS representation to look at planning across the region.

Commissioning Group established to oversee the delivery of the optimised integrated care model

Additional 'South Theatre' at the Royal Glamorgan Hospital - An old obstetric theatre has been recommissioned to support the SBUHB disaggregation and increase capacity and efficiency. This alongside the 'Snowdrop Centre' has transformed the delivery of Breast services across CTMUHB.

Specific Improvement Groups/Boards

- PIT programme
- Planned Care recovery
- Service Improvement Groups
- Cross Cutting Improvement Groups – Theatre, Pre assessment, Diagnostics, Outpatients and Therapies & Audiology.

All updates feed into the Improving Care Board.

Annual Planning Process

Annual Demand and Capacity Plan established to manage demand and making best use of capacity.

Escalation Status programme work

Regional Working

- A Residential and Nursing Care for Older People Report has been completed and approved by the Regional Partnership Board and actions being implemented.
- Alternative bed options being worked-up by all CTM local authorities to aid patient flow and 'Discharge to Recover then Assess' (D2RA) out of hospital stabilisation and onward decision-making.
- Welsh Government supporting intervention with Bridgend County Borough Council regarding backlog of patients Medically Fit for Discharge.
- Regional Pathology Programme Board (Formerly Regional Pathology Steering Group).
- South East Regional Programmes of work – Collaborative approach to restoration with a number of targeted work streams.

Governance Structures

- Operational Services Management Board (Health Board wide)
- Improving Care Board (Health Board wide)
- Six Goals/Unscheduled Care Board
- Cancer Board
- Weekly Cancer Meetings
- Planned Care Recovery Board/ Planned Care Recovery Operations Board.
- Innovation Board

Operational Processes

- Clear criteria to prioritise based on clinical need
- Centralised decision-making around use of spare capacity across the organisation.
- Robust Interventions Not Normally Undertaken (INNU) application.
- Weekly performance tracking.
- Robust Demand and Capacity with mitigating actions.
- Service improvement and transformation

Sources of Assurance (Internal and External)

• Integrated Performance Report • Harm Reviews • Assessment Dashboard • Update reports on specific services experiencing pressure, e.g. Ophthalmology, Urology • Performance RTT, Cancer trajectories • Follow-up reports on outpatients not booked • PIT Programme reports • Planned Care Recovery Update report • Escalation processes leading to Chief Operating Officer Report to Quality & Safety Committee including Care Group performance review meetings. • Organisational Risk Register via Care Group Risk Registers. • Planning, Performance & Finance monthly report. • TI meetings • Audit Wales commencing a Planned Care Audit in August 2024. • Audit Wales commencing a Health Protection Audit in August 2024.			
Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Indicators of Success (following implementation of mitigating actions)
1. CTMUHB digitally based enabling systems	• Manual processes in areas of no system. • Scope of digital Pre-assessment system • Digital dictation consolidation and standardisation • Theatre system update • Need for digital outpatient system • Consultant connect implementation • Attend anywhere use for virtual activity • WPRS full roll out	• Increased utilisation • Reduction in patient attendances • Reduction in patient follow up appointments • Reduction in demand • Reduced paper and manual process • Increase in data information	• Decreased CAN/DNA rate • Increased utilisation • Decreased missed opportunities • Reduction in referral demand - Reduction in waiting list
2. Robustness of cancer tracking and specialty-specific elective data	• Weekly performance meeting • Implementation of online escalation process for all patients outside of agreed component waiting times. • Canisc replacement ongoing. Implementation of Breast, Urology & lower GI datasets • Training undertaken for all cancer trackers to ensure consistency and compliance with new guidance	• Performance monitoring • Patient identification • Improved pathway monitoring	• Increase in performance SCP - Decrease in waiting list back log
3. Improvements being made in elective care trajectories albeit not fully embedded.	• Contract awarded for endoscopy insourcing to increase endoscopy capacity. Commenced in November 2023 to September 2024 • Regional Ophthalmology service with increased activity across the region for CTMUHB patients. • Reconfiguration of elective surgery has seen an increase in activity. This will continue to be monitored and developed Completed, will move to control at the next iteration. • Reconfiguration of Trauma ongoing assessment • In sourced additional staff to open additional theatre activity until theatre plan fully recruited to. • Effective initiation of business continuity plans to respond to increased capacity pressures and challenges in the service (ongoing). • In Development – Clinical Services Plan.	• More capacity • Reduced waste • Consolidated pathways • Increase in workforce - Increased utilisation	• Increase in activity • Reduced fellow sessions • Reduction in waiting times - Reduction in >104 week wait

Linked National Priority Measures

Access to Timely Planned Care

- Number of patients waiting more than 104 weeks for treatment;
- Number of patients waiting more than 36 weeks for treatment;
- Percentage of patients waiting less than 26 weeks for treatment;
- Number of patients waiting over 104 weeks for a new outpatient appointment;
- Number of patients waiting over 52 weeks for a new outpatient appointment;
- Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%;
- Number of patients waiting over 8 weeks for a diagnostic endoscopy; and
- Percentage of patient starting their first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route).

Current Performance Highlights

Latest RTT Performance not available at time of reporting – will be included in future BAF iterations when available.

Were there any significant incidents affecting this strategic Risk this period:

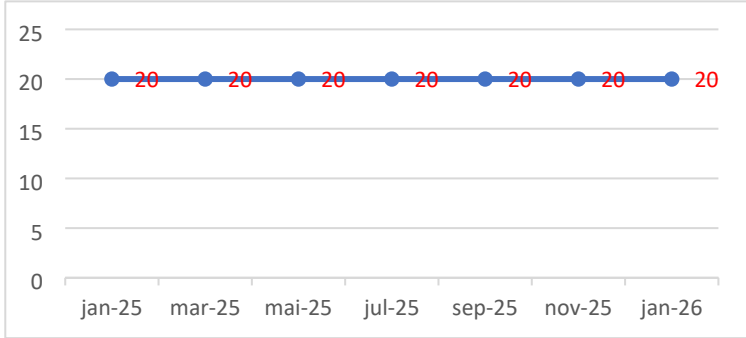
Critical incident declared at Princess of Wales on 9th October 2024. Severe water ingress with immediate impact on clinical pathways, bed capacity, all theatre elective capacity (inc cardiac) and trauma capacity.

Associated Risks escalated to the Organisational Risk Register

5932	~~Roof covering replacement works to resolve identified roof integrity issue and consequent risk of tiles falling internally and externally from weakened roof at POWH Phase 1.~~	~~20~~
5961	~~Remedial roof works to resolve the water ingress at POWH.~~	~~20~~
4491	Failure to meet the demand for patient care at all points of the patient journey (this risk is currently under review with the care group)	20
6294	Insufficient Consultant Workforce – Endoscopy/Gastroenterology	20
5417	~~Risk de-escalated from the Organisational Risk Register in January 2026 as risk score reduced to a 12.~~	~~20~~
6280	Suspension of the Regional Hepato-Pancreato-Biliary service model.	16
6451	Orthoplastic Referrals for limb reconstruction and infections	16

Strategic Goal(s): Improving Care • Delivering safe and compassionate care • Developing new models of care • Digital transformation for patients and staff • Ensuring timely access to care Sustaining Our Future • Becoming a green organisation • Ensuring our Services financial sustainability Embedding value-based healthcare • Ensuring our estate is fit for the future Risk score 20		
Strategic Risk: Enough capacity to meet emergency demand - (Risk No.1b)		
If the Health Board is unable to meet demands for services at all points in the patient journey.	Then its ability to provide high quality and affordable care and to meet access targets will be reduced	Resulting in avoidable harm to patients, poor patient experience, diminished staff morale, and loss of trust and confidence from the wider community, ongoing overspends.

Risk Lead	• Chief Operating Officer	Assurance committee	• Quality, Safety & Experience Committee • Operational Delivery Committee (Performance Targets)

	Consequence	Likelihood	Score	Risk Score Trend this Period:
Initial	4	5	20	No change to risk scores this period.
Current	4	5	20	
Target	4	3	12	
Risk Appetite	Cautious (<i>quality and safety; trust and confidence; legal and regulatory</i>)			Risk Score Trajectory
				
Rationale for assessment of risk score: <i>Including where risk score remains unchanged and for any changes</i>				~~Critical incident declared at Princess of Wales on 9th October 2024. Roof integrity issues with immediate impact on clinical pathways, bed capacity, all theatre elective capacity (inc cardiac) and trauma capacity~~ - Impact of a temporary centralisation of stroke into one site. - There has been continuous planning on clinical pathways and diversion of emergency intakes that again has impacted on the capacity and resilience across the full CTMUHB system. ~~There has been a requirement to deescalate and close 190 inpatient beds on the POW site. With re-provision of the capacity across CTMUHB acute and community.~~ - There has also been significant reallocation of internal capacity at POW and RGH to respond to the critical incident. - Planning continues on recovery phase following critical incident with the impact not yet quantified. - There has been some improvement against trajectories for emergency demand. Specifically, in total reduction of lost ambulance hours. - The risk score has been reviewed and despite critical incident remains unchanged, due to the following potential impacts. - There has been a reduction and re-alignment of bed capacity at POW and RGH. - There has been a diversion of emergency intakes from POW to RGH.

	- There remains a high number of clinically optimised patients in core capacity that is impacting on patient flow. - The financial and economic challenges faced by the third sector and local authority partners has an impact on the Health Boards ability to mitigate this risk, as capacity cannot be protected. - Workforce recruitment continues across the care group to enable a sustainable capacity model. There continues to be a reduction of ADH and WLI activity attributed to standardisation of pay. The conversion from locum to substantive and establishing COVID un-commissioned capacity remains a priority. - Regional working continues and the positive and negative impact of this will be continuously reviewed. It is anticipated that the risk score may remain quite stagnant as the pace of improvement is constrained by workforce, financial and environmental constraints on the service.
Risk Treatment Assessment <i>i.e. Treat, Tolerate, Transfer etc.</i>	It is recognised that there is an element of tolerating this risk in terms of the pace in being able to mitigate it. There are, however, ongoing risk treatment activity outlined in the mitigating actions section.

Current Control Measures	
Six Goals for Urgent and Emergency Care Programme (signed off by ELG on 5 June 2023): - Admission Avoidance - Integrated Front Door - Acute Hospital Flow and Discharge - Integrated Discharge In addition to setting up the National Six Goals programme for Urgent & Emergency Care, Welsh Government have now outlined the national direction for urgent care with health boards expected to deliver against key objectives aligned to national policy. This is an opportunity to radically transform the way services are both designed and delivered, ensuring the best possible outcomes can be achieved, maximising sustainable throughput, with an emphasis on improving productivity and efficiency within the envelope of existing resource. The key areas for improvement each Health board are expected to incorporate into their improvement programme are: - Effective waiting List Management Systems: clear national pathways; focused treat in turn; effective booking processes; robust demand management - Outpatients and Planned Services within USC: utilisation of SOS and PIFU; additional advice & guidance services - Diagnostics: regional and community diagnostic centres; straight to test pathways; diagnostic pathway best practice - GiRFT/SEDIT: Clinical Implementation Networks: Emergency Medicine All areas of the programme will focus on the following crosscutting themes: - Increased efficiency: streamlining processes to reduce waiting times, eliminate unnecessary delays. Ensuring patients receive the care in the lowest acuity setting for their needs. - Enhanced Quality of Care: ensuring our patients receive the right care at the right time, by sharing best practices, standardising procedures, and improving coordination between services. Reducing overcrowding within the UEC system to reduce harm and improve patients and staff experience. - Optimised resource utilisation: making better use of the available resource, including staff, equipment, and facilities, to ensure maximum productivity and minimal waste. Lowering the number of avoidable attended to ED by directing patients to more appropriate urgent and community settings. - Improved Patient Outcomes: focusing on patient-centred care to improve outcomes, satisfaction, and overall experience, whilst ensuring our care is well-co-ordinated and effectively managed. - Reduction of Variability: minimising variations in clinical practices and outcomes by implementing evidence-based guidelines and protocols, delivering consistent high-quality care and minimising harm. - Data utilisation: using our data and intelligence to pinpoint areas for improvement, regularly monitor key performance matrix and empowering data-driven decision-making to drive continuous improvement. - Support Workforce Development: training our staff to develop the right skills and knowledge to help implement and sustain necessary changes and create the environment for effective cross-sector working. Programme 6 Goals Programme Board - Diabetes Programme Board	

- Stroke Programme Board. South Central Stroke Operational Delivery Group re-established, inaugural meeting August 2025.
- Orthogeriatric Programme
- MTC Programme Board
- Strategic Transformation of Acute Medicine (STAMP)
- Improving Care Board
- Operational Management Board
- Speciality Specific and Cancer Improvement Trajectories Completed.

IMTP – investment agreed by Board.

Specific Improvement Groups/Boards

- Optimise Project Board
- Orthogeriatric Project
- SDEC Project Board
- UTC Project Board
- FLS Project Board
- Frailty Project Board
- Diabetes Project Board
- Single Point of Access Project Board

All updates feed into the Improving Care Board.

Annual Planning Process

Recovery Planning post critical incident at POW

Lessons learnt from Winter Planning process currently being analysed from a lesson learnt perspective.

Partnership Leadership Team established with LA and NHS representation to look at planning across the region.

Commissioning Group established to oversee the delivery of the optimised integrated care model.

Annual Demand and Capacity Plan established to manage demand and making best use of capacity.

Escalation Status programme work

Regional Working

- A Residential and Nursing Care for Older People Report has been completed and approved by the Regional Partnership Board and actions being implemented.
- Alternative bed options being worked up by all CTM local authorities to aid patient flow and 'Discharge to Recover then Assess' (D2RA) out of hospital stabilisation and onward decision-making.
- Welsh Government supporting intervention with Bridgend County Borough Council regarding backlog of patients Medically Fit for Discharge.
- South Central Regional Programmes of work – Collaborative approach to restoration with a number of targeted work streams e.g., Stroke

Governance Structures

- Operational Services Management Board (Health Board wide)
- Improving Care Board (Health Board wide)
- Six Goals/Unscheduled Care Board
- Cancer Board
- Weekly Cancer Meetings
- Planned Care Recovery Board

Operational Processes

- Clear criteria to prioritise based on clinical need.
- Centralised decision-making around use of spare capacity across the organisation.
- Robust Interventions Not Normally Undertaken (INNU) application.
- Weekly performance tracking.

- Robust Demand and Capacity with mitigating actions
- Service improvement and transformation.

Sources of Assurance (Internal and External)

- Integrated Performance Report
- Assessment Dashboard
- Update reports on specific services experiencing pressure, e.g. Neurology, Stroke
- Performance RTT, Cancer trajectories
- Follow-up reports on outpatients not booked.
- South Central Stroke Operational Delivery Group re-established, inaugural meeting August 2025.
- SDEC Programme
- Optimise
- Ambulance Handover and ED Improvement Plan
- Escalation processes leading to Chief Operating Officer Report to Quality &
- Safety Committee including Care Group performance review meetings.
- Organisational Risk Register via Care Group Risk Registers.
- Planning, Performance & Finance monthly report.
- TI meetings
- Audit Wales commencing an Urgent and Emergent Care Audit.
- Reset fortnight commenced week commencing 19th August 2024 – sets out Care Group plans with an aim to resetting and de-escalating sites ahead of winter.

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Mitigating Actions	Impact of Success (following implementation of mitigating actions)
1. Improvements being made in urgent care trajectories albeit not fully embedded.	• Unscheduled Care SMT to attend National Urgent and Emergency Care summit 27th April 2026 • Urgent Emergency Care Action Plan has been developed in collaboration with NHS Wales Performance and Improvement Team utilising recommendations from key documents such as: ◦ GIRFT recommendations ◦ SDEC Review ◦ Ambulance Patient Handover Guidance ◦ ED Quality Statement ◦ MAG Report (April 2026) • Whole system learning through engagement and collaboration across the health board to mitigate the impact other factors may have on emergency demand, such as flow and discharge. • Sprint learning analysis to understand if this has an impact on emergency demand capacity. • Engagement in a health board session reflecting on winter planning, site flow teams, and extraordinary BCI actions. • Ambulance escalation cards live. Rapid Improvement Action Plan developed, supported by ED Action Cards to achieve Ministerial Advisory Group target of 45 minutes for handover Ambulance. (Welsh Government has a clear expectation that an ambulance handed over is within 15 minutes, MAG target is an interim measure). • ED 12-hour Action Plan completed	• ~~Improved Patient Experience~~ • ~~Improved patient flow~~ • ~~Sustainable workforce~~ • ~~Care closer to home~~	• Improved performance • Reduction in patients >12hrs • Improved community response • Reduced LoS in the Emergency Department • Reduced harm associated with increased waiting times • Improved patient experience

- Internal action plan in development to achieve a reduction in 12-hour Emergency Department Performance.
- CTM Safe Transfer if Patients Policy to be implemented alongside action plan.
- Action plan to review long waits for patients to be seen in ED in development within directorate.
- Review of all patients in ambulatory areas over 24 hours. Planning meeting to be established across Care Groups to facilitate all GP expected patients not attending via ED and establish ambulatory pathways to improve 12 hour waits.
- STAMP roll out across all sites including remodelling of acute medicine footprint/flow in POW and implementation of an 'SDEC First' model for GP expected patients at PCH – Quarter 1 (planned for early February 2026)
- Unite Programme Launch to provide a robust governance framework for all Unscheduled Care transformation projects.
- UTC Pilot PCH extended until July 2026
- Single Point of Access Board
- Reconfiguration of ED footprint – ambulatory footprints at POW
- Re-alignment of clinical pathways
- Internal Professional Standards
- Re-alignment of ward capacity
- Establish un-commissioned capacity with agency staff to support winter pressures/BCI.
- Effective initiation of business continuity plans to respond to increased capacity pressures and challenges in the service (ongoing).
- In Development – Clinical Services Plan.
- Task Group established with Chief Executive Officer Leadership to address clinically optimised patients in Pathway 1 – with a view to creating a model of care delivery for patients closer to home.
- Urgent Care Summit to develop a whole system approach to improvement in:
 - Admission Avoidance
 - Integrated Front Door
 - Acute Hospital Flow and Discharge
 - Integrated Discharge

Linked National Priority Measures

Ministerial Measures:

Access to Timely USC Services

- 45 mins ambulance handover by October 2025
- Zero tolerance for any ED wait over 12 hours by October 2025

Access to Timely Planned Care Services in USC

- As per Planned Care BAF

Current Performance Highlights

Handover 45 Report
(Hospital Emergency Department Handovers)

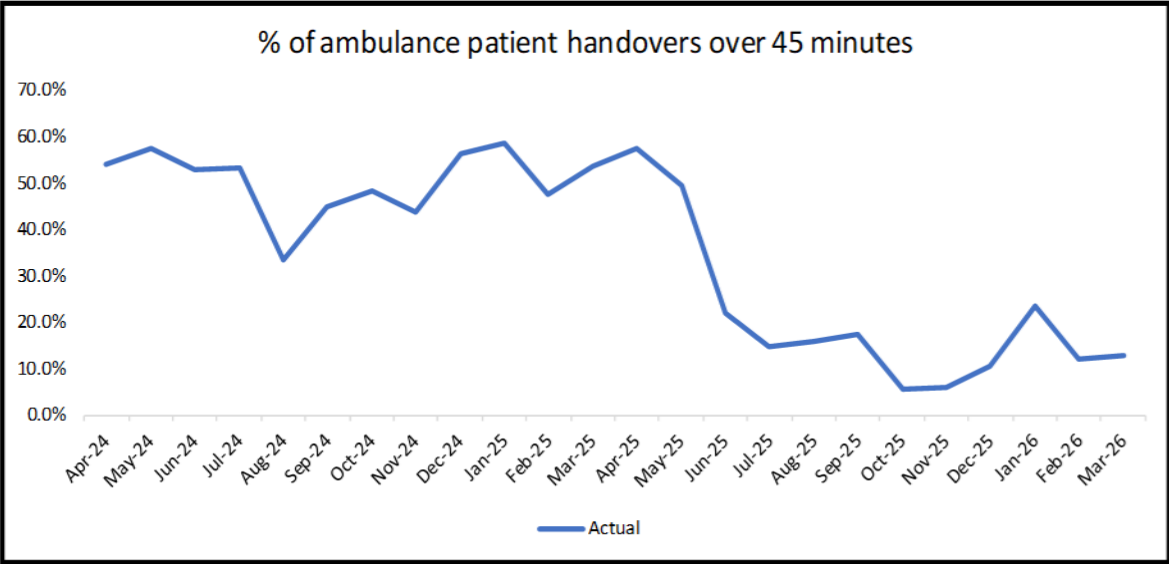
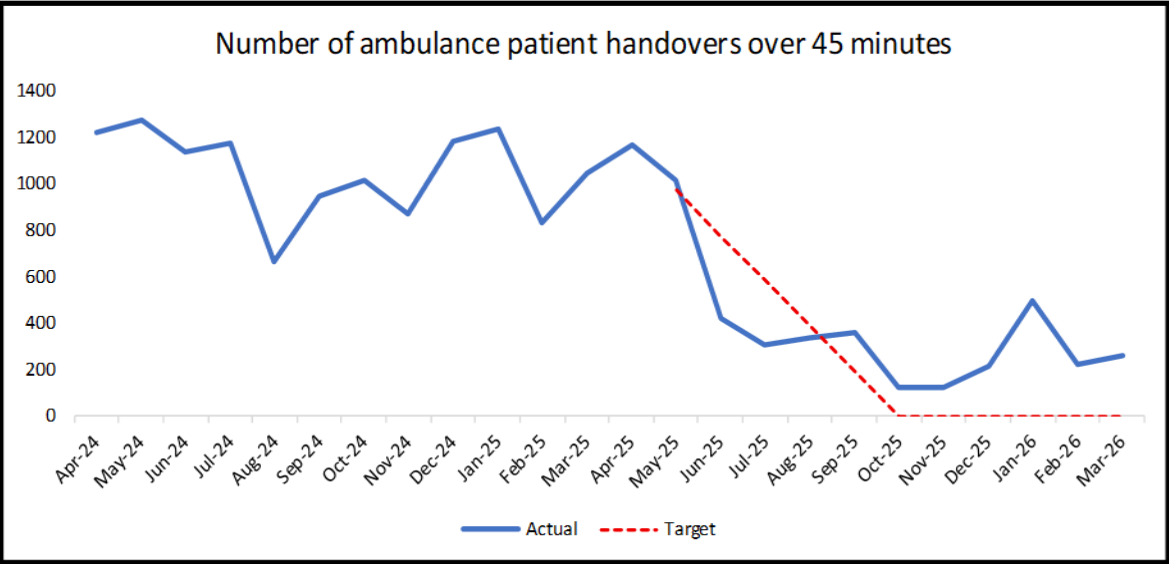


Monthly Handovers Within 45 Minutes % by Hospital - Previous 12 Months to Date (Mar 2025 to Mar 2026)

Hospital Name	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
Bronglais General Hospital Aberystwyth	45%	47%	40%	55%	75%	59%	63%	61%	49%	71%	60%	50%	54%
Glangwili Hospital Carmarthen	33%	36%	34%	36%	43%	54%	78%	80%	61%	59%	47%	58%	61%
Grange University Hospital Cwmbran	36%	33%	41%	41%	45%	37%	68%	65%	50%	43%	36%	43%	49%
Morriston Hospital Swansea	37%	33%	37%	73%	84%	87%	82%	82%	81%	66%	58%	49%	45%
Prince Charles Hosp Merthyr	46%	42%	42%	64%	88%	96%	99%	95%	97%	89%	77%	89%	84%
Princess Of Wales Bridgend	48%	48%	67%	77%	75%	74%	70%	95%	89%	85%	74%	90%	83%
Royal Glamorgan Hosp Pontyclun	43%	39%	50%	91%	87%	79%	76%	93%	94%	92%	77%	86%	92%
University Hospital Of Wales Cardiff	56%	53%	60%	62%	64%	92%	95%	87%	86%	83%	79%	74%	90%
Withybush Hospital Haverfordwest	53%	58%	52%	47%	48%	51%	56%	64%	71%	72%	75%	83%	86%
Wrexham Maelor Hospital Wrexham	31%	31%	29%	34%	52%	29%	30%	28%	29%	48%	26%	32%	29%
Ysbyty Glan Clwyd Hospital	30%	35%	50%	41%	43%	55%	47%	55%	37%	66%	42%	45%	44%
Ysbyty Gwynedd	32%	31%	30%	36%	33%	33%	27%	30%	27%	37%	29%	31%	29%

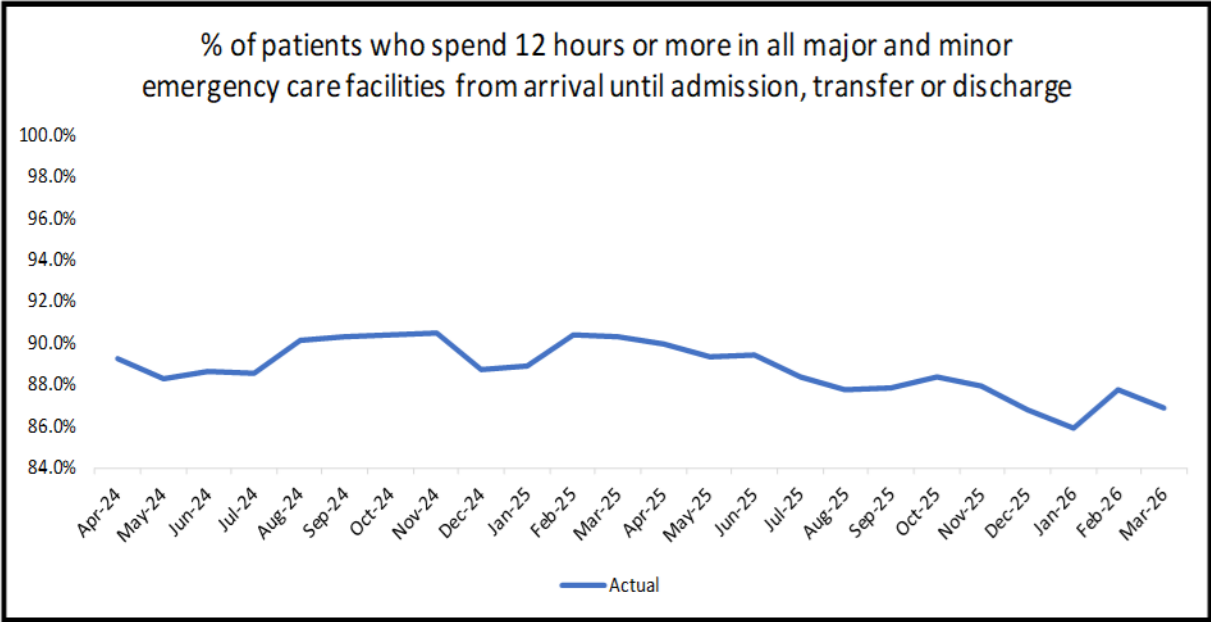
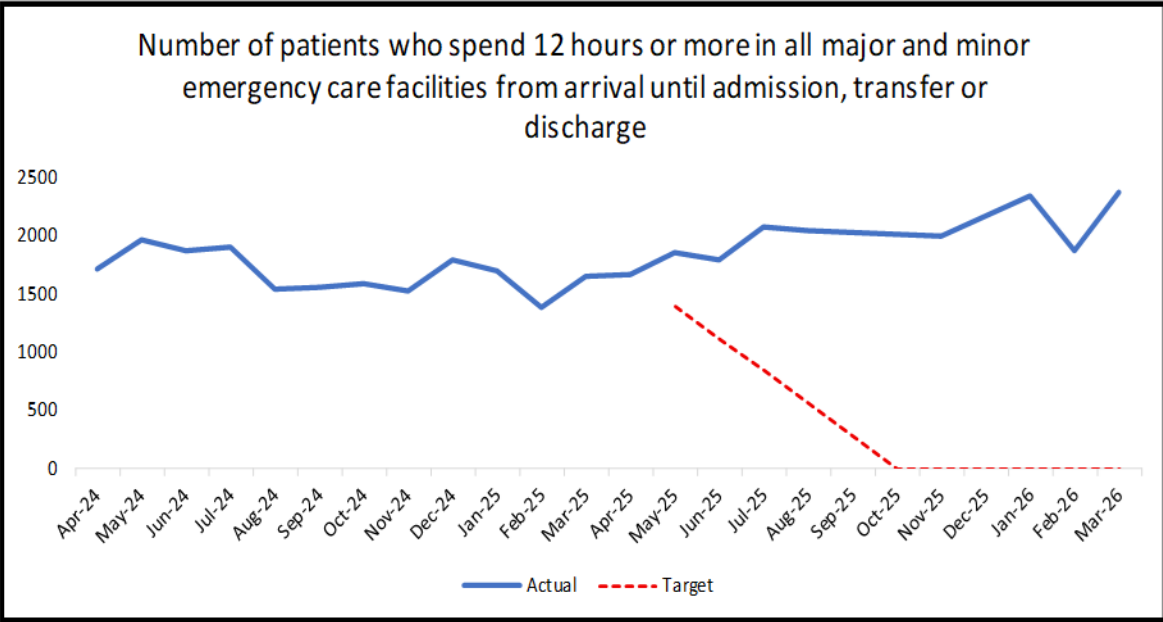
* part month

		2024/25 ACTUAL PERFORMANCE												2025/26 PERFORMANCE											
		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Number of ambulance patient handovers over 45 minutes	Actual	1224	1275	1138	1171	667	948	1011	866	1186	1237	829	1046	1164	1016	416	302	334	356	119	123	211	496	225	261
	Target														969	775	582	388	194	-	-	-	-	-	-
% of ambulance patient handovers over 45 minutes	Actual	54.1%	57.3%	52.9%	53.2%	33.5%	44.6%	48.3%	43.5%	56.1%	58.6%	47.6%	53.6%	57.3%	49.3%	21.9%	14.6%	15.8%	17.3%	5.6%	6.0%	10.4%	23.3%	12.1%	12.7%



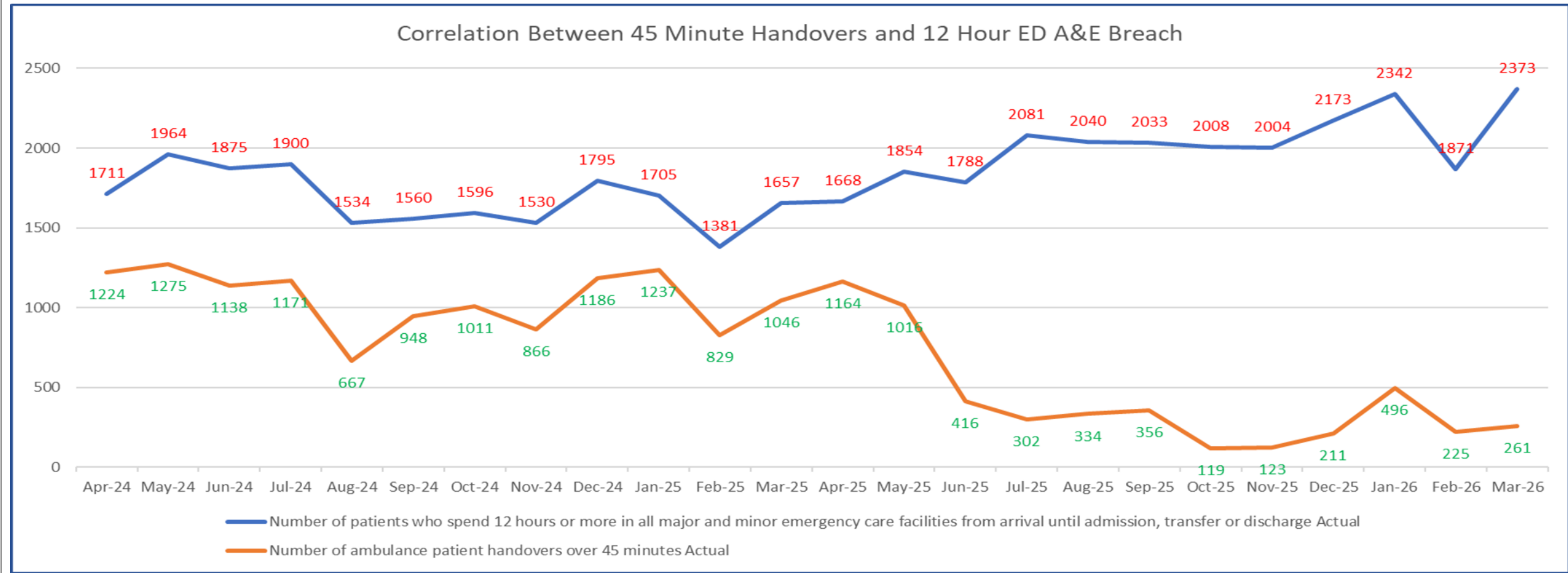
		2024/25 ACTUAL PERFORMANCE												2025/26 PERFORMANCE											
		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge	Actual	1711	1964	1875	1900	1534	1560	1596	1530	1795	1705	1381	1657	1668	1854	1788	2081	2040	2033	2008	2004	2173	2342	1871	2373
	Target														1,391	1,113	835	556	278	-	-	-	-	-	-
% of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge	Actual	89.3%	88.3%	88.6%	88.6%	90.1%	90.3%	90.4%	90.5%	88.7%	88.9%	90.4%	90.3%	89.9%	89.3%	89.4%	88.3%	87.8%	87.8%	88.3%	87.9%	86.8%	85.9%	87.7%	86.8%

		2024/25 ACTUAL PERFORMANCE												2025/26 PERFORMANCE											
		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
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	Target														1,391	1,113	835	556	278	-	-	-	-	-	-
% of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge	Actual	89.3%	88.3%	88.6%	88.6%	90.1%	90.3%	90.4%	90.5%	88.7%	88.9%	90.4%	90.3%	89.9%	89.3%	89.4%	88.3%	87.8%	87.8%	88.3%	87.9%	86.8%	85.9%	87.7%	86.8%



		2024/25 ACTUAL PERFORMANCE												2025/26 PERFORMANCE											
		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
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Number of ambulance patient handovers over 45 minutes	Actual	1224	1275	1138	1171	667	948	1011	866	1186	1237	829	1046	1164	1016	416	302	334	356	119	123	211	496	225	261

		2024/25 ACTUAL PERFORMANCE												2025/26 PERFORMANCE											
		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
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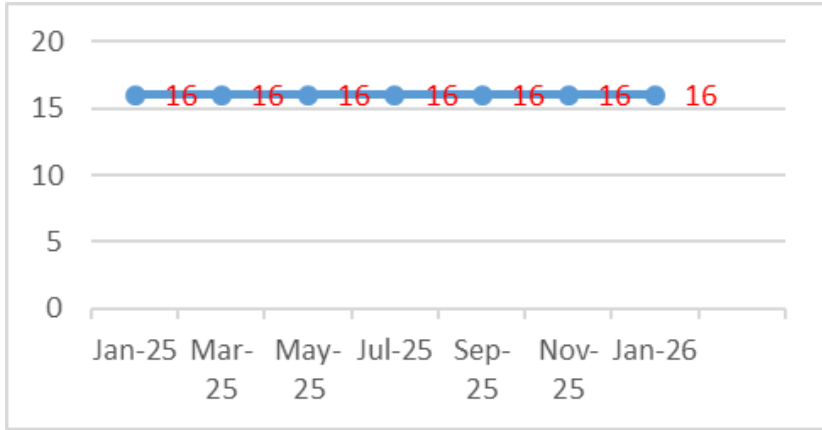
Were there any significant incidents affecting this strategic Risk this period:

Critical incident declared at Princess of Wales on 9th October 2024. Severe water ingress with immediate impact on clinical pathways, bed capacity, all theatre elective capacity (inc cardiac) and trauma capacity.

An urgent temporary move of the Stroke Services was agreed due to the fragility of the Consultant workforce at PCH. The Stroke Service moved from PCH to RGH on Wednesday 8th January 2025. A consultation with the stroke workforce to extend their base on the RGH site for up to 2 months was implemented on the 21st April 2025. 1x substantive consultant recruited June 2025. Start date in Jan 2026. 1x Stroke Consultant long term phased return. 1x Consultant returned from maternity leave.

Associated Risks escalated to the Organisational Risk Register

3826	Emergency Department (ED) Overcrowding	20
4632	Provision of an effective and comprehensive stroke service across CTM (encompassing prevention, early intervention, acute care and rehabilitation). Risk score reviewed and decreased in September 2025 review of the Organisational Risk Register.	16
5045	Access to Neurology Inpatient and Outpatient Services for CTM residents	16

Strategic Goal(s):				Risk score 16	
	Improving Care - Delivering safe and compassionate care - Developing new models of care - Digital transformation for patients and staff - Ensuring timely access to care		Sustaining Our Future - Becoming a green organisation - Ensuring our Services financial sustainability Embedding value-based healthcare - Ensuring our estate is fit for the future.		
Strategic Risk: Ability to deliver improvements which transform care and enhance outcomes (Risk No.2)					
If the Health Board fails to achieve fundamental quality standards or implement improvements in practice and innovations		Then we may not be able to deliver safe, timely, compassionate and effective care in accordance with the Duty of Quality		Resulting in avoidable harm to patients, poor patient experience, diminished staff morale, potential for greater regulatory intervention and loss of trust and confidence	
Risk Leads		- Executive Nurse Director - Executive Medical Director		Assurance committee	- Quality, Safety & Experience Committee - Operational Delivery Committee
	Consequence	Likelihood	Score	Risk Score Trend this Period:	
Initial	4	5	20		
Current	4	4	16	No change to risk scores this period.	
Target	4	3	12	Risk Score Trajectory	
Risk Appetite	Cautious (<i>quality and safety; trust and confidence; legal and regulatory</i>)				
Rationale for assessment of risk score: <i>Including where risk score remains unchanged and for any changes</i>				The Executive Director of Nursing, Midwifery and Patient Care, will be leading a strategic reconfiguration of the Board Assurance Framework for this section to enable more meaningful and measurable objectives that directly influence our ability to reduce the current Duty of Quality risk score to an organisationally tolerated level. This work is essential to ensure that our approach to quality is not only compliant but impactful supporting the delivery of safe, timely, compassionate and effective care. Without this shift, we risk avoidable harm to patients, poor experience, diminished staff morale, increased regulatory scrutiny and erosion of public trust. The revised framework will provide a clearer pathway to improvement, accountability and assurance. This is planned to be ready for March 2026. Work on the revised framework is ongoing, with progress continuing beyond the original March 2026 deadline to ensure a comprehensive and effective outcome. Upon completion, the framework will provide an enhanced structure for improvement, strengthened accountability, and clearer assurance arrangements.	

Risk Treatment Assessment <i>i.e. Treat, Tolerate, Transfer etc.</i>	CTM is seeking to achieve a treated risk score of 12 , reflecting a level that is organisationally tolerated and aligned with our commitment to safe, effective and compassionate care.

Current Control Measures
1. Strategic Frameworks & Governance a) ~~Quality Strategic Plan: Replace expiring Quality Strategy with a measurable plan aligned to CTM2030 and Duty of Quality reporting. KPIs embedded in Annual Duty of Quality Report.~~ Duty of Quality Annual Report, Duty of Candour Annual Report, Strategic Plan and supporting Workplan in progress b) Infection Prevention & Control Strategy (2024–2027): Fully implemented with quarterly progress reports to QSEC and annual Board assurance. Work plan and new operating model in place. c) Safeguarding Strategy (2024–2027): Endorsed and embedded with compliance monitored through annual audits and safeguarding dashboards. d) Clinical Governance Frameworks: i. Clinical Guidelines and SOPs are maintained with an annual review cycle. ii. CTM Learning Academy launched with four strategic aims: workforce development, governance, sustainability, and interprofessional learning. e) Clinical Effectiveness Committee: Oversight of clinical audit programme, NICE guideline compliance, and escalation of issues to QSEC and Board. f) Advanced Clinical Practice Board: Governance for advanced practice professionals. 2. Assurance & Improvement Mechanisms a) Ward Accreditation Programme: Rolling programme across all wards, maternity, and mental health. Targets: 100% accreditation by Dec 2026. Quarterly progress reporting. b) Mortality Governance: Mortality Board operational with standardised dashboard, monthly mortality reviews, and integration of Medical Examiner reports. c) Harm-Free Care Programme: ~~Steering groups~~ included are: for hydration, nutrition, falls, and pressure damage ~~embedded in Improving Care Board. Bi-annual reporting to QSEC.~~ A comprehensive review of the Harm Free Care Programme is currently underway and will be progressed through established internal governance processes to ensure robust oversight and strengthened assurance arrangements are enhanced, with reporting to the QSEC on a bi-annual basis together with any areas of concern escalated by exception. The proposed revised oversight arrangements have been presented to OCB and are due to be scheduled for presentation to EMB for final ratification. d) RADAR Committee: Training standards and compliance monitored quarterly. Framework under review for enhanced governance. e) End-of-Life Care Plan: Managed by Primary Care and Palliative Care teams with assurance through Care Group governance. f) Duty of Quality & Candour: i. Annual Duty of Quality Report with measurable improvement actions. ii. Duty of Candour training embedded in ESR; ~~compliance monitored weekly via Executive-led patient safety meetings.~~ monitoring of compliance shared with the Care Groups • Medicines Management Group chaired by the Assistant Medical Director 3. Learning from Experience & Engagement a) Patient Peoples Experience Framework: Operational forums with bi-annual reports to QSEC. b) ~~Listening & Learning Programme: Minimum four Shared Learning Forums and two major events annually. Attendance and action tracking reported to QSEC.~~ A revised schedule of Listening and Learning events is being developed for 2026/27, with sessions planned on an organisation-wide basis to support shared learning and continuous improvement. The programme will deliver two events annually, comprising one in-person session and one virtual event, ensuring accessibility and broad engagement across services. c) Executive Patient Safety Walkabouts: Monthly walkabouts with documented findings and improvement actions logged and monitored. d) Citizen Voice (Llais): Monthly meetings and outreach clinics with escalation within 5 working days. e) Real-Time Feedback (PREMS/PROMS): i. PREMS live in Emergency Departments. ii. PROMS piloted in Heart Failure/Cardiology and now feature areas such as support for victims of domestic violence, rollout plan in development. iii. Quarterly dashboard reporting to QSEC. f) Staff Ideas Scheme: >1,800 staff registered, >270 ideas generated; quarterly reporting on implementation and impact. g) Launch of the new visiting policy on 1 April 2026 h) ~~Will be launching~~ A pilot launch of the Carers Passport took place 1 April 2026 i) Regular touch point meetings with partners, for example, Coroner’s Office, Welsh Risk Pool

4. Innovation & Improvement

- a) Improvement Community of Practice: >30 QI champions in place.
- b) Monthly QI Training: >490 staff trained; ongoing programme.
- c) Leading for Patient Safety Programme: Phase 2 launched Oct 2024 focusing on acute deterioration and quality management systems.
- d) iCTM Business Plan (2025–2028): Aligned to CTM2030, focusing on experience, efficiency, and effectiveness.
- e) Value-Based Healthcare Programme: Business cases under review; aligned to national priorities.
- f) Care Group Service Improvement Groups: Operational since end of 2024; monthly meetings with improvement teams.
- g) National Safe Care Collaborative Programme: Commenced with CTM participation.
- h) Bereavement Clinical Lead: Implementing All Wales Care of the Bereaved Framework.
- i) Carers Lead who will lead on the Carers agenda.
- j) PTR **Listening to People (LTP) Training (Wales' national approach to handling NHS concerns, complaints, incidents and redress which have replaced PTR since 1st April 2026)**: Updated to incorporate Duty of Candour; compliance monitored.
- k) ~~One year trial of a court of protection lead aligned to Safeguarding.~~ **Pilot of senior Court of Protection lead for evaluation in April 2026.**
- l) Recruitment of a Domestic and sexual violence Health advocate funded for 2 years.
- m) **Extended the Infection, Prevention & Control (IPC) service over 7 days a week and into Community**
- n) **Go Live for the EPMA**

5. Research, Flow & Productivity

- a) Research & Development Strategy: Approved and embedded; oversight at Operational Management Board.
- b) Optimise Flow Programme: Rolled out across all acute sites to improve patient flow.
- c) Workforce Productivity Programmes: Medical and Nursing workforce productivity frameworks established with performance monitoring.

Sources of Assurance (Internal and External)

External Reports

Royal Glamorgan Hospital:

Healthcare Inspectorate Wales (HIW) conducted an inspection of Royal Glamorgan Hospital, Ward 21, Ward 22 and the Psychiatric Intensive Care Unit on 13 – 15 April 2026.

During their inspection areas of concern were found which could pose an immediate risk to the safety of patients. This was discussed during the HIW inspection feedback meeting with senior members of the team and an immediate improvement plan completed and shared with HIW for assurance of actions taken/to be taken with designated timescales and a responsible officer assigned.

~~Internal Audit review on "Embedding the Quality Framework" completed and final report has been received. Reasonable assurance has been provided by the Audit, recommendations are being acted upon and managed via the audit tracker.~~

Internal Audit – Peoples Experience – resulted in Substantial Assurance.

Annual Reports

- Clinical Audit Annual Report.
- Clinical Education Annual Report.
- Safeguarding Annual Report.
- Putting Things Right Annual Report **(2025/2026). Listening to People Report (2026 onwards);**
- Infection Prevention and Control Annual Report.
- Medicines Management Expenditure Committee Annual Report.
- Organ Donation Annual Report.
- ~~Health and Care Standards Annual Report; (incorporating patient survey)~~
- GMC Survey
- Improvement to be reported through Improving Care Board / Change to be reported through Strategic Transformation Board.

- ICTM (Improvement and Innovation) Annual Report
- ~~Annual Duty of Quality~~ **Annual Report**
- **Duty of Candour Annual Report**

Quarterly Reports

- Quality Dashboard.
- Integrated Performance Dashboard.
- Quality Governance – Regulatory review progress updates.
- IPC Highlight reports.
- Care Group reports.
- High level update on mortality indicators.
- Research and Development Update.
- National Clinical Audit and NCEPOD studies.
- Maternity and Neonatal Improvement Programme Highlight Report.
- ~~Llais briefing papers.~~
- RADAR Reports.
- Improvement portfolio report.
- ~~Multiple engagement events underway.~~

Internal Assurances

- Executive and Independent Member Patient Safety Walkabouts framework. The revised framework now implemented which includes 'Purpose, Form and Function' of IM Walkaround Visits.
- ~~The Health Board has strengthened the internal governance of all HIW open action plans by developing a central tracker system where any exceptions will be reported to the weekly clinical executive patient safety catch-up. HIW Tracker is now in place.~~ **A strengthened approach to the governance of Healthcare Inspectorate Wales (HIW) Inspections and subsequent Improvement plans has been implemented through the development and full embedding of a centralised HIW tracker using the electronic platform of AMaT, this provides improved oversight and consistency of monitoring. This approach supports enhanced organisational oversight and reinforces the Health Board's commitment to robust governance and continuous improvement.**
- Launched Nursing & Midwifery Delivery Plan and agreed a set of nursing care related audit standards monitored via the Senior Lead Nurse Forum with onward reporting on annual basis to the Quality & Safety Committee.
- Medicines Safety Group, Access to Medicines Group established. Replacing the Medicines Formulary Committee with a broader remit.
- ~~Health Inspectorate Wales unannounced visits.~~
- Medication Prescription and Administration incident update, which reports into the Medication Steering Forum.
- All Safeguarding Hubs working collaborative across CTM population.
- Planned Level 3 Safeguarding training for all Senior Clinical leaders (Execs – Care Group directors); partially complete. New Directors now require training, safeguarding team leading a short review to ensure appropriate level of training, L2/3 for clinical and non-clinical directors (completed May 2025).
- Multi-agency training days established and being rolled out in terms of Safeguarding training, with the aim of maintaining robust and strong engagement and relationships with agency partners.
- Recruited a Safeguarding Practice Development Nurse to support Safeguarding Education across CTM.
- Contacted (letter, key message and verbal reminders) all medical teams to emphasise, and expect, need to complete level 2 Safeguarding training and certain areas level 3.
- Harm Free Care Agenda
- Patient Safety Solutions – safety alerts and notices.
- Mental Capacity Act (LPS).
- Executive Director of Nursing and Executive Director of Therapies and Health Science have undertaken the relevant training on Duty of Quality & Duty of Candour to ensure that there is sufficient knowledge and influence in relation to the legislation at Board level.
- HIW undertake adhoc reviews of medical training within the Health Board.
- Review of Interventions Not Normally Undertaken (INNU) processes to ensure there are robust levels of compliance within clinical practice and appropriate assurances provided.
- ~~Internal Audit undertook a review which considered the processes and procedures implemented by the Health Board to ensure compliance with the Duty of Candour. The final report is awaited, and any recommendations will be acted upon and managed via the Audit Tracker~~
- ~~Internal Audit review undertaken on embedding the Quality Framework. Final report received and reasonable assurance allocated. Recommendations are being acted on and being managed via the Audit Tracker~~
- Staff survey closed. Higher response rate received than in previous years. The final CTM response rate was 26.7% which equates to 3553 members of staff. This is the highest rate among the Health Boards of our size in Wales and CTM's highest response rate to date.
- Ward Accreditation Programme is embedded across the Health Board in Inpatient Areas.

- Medical Workforce Delivery Group for Medical Workforce Matters.
- Action Plan is in place to address the backlog of open coroner cases caused by a significant increase of number of inquests of the last 12 months. **The OCP is now complete and will be implemented on 5 May 2026 with this being fully recruited to and complete by 31 July 2026.**
- Legal Services Recovery Plan in place which will consider if there is enough capacity to manage all legal activity and if internal processes and systems need to be revisited to make changes and identify areas for further improvement. **An Organisational Change Process (OCP) has concluded and will be implemented start of May 2026**
- CTM Pathology services accredited to ISO 15189:2022 the international standard that specifies requirements for quality and competence in medical laboratories, ensuring accurate and reliable test results essential for patient diagnosis and treatment.
- Cardiac Physiology services in PoW are accredited to British Society of Echocardiography for TTE, Training, Stress, TOE.
- New group being constructed which supports Physician Associates in line with new National Guidance.
- All Wales Medical Directors Meeting has discussed requirement to implement a more robust process for Professional Standards. Professional Advisory Group (PAG) and Responsible Officer Advisory Group (ROAG) to commence imminently as part of the process in CTM with Medical Directorate Office to support.
- **Implementation of weekly Learning from Events Panels**

Qualitative Intelligence

- Monthly PREMS qualitative feedback received.
- Ongoing weekly **Quality and Safety** huddles take place with Executive **the three Deputy** Directors, **Assistant Director of Quality & Safety** and ~~Care Group Directors~~, and **the** Quality and Safety Team to review concerns and complaints compliance across the Health Board **with a weekly brief shared with all three clinical Executive Directors for assurance, awareness as well as an escalation being noted**
- Development of high-level dashboards accessible to Ward Managers and to Nurse Directors to support high level overview and decision-making using Workforce and Quality Indicators.
- Ongoing monthly meetings with Executive Director of Nursing, Directors of Nursing and Ward Managers.
- Service User and Staff Stories.
- Executive Nurse Director and Deputy Executive Nurse Director undertake weekly clinical focussed clinical area visits.
- Improvement case studies.
- Social Media feedback and intelligence.
- ~~Listening and Learning forum.~~
- ~~Weekly executive/deputy executive led patient safety meetings.~~
- Performance and Assurance Directorate of the NHS Wales Performance & Improvement (formerly NHS Executive) Dashboard reports inform the Health Board in terms of compliance across the Patient, Care and Safety portfolio.
- CTM now have access to the All-Wales Beacon Dashboard which allows us to benchmark quality metrics.
- iCTM joint working with academic partners to explore cutting edge quality and safety activity to support the Health Board's continuing improvement journey.
- The Health Board is represented at Duty of Candour Safety & Learning Network, including currently chairing the Network meetings.
- Partnership Working with Cardiff & Vale re South Central Regional Stroke Network.
- Regular Director of Therapies & Health Sciences Team quality assurance visits to clinical services.

External Assurance

- Letter from Public Health Wales complimenting CTMUHB on the excellent Bowel Screening service provided for patients requiring a bowel colonoscopy for suspected cancer.
- External audit in June 2024 in collaboration with Arjo Huntleigh regarding pressure ulcer prevalence has been completed and considered at the January 2025 Quality, Safety & Experience Committee.
- Health Education Improvement Wales (HEIW)– undertake regular reviews of services with respect to medical training of resident doctors.
- Ombudsman's Annual Letter.
- Internal Audit Review – CSG & Care Group Quality Assurance. August 2022 – outcome of Reasonable Assurance.
- ~~The Health Board is in the process of strengthening the internal governance of all HIW open action plans by developing a central tracker system where any exceptions will be reported to the weekly clinical executive patient safety catch-up. Local governance of HIW actions will take place through our new Care Group quality and safety committees. The system will allow for the Care Group leads to have a dashboard of all their HIW Inspection activity and continuous monitoring of the improvement plans.~~
The AmAT Inspection Module is being **fully** implemented for **assurance and monitoring of HIW Audit Inspection** Recommendations with the first report received in May 2024 **bi-monthly reports received** at the Quality, Safety & **Experience** Committee, which will be a hybrid approach as CTM fully transitions to the new automated system.
- Performance and Assurance Directorate of the NHS Wales Performance & Improvement (formerly NHS Executive) governance and incident management.
- Performance and Assurance Directorate of the NHS Wales Performance & Improvement (formerly NHS Executive) Maternity and Neonatal SI closures.
- Annual Undergraduate Review.
- General Medical Council National Survey Feedback.
- A Medical Education Governance Meeting has been constructed to monitor Health Education Improvement Wales (HEIW) visits and recommendations. The first meeting commenced 27/10/2025.
- **Submission of bi-annual Nurse Staffing Act (Wales) Compliance and Assurance Reports to Board and Welsh Government.**

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Indicators of Success (following implementation of mitigating actions)
1. Roll out of the Clinical Ward/Department Assurance Programme. Ward assurance provides ongoing confidence that core standards of care and safety are being met, identifying risks and areas for improvement. Ward accreditation is a more formal assessment that confirms a ward has met and can sustain agreed quality standards.	Rolling programme commenced. This will now extend into a yearly assurance programme which will encompass all data repositories	Ward/Department Accreditation is an "improvement tool that evaluates the quality of patient care in an inpatient setting. The program was implemented across Cwm Taf Morgannwg clinical areas in April 2024. The program aims to provide a measurement of quality and standards of care which Assurance for its Wards and Areas (Bronze, Silver, and Gold awards) Extending program into Mental Health and Maternity plus a further 20 areas across the acute site throughout 2025.	Currently 35 wards completed. 8 white and 19 reaching Bronze accreditation. There is a review of the assurance framework being undertaken. While this is completed, the team has continued to undertake targeted short assurance visits focused on key quality and safety indicators. While these visits are not scored for accreditation purposes, they provide ongoing visibility of ward standards and emerging risks, and are used to inform local actions and escalation where required. Results reviewed via panels to provide assurance to the Board, and further the wards involvement. Develop a bespoke Power App to: - o Simplify data capture - o Streamline reporting - o Provide real-time visibility of ward performance - o Reduce manual processes and consolidate information onto one platform Implementation continues and will now extend outside of acute physical health areas to include mental health settings and community care. At this stage, the ward accreditation programme is paused for review; however, assurance continues to be maintained through existing ward assurance programmes, alongside the development of a more robust and consistent ward assurance framework
2. Strategy & Framework Reviews and Development Safeguarding Strategy - o Safeguarding Strategy completed and submitted to safeguarding executive committee on 21.10.24. - o Development and implementation of a safeguarding dashboard	Complete in terms of Safeguarding Strategy. Timeframe for Safeguarding dashboard to be implemented is planned to be available in draft by the end of May 2025. June 2026 (currently being piloted)	The Safeguarding strategy and framework give a comprehensive approach to Safeguarding. It provides a framework for identifying risks, responding to concerns, and promoting a culture of vigilance and responsibility throughout our organisation.	Pilot dashboard has been developed and is in the pilot stage for user ability data presentation. There is a national launch of the safeguarding module on the once for wales Datix site which is being piloted to capture professional concerns 1.9.25. This will not capture all safeguarding only professional concerns currently. This is now implemented. There is a robust work plan which is in place to support implementation of the safeguarding strategy and framework. The monitoring of these actions will be overseen thorough the safeguarding executive committee.

			Work continues in line with strategic plan. The risk associated with previous backlog of look after children health assessments now being reviewed as a number of actions have been undertaken to ensure the service is robust such as appointment of a new team leader, a live tracker implemented and improved governance arrangements with the. This review has now been completed and there is minimal backlog.
3. Data and Audit - Real-time performance and quality data accessible via electronic systems across the organisation.	Mortality Data Improving – CTMUHB are now collecting data on mortality with a plan to standardise the way mortality is reported through the Care Groups with oversight from a Mortality Board, which is now established. Agreement with Archus to establish a robust process for data monitoring.	Visibility and granularity of data will be available to support clinical decision making and learning, as well as identifying areas that may require greater focus.	Monitoring the performance data dashboards to determine if improvements are being made and sustained.
	CTMUHB is represented on the work being undertaken with the Performance and Assurance Directorate of the NHS Wales Performance & Improvement (formerly NHS Executive) to explore how benchmarking in quality performance can be shared across NHS Wales. The Performance and Assurance Directorate of the NHS Wales Performance & Improvement (formerly NHS Executive) are also rolling out a National Quality Safety Framework to support a consistent approach to quality reporting.	CTMUHB has actively participated in the NHS Wales Performance & Improvement's (formerly NHS Executive) rollout of the National Quality & Safety Framework. This Framework ensures we measure quality across the six domains of quality and is consistent with all NHS Wales organisations. The domains being: • Safe Care • Timely Care • Equitable Care • Effective Care • Efficient Care • Person-Centred Care The Framework enables CTMUHB to benchmark our quality performance indicators against other NHS Wales organisations. In addition to the Framework, the Q&S team utilises the NHS Wales Performance & Improvement's (formerly NHS Executive) Beacon Dashboard to maintain alignment with other organisations across NHS Wales. The NHS Wales Performance & Improvement (formerly NHS Executive) workstream has also supported benchmarking of our Annual Q&S Report, thus ensuring a level of consistency with other organisations across NHS Wales.	CTMUHB has seen notable improvements in productivity across the Quality & Safety agenda. Our Learning Processes, including the Listening & Learning Framework with its central repository and bi-annual Listening & Learning event, have supported improvements in cascading learning across CTMUHB. Rather than relying solely on standalone learning events—which are currently under review for their impact— CTM are reviewing areas which would support continuous learning through shared narratives, targeted improvement priorities, system-wide feedback loops, and the spread of evidence-based practice across wards and services, ensuring learning is embedded, sustained, and aligned to organisational priorities. Implementation of a Quality and Safety steering group which will be anchored by the Assistant director of Quality and safety will enhance this. This group will report to the Harm free care strategic oversight group for assurance and oversight ~~By focusing on timeliness and effective care, CTMUHB has significantly enhanced its concerns response compliance. CTMUHB is now recognised~~

			~~as an exemplar for concerns management across NHS Wales. Our team regularly benchmarks our performance against similar NHS organisations.~~ CTMUHB's position in relation to NRI compliance has also improved over the last year. Embedding the Listening to People Framework
	Timescales dependent on external sources; Ambition to develop live clinical quality dashboard – live for maternity and neonatal services– to be rolled out for other areas by the end of the financial year; Work in progress for other areas.	- Improved decision making and therefore improved patient care. - Improved oversight of patient care from ward / team to Board against evidence-based standards and local indicators - Stimulate clinical team discussion and quality improvement areas. - Decision making - Real time insights to ensure mobilisation of support, adjustments and actions where needed	Action complete for Maternity. This action will be revised to reflect other areas across CTM in due course.
4. Feedback from staff and our communities on the ability to raise ideas, freedom and support to make change and empowerment. Holding engagement sessions for staff.	- Staff ideas scheme implemented (May 22) for raising ideas for improvement – to increase participation in 23/24 – Implemented. Ongoing and numbers increasing through the year. Onsite events planned for Quarter 1/ Quarter 2 2024-2025 – completed. Ongoing programme. - Improvement into practice training taking place every other month. - Permanent funding secured for PREMs and full deployment across the Health Board is planned. Further activity is also scheduled to increase awareness around the mechanism for sharing feedback using the "Have Your Say" process. Recruited and appointed to posts.	Embed Quality Improvement into everyone's day to day jobs, providing them with the tools, skills and ability to make improvements within their areas. Ensuring our people have the skills and empowerment to make changes and improvements. To ensure as a Health Board we have the ability to track patient experience and use this data to continually improve our services to patients, families and communities.	Simply Do is implemented across CTM and actively promoted by the ICTM Improvement Team Viva Engagement Platform Launch December 2025 Rolling programme of challenges for staff with measures around ideas, engagement and implementation. PREMS data now being routinely provided to Care Groups and to Q&S Committee. Working though potential for improved integration between planning, engagement and peoples experience with external stakeholders (e.g. Llais) Support and adjustment in transition to new PREMS/PROMS platform being led through VBHC.
5. Improving flow and efficiencies and productivity	Medical & Nursing Workforce Productivity Programmes operating within the transformational programme governance structure and delivering to plan.	Medical: Medical Workforce Productivity Programmes - Ensuring that the workforce meets the requirements of the Health Board – job planning, financial prudence (monitoring medical spend and exploration of potential savings and efficiencies), workforce establishment.	Medical: Improved financial control on medical spend and improved productivity in terms of outpatients and theatres efficiencies. Ensuring appropriate management of contracts Nursing: Nursing productivity:

		Nursing: CTMUHB has been actively working on the Nursing Workforce Productivity Programme as part of its broader strategy to improve efficiency and effectiveness within the health board. Key actions under this programme include: • Bank Modernisation Action Plan: This includes proactive recruitment across 12 months. • Flexible Working Policy: Launched with accompanying promotion and implementation of an oversight mechanism in place which aligns to retention as a key initiative. • Internal Lateral Moves Scheme: For Band 5 Nurse and Midwives, launched in February 2024, and expanded to include Band 2 Health Care Support Workers and Band 5 Midwives in December 2024/5. • Framework agency reduction: to achieve a 20% reduction in the use of framework agency registered nurses	• Processes and installing of KPIs for the bank service (partially achieved). • Implementation and use of flexible working policy (implemented and active). • Implementation of lateral moves scheme (implemented and being actively utilised). Demonstrated progress against a reduction in framework agency spend (partially complete, progress across the care groups, await year end position). • Comms issued to start agency via exception from December 2025. • Working with finance, workforce and operations on reporting and surveillance model on quality, operations and finance combined. • Joint work with workforce colleagues on sickness absence reduction, implementation of approach, reporting and management support. • This programme is being updated for both Medical and Nursing productivity as part of CTM's approach to IMTP, formative update will be provided in the new financial year
6. Fragility of the Legal Services Directorate	The next phase of the OCP has concluded and will be implemented at the start of May 2026, which includes the recruitment of key staff to strengthen the team and address the gaps identified following the recovery plan • Legal Services Recovery Plan in place which will consider if there is enough capacity to manage cases effectively, if internal processes and systems need to be revisited to make changes and identify areas for further improvement. • Recovery plan also considering the stability of the Legal Services Directorate.	• Improved patient and stakeholder experience. • Improved compliance and performance. • Sustainable service fit for the future. • Robust systems and processes.	• Compliance and performance metrics within the Integrated Performance Dashboard. • Decrease in cases being referred or escalated to next stages in the relevant process. • Increased compliance in KPI across legal and PTR. • Reduction in recovery measures in line with improving performance. • Plan to exit the recovery phase to the 'Business as Usual' model and the implementation of the revised structure. Following implementation of the OCP (including recruitment of full complement of the new team to be complete July 2026) • Implementation of the revised operating procedures and process maps. • Work has restarted in collaboration with workforce colleagues in implementation of the new structure following OCP. • Improving reporting and engagement with external stakeholders. • Improving reporting, assurance and engagement with external stakeholders, including ongoing regular monthly meetings led by the assistant Director of Quality & Safety and the Deputy Director of Nursing with the Coroners Office, NHS Wales Shared Services

- Partnerships, Legal & Risk teams and Llais Cymru
- Formal correspondence has been issued to external solicitors, with follow-up meetings held with a number of firms to address concerns and provide assurance on recovery actions, capacity improvements and revised processes
 - Working with finance colleagues on clinical negligence position and forecasting associated CTM share for 2026/27.

Linked National Priority Measures

Care Closer to Home

- 6. Percentage of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes.
- 7. Percentage of patients (aged 12 years and over) with diabetes achieving all three treatment targets in the preceding 15 months.

Patient Safety Solutions

Infection Prevention and Control

- Six Tier One IP&C Targets.
- National IP&C Guidance – to include implementation of respiratory and non- respiratory pathways.

NHS Wales National Framework – provides a unified, evidence-based structure for infection prevention and control, ensuring robust governance, surveillance, training, decontamination standards, and board-level assurance across all healthcare settings.

Children's Charter

To reinforce children's rights and endorse CTM's commitment to upholding these rights within its services.

Safeguarding

- National Improvement Plan.
- Further Mental Capacity Act (MCA) awareness being funded by Welsh Government along with measures to strengthen current Deprivation of Liberty Safeguards until MCA becomes the dominant legislation.
- Independent Review (by HIW/CIW) being undertaken of CTM Region Safeguarding Boards in relation to Child Protection Practices including the sharing of information.

Chief Nursing Officer's Launch of the Nursing and Midwifery Priorities – 2023-2024 – Development of a Nursing and Midwifery vision underway. **Chief Nursing Officer's Launch of the 2025-2030 Strategic Vision – We are ensuring full alignment with CTM's Nursing Strategic Plan, and the Executive Director of Nursing and Midwifery is working collaboratively with peers across Wales to support the implementation of the Chief Nursing Officer's 2025-2030 Strategic Vision**

National Patient Experience Framework.

New national nurse education standards

Dementia Standards - which include standards for inpatient hospital admissions.

NHS Wales Quality and Safety Framework: Learning & Improving. Published by WG September 2021.

The Health & Social Care (Quality & Engagement) (Wales) Act 2020 - Improving quality and public engagement in health and social care.

National Value Based Healthcare Strategy – alignment of CTMs programme of work to meet national priorities.

Full engagement in the Chief Medical Officers priority to strengthen clinical leadership and the Medical Director closely involved with the National Work (Ministerial Advisory Group Report)

Current Performance Highlights

Please refer to the following sections of the Integrated Performance Dashboard to triangulate risk, assurance and performance:

- Quality Dashboard
- Maternity & Neonatal Dashboard
- Cancer Standards.
- Unscheduled Care.

• Six Goals Programme (Emergency & Urgent Care, D2RA). • Waiting List Delays. • Mortality Indicators. • Tier 1 IP&C Indicators. • Nurse Sensitive Outcome Measures – Falls, Pressure Ulcers, medication administration. • Sepsis. • Mental Health Measures. • Putting Things Right Compliance. From 1st April Listening To People (LTP) has been introduced and therefore compliance reporting will move to LTP compliance • Patient Safety Solutions compliance

Were there any significant incidents affecting this strategic Risk this period:

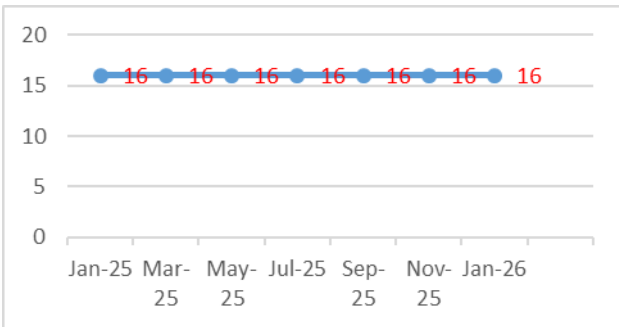
Significant **Nationally Reportable** incidents (NRI or LRI) are managed in according with the Incident **Management** Framework and reported to the Quality, Safety & **Experience** Committee.

CTM Health visitors are taking industrial action which has been extended to July 19th 2026. This presents a strategic risk to the Health Board’s ability to deliver the full health visiting offer, with potential impacts on early identification of vulnerability and safeguarding. Mitigated through prioritisation of statutory activity, strengthened safeguarding oversight and ongoing governance monitoring.

Associated Risks escalated to the Organisational Risk Register		
6052	Patient hydration risks associated with the replacement of aged Beverage Trolley fleet (ultrakarts). New risk escalated to the Organisational Risk Register in September 2025.	20
4632	Provision of an effective and comprehensive stroke service across CTM (encompassing prevention, early intervention, acute care and rehabilitation)	16
5045	Access to Neurology Inpatient and Outpatient Services for CTM Residents	16
4417	Management of Security Doors in All Hospital Settings	16
6228	Effective and efficient management of requests from the HM Coroner. ~~Risk score reduced to a 12. De-escalated from the Organisational Risk Register in January 2026.~~	16
6229	Timely development of management and response to Learning from Event Reports (LFERs).	16
6231	Proactive management and compliance with cases that qualify for consideration under the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.	16
1793	~~Lack of isolation facilities available – negative pressure rooms. New risk escalated to the Organisational Risk Register in September 2025.~~ De-escalated and removed from the Organisational Risk Register in February 2026	16
6232	Stability of the Legal Services Function.	15
6217	~~A number of Nationally reportable incidents have been raised since February 2025 within Obstetrics / Maternity.~~ De-escalated and removed from the Organisational Risk Register in February 2026	15
4691	~~New Mental Health Unit~~ The Provision of Safe and Appropriate Estate for Inpatient Mental Health Care	15

Strategic Goal(s):			Risk score 16
 Improving Care - Delivering safe and compassionate care - Developing new models of care - Digital transformation for patients and staff - Ensuring timely access to care	 Sustaining Our Future - Becoming a green organisation - Ensuring our Services financial sustainability Embedding value-based healthcare - Ensuring our estate is fit for the future	 Inspiring People - Viable and inspiring leadership. - Promoting diversity and inclusion. - Embedding our values and behaviours. - Encouraging local employment	
Strategic Risk: Enough workforce to deliver the activity and quality ambitions of the organisation (including culture, values and behaviours) (Risk No. 3)			
If the Health Board fails to identify and plan for its current and future workforce requirements, and to promote CTMUHB as an attractive place to work		Then we may fail to ensure we have the right people with the right skills and experience, in the right place at the right time and cost to meet service demand.	Resulting in increased gaps in our workforce which adversely affect the quality of care, increased burden on other workforce and the employee experience, with a potential increase in variable pay impacting our ability to deliver high quality and affordable services fit for today and tomorrow.

Risk Lead	Executive Director for People	Assurance committee	- Quality, Safety & Experience Committee - Operational Delivery Committee

	Consequence	Likelihood	Score	Risk Score Trend this Period: No change to risk scores this period. Risk Score Trajectory 
Initial	4	5	20	
Current	4	4	16	
Target	4	2	8	
Risk Appetite	Cautious (quality and safety; trust and confidence; legal and regulatory)			

Rationale for assessment of risk score: <i>Including where risk score remains unchanged and for any changes</i>	This risk is complex and reflects increasing recruitment & retention challenges with skills shortages across health and social care on a local, national and international scale. There are also workforce challenges and risks aligned to Health Visitor industrial action, proposed shift patterns changes and Llantrisant Health Park (regional workforce model agreement and outcome of the demand and capacity model for South East Wales). The latter is potentially impacting on timelines and delivering a multi-disciplinary workforce in a sustainable and affordable workforce plan. Therefore, although we are “treating” this risk it is recognised that significant progress on this will not be achieved in the short term. Patient safety and quality could be compromised or delayed, increasing waiting times, because of workforce gaps due to lack of available skilled workers either in local or national labour market to meet demands and to avoid and reduce high-cost variable pay. This could also impact on the delivery of planned activity to meet targets leading to increased performance scrutiny. Staff wellbeing and morale is still a concern.

	Sickness rates ~~continued to decrease~~ increased to from 8.79% in December 2025 to 8.32% in January 2026 to 7.55% in February 2026. This is an increase of 0.48% on the February 2025 rate of 7.07%. The rolling 12 months sickness rate was 7.41%. , compared to 8.05% in December 2024. The rolling 12 months sickness rate was 7.34%. There remains a risk to the financial impact if this continues ~~Forecasted with~~ agency spend at for M12 2025/2026 is £9.42m which is a 3.8% at £7.771m for M&D. and £11.67m For Nursing and Midwifery staff groups the position is a forecasted reduction of 38% £13.3m at M12 2025/2026. Turnover ~~reduced further in March 2026 to 8.29% from 8.50% in January 2026.~~ slightly decreased to 8.50% in January 2026 from 8.54% in November 2025. Job Planning compliance remains at 44% as at April 2026. There is considerable variation between care groups. This is being addressed by the Medical Workforce Productivity Programme Rates did increase to 46% in December 2025 but reduced due to the expiry of other job plans during this period. While Turnover has continued to steadily fall over the last 12 months increasing our retention, and while our approach to recruitment has been strengthened, we still have areas to improve, including solutions for hard to fill posts and improved time to hire. High sickness rates also continue to significantly impact on workforce availability. The workforce risk remains significant and remains at 16 based on the following: • Late delivery of key objective/service due to lack of staff – waiting list and capacity issues • Unsafe staffing level (>1 day)/competence. • Low staff morale. • Sickness rates • Poor staff attendance for mandatory/key professional training. • Reliance on temporary workforce usage and spend
Risk Treatment Assessment <i>i.e. Treat, Tolerate, Transfer etc.</i>	This risk will continue to be treated through targeted action under the CTM People Plan, working with Care Groups and professional leads to strengthen workforce planning, recruitment, retention and wellbeing, and embed improvements into business-as-usual. Key activity includes improving access to workforce data and dashboards, building workforce planning capability, delivering targeted and international recruitment, strengthening retention through employee experience and career development, supporting wellbeing and reducing sickness absence, and reducing agency reliance through sustainable workforce productivity measures. These actions are expected to progressively reduce the risk, though progress remains influenced by national workforce supply constraints. Work is also underway with staff and Trade Union colleagues to agree consistent nursing, midwifery and HealthCare Support Worker shift patterns that support patient safety, staff wellbeing, workforce availability and financial sustainability.

Current Control Measures
Strategic Alignment • People Plan launched – sets out People priorities and promises aligned to CTM2030 to drive cultural and workforce transformation. • Integrated Medium-Term Plan (IMTP) and Education & Training Plans (ETPs) – professionally assured and approved at Executive level prior to submission to HEIW each March, ensuring alignment with national workforce plans. • Savings Delivery Plan (SDP) – identifies workforce productivity priorities for 2025/26 with named leads across Nursing, Medical, and wider workforce groups. • Value & Effectiveness Programme – identifies the workforce workstream priorities for 2026/2027.

Recruitment and Resourcing

- Vacancy Scrutiny Panel – ensures recruitment aligns to strategic priorities, maintains financial probity, and supports safe service delivery.
- Job Evaluation / Matching – maintains internal equity and compliance with national pay frameworks.
- Standardised Recruitment Process – delivered via *Trac* and supported by NWSSP Recruitment Services to ensure consistency, transparency, and legislative compliance.
- Medical Workforce Recruitment Plan – includes international recruitment, job description standardisation, and productivity actions reported through to Medical Workforce Productivity Programme Delivery Group.
- Time to Hire – monitored monthly through Care Group Senior Teams.
- Advertising and Agency Controls – all adverts and social media recruitment coordinated via Communications and Attraction teams; agency use governed by Procurement (Proc4 / DOI).
- Living Wage Employer – ensures fair pay and equity across CTM.
- Annual Service Level Agreement with Educ8 training to fund full time band 4 role to support apprenticeship academy.

Retention and Employee Experience

- Retention Programme – re-established with clear vision, governance, and measurable objectives.
- Stakeholder Engagement – ongoing collaboration with Care Groups, People Services, and HEIW.
- Nursing Retention Plan – tracked through RAG status and monitored ~~monthly~~ **quarterly with stakeholders**.
- Manual Retention Dashboard – monitors turnover, attrition, and stability.
- 'Moving On' and 'Joining Well' Surveys – provide insight into onboarding and exit experiences, with dashboards to inform improvement actions.
- Lateral Moves Scheme – supports internal mobility and retention for Band 2 HCSWs, Band 3 HCSWs from December 2025, and Band 5 nursing and midwifery roles.
- Flexible Working Policy (All Wales) – governs equitable decision-making and recording via ESR.
- Corporate Induction and PDR ("Your Conversation") – support early engagement, wellbeing, and feedback.

Workforce Productivity and Temporary Staffing

- Nursing & Midwifery Productivity Programme – includes bank and roster optimisation workstreams to reduce agency usage and spend (introduction of agency by exception for registered nursing and midwifery from December 2025). **Revised objectives under NMPP FOR 2026/2027 aligned to the Value and Effectiveness Programme.**
- Medical Workforce Productivity Programme – includes **increased job planning compliance, medical** recruitment and agency reduction plans.
- ~~Locum Management via Locum's Nest – provides visibility and control over medical and dental agency usage.~~ **HCRG new Managed Service Provider contract awarded to provide M&D Bank and Agency service (and AHP and HCS agency requirements)**
- Rate Cards (Consultant and Non-Consultant) – ensure consistency and cost control.
- Bank KPIs and Agency Spend Tracker – phase 1 has been built and available in the nurse dashboard. Further work to develop the next phase remains under development with a specification to be agreed. This will support targeted improvement and oversight.

Day-to-Day Workforce Management

- HealthRoster – used across all staff groups with established "golden rules" for safe, efficient scheduling.
- Job Planning Guidance – supports fair allocation of medical time and resources.
- Sickness Management Framework – scoping of organisation-wide project underway to reduce sickness rates by 1% by October 2026 (baseline target July 2025 (rolling 12 months) rate 6.98% to 5.98%).
- Fixed Term Contract Policy (ongoing review) – will strengthen compliance with employment legislation.

Workforce Planning

- Strategic Workforce Planning Framework – underpins all planning activity, aligned to IMTP and HEIW standards.
- Active participation in All-Wales Workforce Planning Networks – across Nursing, AHP, Pharmacy, Mental Health, Perinatal, and Primary Care.
- Implementation of new Wales Resident Doctor contract, both for resident doctors and clinical fellows (LEDs) employed by CTM.
- Engagement in national student and PA recruitment streamlining processes – ensures future workforce pipeline sustainability.
- Audit Wales SWP recommendations – tracked through the Audit Tracker and monitored by the Audit, Risk & Assurance Committee. Majority are now business as usual.

Workforce Data, Analytics and Systems

- Electronic Staff Record (ESR) – master workforce system ensuring national data alignment and accurate reporting.
- Establishment Reporting – developed for medical workforce, with nursing, midwifery and HCSW dashboards in progress.
- Ongoing collaboration with HEIW – to enhance data accuracy and analytics capability.
- System Integration – ESR, HealthRoster and Locums Nest aligned to improve interoperability and efficiency.

Culture, Values and Behaviours (CVB)

- Organisational Values published – underpin all people practices.
- Leadership Development Programmes – focused on compassionate, inclusive leadership.
- Staff Engagement and Recognition – mechanisms include surveys, listening events, Seren Awards, and focus groups.
- Equality, Diversity and Inclusion Strategy – with staff networks and mandatory anti-racism training.
- Speaking Up Safely Guardians and anonymous reporting platform Work in Confidence (WiC) – strengthen psychological safety.
- Care Group Culture and Behaviour Plans – local responses to Staff Survey results embedded in delivery plans.

Sources of Assurance (Internal and External)

Workforce Data and Analytics

Internal assurance

- M&D Establishment Reporting (substantive in-post, ledger, variable pay, job planning compliance) - reviewed by Medical Workforce leadership and Care Groups.
- People/Workforce Metrics Report (staff-in-post, turnover, sickness (including RTW compliance), PDR, statutory and mandatory, age, bank and agency spend, gender pay gap and staff engagement index) to Operational Delivery Committee (ODC) and Local Partnership Forum (LPF); included in the Integrated Performance Report (IPR) to Board and into Values & Effectiveness Board via Nursing & Midwifery & Medical Productivity programmes.
- As at March 2026: staff-in-post +3.15% YoY (mainly E&A due to filling posts); turnover 8.29% (down from 8.50% in January 2026; 9.54% in March 2025); sickness reduced from 8.79% Dec 25 to 7.55% in February 2026 (vs 7.07% in February 2025); PDR increased from 70.79% in January 2026 to 70.97% in March 2026 (target 85%); M&D appraisals 80.95% (Oct – Dec 2025).
- ~~Ongoing People Metrics uplift to align with the People Plan.~~

External assurance

- Quarterly vacancy returns submitted to Welsh Government for NHS vacancy statistics.

Medical Workforce Productivity Programme Board

Internal Assurance

- Medical Workforce Productivity Programme (MWPP): Delivery Group dashboards - Bank and Agency spend increased from £2.6m (Feb 2026) to £2.4m (Feb-25)
- Job planning compliance
- Audit Updates
 - Medical & Dental Variable Pay Audit and M&D Job Planning Audit- recommendations on Audit Tracker (reported to ARC Nov-25 and updated in readiness for February for April/May 2026)
 - Majority of actions are incorporated into the FCP and SOP draft submitted to ARAC in February 2026. These will now be updated in line with the new HCRG, M&D bank and agency provider in place.
 - Medical & Dental Medical Rostering Audit – this process is being revisited in light of the implementation of the new Resident Doctor contract.
- SAS doctors regrading process in place. launches (process agreed between Finance, People and Executive Medical Director's office) first cases considered in Oct-25.
- Resident Doctor contract changes escalated to Executive Leadership Group (ELG) for information and awareness. CTM Implementation Group in place is established, alongside CTM membership at both NWSSP and NHS Employers led All Wales groups.

Nurse Productivity Programme Board

Internal Assurance

- Nurse Productivity Programme Board - Agency spend reduced YTD from £20.04m TO £12.47m as at M11 2025/2026. (Dec-24) to £1.3m (Dec-25). This reduction is due to three factors: the reduction in hourly agency rates for RN shifts following the renewed All Wales Consolidated Agency Contract March 2025, agency by exception work and reduced annual leave during Christmas and New Year.
- Agency usage trending report - RN and HCSW agency usage for since January 2026 continues to and across the year show a general downward trend.
- Bank usage remains steady across RN and HCSWs.
- HealthRoster optimisation and data quality improvements continue as one of the workstreams for NMPP 2026/2027. underway; Month-5 pay arrears flagged in variance commentary.

External Assurance

- None mandated beyond audit reporting to ARC, benchmarking available via national productivity references where applicable.
- A revised all Wales Bank Terms of Engagement and an implementation plan is being updated to roll out Quarter 1 2026/2027 April 2026.

Workforce Planning

Internal assurance

- Executive Leadership Group (ELG) approval of ETP Commissioning submission (Mar-26) to HEIW.
- ~~Workforce Shape & Supply Steering Group with task & finish groups; alignment to Care Group plans and IMTP.~~

Lack of coordinated regional workforce plans.	- Development of LHP Workforce Plan (FBC (draft March 2026) due May 2026). - Workshops to develop Perinatal, Ophthalmology and Theatres workforce plans.	Ensure right skills, roles and staffing models across regional services.	Ensure right skills, roles and staffing models across regional services.
New and Extended Roles			
Inconsistent governance for new and extended roles (PAs, ACPs, RNAs).	- Developed Framework and PA Working Group. - Supported rollout of ACP and RNA roles aligned to national standards.	Strengthen workforce governance, ensure appropriate deployment and maximise skill mix.	- Governance framework in place. - Positive use of PAs, ACPs and RNAs - reducing workforce gaps and agency reliance.
Workforce Productivity			
Inefficient roster and temporary staffing models; agency dependency.	- Nurse Productivity Programme (Roster & Bank optimisation). - Medical Workforce Productivity Programme (£3m target).	Reduce agency reliance and optimise workforce efficiency.	- Improved rostering efficiency and bank utilisation. - Reduced long-term agency usage.
Sickness Absence			
High sickness absence rates impacting availability.	Comprehensive data review and organisation-wide action plan	Co-ordinated improvement in attendance and wellbeing.	1% reduction in sickness absence in 25/26 vs 24/25.
Workforce Data and Analytics			
Limited establishment reporting and analytics capability.	- Developed Nursing & Midwifery establishment reports. - Developing dashboards and robotics strategy.	Improved workforce visibility, data-driven decisions and capability.	- Live reporting accessible. - Improved workforce data quality and analytical use.
Workforce Systems			
Limited interoperability across systems.	- M&D Bank/Agency Tender and ESR Go implementation. - People Systems Group established. - Preparation for Future ESR 2.	Improve efficiency, reduce agency spend and strengthen system integration.	- ESR Go implemented. - Reduced agency usage. - Readiness for national system transition.
Attraction, Resourcing and Recruitment			
No signed-off Recruitment & Retention Plan; inconsistent processes.	- Draft Recruitment & Retention Plan. - Updated policy and SOPs. - Recruitment training and SharePoint resources. - Active attraction and social media strategy.	Standardise processes, strengthen employer brand and improve fill rates.	- Policy/SOPs approved. - Increased site traffic and engagement. - Reduced vacancy rates.
Timescale for implementation of new Resident Doctor contract in August 2026	- Participation in All Wales workstreams - CTM Resident Doctor Contract Implementation Group	CTM being up to date with the rest of Wales on this project	- Contract implementation in August 2026 - Accurate rota build and roster – payroll systems
Retention			
Low participation in exit process and limited retention data. Retention Programme Plan established but not agreed.	- Relaunched Lateral Moves Scheme and widened access to Band 3 HCSW's. "Moving On" process due to launch. Plan to Re-establish Retention Steering Group. - Improved retention data analytics.	Improve staff experience, reduce turnover and inform targeted interventions.	- Higher exit feedback response rate (target 30%). - Visible retention metrics. - Reduced voluntary turnover.
Culture, Values & Behaviours			
Seen as corporate not locally owned	- Divisional datasets shared quarterly. - Directorate-level leadership accountability. - Measures embedded in People Plan	Strengthen local ownership and connect values to daily behaviours.	- Improved staff survey results on "values in action." - Increased participation in CVB activities. - Reduced variation in staff experience.

Linked National Priority Measures

Workforce		
23. Agency spend as a percentage of the total pay bill 27. Percentage sickness rate of staff		
Current Performance Highlights		
Key Progress Highlights:		
Workforce Planning: IMTP Education Commissioning for 2027/2028 submitted to HEIW for 31 March 2026 or outputs in 2030. In addition, submitted the People Chapter and Minimum Data Set (MDS) - A revised All Wales Bank Terms of Engagement and an implementation plan is being updated to roll out April 2026. - Work is underway to address the skills, establishment and pay arrangements for bank staff following the Band 2-2 changes to ensure a viable, appropriately skilled and available bank workforce by July 2026 Workforce Planning: LHP Phase 2 Workforce Planning and narrative for the workforce section of the joint LHP/SEW regional OBC/FBC is under development in partnership with key stakeholders and across the SEW region in readiness for submission to HBs in June/July 2026 Productivity & Agency Reduction: Tender for the Managed Service provision for M&D bank and agency staff contract awarded. Recruitment: work underway with Nursing & Midwifery, People and Finance to increase the number of allocated nursing and midwifery student streamlining for September 2026. An updated position is being discussed at ELG and reporting to HEIW on 5 May 2026, that considers safety, affordability and sustainability. AFC Bank: 800 Bank only staff identified, bank only workers following the Band 2-3 changes to ensure a viable, appropriately skilled and available bank workforce and on track to meet the deadline of July 2026. ~~Workforce Planning: LHP OBC Phase 2 Workforce Planning section completed and included in the submission to WG on 7 December 2025. Responses to scrutiny questions sent in January 2026 and work underway to develop the workforce section of the FBC in partnership with key stakeholders.~~ ~~Workforce Planning: IMTP Education Commissioning for draft submission sent to HEIW 31 January 2026, People Chapter being finalised and Minimum Data Set (MDS) discussions across strategic planning, activity, finance and people in place.~~ ~~Workforce Data & Analytics: Enhanced reporting via establishment dashboards, improved data quality, and interoperability between ESR, HealthRoster and Locum systems to strengthen evidence-based decision making.~~ ~~Productivity & Agency Reduction: Tender progressing regarding Managed Service provision for M&D bank and agency staff.~~ ~~Recruitment: international recruitment for hard-to-fill medical roles 2025/26 with NWSPP progressed, with two specialist grade psychiatrist started. A further Haematology doctor onboarding and four two ITU doctors being offered to targeted have been offered via NWSPP's overseas campaign in Jan/Feb 2026 with first Dr to join in June 2026. Actions to improve internal recruitment resources and training for hiring managers are under way. Focus on building healthier communities and inspiring people, CTM~~ ~~Successful 3 careers events have partnered with local authority employability teams, DWP and Careers Wales to provide 3 x career events took place in March 2026 (c900 plus attendees) supporting potential applicants to apply for roles in CTM. Retention initiatives strengthened through the re-established Retention Programme; Lateral Moves Scheme extended to Band 3 HCSWs.~~ ~~Recruitment: work underway with Care Groups and Corporate nursing to confirm vacancies for nursing and midwifery student streamlining for September 2026.~~ ~~Retention: Lateral Moves Scheme monitoring: Register cleansed. 346 eligible transfer requests (Jan 2025), scheme widened to include Band 3 HCSWs and time to hire has reduced by 34% since October 2025 (77 days to 51). 56% of eligible requests have successfully resulted in a transfer. Conversations to further widen access are planned with Facilities and AHPs.~~ ~~Productivity & Agency Reduction: Phase 2 of the agency by exception for Nursing and Midwifery launched on 1 February 2026 supporting Care Group nursing and midwifery to approve and action agency requirements in line with standards agreed at Nursing and Midwifery Productivity Programme improving efficiency and accountability.~~ ~~Wellbeing & Attendance: Sickness absence M&D internal advisory audit launched.~~ ~~Promoted and delivered a positive CTM Apprenticeship Week 9 Feb to 13 Feb 2026.~~ ~~Reframed leadership approach to NHS Staff Survey 2025 with activation of care group leadership response to local results enabled by corporate teams.~~		
Were there any significant incidents affecting this strategic Risk this period:		
None identified.		
Associated Risks escalated to the Organisational Risk Register		
5753	Inadequate Special School Nurse Provision.	20
6294	Insufficient Consultant Workforce - Endoscopy / Gastroenterology.	16-20
4973	Clinical Medical Cover within CTM Adult Mental Health Services.	16
5576	Palliative Medicine Staffing Closed on the Organisational Risk Register in March 2026	16
6234	National skills shortage in Estates Roles (Private sector salaries are impacting the CTMUHB's ability to be competitive in the recruitment market) resulting in recruitment and retention challenges throughout the department. Risk likelihood score has been reduced from a 4 to a 3 and the risk de-escalated from the Organisational Risk Register in January 2026.	16
2713	Backlog of Reporting Radiology Examinations. New risk escalated in October 2025. Score reduced to 12 and removed from the Organisational Risk Register in April 2026	16
6318	Tier 3 SHED Team Service Delivery. New risk escalated in October 2025	16

5877	New Worker Contract for Out of Hour GPs. New risk escalated in November 2025.	16
6397	Shortage of GPs to deliver urgent primary care services for escalation. New risk escalated to the Organisational Risk Register in January 2026.	16
6475	Industrial action of Health Visting staff members of the UNITE union. New risk added to the Organisational Risk Register in January 2026	16
6232	Stability of the Legal Services Function.	15

Strategic Goal(s):



Creating Health

- Reducing health inequalities
- Equal focus on mental and physical health
- Supporting our communities
- Being a healthy organisation



Sustaining our Future

- Becoming a green organisation
- Ensuring our Services financial sustainability Embedding value-based healthcare
- Ensuring our estate is fit for the future

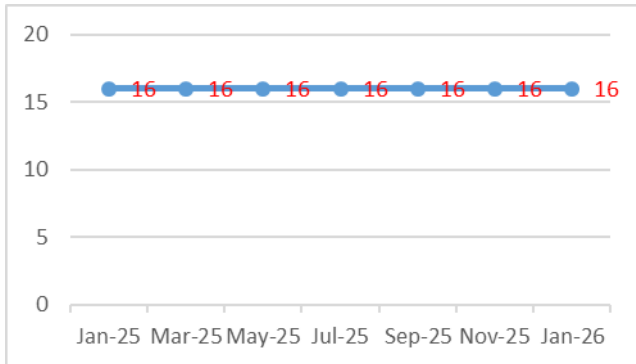
Risk score

16

Strategic Risk: **Effective Community and Partner Engagement in Service Changes and Developments (Risk No.4)**

If the Health Board does not engage effectively with our population to understand their needs, and with partners in local government social care and the third sector, to understand their viewpoints	Then we will fail to prioritise our efforts and resources appropriately, and to achieve a consensus for change in implementing our Population Health Strategy	Resulting in - Lack of trust between the community and the Health Board. - Loss of opportunity to build relationships and create an inclusive environment where people connect, collaborate, and share ideas. - Challenge to public decisions relating to future service developments due to limited engagement. - The inability to affect positive change in terms of improving health inequalities and health outcomes.

Lead Director	Director of Communications, Engagement & Fundraising.	Assurance committee	Strategic Development Committee

	Consequence	Likelihood	Score	Risk Score Trend this Period: No change to risk score this period. Risk Score Trajectory 
Initial	4	5	20	
Current	4	4	16	
Target	4	2	8	
Risk Appetite	Cautious (<i>quality and safety; trust and confidence; legal and regulatory</i>)			
Rationale for assessment of risk score: <i>Including where risk score remains unchanged and for any changes</i>				In recognition of the gaps identified around additional capacity requirements to develop and implement an engagement and involvement strategy associated with the Clinical Service Plan and wider service change requirement as well as the need to define a clearer process and procedure for supporting transformation and service change, the risk score has been increased in terms of likelihood to a 4 in July 2025. The gaps are captured in the mitigating action plan section of this risk.
Risk Treatment Assessment <i>i.e. Treat, Tolerate, Transfer etc.</i>				This risk is being actively managed via the communications team and wider engagement function. As above, we will need to tolerate the fact that management of the risk will need to be ongoing.

Current Control Measures

Strategies & Plans

- 2030 Strategy – 'Our Health Our Future'
- Implementation of key actions in the Population Health Plan approved by Board in May 2021. *Framing and incorporating these actions as part of the Unified Transformation Programme – Creating Health. Completed*
- Public Engagement Plan for 'Our Health Our Future'
- Becoming an Engaging Organisation
- Work programme set out in 'Becoming a Population Health Organisation: a discussion and options paper for Board', May 2021

Engagement Forums

- Regional Partnership Board
- Public Service Board
- Area Partnership Board
- CTM2030 Leaders Groups
- Acute Clinical Services Plan – Senior Leaders Group
- CTM Leaders Forum - New Terms of Reference developed with a further review scheduled for 2025.
- Staff Q&A
- (Staff) Leaders' Forum
- Stakeholder Reference Group
- Strategy Groups: Born Well, Growing Well, Living Well, Ageing Well and Dying Well
- Engagement with community groups by Lead Independent Members
- Links with Llais including representation on Board.
- Regular joint executive meetings with the three local authorities
- Accelerated Cluster Development Programme Board – engagement across Primary Care
- Health and Social Care Integration Board
- Forum with local authority Chief Executives to address health inequalities.
- Community Voluntary Councils (Interlink RCT, BAVO, VAMT)
- OPAG (Older Person's Advisory Committee)
- CTM 50+ Forums
- Maesteg Stakeholder Reference Group
- Partnership with CTM WISE (Wellness Improvement Service)
- Regional Mental Health Forum
- Partnerships with colleges and education providers
- CTM Strategic Engagement Forum (established Sept 24). Chaired by Head of Engagement and Involvement.
- A collaboration with Veterans is being established through the development of a forum with partners from the Veteran Hubs, wider Armed Forces community, third sector organisations, Primary Care and CTMUHB.
- Working group for health protection and vaccination, including members of the community leaders' network

Needs Assessment & Consultation Processes

- Population Needs Assessment (Regional Partnership Board)
- Formal consultation processes for service reconfiguration, e.g. vascular

Organisational Structures

- Creating Health, Improving Care, Sustaining our Future and Inspiring People Strategic Pillars

Sources of Assurance (Internal and External)

Board Development Session – held on the 14th December 2023 in relation to community engagement and the maturity journey for the Health Board in further developing its approach to being an engaging organisation.

Routine discussions with Board undertaken in relation to the engagement strategy for the Acute Clinical Services Plan.

On the 7 April 2025, the Welsh Language Commissioner published her five-Year Plan, within which she encouraged others to speak with CTM as an example of good practice, this endorsement provided CTMUHB with the opportunity to showcase the work being done across the health board to enable our staff to learn and use the Welsh language.

Reports to other committees

- Community Health Council briefing papers to Quality, Safety & Experience Committee.

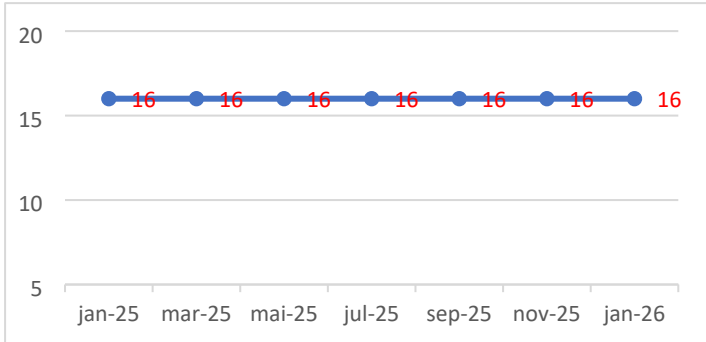
External
Activity commissioned from Opinion Research Services will provide detailed intelligence of stakeholders within CTM communities, including those at the hyperlocal level, enabling greater effectiveness and efficiency of public engagement and involvement activities.

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Indicators of Success (following implementation of mitigating actions)
Review the Becoming an Engaging Organisation Strategy	- Revisit to ensure the principles support the direction of travel, particularly their consistency and alignment with the ACSP engagement strategy, - Board Development Session reviewed the strategy on the 14th December 2023, outputs of which will now be taken forward. - Engaging with the Consultation Institute to develop and embed robust systems and processes within the Health Board for managing consultation. Work has begun with the consultation institute to improve our understanding of our stakeholders, and the risks associated with service change. Consultation desk review now complete. This will be removed on the next iteration. The content of the review is informing engagement planning going forward. - Development of specification for procurement of consultation partner to support creation of hyperlocal stakeholder mapping to enable improved targeting of engagement activities and resources. Collaboration with Regional Partnership Board on use of stakeholder management system to provide increased rigor and improved data capture. - External expertise commissioned from Opinion Research Services (ORS) in October '24, to develop stakeholder mapping. Outputs will provide broader and richer understanding of population characteristics, key influencers, and effective methods of involvement and engagement. Outputs will be delivered in last quarter 24/25. This work has begun, and interviews are scheduled to take place with Independent Members and key senior Health Board staff throughout January 2025. - Collaboration with South East Wales Health Boards to formalise Regional Communication and Engagement plans and activity. - Defining the additional capacity requirements to develop and implement an engagement and involvement strategy associated with the ACSP and wider service change requirements. - Discussions to identify opportunities to improve robustness of partnership between Communications and Engagement and planning and transformation, and development of better-defined processes and procedures for supporting transformation and service change. - Closer, more formalised working relationships between Strategy and Planning and Communications and	- Alignment across health board strategy and change programmes. - Ensure Board awareness and continued relevance of strategy with current strategic and operational ambitions and objectives. - A more informed approach to public engagement and consultation activities relating to significant services change, based upon legal precedence and best practice and resulting in reduced risk of judicial review. - Identification and commissioning of an external provider with requisite experience and ability to lead development of stakeholder mapping to inform strategic service change. - Increased efficiency of public engagement planning and actions through shared data, targeting and delivery. Development of shared objectives and identification of opportunities for collaborative engagement activities. - Broader and richer understanding of population characteristics, key influencers, and effective methods of involvement and engagement Joined up working and efficient and effective use of shared capacity across the three South East Wales Health Boards. - Adequate capacity to engage and involve the population and wider stakeholders in ACSP and service change programmes. - More effective, efficient and sustainable support for service change and transformation with lower risk. - Closer working with the Strategy & Planning directorate will enable	- Consistency of narrative across strategic resources and change plans. - Continued Board support for BHT strategy and for development of involvement. Engagement and consultation resources aligned accordingly. - Delivery of a best-practice effective engagement and consultation plan to support strategic service change with minimal challenge and mitigating against judicial review. - Securing of partner to delivery through procurement process on budget and against expected schedule. - Delivery of shared engagement and involvement plans and delivery, realised through partnership working. Greater reach/traction of activities, with higher rates of participation/interaction. - Provision of a stakeholder map by ORS to be used for targeted involvement/engagement/consultation - Development and implementation of a Regional Communication and Engagement Plan. - Development of the ACSP and service change public engagement/involvement strategy for CTMUHB. - A single policy/process for support of service change and transformation. - An annual plan for public and community engagement activities and objectives. - Improved vaccination uptake rates across CTM communities, and engagement with, and ownership of health messaging by third-sector groups (e.g. promotion through third sector owned channels and fora) - Improved patient feedback measures indicating improved access and experience of veterans when accessing CTM services. Increased engagement of veterans in future opportunities to influence and inform the development of health services.

	Engagement, including Head of Internal Engagement attendance at Strategy & Planning team meetings. • Development of a community working group to collaboratively tackle low vaccination uptake in CTM. • Delivery of Wales' first veterans' health event, in partnership with Valley Veterans and community partners. Sharing of learning within CTM and the wider Welsh health system. • Recruitment to increase capacity of engagement and involvement function	the Comms and Engagement team to better plan and prioritise public and community engagement activities that align with the CTMUHB's strategic objectives. • Development of closer working relationships with community groups and populations, and improved insight into barriers experienced by communities in relation to their health and wellbeing. • Improved understanding of barrier facing veterans residing within CTM and development of improved information, processes, and support to improved veterans' health and wellbeing. • Increased capacity and broaden expertise/experience to manage increasing demand upon function	
Linked National Priority Measures			
Nil			
Current Performance Highlights			
• Survey shared with all CTMUHB staff, to audit effectiveness of internal communications and engagement and opportunities to improve, including implementation of new engagement platforms. • CTMUHB chaired Stakeholder Engagement Forum creating productive outputs, developing single plan for engagement priorities for 25/26 with Public Health, People, Welsh language, RPB. • Revised approach to CTM2030 Leaders' Network to be implemented in April, to improve focus on enabling community groups to take actions that improve health and wellbeing of communities. • Definition and costing of the additional capacity requirements to develop and implement an engagement and involvement strategy associated with the ACSP and wider service change requirements.			
Were there any significant incidents affecting this strategic Risk this period:			
None identified.			
Associated Risks escalated to the Organisational Risk Register			
Nil			

Strategic Goal(s):			Risk score 16
 Improving Care • Delivering safe and compassionate care. • Developing new models of care. • Digital transformation for patients and staff • Ensuring timely access to care	 Sustaining our Future • Becoming a green organisation • Ensuring our Services financial sustainability Embedding value-based healthcare • Ensuring our estate is fit for the future		
Strategic Risk: Delivery of a digital and information infrastructure to support organisational transformation – (Risk No.5)			
If the Health Board does not accelerate its journey in becoming a digital and data organisation, that demonstrates an embedded culture of working digitally, organisational agility and strategic and functional clarity underpinned by operational sustainability	Then We will be unable to design and execute a Health Board wide strategy to transform services that are tailored to meet the needs of our people and our communities.	Resulting in Continuing health inequalities and poor population health outcomes, an inability to transform our cost base and our service design, which will result in slow progress towards improving our population’s and patients experiences, and continue to constrain our ability to work seamlessly across our region.	

Risk Lead	Director of Digital	Assurance committee	- Operational Delivery Committee - Strategic Development Committee

	Consequence	Likelihood	Score	Risk Score Trend this Period: No changes to risk score this period. Risk Score Trajectory 
Initial	4	5	20	
Current	4	4	16	
Target	4	3	12	
Risk Appetite	Cautious (<i>quality and safety; trust and confidence; legal and regulatory</i>)			
Rationale for assessment of risk score: <i>Including where risk score remains unchanged and for any changes</i>				Trajectory and Next Steps - The risk score remains unchanged this period due to the balance between progress and persistent vulnerabilities. However, the trajectory is cautiously optimistic, with mitigating actions underway: - Renewal of CTMUHB’s strategy for AI, data and digital transformation, - Continued implementation of the Cyber Improvement Plan and Information Security Policy. - Strengthening of governance frameworks for AI, supplier management and digital inclusion - Ongoing collaboration with NHS Wales organisations and internal stakeholders to refine strategic oversight and assurance. Improvements - CTMUHB continues to make tangible progress across several dimensions of digital transformation: - Digitisation of Medical Records: Ongoing rollout and integration across sites. - Cyber Resilience and Security: Deployment of a new network monitoring tool and enhanced reporting functionality. Enhancements to automated cyber threat alert classification and response, with a particular focus on strengthening out-of-hours capability. A new Head of Cyber has now been

	appointed. Monthly reviews by the Cyber Security & Availability Board ensure proactive threat management. - Advanced Technologies: Operational use of 15 AI applications across the UHB such as Dragon Medical One, IBEX, Heartflow, and CTMUHB's own CCLLM and ED Attendance Prediction tools. Interim Governance frameworks for AI are in place, prior to formal endorsement by the Board. - Infrastructure and Standardisation: Improvements in digital infrastructure across sites, consolidation of clinical systems post-Bridgend disaggregation, and standardisation of digital tools and processes. - Strategic Enablers: Mobilisation of contracts for e-prescribing, formalisation of shared care record agreements, and development of a patient-centred contact programme. Remaining Vulnerabilities and Risk Justification Several factors justify maintaining the current risk score: - Cyber Threats: The cyber threat landscape continues to evolve, with persistent reconnaissance activity and attempted phishing providing ongoing indicators of increased and changing risk. Indicators of compromise were identified in May 2025. Although managed without service disruption, the National Cyber Security Centre continues to advise caution. The risk of cyber-attacks remains high and is scored at 20. - Resource Constraints: The Digital & Data team is required to balance the increasing organisation demand and expectation, against the current financial envelope for capital and revenue allocations. Staffing challenges persist, and some national programmes do not have approved business cases or funding alignment. - Operational Sustainability: While strategic clarity is improving, gaps remain in asset registers, policy adherence, and workforce capacity to fully embed digital culture and agility. - Low Maturity Against International Benchmarks: CTMUHB remains at a low level of maturity and capability when assessed against international benchmarking frameworks such as HIMSS for Electronic Patient Records (EPR), and similarly for AI and Business Intelligence. This limits our ability for our patients to interact with us digitally, for our staff to work digitally and thus is limiting the expected returns and benefits we anticipate from our digital programme.
Risk Treatment Assessment <i>i.e. Treat, Tolerate, Transfer etc.</i>	It is considered that the Health Board is continuing to 'Treat' this risk as it has a number of actions it is taking forward to mitigate this risk.
Current Control Measures - Population Health Strategy – Aligns digital infrastructure with population health priorities. - Digital & Data Delivery Programme – Oversees implementation of digital initiatives and transformation projects. - IT Infrastructure Review – Ongoing assessment of infrastructure resilience, availability, and scalability. - Digital Investment Fund – Supports strategic digital projects and innovation. - Information Security, Records Management and Information Governance Policies & Improvement Programmes – Includes the Cyber Improvement Plan, Information Security Policy, and governance frameworks for AI and data protection. - Project Portfolio Board – Monitors delivery of digital projects and ensures alignment with strategic goals. - Cyber Security & Availability Board – Monthly review of threat landscape and mitigation actions. - AI Governance Framework – Endorsed by SIRO, Caldicott Guardian, and DPO; supports safe deployment of AI tools. - Digital Maturity Benchmarking – Recognition of low maturity against international standards such as HIMSS for EPR, AI, and BI; informs capability development planning. - E-Prescribing Mobilisation – Contract and project mobilisation underway. - Shared Care Record Agreements – Formalised data controllership arrangements for NHS Wales. - Non-Corporate Communication Channels Policies – Strengthens governance of informal digital communications. - Bridgend Clinical Systems Consolidation – Supports operational continuity post-disaggregation. - Patient-Centred Contact Programme – Development of digital tools to improve patient engagement and communication. - Risk-Based Management of Digital Debt – Prioritised approach to legacy systems and technical debt.	

- Incident Response Capability – Proven ability to manage cyber incidents without service disruption (e.g. May 2025 hostile actor compromise).
- Digital Inclusion and Accessibility Workstreams – Ensures equitable access to digital services across communities.

Sources of Assurance (Internal and External)

Reports to Operational Delivery Committee incorporating

- Periodic audits by Wales Audit and regular audit from Internal Audit
- All-Wales Information Governance Toolkit and ICO Audit Review.
- NIS-D Cyber Assessment Framework and Improvement Plan (CRU).
- Digital Programme Assurance Report covering digital and data elements of the IMTP.
- Medical Records Assurance Report

Reports to other committees

- Progress updates against Population Health Strategy
- Clinical Safety
- Planning, Performance & Finance

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Indicators of Success (following implementation of mitigating actions)
1. Closing the gap in Digital Literacy	Investment required in training resources to embrace and use existing technology, digital tools and basic troubleshooting. Publicise and expand the use of digital material already available. Included within the IMTP Proposal – funding to be determined. The Head of Digital Business Change is progressing with the development of an overarching strategy to support digital and data literacy. Through various programmes we are investing in a business change capability Timeframe: 2-3-year programme of work	Raising digital literacy across the Health Board and community Implementing industry standard approach to Business Change aligning with Workforce	Less calls to the IT Service desk. Easier to deploy new digital solutions.
2. Training and Awareness Programme	Resources required to prioritise the development of a training and awareness programme. Included within the IMTP and identified as a requirement within the functional proposal for Digital & Data Timeframe: 2-3-year programme of work. Across the programmes funded by Welsh Government and the IMTP e.g. ePMA, we are working with Workforce colleagues to develop an approach to digital clinical training. Additional business change facilitators will support this activity. The Chief Nursing Information commenced on 1 April 2026. ~~has been appointed, they will be working collaboratively with the Head of Digital Business Change & Benefits to develop~~	Developing capabilities to support service change enabled by digital and data technology.	We are building our wider Digital training capability and skills facilitate training. Increase confidence and capability of all our staff in the use of digital and data technology for all the workforce. Develop a clinical digital skills strategy and framework adopting national and UK best practice to ensure that our colleagues feel confident in the increased reliance of technology in their day-to-day practice.

	~~a strategy on developing digital and data clinical skills fit for today and the future.~~ Working within the Digital Clinical Network and Digital Transformation function the CNIO will support the development of a plan for digital and data clinical skills.		
3. Maintaining a healthy cyber posture	Delivery of the cyber improvement plan (business sensitive) Timeframe: This action will not have a specific timeframe as will be a continuing activity without an endpoint.	Reduce risks for critical assets	Reduction in risk exposure scores across key management platforms
4. Tested and integrated cyber incident management plan	All Wales Cyber Incident Response exercise has been developed and was undertaken in September 2025. Lessons learnt report has been presented to CTM Civil contingencies/ EPRR group. The CTM Cyber Incident Response plan is under review from the Emergency Planning Response & Resilience (EPRR) team with a view to ensuring it links to organisational plans and terminology in a consistent manner. Testing of the Cyber Response Plan remains ongoing, including monthly scenario-based exercises and targeted ad-hoc testing of specific systems. The ePMA business continuity test was successfully completed in February 2026, and a forward testing schedule has been agreed for the next three months. with monthly focused exercises and additional ad-hoc tests of specific systems completed in January and February 2026. A testing schedule has been agreed for the next three months.	Improved response to cyber threat	Awareness and improvement to the cyber improvement
5. Develop a baseline Asset Register and product catalogue.	Architectural components (including digital applications) are being captured on the all Wales Ardoq system - a centralised repository that continuously connects and updates data about our business strategy, processes, software systems and integrations. (A digital plumbing map) The Armis passive network monitoring tool is now providing visibility and insight into what is connected to the network and contributes to the Ardoq system.	Greater insight into digital assets Greater understanding of risk profile	Improved cyber posture

	A replacement to our current IT Service Management tooling (Service Point) noted in Internal Audit - CTMUHB-2324-18 - is needed to fully manage this in the most effective way.		
6. Poor adherence to policies	Recognised requirement for policies to balance enablement with protection and for national digital strategies to place greater value on indirect clinical risk. National discussions ongoing as to whether national policies should be 80:20 based, so that local circumstance can be incorporated within policies, improving adherence. This needs to be undertaken alongside increased training and awareness of policies as part of the OCP process. Through the implementation of new digital solutions, the Health Board will aim to reduce unwarranted variation. Timeframe: It is anticipated that this activity will take 24 months to complete recognising the need to ensure it is managed through the new Care Group Structure.	Standardisation of working practises and processes.	Reduction in variation in working practises and processes across CTMUHB
7. Insufficient capital and revenue resource allocation and the capacity of the skilled workforce – exacerbated by the short-term nature of funding and seldom meets post implementation requirements.	Prioritise existing resources and available funding to meet the highest risk areas. The 2025/26 Digital & Data capital programme was delivered on time and to budget, with a total outturn of c£14.3m (£13.7m internal digital spend and £0.65m supporting wider capital schemes). The discretionary allocation increased from £1.88m to £3.64m due to slippage elsewhere, enabling further investment in cyber security, network resilience and server capacity. In addition, Welsh Government funding (including c£7.98m of All-Wales slippage funding) supported significant improvements to core digital infrastructure, networks, devices and clinical digital enablement. Commissioning of these assets will continue at pace during 2026/27, particularly core network switch replacements at acute sites, with resourcing pressures in the Voice and Data team being mitigated through additional contract support.	Sufficiently sized Digital and Data function able to meet the needs of the UHB whilst enabling Digital Transformation.	Improved project and programme delivery timeframes. Improved user experience with BAU digital services. Reduction in number of digital incidents and problems. Faster rollout of equipment purchased via capital.

	We have allocated additional revenue resources this year and a recruitment plan is forming. A list of Digital capital requirements has been created and shared with WG totalling £10.8m. There are several high value assets that will become end of life in FY25/26 and FY26/27 that were purchased in the past via end of year slippage with no currently identified funding routes for replacement. To date for 2025/2026 we have been awarded £9,909,000 in Capital. This enables us to replace end-of-life legacy core networking, firewall, and server equipment. Work to upgrade infrastructure is prioritised within Digital and Data team, aligned to availability of skillsets. As a result, there is a delay in some equipment being replaced or deployed. Timeframe: N/A - Rolling Annual Replacement. There remains a gap in the required Capital and Revenue to meet several core system deliveries and wider improvement opportunities, which is a continuing National challenge that all organisations are facing.		
8. Immaturity of the existing Electronic Health Record, which is difficult to integrate with, does not adhere to WG data and technical standards and whose Critical supplier(s) are unable to respond to CTMUHB's requirements and ministerial priorities within defined timescales.	WG have received endorsement from DDAT to proceed with the development of a needs assessment for an EHR for Wales, which they anticipate will be ready to go to the external (private sector) market in September. A National Target Architecture review is taking place; this being led by DHCW/Channel 3/ Aire Logic. CTMUHB have been feeding into the review. Timeframe: End of Quarter 4 2025/2026 Quarter 2 2026/2027	Functionality is more enabling for clinicians and patients, meeting more of their needs and requirements. Improved system integration. Improved data integration. Flexibility in system replacement. Improvement in timescales for delivery of functionality	Improved data driven decision making. Reduction of costs for systems. Reduction of vendor lock-in.
9. Critical supplier(s) unable to respond to the UHB's requirements and ministerial priorities within defined timescales.	Need to develop a more robust SLA and contract monitoring and management process for critical suppliers. A draft supplier and contract management framework has been created alongside Cyber to create a tiered approach to supplier management with a variety of controls based on the tier. This has been approved by the Digital and Data Leadership Group and be	Improved working relationships with critical suppliers Improvement in timescales for delivery of functionality	Improved system availability Increased productivity

	submitted for Health Board governance approvals. Timeframes – 1 Year. The Health Board is in a planned programme of work with the relevant critical suppliers to ensure delivery against key objectives in year 1)		
10.Capacity within current team to deliver digital transformation agenda.	Work with other NHS Wales partners, industry, academia and third sector organisations to improve our current digital competencies across the Health Board and our communities. Adoption of self service for basic Business Intelligence Recruitment to vacant posts. Resources required for CTMUHB to have the skills and expertise to use data and digital tools effectively- capacity and capability gaps exists when compared to other HBs and DHCW ~~Recruitment for the roles that have been funded by national and local programmes is ongoing. Majority of post are now filled with the last few members of staff starting Q4 of 2025/2026.~~ Unable to recruit some technical roles to support programme roll out.	Increased capacity facilitated through various Digital programme	Working with ChangeHub to broaden understanding of transformation that is enabled via Digital. Successful delivered transformation through the implementation of digital solutions.
11.Delayed delivery of the digital patient notes programme	Resourcing required to increase activity and accelerate completion of the programme. The current contract for patient record scanning (Cito) has been renewed on a like for like basis. Legacy scanning for historical records remains an ongoing issue exacerbated by a renewed destruction embargo as part of the Infected Blood. ~~is due to expire in March 2026, the Digital Transformation (Medical Records) and the Executive Team have approved the approach for re-procurement. Procurement on track to complete by expiry date (March 2026).~~ ~~We are backfilling a medical records role to create more capacity on the business case.~~	Large volumes of paper are still required to be stored. Historical records are not being scanned and there for will still require accessible storage areas	Remains a key element for our digital journey / alongside reduction and removal of paper from day-to-day clinical use. The introduction of new technologies designed to reduce the creation of paper at source will overtime reduce the level of digitisation (scanning) required e.g. once ePMA is completed rolled it in estimated that this will reduce our scanning activity by 7%. The team current scan around 350k documents a month (creating 700k images).

	We are currently undertaking baseline assessment on current scanning demand aligned with our strategic roadmap for modular patient record capability. Timeframe: 2-3-year programme of work.		
12.Limited progress to reduce/remove paper processes and move to a fully integrated digital patient record.	Scoping of a business case to implement an integrated health record complemented by a digitally enabled patient centred contact programme is now the focus for the Digital and Data team. The July 2024 Board approved the recommendation to proceed with the preparation of relevant documentation to procure a strategic partner to support and deliver a modular electronic patient record. National data resource programme has delivered University Health Board's clinical data resource, which supports capture and transfer of clinical information in line with common language, terminologies and standards. Proposal being made to the Digital Services for Patients & the Public which will enable the use of the NHS Wales patient portal and secure, authenticated digital communications between patients and clinicians in line with technical, information and clinical safety standards. Patient Centred Contact Transformation has continued at pace. ~~Recruitment is now almost complete, significant progress has been made with patient engagement. The procurement documentation has been completed for the technical solution~~ has commenced, with contract award planned within Q1 26/27. that are key enablers to deliver the programme benefits. Approval has been granted to proceed with procurement of digital tools in Q4. Timeframe: 2-3-year programme of work.	Reduction paper-based processes – undertaking process re-engineering replacing process with automated clinical workflow. Reusable digital data to enhance decision making	Improved productivity Reduction in errors associated with paper-based records and processes
13.Recruitment challenges due to short term funding allocations leading to an increased use of 3 rd party contractors and fixed term contract arrangements.	Work completed to understand substantive baseline. Need to prioritise recruitment of new roles aligned to Health Board Integrated Medium-Term Plan (IMTP). Timeframe: Additional resources are being added to the team this year however	Adequate resourcing pool within Digital and Data	Reduction in contingent staff costs

	recurrent funding is still a challenge for some of the National/Local Programmes.		
14.CTMUHB lack the Digital and Data assets and capabilities to enable the move of clinical services to the community and closer to home, which underpin ACSP.	Business case for the Mental Health EHR has been approved and funded. Options appraisals need to be undertaken for digitising the community services, running virtual care service, seamless integration of data and enabling more seamless care.	Transformational shift to integrated health and care services between the UHB and the and enhanced community care capacity across the system.	Reduction in ambulance transfer Reduction in length of stay Admission avoidance Improved patient experience and flow
15.Challenges with National Programmes and interdependencies on CTMUHB digital programmes.	The Digital and Data IMTP submission has now been approved, this includes funding to engage a strategic partner to support and develop our digital and data strategic roadmap, and a procurement activity is underway. The Ministerial Advisory Group (MAG) report has now been published which highlights challenges with Digital Transformation across NHS Wales, the UHB is analysing the detail of the report.	Speed up delivery of digital transformation. Improved utilisation of cutting-edge clinical technologies e.g. AI. Improved digital maturity as measured against the HIMSS Electronic Medical Record Adoption Model. (CTMUHB is currently at stage 0).	Improved operational performance and productivity. E.g. better electronic test requesting, better waiting-list management and referral management. Improved patient access to clinical services. Enabling staff to deliver high quality care.

Linked National Priority Measures

Digital and Technology

National Clinical Framework (WHC 2021/03) Welsh Government, March 2021),
Quality and Safety Framework: Learning and Improving (WHC 2021/022 September 2021)
Value Based Health and Care
Coding standards

Current Performance Highlights

- **Electronic Prescribing (ePMA)** - Planned go-live **for the early adopter site (Ward 4 PoW) delivered in March 2026** during November 2026 in Princess of Wales in Bridgend. **Implementation Timescale:** March 2026 and throughout 2026
- **NHS Wales APP** -A Ministerial priority in October 2025 was deploy referral information in the NHS Wales App. This has been delivered. Since the Phase 2 rollout, which included Secondary Care notifications in October 2025, there has been a **36.7% increase in CTM patients registered on the app, rising to 103,817 CTM patients as of 19 April 2026** ~~22.97% increase in CTM patients registered on the app, rising to 93,460 CTM patients as of 16 February 2026.~~
- **Medical Records & Patient Contact Services Operations** - The demand on the operational service remains high, with a high turnover of staff impacting our capability to deliver the current increased demand. **Medical Records and patient contact services were key to delivering appointments for an additional 24,000 patients in 25/26 as part of the WG initiative to reduce waiting lists.**
- **Llantrisant Health Park (LHP) Digital Workstream** - A new LHP Digital Workstream has now been stood up to the support the programme. A Digital by Design narrative have been developed for the Business Case. The workstream will now be extended to include colleagues from Aneurin Bevan University Health Board and Cardiff and Vale University Health Board as well as Tektology, our strategy digital partner.
- **Mental Health Procurement** - **CTM and BCU are waiting for WG approval to award the contract.** ~~The evaluation has been completed and we are awaiting the final procurement outcome report. A newly appointed Programme Manager and the established Project Manager are undertaking site visits and have started a baseline assessment.~~
- **Radiology - Radiology Information System Programme go live 16th March 2026.** ~~The implementation of the Radiology Information System Programme is progressing to plan with a go live of 16 March 2026~~
- **Pathology** - The programme has shifted from a Health Board Go Live to a per-discipline Go Live approach. Each discipline has been assigned a tranche (Tx) and deployment order. **The current deployment timelines are June for T3 (Microbiology) and July for T4 (Blood Sciences), with Blood Transfusion aiming for completion in 2026/27.** ~~The programme will not be completed by March 2026, with 542 severe 1 and 2 defects still open. The deployment timelines for tranches T3 and T4 have not been scheduled to meet the March 2026 deadline. Blood Transfusion (BT) is likely to be implemented in 2026/2027, after Microbiology and Blood Sciences.~~
- **Clinical Coding** - is currently undergoing Service Change as we upskill our team to meet the requirement of Artificial Intelligence (AI) and digitised ways of working. In the first phase we are seeking to train 4 of the 7 Support Staff to qualify as clinical coders. Coding performance is presently at 81% compared with the Welsh Government target of 95%. This is attributable to needing to prioritise the data science resource away from maintaining the Auto coder to focus on ePMA integration. As a consequence, we are having to manually code all FCE until capacity is released from supporting the EPMA and 6 goals programmes. We are currently at 95% for the first quarter (April-June) and predict we will hit the 95% coded completion for the second quarter by December 2025.
- **AI Development and Strategy** - Infrastructure is being developed which will enable services to use Large Language Models (LLMs) for clinical care support in a manner that is secure and lawful. Alongside this expertise has been sourced with the intention of assisting services gaining the requisite Medicines & Healthcare products Regulatory Agency (MHRA) approvals for ‘software as a medical device’. This should enable innovators across the UHB develop and test their applications in a performant and secure sandbox environment.

- **Legacy Equipment Replacement** - CTMUHB has secured additional investment in Digital & Data from Welsh Government, enabling a significant upgrade to the organisation's core digital infrastructure. This funding underpins a comprehensive legacy equipment replacement programme, covering the core network, server infrastructure and Wi-Fi estate. These upgrades will improve resilience, performance, and the reliability and availability of critical digital services. PoW, RGH and PCH have suffered core network and paging incidents in January, February, and April 2026. Core network replacement is currently underway, and implementation has commenced at the Princess of Wales Hospital, before progressing to the Royal Glamorgan Hospital and Prince Charles Hospital.
- **Six Goals** - Work on the digitised and fully interoperable Emergency Department huddle has progressed to the stage of User acceptance testing, with early feedback again being positive.

Were there any significant incidents affecting this strategic Risk this period:

Critical incidents under NIS-D: - There were no incidents reported to the CRU during this period. However, a small number of high-impact incidents did occur at both local and national level. These included network disruptions at several district general hospitals, mainly linked to legacy core infrastructure, which is being replaced. There were also two incidents affecting cloud-based services, including M365. In response, Business Continuity procedures were put in place where required.

A problem with the cooling systems in the DHCW CDC National Data centre resulting in Welsh Clinical Portal (WCP) and Welsh Patient Administration Services being affected resulting in service downtime. This was reported under NIS-D. Integration Services have experienced ongoing and unresolved messaging delays, affecting most national systems (including LIMS, MPI, Radiology, Scan4Safety and ICNET), with incidents occurring at least weekly for over three months and delays of up to seven hours. These issues have repeatedly triggered Business Continuity SOPs, causing significant disruption to clinical workflows and information flows, and are now assessed by the CTM MDT as having a material functional impact at a time of sustained clinical pressure

Strategic risk assessment	Holding information securely and confidentially	Effective governance, leadership and accountability	Obtaining information fairly and efficiently	Recording information accurately and reliably	Using information effectively and ethically	Sharing information appropriately and lawfully
Impact	5	4	4	3	3	3
Likelihood	4	2	2	4	4	5
Risk	20	8	8	12	12	15

Associated Risks escalated to the Organisational Risk Register

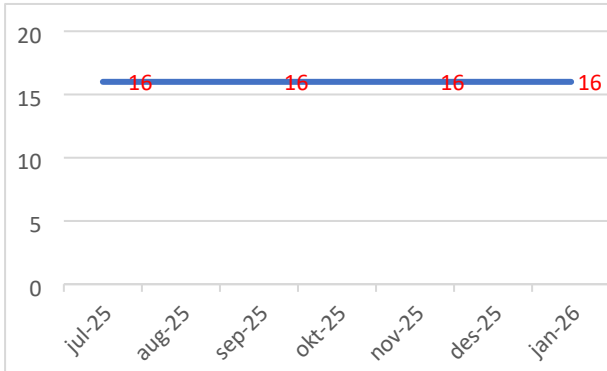
5276	Failure to deliver replacement Laboratory Information Management System, LIMS Programme, by summer 2025.	20
4664	Ransomware attack resulting in loss of critical services and possible extortion	20
5226	Risk of damage to records and equipment due to leaking roof in the Williamstown Records Hub. Escalated to the Organisational Risk Register March 2025. Risk de-escalated from the Organisational Risk Register in May 2025.	20
4671	NHS Computer Network Infrastructure unable to meet demand	16
6039	Increased cost of VMWare Licensing. Risk Score reduced to 8 and removed from Organisational Risk Register in March 2026	16
3337	Use of Welsh Community Care Information System (WCCIS) in Mental Health Services Lack of a Single Electronic Patient Record in Mental Health Services in CAMHS	15
4672	Absence of coded structured data & inability to improve our delivery of the national clinical coding targets and standards	15
5040	Digital Healthcare Wales interdependencies	15

Strategic Goal(s)			Risk score
 Improving Care - Delivering safe and compassionate care. - Developing new models of care. - Digital transformation for patients and staff - Ensuring timely access to care	 Sustaining our Future - Becoming a green organisation - Ensuring our Services financial sustainability Embedding value-based healthcare - Ensuring our estate is fit for the future		16

Strategic Risk: **Ability to maintain a safe and fit for purpose estate infrastructure – (Risk No. 6)**

If: CTMUHB does not have enough capacity and/or resource to be able to deliver and maintain a safe and fit for purpose estate.	Then: there is a risk that it may not be able to maintain an estates infrastructure that keeps services functioning, meets statutory compliance regulations and provide enhancements / improvements for patient care and staff wellbeing for now and the future.	Resulting in: - An inability to deliver its services efficiently and effectively. - Poor environment and experience for patients and staff - Infrastructure problems - Unable to replace failing/ageing equipment. - Business continuity problems - Poor Estate compliance - Regulatory Compliance issues - Lack of digitally enabled facilities - High carbon footprint - Loss of services and productivity - Increased backlog maintenance

Risk Lead	Executive Director of Finance	Assurance committee	Operational Delivery Committee

	Consequence	Likelihood	Score	Risk Score Trend this Period: No change to risk scores this period. Risk Score Trajectory 
Initial	4	4	16	
Current	4	4	16	
Target	4	2	8	
Risk Appetite	Cautious <i>(quality and safety; trust and confidence; legal and regulatory)</i>			
Rationale for assessment of risk score: <i>Including where risk score remains unchanged and for any changes</i>				A score of 16 has been calculated using the Risk Scoring Matrix and the "Environment and Estate Infrastructure" Domain. Due to the pace of which mitigations will be realised the risk score has been reviewed and remains unchanged.

	Risk reviewed in April 2026 - due to this period in the financial year it is recognised that currently there is limited movement in available capital and therefore additional improvements and investments in infrastructure is limited. However, in November 2025 CTMUHB Board approved the Prince Charles Hospital (PCH) Refurbishment Project Finalised Phase 3 Full Business Case for submission to Welsh Government for capital funding – approval is awaited. In recognising the above position and recent data available from the Estates, Facilities, Performance Management System, which reports a figure of £95m, risk adjusted to £76m, for backlog maintenance the risk score remains unchanged.		
Risk Treatment Assessment <i>i.e. Treat, Tolerate, Transfer etc.</i>	Whilst recognising the challenges outlined in this risk the health board is continuing to Treat this risk; however, pace of change is not at the desired rate and there are elements where the risk will need to be Tolerated .		
Current Control Measures			
• Prioritisation of Estate Activity based on risk-based decision making. • Pursue all capital funding options from Welsh Government to address backlog maintenance and statutory compliance such as: ◦ Applications to the Targeted Estates Fund (TEF) to access funding under the infrastructure monies. ◦ Applications to the All-Wales Capital Programme on an annual basis. ◦ Discretionary Capital • Maximise current revenue allocations, optimised for statutory compliance and risk priorities. • Maintenance Programme established managed via the Planet Facilities Management System (Planned and Reactive Maintenance Jobs). • In 2024-2025 the estates’ operational function was digitised, the estates operatives were provided with mobile devices so that they are now able to work in real time, this has helped to maintain performance despite the staff shortages. • CTMUHB has the highest capital allocation in 2025-2026 than any other Health Board in NHS Wales. However, this still does not mitigate all the gaps in controls and the resulting impact of this risk.			
Sources of Assurance (Internal and External)			
Internal • Regular monitoring through CTMUHB’S Executive Capital Management Group. • Capital Scheme Delivery Programme. • Annual Estates and Energy Performance Report received at the Operational Delivery Committee (and Planning, Performance and Estates Committee prior to that Committee being disbanded) • Routine performance reports submitted quarterly to the Estates and Capital Governance Board and monthly at the Estates Operational Management Team meetings. • Escalation of risks through the Capital and Estates Risk Escalation Group. • Comprehensive internal audit programme.			
External • NHS Shared Services Partnership- Specialist Estate Services (NWSSP–SES) have collected Estates and Performance Monitoring system data (EFPMS) on behalf of Welsh Government. • ISO 14001 Certification – Environmental Management achieved. • Regular reporting and monitoring with Welsh Government. • Comprehensive external audit programme.			
Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Indicators of Success (following implementation of mitigating actions)
1. National Skills shortage in Estates Roles (<i>Private sector salaries are impacting the CTMUHB’s ability to be competitive in the recruitment market</i>) results in staffing challenges to deliver the estates functions.	• The Estates Directorate have engaged CTMUHB’s Organisational Development department to see what can be done to reverse this recruitment and retention trend. • Concerns have been raised at a national level. • Ongoing activity continues with the support of the People Directorate to explore routes to further promote and attract candidates to roles advertised particularly around the	• Competitor in the market. • Successful recruitment to roles when advertised.	• Full establishment and retention of Estates Workforce. • Estates Maintenance performance activity will demonstrate an improvement. • Whilst recognising that there continues to be a National UK skills shortage the Health Board has had recent success in appointing to two Senior Estate Manager roles, and due to robust succession planning filled other gaps within the team which has provided stability.

	Band 6 opportunities within the team as it is acknowledged that recruiting to these roles continues to be a challenge.		•
2. Increasing Backlog Maintenance position.	- Secured Targeted Estates Funding (TEF) - Proactive in securing additional funding from Welsh Government when available.	• Reduced backlog maintenance	- Targeted schemes delivered. - Improved patient environment - Reduced estate risks.
3. Secure Funding to deliver Capital Schemes	Various business cases in development for example, Phase 3 Prince Charles Hospital, Llantrisant Health Park and Maesteg etc, all of which are ongoing schemes.	• Reduction in backlog maintenance and lifting of Fire Enforcement Notice.	• Funding secured to deliver the project
4. Deliver schemes within a live environment	- Dialogue with service leads. - Secure decant where appropriate.	• Minimal impact on service whilst project is delivered.	• Business continuity is maintained whilst the project is delivered.

Linked National Priority Measures

Energy and Environmental Targets as listed in the CTMUHB Decarbonisation Action Plan (DAP).
Deliver the Capital programme within the agreed Capital Resource Limit (CRL).

Current Performance Highlights

Please refer to the Estates Performance Report submitted to the Operational Delivery Committee in April 2025 available here: [29 April 2025 - Cwm Taf Morgannwg University Health Board](#)
The next submission will be shared with the Operational Delivery Committee on 30th April 2026.

Were there any significant incidents affecting this strategic Risk this period:

Associated Risks escalated to the Organisational Risk Register

6234	National skills shortage in Estates Roles (Private sector salaries are impacting the CTMUHB's ability to be competitive in the recruitment market) resulting in recruitment and retention challenges throughout the department. Risk score reduced to a 12 in January 2026, therefore risk de-escalated from the Organisational Risk Register.	16
6235	Insufficient funding to address backlog maintenance across the estate.	16
6379	CT Scanners at RGH damaged by power outage and manual generator/UPS switch over. Risk closed in February 2026.	16
4417	Management of Security Doors in all Hospital settings.	16
4958	Inadequate robust fire management response to fire incidents on site	16
4933	Inadequate response to a fire incident on site	16

Strategic Goal(s):



Creating Health

- Reducing health inequalities
- Equal focus on mental and physical health
- Supporting our communities
- Being a healthy organisation



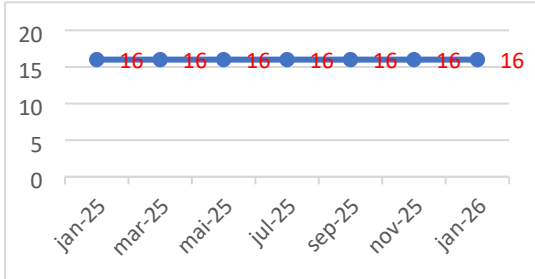
Sustaining our Future

- Becoming a green organisation
- Ensuring our Services financial sustainability Embedding value-based healthcare
- Ensuring our estate is fit for the future.

Risk score
16

Strategic Risk: Fulfilling our Environmental and Social Duties and ambitions (Risk No.7)		
If the Health Board’s decisions fail to reflect our values or consider the long-term environmental or social impact	Then we will not fulfil our Socio-economic duty, our statutory emission reduction targets, our Wellbeing of Future Generations objectives and our value-based healthcare principles	Resulting in negative environmental and social impacts, and loss of trust and confidence among stakeholders

Risk Lead	Executive Director of Strategy and Transformation	Assurance committee	Strategic Development Committee

	Consequence	Likelihood	Score	Risk Score Trend this Period: No change to risk scores this period. Risk Score Trajectory 
Initial	4	5	20	
Current	4	4	16	
Target	4	2	8	
Risk Appetite	Cautious <i>(quality and safety; trust and confidence; legal and regulatory)</i>			
Rationale for assessment of risk score: <i>Including where risk score remains unchanged and for any changes</i>				It is anticipated that the risk score may remain quite stagnant as the pace of improvement is constrained by workforce and financial capacity constraints, which limits the available investment into the environmental infrastructure.
Risk Treatment Assessment <i>i.e. Treat, Tolerate, Transfer etc.</i>				It is recognised that there is an element of tolerating this risk in terms of the pace in being able to mitigate it. There are, however, ongoing risk treatment activity outlined in the mitigating actions section particularly around the Climate Adaption Plan.

Current Control Measures
Building Healthier Communities The Building Healthier Communities Steering Group aims to support delivery of the Socio-Economic Duty – for example, procurement, foundational economy, employability, probation. Environmental Sustainability Group The Governance and assurance arrangements for Environmental Sustainability have been overhauled and the ESG now reports directly into the Strategic Development Committee and is chaired by an Executive Director. Wellbeing and Socio-economic duties - Integrated Medium Term Planning Process aligned to the seven Welsh wellbeing goals and five ways of working. ‘CTM 2030’ delivery focusses on community developments, employment and local procurement where possible.

• CTM becoming established as an Anchor Organisation. Socio-economic duties are also considered as part of the controls and impact captured within the following Strategic Risks St 8, St 3 and St 4. Environmental Sustainability – Net Zero • Climate Action Plan will be presented to March 2026 Board for approval and was formally endorsed. • ~~Established a CTM Environmental Sustainability Group as part of transformation agenda.~~ • ‘CTM 2030’ seeks to ensure that services take account of the impact on the environment. • All-Wales approach to sustainable procurement • Green CTM Staff Forum • Waste management – elimination of landfill for foodstuffs. • Use of less environmentally impactful anaesthetic gases • Workshop delivered to Board Members in 2025. ~~The Board will be provided with regular briefings through SDC updates and future briefings.~~ • High level adaptation risks have been approved with a plan developed to address some of the challenges we will face – these are included in the Climate Action Plan • The programme is managed by a Sustainability Manager • REFIT Programme – Has been received, funding of £11.4m for PV, LED lighting, BMS optimisation as well as a small ASHP and battery storage project. Public Services Board Climate Change Action Group (Director Level) has been established. The Targeted Estates Fund (TEF) application for “Whole CTMUHB- Decommissioning of nitrous oxide plus gas capture” has been awarded. Project manager has been assigned to oversee the works. The project is scheduled to be complete within the 2025-2026 financial year. Innovation Activity – Sustainability Manager exploring opportunities around innovation and sustainability.
Sources of Assurance (Internal and External) Wellbeing and socio-economic duties • Wellbeing Statement accompanying-Annual Plan • Progress reports against the Annual Plan • Case studies of projects contributing to wellbeing and equality, e.g. Connected Communities, Healthy Schools, Social Prescribing, Sustainable Procurement • Building Healthier Communities Steering Group • Healthy Housing Alliance Environmental Sustainability – Net Zero • Environmental Sustainability Annual Report • ISO 14001 (Certified Environmental Management System) accreditation • NWSSP Internal Audit Services – Decarbonisation (Follow Up) Internal Audit Review. Board / Committee Assurance mechanisms The Decarbonisation programme updates are assigned to the Strategic Development Committee for reporting and assurance / scrutiny purposes. The Climate Action plan was received and approved at the Board meeting held on the 26 March 2026. ~~has received comments and assurance from Executive Leadership Group and Strategic Development Committee, seeking final approval through Board on 26th March 2026.~~ Independent Assurance NWSSP Internal Audit Services review of Decarbonisation Action Plan delivery has been undertaken. All Health Boards are subject to this review. Outcomes have been reported to the appropriate committee and associated actions added to the strategic risk as appropriate. Copy of the report available upon request from the Corporate Governance Team. Requirements for the audit have been incorporated into the new climate action programme to ensure compliance.

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Indicators of Success (following implementation of mitigating actions)

1. Climate Action Plan. Plan to be produced in line with the Welsh Government Climate Adaptation strategy due to be published April 2026.	Board sessions have been presented to the board to increase awareness and knowledge. The PSB have developed a CCRA for the region. Climate Action requirements are being established and risks developed in line with WG policy.	The intended impact of this mitigation is to better enable the future sustainability of the services provided by CTMUHB in response to the current and expected impacts of climate change.	Long term success indicators due to the nature of the risk.
2. Procurement framework to reduce carbon footprint of goods and services purchased from outside the organisation.	The procurement team are included within the part of Environmental Sustainability Group and wider decarbonisation networks. This is ongoing, however, pace of progress likely to be slowed as financial considerations become more dominant.	Procurement processes always consider the carbon impact as part of the decision-making process.	Reduction in carbon footprint associated with procurement processes over the medium to long term.
3. Mapping against 'More Equal Wales' guidance for Socio-economic Duty which came into effect in April 2021.	To include as discussion point as part of Building Healthier Communities work moving forward, including public health involvement. Ongoing.	Tackling inequality is a focus of decision making.	Long term success indicators due to the nature of the risk.
4. Global energy crisis will impact on service delivery for our communities and staff; this is being closely monitored, as it will impact upon health and wellbeing.	CTMUHB Financial Care Wellbeing Pathway launched to support the workforce recognising the impact of the cost of living increase impacting our workforce and population. Working alongside community partners to access identify and access opportunities for community support. Ongoing.	Impact of cost of living rises are reduced where possible.	Long term success indicators due to the nature of the risk.
5. Access to the necessary capital needed to deliver decarbonisation plan is limited	Climate Action Plan will be costed. Access to alternative funding streams utilised when appropriate	Capital works set out within the Climate action plan are completed when funding is secured.	Long term success indicators due to the nature of the risk.
6. There are organisational policies which will be required (i.e. building and estates strategic plan) to feed into the decarbonisation programme	This has been flagged as a risk; however, policies will be managed under alternative programmes.	Through flagging these risk the aim is to influence the development of plans which impact on the decarbonisation programme.	Long term success indicators due to the nature of the risk.

Linked National Priority Measures

Economy and Environment

- Emissions reported in line with the Welsh Public Sector Net Zero Carbon Reporting Approach
- Qualitative report detailing the progress of NHS Wales' contribution to climate action as outlined in the organisation's plan.

Qualitative report detailing evidence of NHS Wales advancing its understanding and role within the foundational economy via the delivery of the Foundational Economy in Health and Social Services 2021-22 Programme

The Welsh Government Energy Service have published an updated strategic delivery plan (SDP) which outlines the high-level actions for decarbonisation within the NHS covering 2025-2030. Actions contained in the SDP are being reviewed and allocated to strategic leads.

Wellbeing of Future Generations Act

A More Equal Wales – Socio Economic Duty

Current Performance Highlights

- Decarbonisation Reporting has taken place of the course of the year.
- Annual Carbon Emissions report. Data has been reported for Carbon Emissions and submitted to Welsh Government in September 2025.
- The annual CTMUHB Annual Report & Accounts has captured the objectives and progress of embedding the Wellbeing for Future Generations Act (WBFGA).
- CTMUHB won 2 NHS Wales Sustainability awards and was shortlisted for several others. Significant funding was secured through SBRI and SFIS programmes developing solutions to waste sustainability challenges.
- All 3 of the ED's across the organisation have achieved Bronze GreenED accredited status.
- The Solar Panel Installation at Coed Ely Solar Farm is complete. This will help lower CTMUHB's emissions as it will receive 1MW of low-carbon power through an innovative power purchase agreement. The Coed Ely Solar Farm will provide enough energy to power approximately 8,000 homes annually while supplying low-carbon electricity directly to the Royal Glamorgan Hospital via a private wire network spanning three kilometres. **Project is also underway to connect a direct wire to Prince Charles Hospital from a local school in Merthyr providing their surplus renewable energy.** This innovative approach ensures that up to 15% of the hospital's annual electricity demand is met sustainably rising to 100% on peak summer days. Funding has been awarded through the ReFIT programme to fund efficiency and carbon reduction activities across the Health Board.

Were there any significant incidents affecting this strategic Risk this period:		
Associated Risks escalated to the Organisational Risk Register		
5374	Fulfilling our environmental and social duties.	16

Strategic Goal(s):



Creating Health

- Reducing health inequalities
- Equal focus on mental and physical health
- Supporting our communities
- Being a healthy organisation



Sustaining our Future

- Becoming a green organisation
- Ensuring our Services financial sustainability Embedding value-based healthcare
- Ensuring our estate is fit for the future

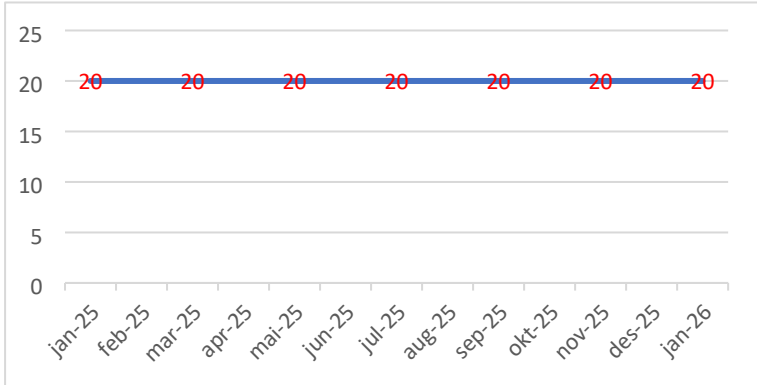
Risk score

20

Strategic Risk: Prevention and early Intervention to support Healthy Life Expectancy (Risk No.8)

If CTMUHB does not effectively shift its services to prevention and early intervention and engage the population to improve their health	Then There will be a decrease in Healthy Life Expectancy (HLE) and an increase in the gap between the most and least deprived and an unsustainable health service. We will also fail to improve healthy life expectancy and reduce inequalities in healthy life expectancy	Resulting in poorer health outcomes, greater inequalities and an unsustainable health service.

Risk Lead	Executive Director of Public Health	Assurance committee	Strategic Development Committee

	Consequence	Likelihood	Score	Risk Score Trend this Period: *The consequence score has reduced for the target score assessment, as there will be an element of both mitigation and adaptation. The Health Board aims to reduce the behaviour and health risks (primary, secondary, tertiary prevention); however, the organisation will still need to adapt as appropriate. No change to risk scores this period. Risk Score Trajectory  <table border="1"><thead><tr><th>Month</th><th>Score</th></tr></thead><tbody><tr><td>Jan-25</td><td>20</td></tr><tr><td>Feb-25</td><td>20</td></tr><tr><td>Mar-25</td><td>20</td></tr><tr><td>Apr-25</td><td>20</td></tr><tr><td>May-25</td><td>20</td></tr><tr><td>Jun-25</td><td>20</td></tr><tr><td>Jul-25</td><td>20</td></tr><tr><td>Aug-25</td><td>20</td></tr><tr><td>Sep-25</td><td>20</td></tr><tr><td>Oct-25</td><td>20</td></tr><tr><td>Nov-25</td><td>20</td></tr><tr><td>Dec-25</td><td>20</td></tr><tr><td>Jan-26</td><td>20</td></tr></tbody></table>	Month	Score	Jan-25	20	Feb-25	20	Mar-25	20	Apr-25	20	May-25	20	Jun-25	20	Jul-25	20	Aug-25	20	Sep-25	20	Oct-25	20	Nov-25	20	Dec-25	20	Jan-26	20
Month	Score																															
Jan-25	20																															
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Initial	5	4	20																													
Current	5	4	20																													
Target	4*	2	8																													
Risk Appetite	Cautious (<i>quality and safety; trust and confidence; legal and regulatory</i>)																															
Rationale for assessment of risk score: <i>Including where risk score remains unchanged and for any changes</i>																																
The risk score has remained unchanged. Some mitigations have been slow to implement and have impacted the speed at which the trajectory will change, For example: ○ Delays to the funding of the children’s weight management service, the opportunity to influence weight and subsequent risk of diabetes and other comorbidities is limited. ○ Delays in recruitment of Public Health (PH) posts presented challenges in delivering PH interventions such as Income maximisation work for at risk groups ahead of winter Also, despite funding being made available via the IMTP for the continuation of Children’s services such as Pipyn, a gap still remains in the wider provision of weight management services and resulted in a slower than anticipated start to the programme.																																

	Whilst not inevitable, the current trajectory indicates increasing health risks reduced healthy life expectancy and widening inequalities. CTM has a higher percentage of more deprived areas than other Health Board areas in Wales, with 51.9% of the population in CTM are living in the two most deprived fifths in Wales (WIMD, 2025). Linked to this, CTM lags behind the national average in healthy lifestyle behaviours and health outcomes and growth in healthcare demand may be higher than in the rest of Wales. Both life expectancy and healthy life expectancy in CTM is below the Welsh average. The gap in life expectancy at birth between the most and least deprived in CTM is now estimated at 6 years for males and 5.3 years for females. With regards to Healthy life expectancy, the gap is greater, at 10.7 years and 12.1 years for males and females respectively (PHW 2024). In CTM, the population is ageing; by 2040, a significant (20%) increase is projected in the number of people aged 65+, with the most significant (48%) increase in those aged 85+.The number of people with chronic diseases including cardiovascular diseases, respiratory diseases, diabetes and rheumatoid arthritis is also projected to increase significantly in the next 5 years therefore placing increased demand on services and health board budgets Capacity to support a prevention and population health approach continues to be a challenge linked to short term funding for prevention activities in public health and competing priorities for existing resources across the health board. If CTMUHB is going to deliver a sustainable service for our population and meet our obligations under the wellbeing goals of the WBFGA (A more equal Wales, A healthier Wales) then a shift of resources and services to prevention and early intervention will be needed to effectively engage the population to improve their health.
Risk Treatment Assessment <i>i.e. Treat, Tolerate, Transfer etc.</i>	This risk will be treated and managed through programmes of primary, secondary and tertiary prevention across the health board, as well as in partnership with system partners to influence the wider determinants of health.

Current Control Measures

Strategies & Plans

- Welsh Government strategies/ plans: “Healthier Wales”, “Healthy Weight Healthy Wales”, “Smoke Free Wales”.
- CTM 2030 Strategy – ‘Our Health Our Future’
- Work programme set out in ‘Becoming a Population Health Organisation: a discussion and options paper for Board’, May 2021, updated November 2022.
- Public Service Board – Well Being Plans.
- Creating Health delivery plan approved.
- CTM Health Protection Strategy drafted and approved.
- Development of Acute Clinical Service Plan (ACSP).
- Business case developed as part of IMTP process for child weight management but not yet approved.

Engagement Forums

- CTM Creating Health Portfolio Board
- Regional Partnership Board
- Public Service Board
- Area Partnership Board
- CTM2030 Leaders Groups
- Strategy Groups: Born Well, Growing Well, Living Well, Ageing Well and Dying Well
- Engagement with community groups by Lead Independent Members
- meetings with the three local authorities

- Accelerated Cluster Development Programme Board – engagement across Primary Care
- Health and Social Care Integration Board
- Forum with local authority Chief Executives to address health inequalities.
- CTM Health Protection Board
- Welsh Government Health protection Operational and Resilience Group

Needs Assessment & Consultation Processes

- Population Segmentation & Risk Stratification
- Pharmaceutical Needs Assessment
- Health Needs Assessments, e.g. Homeless People, Prison Health, staff wellbeing
- Wellbeing Assessment (PSB)
- Population Needs Assessment (Regional Partnership Board)
- Formal consultation processes for service reconfiguration, e.g. vascular

Organisational Structures

- CTM Leaders Network
- Creating Health, Improving Care, Sustaining our Future and Inspiring People Strategic Pillars
- Primary Care clusters

Services:

- Integrated Level 2 and Level 3 Weight Management Services – established in September 2022.
- Smoking Cessation Service
- All hazards Health protection Service
- Pipyn Service

Sources of Assurance (Internal and External)

Wellbeing and socio-economic duties

- Wellbeing Statement accompanying Annual Plan
- Progress reports against the Annual Plan

Reports to Board

- Creating Health Programme
- Annual Director of Public Health Annual Report
- Creating Health Portfolio Board reports to the transformation board

Reports to Population Health & Partnerships Committee

- Population Health Management Programme
- Health Protection Programme
- Vaccination Programme Reports
- Regional Partnership Board Annual Report
- Transformation Fund and Leadership Board Updates
- Mental Health Strategic Update
- ACSP updates provided to the Committee.

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Indicators of Success (following implementation of mitigating actions)
1. Delay in developing health protection / immunisation capacity.	Recurrent funding for 24/25 onwards now secured. Increase in allocation of £1.06ms, however, total allocation remains below the	The funding for Health Protection would be sufficient to deliver all key priorities in the Health Protection strategic plan.	Priority areas allocated identified and fully funded.

	Welsh "Fair Shares value". All Hazards Health Protection plan signed off for implementation. Development of a HP strategy and associated priorities. Scoping exercise to follow to identify any continuing gaps in HP provision against the budget allocated for 2025-2026. A case made to Welsh Government for additional funding to further close the gap in funding per head between CTM and the rest of Wales.		Any residual gaps in funding the strategic plan identified. An uplift in funding to a sufficient level to enable full delivery of the Health Protection strategic plan for 26/27 onwards.
2. Strategic Focus on prevention/ inequalities	CTM2030 strategy; Creating Health Portfolio board. Creating Health Delivery Plan drafted in Q4 2023/24. Creating Health Delivery Plan refresh planned for April 2026 Health Protection Strategy. Vaccine equity strategy CTM Population Health Framework under development	Decreased variation in access and outcomes across the population of CTM. Increased prevention activities will avoid harm and reduce the financial burden of chronic disease. Clear focus and strategic aims to help develop CTM as a Population Health Organisation Improved understanding of requirements for change Embedding of Marmot principles in all core activities of the health board	Delivery of the outcomes associated with the Health Protection strategic plan. Delivery of the milestones in the Creating Health Delivery Plan Measurable improvement in the difference in outcomes between least and most deprived as measured in the creating health dashboard. Measurable increase in investment in prevention activities/programmes across the Health Board. Deliverables articulated related to CTM Population Framework with performance monitored against them. Measurable improvement in the difference in outcomes between least and most deprived as reported in the creating health dashboard.
3. Capacity for population health management	Population health management programme maturing alongside primary care clusters; implementation within health board. Review of resource options underway, consideration for external short-term capacity Work underway to consolidate a shared clinical record.	The use of Population Health Management (PHM) data to inform strategic planning and operational delivery maximised.	PHM priorities defined as part of the Local Public Health Team portfolio. A clearly defined strategic plan for the delivery of PHM in CTM. A robustly resourced PHM function in CTM.
4. Impactful action to address health inequalities	• Whole system approach to Healthy weight • Help me quit/ hospital programme. • WISE • Cancer inequalities group • Implementation of Stroke equity Audit recommendations.	Decreased variation in access and outcomes across the population of CTM. Increased focus and alignment of resources to meet the needs of vulnerable groups	Measurable improvements in outcomes for vulnerable groups. Less variation in access and outcomes across the CTM population.

	- HP intervention plan for vulnerable groups to be developed once HP posts recruited e.g. Prison health, vulnerable communities' events. - Vaccination equity strategic plan in place		Improvement in outcomes associated with the Vaccine Equity Plan. Delivery of outcomes associated with vulnerable groups highlighted in the HP Strategic plan. Measurable improvement in the difference in outcomes between least and most deprived as measured in the creating health dashboard.
5. Coherent prevention (primary, secondary, tertiary) for high burden diseases such as diabetes, cardiovascular disease, etc	Partnership work underway with PHW to address diabetes, with links to CVD, MSK etc. A business case submitted as part of the IMTP to fund a children's weight management service.	Consistency and alignment with national programmes of work focussed on prevention and the burden of chronic disease. Clearly defined primary, secondary and tertiary CTM prevention programmes where appropriate. Resources moving into prevention strategies	CTM representation at all relevant partnership boards and programmes of work. Chronic Disease Risk Reduction as a programme of work in the Local Public Health Team portfolio Improvement in outcomes for patients with chronic disease A funded child weight management service agreed. A funded child weight management service in place
6. Ability to influence wider system partners/ determinants of health	Engagement in partnership fora (RPB, PSB, Leaders groups)	Improved collaboration and partnerships to adopt a whole system approach to impact wider determinants of health for the CTM population.	CTM representation at all relevant partnership boards and programmes of work. Collaborative projects delivered in partnership influence wider determinants.

Linked National Priority Measures

Population Health – Ministers Measures Phase One

- Percentage of adults losing clinically significant weight loss (5% or 10% of their body weight) through the All-Wales Weight Management Pathway
- Qualitative report detailing progress against the Health Boards' plans to deliver the NHS Wales Weight Management Pathway
- Percentage of adults (aged 16+) reporting that they currently smoke either daily or occasionally.
- Percentage of adult smokers who make a quit attempt via smoking cessation services.
- Qualitative report detailing the progress of the delivery of inpatient smoking cessation services and the reduction of maternal smoking rates.

NHS Performance Framework Quadruple aim one:

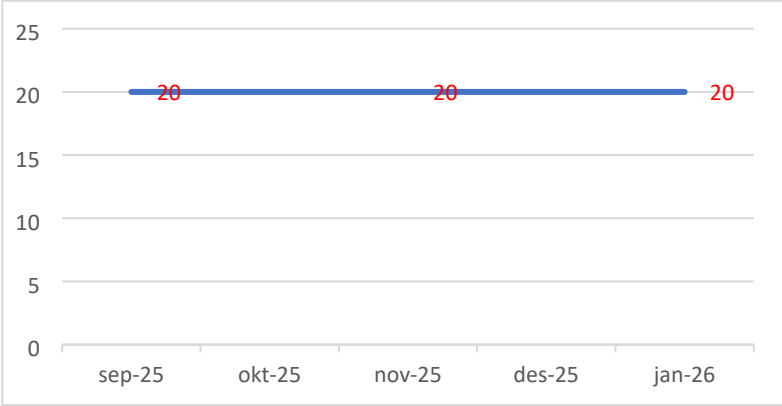
- Percentage of children who are up to date with the scheduled vaccinations by age 5 ('4 in 1' preschool booster, the Hib/MenC booster and the second MMR dose)
- Percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15
- Percentage uptake of the influenza vaccination amongst adults aged 65 years and over
- ~~Percentage uptake of the COVID-19 vaccination for those eligible~~ **Percentage uptake of the Respiratory Syncytial Virus (RSV) vaccination for those turning 75 years old**
- Percentage of adult smokers who make a quit attempt via smoking cessation services.
- Percentage of adult smokers who make a quit attempt via smoking cessation services who are co-validated as quit at 4 weeks.
- Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs or alcohol)
- Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment.
- Percentage of patients (aged 12 years and over) with diabetes who have had foot surveillance recorded within the last 15 months.**
- Percentage of patients (aged 12 years and over) with diabetes who have had their urine albumin recorded within the last 15 months.**
- Percentage of population (adult) receiving NHS dental care over a 24-month period – General Dental Services (GDS)**
- Percentage of population (child) receiving NHS dental care over a 12-month period – General Dental Services (GDS)**
- ~~Percentage of well babies entering the new-born hearing screening programme who complete screening within 4 weeks~~
- ~~Percentage of eligible new-born babies who have a conclusive bloodspot screening result by day 17 of life~~

Current Performance Highlights		
Please refer to Integrated Performance Dashboard - Quadruple Aim 1.		
Were there any significant incidents affecting this strategic Risk this period:		
No		
Associated Risks escalated to the Organisational Risk Register		
6179	High and increasing prevalence of overweight and obesity in children and adults	20
5579	Rising childhood obesity rates resulting in an increase in obesity related conditions and poorer health outcomes.	16
5726	Public Health Funding for Microbiology Testing Risk closed in April 2026	15
5820	Potential inability to deliver all elements of the Health Protection Strategic priorities as a result of reduced allocation of funding.	12

Strategic Goal(s)			Risk score 20
 Sustaining our Future - Becoming a green organisation - Ensuring our Services financial sustainability Embedding value-based healthcare - Ensuring our estate is fit for the future			
Strategic Risk: Failure to deliver a sustainable plan and manage revenue resources within the Revenue Resource limits set by Welsh Government (WG) – (Risk No.9)			
If the Health Board fails to deliver and sustain an approved Integrated Medium-Term Plan and manage its revenue resources within the 'Revenue Resource limits' set by WG.	Then we may fail to fulfil our two statutory financial duties (i.e. Approved IMTP and break even over 3-year period)	Resulting in Breach of statutory duties, application of the escalation framework by Welsh Government, trust and confidence in the Health Board (reputational impact).	

Risk Lead	Executive Director of Finance	Assurance committee	Operational Delivery Committee

The development of this new strategic risk will follow in the September iteration of the Board Assurance Framework Report.

	Consequence	Likelihood	Score	Risk Score Trend this Period: No change to risk scores this period. Risk Score Trajectory 
Initial	4	5	20	
Current	4	5	20	
Target	4	3	12	
Risk Appetite	Cautious (<i>quality and safety; trust and confidence; legal and regulatory</i>)			

Rationale for assessment of risk score: <i>Including where risk score remains unchanged and for any changes</i>	As part of the 2026-2029 IMTP, the Health Board has submitted a balanced financial plan for 26/27 for both Capital & Revenue resource. Both of these plans include risks, particularly the Revenue Plan which includes the delivery of £31.3m of savings together with £38.6m of risks and an assumption that WG will support the £18.4m Welsh Risk Pool pressure if the HB delivers a break-even financial position. The HB awaits the formal response of the submitted IMTP and if the plan is approvable, development of robust savings plans will be critical to provide WG with confidence upon the deliverability of the IMTP financial plan. The financial outlook for 2027/2028 and beyond looks very challenging and there is a significant risk to achieving a recurrent balanced financial plan. ~~The Health Board has submitted a balanced financial plan for 25/26 but this plan includes significant risks, including the delivery of £31.3m of efficiency savings together with anticipated allocation risks.~~

	The Month 10 Year To Date (YTD) position was a £1.4m deficit with a savings shortfall of £5.2m. Welsh Government (WG) have confirmed allocations for national insurance changes and 24/25 pay awards, these have both been lower than anticipated resulting in an unplanned £3.8m recurrent cost pressure Following confirmation from WG of funding to support the increase in Welsh Risk Pool contributions together with the impact of the Band 2/3 Healthcare Support Worker settlements, the level of risk in achieving a breakeven position for 2025/26 is now minimal. <table><tr><th></th><th>M10 YTD</th><th>Year-end Forecast</th><th>Recurrent Forecast</th></tr><tr><th></th><th>£m</th><th>£m</th><th>£m</th></tr><tr><td>Savings Shortfall</td><td>5.2</td><td>5.6</td><td>4.8</td></tr><tr><td>Operating Variances</td><td>(0.5)</td><td>0.7</td><td>1.2</td></tr><tr><td>Plan Phasing adjustments</td><td>2.8</td><td>0</td><td>0</td></tr><tr><td>Financial Plan Improvements</td><td>(4.0)</td><td>(4.8)</td><td>(2.7)</td></tr><tr><td>Accountancy Gains</td><td>(5.3)</td><td>(5.3)</td><td>0</td></tr><tr><td>Financial Allocation Adjustments</td><td>3.2</td><td>3.8</td><td>3.8</td></tr><tr><td>Band 2/3 Framework</td><td>0</td><td>0</td><td>2.8</td></tr><tr><td>Other Mitigating Actions</td><td>0</td><td>0</td><td>0</td></tr><tr><td>Grand Total</td><td>1.4</td><td>0</td><td>9.9</td></tr></table> The latest assessment of the recurrent forecast indicates a deterioration from a planned £1.7m surplus to a £9.9m deficit. The full year effect of the Welsh Risk Pool which were supported for 2025/26 non recurrently remains a risk to this position if no further support is confirmed by WG. Following the publication of the Welsh Government draft budget, the financial outlook for 2026/27 looks very challenging and there is a significant risk to achieving a balanced financial plan for 2026/27. Therefore, the risk score remains unchanged on this review.		M10 YTD	Year-end Forecast	Recurrent Forecast		£m	£m	£m	Savings Shortfall	5.2	5.6	4.8	Operating Variances	(0.5)	0.7	1.2	Plan Phasing adjustments	2.8	0	0	Financial Plan Improvements	(4.0)	(4.8)	(2.7)	Accountancy Gains	(5.3)	(5.3)	0	Financial Allocation Adjustments	3.2	3.8	3.8	Band 2/3 Framework	0	0	2.8	Other Mitigating Actions	0	0	0	Grand Total	1.4	0	9.9
	M10 YTD	Year-end Forecast	Recurrent Forecast																																										
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Risk Treatment Assessment <i>i.e. Treat, Tolerate, Transfer etc.</i>	The financial plan highlights a high level of risk for in year achievement but with a far more significant level of risk for 2027/2028 and beyond. This risk will therefore be <i>treated</i> until there is confidence that the Health Board can achieve the planned break-even position.																																												

Current Control Measures
Financial Management - Financial Accountability letters issued by CEO. - Budget setting process and Budgetary control framework paper to be presented to EMB for approval. - Standing Financial Instructions - Scheme of Reservation & Delegation - Local Counter-Fraud Service - Monthly financial performance reviews for Care Groups and corporate directorates
Sources of Assurance (Internal and External)
Financial Management - Annual Report and Accounts - Monthly Finance Reports - Monitoring Returns to Welsh Government

- Internal Audit Programme - External Audit Programme - Losses and Special Payments Report to Audit & Risk Committee			
Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Indicators of Success (following implementation of mitigating actions)
1. Understanding of budgetary control and procurement processes in some services	- Deliver budget holder training within Care Groups/Directorates – <i>Ongoing throughout 2026/2027.</i> - Deliver procurement training to departments where compliance with procurement processes is low - <i>Ongoing throughout 2026/2027.</i>	Budget holders, through regular training, will be better informed in terms of process and best practice. Greater focus on compliance. Informed decision making through confidence gained through training and experience.	Improved Budget Management. Budget holders will have a clearer understanding of their roles and responsibilities and will be equipped to deliver effective and efficient financial management and accountability.
2. A recognised risk of shortfalls in savings delivery	- Develop a more streamlined project and programmatic approach to planning and delivery of efficiency savings schemes, with a focus on cost reductions and managing expenditure within allocated budgets for 26/27 as well as identifying pipeline schemes in delivery for 27/28. ~~for 25/26 as well as schemes in delivery for 26/27.~~ - Disseminate the learning from the Health Board's Value Based Healthcare projects to drive service planning and improvement going forward. - Developing the Value & Efficiency Programme with a focus on 'Enabling schemes' to support savings identification and delivery.	A programmatic approach will support consistency and will help in clearly defining roles, responsibilities, and deliverables. Shared learning across directorates will identify areas of best practice and what has worked well.	Improved financial resilience and sustainability.
Linked National Priority Measures			
1. YTD position 2. Savings plan position			
Current Performance Highlights			
- The M1 YTD position yet to be reported was a £1.4m deficit. Latest savings plans have only identified £14m of the £31.3m savings plan required. ~~WG have confirmed allocations for national insurance changes and 24/25 pay awards, these have both been lower than anticipated resulting in an unplanned £3.8m cost pressure.~~ - There is a high minimal risk to delivering a balanced financial plan for 2026/2027			
Were there any significant incidents affecting this strategic Risk this period:			
~~WG not fully funding National Insurance Changes and 2024/25 pay awards has resulted in an unplanned £3.8m cost pressure, in addition NWSSP have indicated a potential £6.1m risk to the Welsh Risk Pool contribution for 2025/26 in addition to the £1.5m already provided within the IMTP.~~			
To be confirmed – awaiting Month 1 reporting.			
Associated Risks escalated to the Organisational Risk Register			
6239	~~Failure to reduce the £7.8m recurrent deficit at the start of 25/26 down to the planned £1.7m recurrent surplus at the end of 25/26~~		20
	Risk score reduced in terms of consequence in March 2026 and therefore de-escalated from the Organisational Risk Register		
6596	~~Failure to reduce the £9.2m recurrent deficit at the start of 26/27 down to the planned £0.3m recurrent surplus at the end of 26/27~~		20

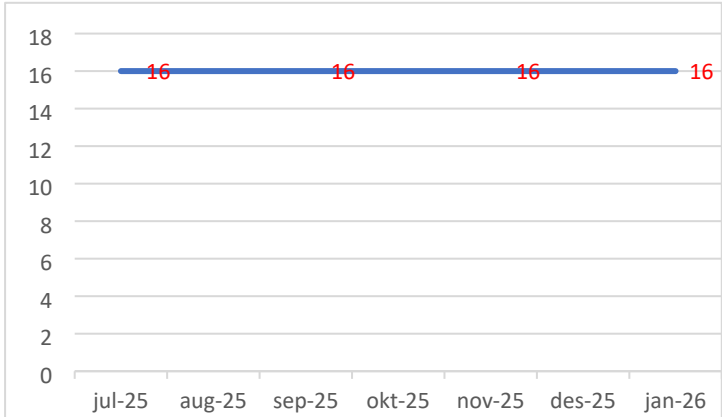
6597	Failure to achieve the planned break-even position in 2026/2027	20
6240	~~Failure to achieve the planned break-even position in 2025/26.~~	~~16~~

Strategic Goal(s)			Risk score 16
 Improving Care - Delivering safe and compassionate care - Developing new models of care - Digital transformation for patients and staff - Ensuring timely access to care	 Sustaining Our Future - Becoming a green organisation - Ensuring our Services financial sustainability Embedding value-based healthcare - Ensuring our estate is fit for the future		

Strategic Risk: Ability to develop a fit for the future estate to reflect our future clinical service model – (Risk No.10)

If CTMUHB is unable to invest in its estate so it's fit for future.	Then there is a risk that CTMUHB may not be able to deliver the required enhancements / improvements to support patient care and staff wellbeing for the future and to align with the strategic vision and ambitions.	Resulting in - Being unable to deliver its services efficiently and effectively in the right place with the right provision at the right time in modern and fit for purpose healthcare facilities. - Impact on environment for patients and staff - Future site development plans may not be fit for purpose. - Less ability to ascertain NHS capital or alternative financial support for the future development of its sites. - Lack of digitally enabled facilities - High carbon footprint

Risk Lead	Executive Director of Finance	Assurance committee	Strategic Development Committee

	Consequence	Likelihood	Score	Risk Score Trend this Period: No change to risk scores this period. Risk Score Trajectory 
Initial	4	4	16	
Current	4	4	16	
Target	4	2	8	
Risk Appetite	Cautious (quality and safety; trust and confidence; legal and regulatory)			

Rationale for assessment of risk score: Including where risk score remains unchanged and for any changes	A score of 16 has been calculated using the Risk Scoring Matrix and the 'Environment and Estate Infrastructure" Domain. Due to the pace of which mitigations will be realised the risk score has been reviewed and remains unchanged. Risk score reviewed in April 2026 and no changes made. The Strategic Clinical Services Plan is still being developed. Funding for the estate is based on the highest risk factor and therefore funding allocations are based on informed risk-based decision making.

Risk Treatment Assessment <i>i.e. Treat, Tolerate, Transfer etc.</i>	Whilst recognising the challenges outlined in this risk the health board is continuing to Treat this risk; however, pace of change is not at the desired rate and there are elements where the risk will need to be Tolerated .

Current Control Measures

The Health Board will continue to seek all opportunities for WG funding such as Targeted Estates funding (TEF) to address high priority backlog issues.

Sources of Assurance (Internal and External)

Internal

- Regular monitoring through CTMUHB’S Capital Programme Board.
- Capital Scheme Delivery Programme
- Project Boards established for specific capital schemes.

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Indicators of Success (following implementation of mitigating actions)
1. Estate strategy to be developed on completion of the Clinical Service Strategy.	Delivering against IMTP priorities in the interim.	Fit for purpose Estate	Service delivery outcomes met.
2. Enough Funding to deliver Capital Schemes.	Delivering against IMTP priorities in the interim.	Fit for purpose Estate	Service delivery outcomes met.

Linked National Priority Measures

Current Performance Highlights

Were there any significant incidents affecting this strategic Risk this period:

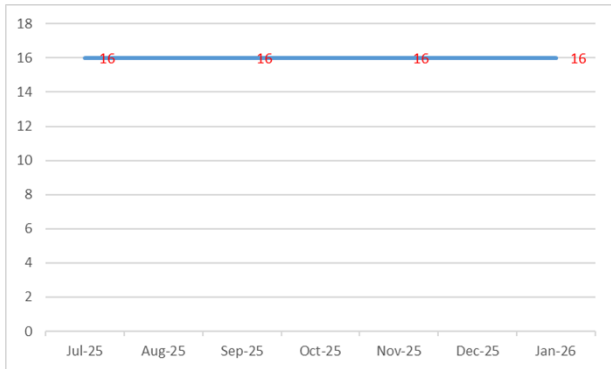
Associated Risks escalated to the Organisational Risk Register

6234	National skills shortage in Estates Roles (Private sector salaries are impacting the CTMUHB’s ability to be competitive in the recruitment market) resulting in recruitment and retention challenges throughout the department. Risk score reduced to a 12 in January 2026, and therefore risk de-escalated from the Organisational Risk Register.	16
6235	Insufficient funding to address backlog maintenance across the estate.	16

Strategic Goal(s)			Risk score
 Improving Care - Delivering safe and compassionate care - Developing new models of care - Digital transformation for patients and staff - Ensuring timely access to care	 Sustaining Our Future - Becoming a green organisation - Ensuring our Services financial sustainability Embedding value-based healthcare - Ensuring our estate is fit for the future	 Creating Health - Reducing health inequalities - Equal focus on mental and physical health - Supporting our communities - Being a healthy organisation	16

Strategic Risk: Delivery of an Integrated Care Model (Risk No.11)		
If CTMUHB is unable to develop and deliver an integrated care model - both within the NHS and with wider social care and Third Sector partners - that is community based, proactive and which achieves greater continuity and coordination of care.	Then there will be: - A lack of collective responsibility for planning services, improving health and reducing inequalities in the population served. - Failure to wrap around robust community services which are responsive to patient needs around the GP practice teams. - A negative impact on Primary Care teams and demand for services resulting in instability of Primary Care services. - A negative impact on productivity and value for money; and - Limited support to broader social and economic development.	Resulting In: CTMUHB being unable to improve outcomes and reduce health inequalities for its population and therefore failure to deliver the objectives set out in CTM 2030.

Risk Lead	Chief Operating Officer	Assurance committee	Strategic Development Committee

	Consequence	Likelihood	Score	Risk Score Trend this Period: No change to risk scores this period. Risk Score Trajectory 
Initial	4	4	16	
Current	4	4	16	
Target	4	2	8	
Risk Appetite	Cautious (quality and safety; trust and confidence; legal and regulatory)			
Rationale for assessment of risk score: <i>Including where risk score remains unchanged and for any changes</i>				The current score remains unchanged, although there has been progress with control measures since the risk was originally scored. This includes the establishment of Hospital at Home, the Regional Partnership Agreement and progressing Locality delivery options.
Risk Treatment Assessment <i>i.e. Treat, Tolerate, Transfer etc.</i>				This risk will be treated and managed through transformation programmes across CTMUHB and in regional programmes with system partners

Current Control Measures

The Integrated Community Care System Program – work to support the development of an integrated services set of metrics in order to progress building of performance score cards, which focuses on older people, people living with frailty and their carers. Work plan and milestones have been agreed, **outline plan circulated for comments and development**. A Regional Partnership (Section 33) Agreement has just been signed off by CTMUHB and the three local authorities, has been signed and sealed by all organisations.

Commissioned National Association of Primary Care to work with key stakeholders to develop a clear model for delivery. Current work includes preparing narrative to incorporate into CM and Regional Strategy documents, **awaiting written document from National Association of Primary Care (NAPC)**.

Established Primary Care & Community Transformation Board with high Executive leadership.

Strengthening cluster clinical leadership capacity to help inform, influence and engage others on future models.

Continuously reviewing leadership capacity in Primary Care and Community Care Group. Strong medical leadership structure now in place.

Reviewing Locality delivery options and governance as complex regional landscape. The intention is to commence engagement amongst front-line teams about closer joint working. Work to refine Joint Partnership Board structures is ongoing.

Primary and Community Care Transformation Programme established. Its main purpose is to establish a sustainable model for primary and community care that underpins the future model of care across the Cwm Taf Morgannwg region under the Strategic Clinical Services Plan (SCSP). **The programme will incorporate the principles and output of the community by design national programme**. The scope includes:

- General Medical Services
- Community Pharmacy
- Community Services.

Alignment and integration opportunities will be explored in relation to mental health and substance misuse services, children's and families' services as the work matures. The Service Director of Mental Health is also a member of the Board, as are Clinical Director for Therapies and the Chief Pharmacist.

Undertake comprehensive listening exercise to understand the issues to inform the improvement programmes.

CTM Regional Partnership – Local Authority, NHS and Third Sector leadership meeting bi-monthly. Regional Integration Fund (RIF) allocation supports regional working initiatives, including integrated care. Regional Partnership oversees production of Needs Assessment and Care Sector Market Stability Report. Establishment of a number of Boards/Working Groups to deliver against needs assessment.

Integrated Leadership Board – Senior level board underpinning the CTM Regional Partnership, established to provide integrated Executive-level leadership across health and social care across the region.

Partnership Leadership Team – established with Local Authority and NHS representation to spot challenges and progress opportunities across the partnership – meets monthly.

Implementation of the National Single Point of Access (SPOA) Framework as directed by the National 6 Goals Framework informing the Primary Care Transformation Programme.

Connectivity and alignment of this programme with other programmes such as Frailty Board, 6 Goals is a key remit of the Integrated Care Board.

The 3Ps programme is supporting people to make informed decisions about their health care, supporting them to manage their health while waiting for treatment. This work is being taken forward via a partnership approach in CTM, including the Community Voluntary Councils.

Sources of Assurance (Internal and External)

Reports

- Integrated Performance Report
- Regional Partnership and Integrated Leadership Board – highlight reports.
- Strategic Development Committee reports
- Regional Integration Fund reports
- WG Integration accountability meeting report on 12 February 2026 which identified areas of strength and pointed to areas where further focus is advised, **as noted in the March iteration of the Board Assurance Framework and has now been responded to by the RPB chair**.
 - ~~Inconsistent integrated working across the region;~~
 - ~~Assessment delays and hospital flow constraints;~~

- Workforce pressures and specialist capacity gaps;
- Process redesign and model modernisation;
- Domiciliary Care and reablement capacity;
- Seven-day service delivery;
- Falls and care-home conveyance pressures;
- Cultural change and practice improvement;
- Strengthening hospital avoidance and early intervention capacity;
- Improving real-time system oversight.

Board and Committee Assurance

The Board and the Strategic Development Committee are provided with updates on the developments with regards the Integrated Care Model as required within their respective cycles of business.

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Indicators of Success (following implementation of mitigating actions)
Data and digital solutions will be needed alongside strategic ambitions	Scoping for new community care digital record which is integrated with GP practices and interface with social care. Work with Local Authorities on the introduction of 'MOSAIC' which is replacing WCCIS as the social care records platform. Established a connecting care programme board to mirror the national programme, this incorporates implementation of a single clinical mental health record, a community care system record as well as alignment of those and the primary care and local authority systems.	The use of joined up data across local health and care partners and techniques like can offer deeper insight into the holistic needs of the different population groups and the drivers of health inequalities.	Integrated records and data sharing agreements in place
Evidence base for alternative delivery models for practices	Commissioned to address gap. Exploring stage and taking lessons learn from previous directly managed practices and different models across the UK. The Primary Care & Community Transformation Board is providing the system leadership and governance needed to move the Health Board with an evidence-led approach to alternative delivery models for integrated community service.	To support sustainability of GP practices and support robust primary care services	Financially viable practices across the CTM footprint who are innovative and forward thinking in the delivery of care. A Strategic plan for primary and community services
There is more to do to 'think and act as a single system'. This aim runs counter to traditional funding, planning and regulatory systems. A Healthier Wales is a clear strategy, but a more enabling national delivery framework would assist.	Regional Partnership Agreement (RPA) established to improve joint-decision making and integrated service models. Workforce and Digital leads to be convened to support progress.	To create more of a single system approach.	The outcomes and performance framework in the RPA contain leading measures which will indicate if we are changing the shape of our system to get better results.
Achieving a sufficiency of social care provision is essential. We need to build on our initial steps and develop a strategic commissioning approach for example for care home places. The re-setting of Joint Partnership Boards as county-level planning and doing fora is critical to effective delivery though local integrated teams.	JPBs being reset through the Primary and Community Care Transformation Program. Development of Regional Needs Assessment and evolution of the Regional Area Plan is an opportunity to gain agreement across the partnership.	Shared space for decision making and constructive challenge. A regional Area Plan with shared commissioning priorities, objectives and outputs.	Primary care transformation programme Joint working with local authority and regional development of integrated approach
Necessary prioritisation of internal transformation activity within the health board has knocked onto the planned timeline for structural integration.	Continued discussion with partner agencies and reprofiling/reassignment of action owners within the integration plan.	Greater internal coherence in terms CTMUHB transformation and reworked for programme for next steps on structural integration.	Greater confidence in CTMUHB's ability to deliver the programme.

Linked National Priority Measures

Ministerial Priorities

- Timely access to care
- Population health and prevention
- Building community capacity
- 6 Goals for Urgent and Emergency Care
- Community by Design

Current Performance Highlights

Focus has been on integrating health services within the Rhondda Cynon Taf (RCT) and Merthyr Tydfil localities as they are separate services at present. Commenced Organisational Change Process August 2025 to integrate health services in the first instance to create intermediate care services to prevent patients from entering acute hospitals where not appropriate and supporting discharge, is now complete. The next stage to create closer joint working with local authority front-line teams is scheduled to commence from February 2026.

In October 2025 the Hospital@Home team were mobilised. This involved:

- A comprehensive workforce plan aligning staff across previously separate services into one unified model.
- Continued strengthening of professional leadership across medical, nursing, therapy, pharmacy, and operational functions.
- A whole-system governance structure embedding Hospital@Home into the Six Goals UEC Programme Board and Improving Care Board, ensuring strategic alignment.

In collaboration with the other Care Groups and Local Authorities there has been a focus on reducing Pathways of Care Delays and a Home First approach

- Sustaining strengthened governance arrangements across Integrated Discharge Board and the Discharge Operational Group to provide shared accountability and remove system barriers.
- Continued digital enhancement of eToC, SDN, and ward-level tools to improve timeliness, accuracy and consistency of discharge information.
- Maintaining a strong focus on earlier identification, proportionate assessment, and standardised escalation, ensuring patients are supported home safely and promptly.

CTMUHB has significantly strengthened both Hospital@Home and POCD management, embedding consistent processes, strong governance and maturing digital enablers. Hospital@Home is now an operational discharge solution delivering measurable reductions in delays, while POCD oversight has become more robust, data driven and multidisciplinary. Future plans will scale these models further, expanding workforce capability, improving digital integration and deepening partnerships working – positioning CTM to deliver safer, timelier discharge and a fully realised Home First system. The next focus is other community services such as specialist nursing.

Focus on the development of the Navigation Hub for admission avoidance, e.g. virtual ward for Same Day Emergency Care and Respiratory; oversight of the Wales Ambulance Service Trust stack to intervene where patients can be triaged and signposted to Primary Care and Community; Care Home intervention service (87% success rate); and also falls service in collaboration with RCT Local Authority. SPOA continues to mature as a central mechanism for demand management, early redirection and clinically led triage. Key achievements include reduced care-home conveyances, full rollout of the falls pathway across all CTM areas, expansion of the virtual ward respiratory cohort and development of multiple new pathways via Navigation Hub (urgent bloods, community nursing, podiatry prescribing, head injury and 111-to-UTC diversion).

CTMUHB expanded its multi-agency Level 1 & Level 2 falls response across all localities, ensuring 8am-8pm coverage, 7 days a week. The model provides safer alternatives to ambulance conveyance, improves responded capability and support early intervention closer to home. Rollout progressed locality by locality, supported by Navigation Hub clinicians and Welsh Government pump-prime funding. Additional investment also enabled training sessions and provision of lifting equipment across community teams.

- Series of engagement & learning events taken place with GPs. Summary of key actions has been included in a communication newsletter to Primary Care.
- Mapping exercise of all the community services completed and shared with NAPC to inform their written document.
- ~~Action plan devised by NAPC together with the leadership team and present and agree priorities and infrastructure at the next Primary and Community Care Board.~~
- CTM Regional Partnership has defined a target model an Integrated Community Care System (ICCS) for our older population. An implementation plan, program delivery team and clear governance route is in place.
- Regional Partnership structures provide the main governance fora for integration with social care. There are generally good working relationships and there have been successes for example in retendering domiciliary care in RCT aligned to D2RA pathways.
- A Regional Partnership (Section 33/Part 9) Agreement signed by CTMUHB and the three Local Authorities - will provide a basis for joint accountability and future integrated services delivery.
- Integrated Performance Dashboard. The Regional Integrated Services Director along with the regional team will collaborate with the two Local Authorities and Health Board to create Local Authority level dashboards of key metrics, providing integrated managers with essential information to support statutory agency deliverables and regional priority measures.
- Impact from the actions and work of the transformation programmes.

- Integrated Manager post developed in conjunction with BCBC colleagues with a view to advertise June 2026.

Were there any significant incidents affecting this strategic Risk this period:

The growth of the ageing population relative to the working-age population, the rise of multimorbidity, and persistent health inequalities, particularly for preventable illness, are all issues that the National Health Service (NHS) will face in the years to come. The greatest contributors to ill health and social care needs include cardio-vascular disease, musculoskeletal disorders, cancer, mental health, dementia and chronic respiratory disease. As a result, the health and social care system will need to be more joined up to enable an increased focus for an integrated model to transform the way we work and care for people, whilst building on community resilience to meet the demand and timely access to care.

Typically, the winter months present additional pressure on the local authority and health board, because of increased rate of acuity, attributed to winter, which includes RSV and the biggest impact norovirus. As a result, the health board had a period of Business Continuity Incident declared and whilst the sustained operational pressure experienced through the Discharge Sprint and Business Continuity Incident (BCI) these periods acted as a critical opportunity for strengthened system wide working.

The Sprint enabled a step change in how the Health Board and Local Authority partners worked together, creating a heightened, shared focus on whole system flow, timely decision making and collective ownership of risk. Through daily multidisciplinary engagement, shared oversight of patient cohorts, and more frequent joint problem solving, partners were able to operate in a more co-ordinated and responsive way, particularly in relation to discharge planning, community capacity and support for people with complex needs.

Although good examples of working relations were noted and made a difference to patients and the whole system approach, there is a notable learning that the health board and partners have identified. This learning will be reflected in a health board and local authority session and work towards plans for next winter, and a whole system review.

Associated Risks escalated to the Organisational Risk Register

4491	Failure to meet the demand for patient care at all points of the patient journey	20
6179	High and increasing prevalence of overweight and obesity in children and adults.	20
6053	~~Failure to secure an alternative Clinical System for GP practices on Vision~~ Risk closed in August 2025	20
3826	Emergency Department (ED) Overcrowding	20
5753	Inadequate Special School Nurse Provision	20
5045	Access to Neurology Inpatient and Outpatient Services for CTM Residents	16
5646	The impact of "Right Care Right Person" (RCRP) approach. Risk score reduced to 12 in November 2025 and removed from Organisational Risk Register	16
5579	Rising childhood obesity rates resulting in an increase in obesity related conditions and poorer health outcomes.	16



Agenda Item

ELG

Audit & Risk Committee

Organisational Risk Register

Dyddiad y Cyfarfod / Date of Meeting	3 June 2026
Statws Cyhoeddi / Publication Status	Open/ Public
Awdur yr Adroddiad / Report Author	Louise Stait, Interim Assistant Director of Governance & Risk
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance & Risk
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For review and endorsement ahead of presentation to Board committees

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Committee / Group / Individuals	Date	Outcome
Service, Function and Executive Formal Review	April 2026	RISKS REVIEWED
Executive Leadership Group	11 May 2026	MANAGEMENT REVIEW AND SIGN OFF RECEIVED

Acronyms / Glossary of Terms

1. Situation /Background

- 1.1 The purpose of this report is for the Committee to review and discuss the organisational risk register and consider whether the assigned risks have been appropriately assessed.
- 1.2 The ORR report is normally produced bimonthly, however it has not been produced since January 2026 due to a key vacancy in the Governance Team. **This iteration of the report therefore reflects more change than usual.**

2. Specific Matters for Consideration

Risk Review

- 2.1. Care Groups and Central leads continue 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.

Risk Training

- 2.5 Risk training, although not a core training requirement under the statutory and mandatory framework, is available via the Electronic Staff Record (ESR).
- 2.6 Due to vacancy in the Governance Team, the sessions have not yet taken place in 2026. Monthly dates are now scheduled and live on ESR, starting with Thursday 11 June and Thursday 2 July.
- 2.7 The sessions are run by the Interim Assistant Director of Governance & Risk jointly with other colleagues who have expertise and/or lead responsibility for Risk including the Business Manager for Chief Operating Office. The session are held virtually via Teams on a monthly basis for a duration of one hour.
- 2.8 Bespoke team sessions on Risk are also available by arrangement.

Recent Committee Feedback on the ORR

- 2.9 In November 2025, the Audit and Risk Committee (ARAC) requested additional context to support interpretation of the Organisational Risk Register, particularly to understand whether risks are improving, deteriorating or remaining stable over time.



- 2.10 The appended summary of the ORR has been produced in response to this feedback.
- 2.11 In addition, simple trend annotations have been applied to the existing heat map (Section 4 of this report) to indicate direction of travel since the previous reporting period. The use of the heat map may be further reviewed and developed (or indeed superseded by an alternative) with members of the ARAC in the coming months.
- 2.12 Also in November 2025, ARAC members requested clearer evidence and consistency when risk scores are changed. In January 2026, the ODC (Operational Delivery Committee) requested clearer alignment / linkage between emerging risks, performance data, and likely impacts ("the 'so what'")
- 2.13 All the above feedback will be considered during 2026 as part of the ongoing continuous improvement of the ORR.

Internal Audit of Risk Management Arrangements (April 2026)

- 2.14 Internal Audit has recently completed a review of risk management arrangements across a sample of Care Groups and corporate directorates and has concluded reasonable assurance overall.
- 2.15 The proposed actions focus on:
- increasing consistency in the format, quality and frequency of review of Care Group and corporate risk registers;
 - strengthening escalation arrangements from teams to ensure risks are escalated in line with the Risk Management Policy
- 2.16 These actions will be taken forward and monitored via established governance arrangements.

3. Key Risks / Matters for Escalation

3.1. NEW RISKS AND NEW ESCALATIONS

Planned Care Group

- Datix Risk ID 6451 - Orthoplastic pathway. Due to business sensitivities the details of this risk are captured in the closed session of the Committee.

Children and Families Care Group

- Datix Risk ID 6475 - Industrial action of SCPHN Health Visiting staff members of the UNITE union. Escalated as a risk due to its ongoing duration, reduced workforce capacity and reliance on short term mitigations, creating a growing risk to universal and preventative child health services, despite immediate safety being maintained. Current score of 16.

DTPS Care Group

- Datix Risk ID 5554 - Ability to comply with legal responsibilities for containment level 3 facilities. Existing risk proposed for escalation following confirmation that the CL3 laboratory cannot be sealed or fumigated, with temporary safety mitigations agreed. Risk currently being reviewed to ensure the rating is a true reflection with potential mitigations also noted. Current score of 20.
- Datix Risk ID 6498 - Lack of Dynamic Mattress Systems in UHB due to over 100 units being condemned and not replaced due to cost. Current score of 16.

Cross-cutting risks

- Datix Risk ID 5797 - Lack of Capacity for Hydroxychloroquine Screening in Ophthalmology. New risk – being reviewed for potential merging with another related risk as "Hydroxychloroquine (HCQ) Retinal Screening Capacity and Pathway Delivery" to capture the HB risk as a whole. Current score of 15.

Finance Directorate

- Datix Risk ID 6596 - Failure to reduce the £9.2m recurrent deficit at the start of 26/27 down to the planned £0.3m recurrent surplus at the end of 26/27. New risk opened for 2026/27 financial year. Current score of 20.
- Datix Risk ID 6597 - Failure to achieve the planned break-even position in 2026/27. New risk opened for 2026/27 financial year. Current score of 20.

Digital Directorate

- Datix Risk ID 6604 - Misdirected clinical correspondence to GP practices. Longstanding risk escalated following discussion by the IG Group. Current score of 16.
- Datix Risk ID 6605 - Legal compliance with access to records requests. Longstanding risk escalated following discussion by the IG Group. Current score of 16.

- Datix Risk ID 6426 – Access to E-Whiteboards. Due to business sensitivities the details of this risk are captured in the closed session of the Committee. Current score of 16.

People Directorate

- Datix Risk ID 4958 – Fire Safety. Due to business sensitivities the details of this risk are captured in the closed session of the Committee.
- Datix Risk ID 4933 – Fire Safety. Due to business sensitivities the details of this risk are captured in the closed session of the Committee.

Executive Director of Therapies and Health Science

- Datix Risk ID 6429 - Physiotherapy MSK Self-Referral Form. Risk score increased from 12 to 16 following longer triage times due to capacity pressures and a recent near miss; immediate mitigating actions have been agreed, with a short-term review scheduled and escalation to the Primary Care Transformation Board, which may enable de-escalation.

3.2. CHANGES TO RISKS

Risk Score Increased

Planned Care Group

- Datix Risk ID 6294 - Insufficient Consultant Workforce - Endoscopy / Gastroenterology. Score increased from 16 to 20. Consultant workforce shortages continue to impact endoscopy and gastroenterology services, with recruitment ongoing and further mitigations under development to support service sustainability.

Risk Score Decreased or De-escalated (and thus removed from ORR)

Diagnostics, Therapies, Pharmacy & Specialties Care Group Care Group

- Datix Risk ID 2713 – Backlog of Reporting Radiology Examinations. Improvements in radiology reporting have reduced the risk score from 16 to 12 and removed it from the ORR, however the position remains fragile as additional funding ends and is being actively monitored for potential re-emergence.

Children and Families Care Group

- Datix Risk ID 6217 - A number of Nationally reportable incidents have been raised since February 2025 within Obstetrics / Maternity. De-escalated and removed from the ORR in February 2026 following internal and external assurance and Care Group agreement.

Mental Health and Learning Disabilities Care Group

- Datix Risk ID 4973 - Clinical Medical Cover within CTM Adult Mental Health Services. Risk score reduced to 12 in May 2026, and removed from ORR.

Digital Directorate

- Datix Risk ID 6039 - Increased cost of VMWare Licensing. Risk score reduced from 16 to 8 following progress with hardware acquisition. Risk has therefore been removed from the ORR, with full implementation and migration planned by summer 2026.

Executive Nurse Director

- Datix Risk ID 1793 - Lack of isolation facilities available- negative pressure rooms. Strategic risk owner changed from END to COO on Datix. Score also reduced from 16 to 12, so will not appear in future ORR reports.
- Datix Risk ID 6229 - Timely development of, management and response to Learning From Event Reports. Score reduced to 12, due to the immediate control measures in place and collaborative working with the Welsh Risk Pool.

3.3 CLOSED RISKS REMOVED FROM THE ORGANISATIONAL RISK REGISTER

Planned Care Group

- Datix Risk ID 5688 - Aging Equipment (Replacement steam steriliser). Closed as equipment has been received, installed and commissioned.

Primary and Community Care Group

- Datix Risk ID 5576 - Palliative Medicine Staffing. Risk score reduced to 6 following interim mitigation, including a temporary change to the YCC unit's designation and admission criteria, and alternative medical cover arrangements due to ongoing vacancies. These measures support current safety but are not a long-term solution. Consideration of the longer term, future service model is being considered by Board at its meeting on 21 May 2026.

Diagnostics, Therapies, Pharmacy & Specialties Care Group

- Datix ID 6379 - CT Scanners at RGH damaged by power outage and manual generator/UPS switch over. Risk closed and removed from the ORR in February 2026 following completion of CT scanner switch replacements.

Finance Directorate

- Datix Risk ID 6239 - Failure to reduce the £7.8m recurrent deficit at the start of 25/26 down to the planned £1.7m recurrent surplus at the end of 25/26. Risk closed at year-end; superseded by new Risk 6596 for 2026/27 (see above).

Digital Directorate

- Datix ID 6372 – Cost escalation risk – Microsoft Enterprise Agreement renewal. Risk closed in May 2026.

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

↑ = score increased since previous report (Jan 2026)

↓ = score decreased since previous report

↔ = score unchanged since previous report

N = new risk identified and added to Datix since January 2026

N↑ = established risk; newly escalated to the ORR following an increase in score.

N↔ = established risk with stable score; newly escalated to the ORR for visibility.

NB: This heat map includes the risks marked as business sensitive / confidential.

NB: This heat map also includes references to the risks marked as business sensitive and confidential

Consequence	5			3337 6451 4958 4933 5797	↔ N↑ N↔ N↔ N	4664 ↔ 5276 ↔			
	4			5820	↔	6318 ↔ 6498 N 6429 N↑ 4417 ↔ 4632 ↔ 4671 ↔ 4885 ↔ 5045 ↔ 5579 ↔ 5761 ↔	5877 ↔ 6235 ↔ 6280 ↔ 6397 ↔ 6424 ↔ 6426 N↔ 5374 ↔ 6475 N 6604 N 6605 N	4491 ↔ 5554 N↑ 5753 ↔ 5821 ↔ 6052 ↔ 6179 ↔ 3826 ↔ 6294 ↑ 6596 N 6597 N	
	3							6231 ↔ 4672 ↔ 5040 ↔ 6232 ↔ 4691 ↔	
	2								
	1								
	CxL	1	2	3	4	5			
	Likelihood								

Emerging Risks Identified for possible future escalation

Identified as part of the risks considered and reviewed for escalation in the May 2026 iteration of the Organisational Risk Register:

- **Planned Care Group** have noted the possible reemergence of a risk regarding the Backlog for Imaging in all modalities (Datix Risk ID 4152). The risk is listed here for awareness – awaiting further update from care group following performance review
- **Facilities Directorate** are continuing to review the risk regarding RGH car parking pressures (Datix Risk ID 6181). This emerging risk is currently rated as moderate, with additional parking capacity expected following removal of the Vanguard unit and introduction of a new permit system, and the position kept under active review due to ongoing pressures.

- **People Directorate** have noted that subject to board endorsement, there is an emerging risk around shift pattern alignment, including the potential for industrial action, noting that the proposals impact a large proportion of our nursing/ midwifery and HCSW (over 3,000 staff). This is a shared risk owned by the Executive Director of People and the Executive Nursing Director.

5. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	The Organisational Risk Register supports delivery of all CTMUHB strategic goals by identifying, assessing and monitoring the principal organisational risks that may impact on their achievement.
Dolen i Feysydd Strategol BIP CTM /Link to CTMUHB Strategic Areas	The Organisational Risk Register provides visibility of risks across all Care Groups and corporate directorates, supporting executive oversight of risks relating to delivery, quality, workforce, finance, estates, digital and enabling functions.
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
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
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))	Safe The ORR exists to identify, monitor and mitigate risks that could cause harm. • This includes clinical, operational, workforce, estates, digital and system risks. • Even non-clinical risks (finance, workforce, digital) are framed through their <i>potential safety impact</i>.
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	The ORR itself has no environmental impact but includes an environmental sustainability risk (5374) relating to delivery of the Health Board's environmental and social duties and Climate Action Plan.

Impact Assessment		
Ansawdd	Yes: ☐	No: ☒



Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Outcome:	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 <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	Yes: ☐ Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	No: ☒ If no, please include rationale below: Not required for 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	

6. Recommendation

6.1 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.

7. Next Steps

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

Organisational Risk Register (ORR) – Summary Version – May 2026

This summary shows the ORR divided into two broad categories of risk:

1. **Care Group-led risks**, where the primary accountability for management and mitigation sits within a Care Group, with executive oversight; and
2. **Directorate-led risks**, where the risk reflects a cross-organisational, enabling or system level issue owned directly by an Executive Director and not linked to a specific care group (for example, digital, workforce, finance, estates or commissioning related risks).

The purpose of this summary is to assist navigation of the full ORR (Datix extract), and support oversight and sense checking. It does not replace the detailed ORR and does not alter the existing process.

1. CARE GROUP-LED RISKS

Datix ID	Strategic Risk Owner	Risk Title	Rating Jan 26	Rating May 26	Trend	Notes
Planned Care Group						
6294	COO (Chief Operating Officer)	Insufficient Consultant Workforce - Endoscopy / Gastroenterology	16	20	↑	April 2026: Score increased. Consultant workforce shortages continue to impact endoscopy and gastroenterology services, with recruitment ongoing and further mitigations under development to support service sustainability. (The impact of these mitigations on the score is currently being reviewed)
~~5688~~	~~COO~~	~~Aging Equipment (Replacement steam steriliser)~~	~~16~~	—	↔	April 2026: Closed as equipment has been received installed and commissioned. Will not appear on future reports.
6451 NEW	COO	Orthoplastic Pathway (<i>Business sensitive risk</i>)	12	15	↑	Due to business sensitivities the details of this risk are captured in the closed session of the Committee.
4152	COO	Backlog for Imaging in all modalities	16	12	↓	POSSIBLE (RE)EMERGING RISK: For awareness – awaiting further update from care group following performance review
Unscheduled Care Group						
3826	COO	~~Ambulatory Department Overcrowding~~ Emergency Department Overcrowding (<i>change of risk title</i>)	20	20	↔	April 2026: Emergency and ambulatory departments remain overcrowded due to sustained system pressure, with a coordinated programme of urgent and emergency care, acute medicine and patient-flow improvements in place to reduce long waits, improve ambulance handover, and stabilise performance
5045	COO	Access to Neurology Inpatient and Outpatient Services for CTM Residents	16	16	↔	April 2026: Mitigations include the appointment of a Consultant Neurologist commencing May 2026, continued interim arrangements, transfer of waiting-list reporting to CTM, and ongoing work with the commissioning health board to address capacity and long waits. Risk score to be reviewed following the consultant's start.
4632	ED T&HS	Provision of an effective and comprehensive stroke service across CTM	16	16	↔	April 2026: The stroke improvement programme is underway with stabilised medical and nursing workforce, daily multidisciplinary huddles, enhanced senior oversight and performance reporting, and improving timeliness of care, with rollout to additional sites and further performance gains planned.
Children and Families Care Group						

Datix ID	Strategic Risk Owner	Risk Title	Rating Jan 26	Rating May 26	Trend	Notes
5753	END	Inadequate Special School Nurse Provision	20	20	↔	April 2026: Risk has been reviewed following national guidance and improved engagement with education partners. Service stability has improved and an updated SLA is in development, with a reduction in risk score anticipated once clinical confirmation and formal agreement are in place.
6475 NEW	COO and END	Industrial action of Health Visiting staff members of the UNITE union	---	16	---	NEW RISK opened Jan 2026 Escalated as a risk due to its ongoing duration, reduced workforce capacity and reliance on short term mitigations, creating a growing risk to universal and preventative child health services, despite immediate safety being maintained.
6217	EMD	~~A number of Nationally reportable incidents have been raised since February 2025 within Obstetrics / Maternity~~	45	45	↔	Feb 2026: De-escalated and removed from the ORR following internal and external assurance and Care Group agreement.
Diagnostics, Therapies, Pharmacy & Specialties Care Group						
5554 NEW	---	Ability to comply with legal responsibilities for containment level 3 facilities	15	20	↑	Feb 2026: Risk escalated following confirmation that the CL3 laboratory cannot be sealed or fumigated, with temporary safety mitigations agreed.
5579	ED PH	Rising childhood obesity rates resulting in an increase in obesity related conditions and poorer health outcomes.	16	16	↔	Apr 2026: Risk reviewed with no change to score. Funding is in place for baseline support, but gaps remain for more complex need and are being addressed through planning.
6429 NEW	ED H&TS	Physiotherapy MSK Self-Referral Form.	12	16	↑	Apr 2026: Risk score increased following longer triage times due to capacity pressures and a recent near miss; immediate mitigating actions have been agreed, with a short-term review scheduled and escalation to the Primary Care Transformation Board, which may enable de-escalation.
6498 NEW	COO	Lack of Dynamic Mattress Systems in UHB due to over 100 units being condemned and not replaced due to cost.	---	16	---	NEW RISK escalated April 2026: A high number of mattresses have been condemned because they are no longer compliant / no longer serviceable, leading to low stock and increased Datix incidents. Plan for resolution under development.
6379	COO	~~CT Scanners at RGH damaged by power outage and manual generator/UPS switch over~~	46	---	---	Feb 2026: Risk closed and removed from the ORR following completion of CT scanner switch replacements.
2713	COO	~~Backlog of Reporting Radiology Examinations~~	46	42	↓	April 2026: Improvements in radiology reporting have reduced the risk score below 12 and removed it from the ORR, however the position remains fragile as additional funding ends and is being actively monitored for potential re-emergence.
Mental Health and Learning Disabilities Care Group						
4973	COO	~~Clinical Medical Cover within CTM Adult Mental Health Services~~	46	42	↔	May 2026: Risk reviewed and score reduced to 12 – will not appear on future ORR reports
6318	COO	Tier 3 SHED (Severe and High-Impact Eating Disorders) Team Service Delivery	16	16	↔	April 2026: Mitigating actions for the Tier 3 SHED Team are in place following joint work with CVUHB, including temporary nurse practitioner cover, drop-in clinics, physical health monitoring and staff training. Current controls and risk score unchanged.
3337	COO & Director of Digital	Lack of a Single Electronic Patient Record in Mental Health Services inc CAMHS	15	15	↔	April 2026: Risk Reviewed; no change to scoring or controls

Datix ID	Strategic Risk Owner	Risk Title	Rating Jan 26	Rating May 26	Trend	Notes
4691	COO	~~New Mental Health Unit~~ The Provision of Safe and Appropriate Estate for Inpatient Mental Health Care	15	15	↔	March 2026: Risk title changed April 2026: The inpatient mental health service review and remodelling programme continues under MHLD governance, with no change to current controls or risk scoring.
Primary and Community Care Group						
5877	COO	New Worker Contract for Out of Hour GPs	16	16	↔	Apr 2026: Implementation of the new out-of-hours GP worker contract remains subject to national negotiations, with interim rota management arrangements in place and ongoing work to increase GP recruitment.
6397	COO	Shortage of GPs to deliver urgent primary care services for escalation.	16	16	↔	April 2026: The shortage of GPs to deliver urgent primary care services remains unchanged, with ongoing monitoring, continued recruitment efforts and interim leadership cover where required.
5576	COO	~~Palliative Medicine Staffing~~	16	6	↓	March 2026: Risk score reduced following interim mitigation, including a temporary change to the YCC unit's designation and admission criteria, and alternative medical cover arrangements due to ongoing vacancies. These measures support current safety but are not a long-term solution. Consideration of the longer term, future service model is being considered by Board at its meeting on 21 May 2026.
Deputy COO Risks						
4491	COO	Failure to meet the demand for patient care at all points of the patient journey	20	20	↔	April 2026: A system-wide programme is in place to reduce the risk of failing to meet patient demand across the whole pathway, through coordinated action on urgent care, patient flow, discharge and planned care recovery, underpinned by strengthened governance and performance oversight
4417	COO	Management of Security Doors in All Hospital Settings	16	16	↔	April 2026: Incident data relating to security door management across hospital sites is under review, with analysis shared with the DCOO to inform an updated assessment and decision on the risk score; COO has requested further review of this risk and its score
Facilities Directorate Risks						
6052	COO	Patient hydration risks associated with the replacement of aged Beverage Trolley fleet (ultrakarts).	20	20	↔	April 2026: 16 trollies purchased – due for delivery at the end of May 2026. This risk will be reviewed when trollies are fully operational.
6181	COO	RGH car parking pressures	12	12	---	Apr 2026: Emerging risk rated as moderate, with additional parking capacity expected following removal of the Vanguard unit and introduction of a new permit system, and the position kept under active review due to ongoing pressures.
Cross-cutting risks						
5797 NEW		Lack of Capacity for Hydroxychloroquine Screening in Ophthalmology	15	15	↔	April 2026: New escalation – being reviewed for potential merging with another related risk as “Hydroxychloroquine (HCQ) Retinal Screening Capacity and Pathway Delivery” to capture the HB risk as a whole.

2. Summary of Directorate-Led Risks

The following are Directorate-led risks, where the risk reflects a cross-organisational, enabling or system level issue owned directly by an Executive Director and not linked to a specific care group. For example, digital, workforce, finance, estates or commissioning related risks.

Datix ID	Risk Title	Rating Jan 26	Rating May 26	Trend	Status update
ED of Strategy & Transformation					
6280	See below under Executive Medical Director - Regional Hepato-Pancreato-Biliary Service (Jointly owned risk)				
5821	Provision of secondary care immunology services by external provider (this is a service that is not provided by CTM UHB)	20	20	↔	April 2026: Arrangements for secondary care immunology remain reliant on external provision, with a commissioning route established for peri-operative referrals and further options being explored through collaboration with other health boards, recognising current funding constraints.
5374	Fulfilling our environmental and social duties	16	16	↔	April 2026: Risk reviewed; additional controls but no substantial change overall
Executive Director of Finance					
6239	~~Failure to reduce the £7.8m recurrent deficit at the start of 25/26 down to the planned £1.7m recurrent surplus at the end of 25/26~~	20	---	↔	April 2026: Risk closed at year-end; superseded by new Risk 6596 for 2026/27
6596 NEW	Failure to reduce the £9.2m recurrent deficit at the start of 26/27 down to the planned £0.3m recurrent surplus at the end of 26/27	---	20	---	April 2026: New risk opened for 2026/27 financial year
6597 NEW	Failure to achieve the planned break-even position in 2026/27.	---	20	---	April 2026: New risk opened for 2026/27 financial year
6235	Insufficient funding to address backlog maintenance across the estate.	16	16	↔	April 2026: No change. Insufficient backlog maintenance funding remains a tolerated risk, with limited mitigation available through discretionary and targeted capital schemes addressing only a small proportion of high-risk estate issues
Executive Director of Public Health					
6179	High and increasing prevalence of overweight and obesity in children and adults.	20	20	↔	April 2026: Level 1 childhood obesity services are in place following confirmed funding, however a significant gap remains in Level 3 provision and the risk score remains unchanged
5579	See above under DTPS Care Group - Rising childhood obesity rates				
5820	Potential inability to deliver all elements of the Health Protection Strategic priorities as a result of reduced allocation of funding	12	12	↔	Although the normal threshold for the ORR is a current score of 15, this risk is also included due to its novel / contentious nature
Director of Digital					
4664	Ransomware Attack resulting in loss of critical services and possible extortion (<i>Business sensitive risk</i>)	20	20	↔	April 2026: Risk reviewed; no change to scoring or controls. Due to business sensitivities the details of this risk are captured in the closed session of the Committee.
5276	Failure to deliver replacement Laboratory Information Management System, LIMS 2.0 Programme within project timeframe	20	20	↔	Apr 2026: Risk reviewed; no no change to scoring or controls. Jointly owned risk with the Executive Director of Therapies and Health Science.

Datix ID	Risk Title	Rating Jan 26	Rating May 26	Trend	Status update
6372	~~Cost escalation risk – Microsoft Enterprise Agreement renewal (Business sensitive risk)~~	46	46	↔	May 2026: Risk closed. Due to business sensitivities the details of this risk are captured in the closed session of the Committee.
4671	NHS Computer Network Infrastructure unable to meet demand (Business sensitive risk)	16	16	↔	April 2026: Risk reviewed; no change to scoring or controls. Due to business sensitivities the details of this risk are captured in the closed session of the Committee.
6604 NEW	Misdirected clinical correspondence to GP practices	---	16	---	May 2026: New risk raised and escalated following discussion by the Information Governance (IG) Group.
6605 NEW	Legal compliance with access to records requests	---	16	---	May 2026: New risk raised and escalated following discussion by the Information Governance (IG) Group.
6424	Mental Health Subject Access Requests (SARs) (IG/15)	16	16	↔	April 2026: Risk reviewed; no change to scoring or controls
6426 NEW	Access to E-Whiteboards (Business sensitive risk)	16	16	↔	April 2026: Risk reviewed; no change. Existing risk, newly escalated to ORR for visibility. Due to business sensitivities the details of this risk are captured in the closed session of the Committee.
4672	Access to a complete, integrated, and coded medical record.	15	15	↔	April 2026: Risk reviewed; no change to scoring or controls.
5040	Digital Healthcare Wales (DHCW interdependencies)	15	15	↔	April 2026: Risk reviewed; no change to scoring or controls.
3337	See above under MH Care Group - Lack of a Single Electronic Patient Record in Mental Health Services including CAMHS				
6039	~~Increased cost of VMware Licensing~~	46	8	↓	Mar 2026 – Risk score reduced to 8 following progress with hardware acquisition. Risk has therefore been removed from the ORR, with full implementation and migration planned by summer 2026.
Executive Nurse Director					
5753	See above under Children & Family Care Group - Inadequate Special School Nurse Provision				
6229	~~Timely development of, management and response to Learning From Event Reports~~	46	42	↓	May 2026: Initial score of 20 but with the immediate control measures in place and collaborative working with the Welsh Risk Pool the likelihood score has reduced to a 4. The current score is therefore now 12.
6231	Proactive management and compliance with cases that qualify for consideration under the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.	16	16	↔	April 2026: Arrangements for managing concerns continue to strengthen, with sustained performance, regulatory transition to Listening to People, and delivery of agreed organisational changes. The risk will remain at its current level until the revised staffing model is fully implemented.
6232	Stability of the Legal Services Function	15	15	↔	April 2026: Risk Reviewed; no substantial change.
4793	~~Lack of isolation facilities available – negative pressure rooms~~	46	42	↓	Feb 2026: Strategic risk owner changed from END to COO on Datix. Score also reduced to 12, so will not appear in future ORR reports.
Executive Director of Therapies and Health Sciences.					
4632	See above under Unscheduled Care Group - Provision of an effective and comprehensive stroke service across CTM				
5276	See above under Director of Digital (jointly owned risk) - Failure to deliver replacement Laboratory Information Management System, LIMS 2.0 Programme within project timeframe				
Director of Corporate Governance / Board Secretary					

Datix ID	Risk Title	Rating Jan 26	Rating May 26	Trend	Status update
4885	Failure to deliver and sustain effective Policy Management System and Process	16	16	↔	April 2026: Controls have strengthened for non-clinical policies following go-live of the new non-clinical policy SharePoint, while clinical policy migration remains at an earlier stage.
Executive Medical Director					
5761	Cross Health Board Data Sharing	16	16	↔	April 2026: Risk Reviewed; no change to scoring or controls
6280	Suspension of the Regional Hepato-Pancreato-Biliary service model	16	16	↔	April 2026: Risk Reviewed; no change to scoring or controls
6217	~~See above under Children & Family Care Group~~				Feb 2026: Risk de-escalated and closed.
Executive Director for People					
4958 NEW	Fire Safety #1 (<i>Business sensitive risk</i>)	15	15	↔	April 2026: Risk Reviewed; no change to scoring or controls but escalated to ORR for visibility. Due to business sensitivities the details of this risk are captured in the closed session of the Committee.
4933 NEW	Fire Safety #2 (<i>Business sensitive risk</i>)	15	15	↔	April 2026: Risk Reviewed; no change to scoring or controls but escalated to ORR for visibility. Due to business sensitivities the details of this risk are captured in the closed session of the Committee.
NOTE: Please see also Risk ID6475 (above): <i>Industrial action of SCPHN Health Visiting staff members of the UNITE union</i> . The risk to service delivery sits with the Care Groups, but the industrial relations element sits with the People Directorate.					
NOTE: Subject to board endorsement, there is an emerging risk around shift pattern alignment, including the potential for industrial action, noting that the proposals impact a large proportion of our nursing/ midwifery and HCSW (over 3,000 staff). (Shared risk owned by Executive Director of People, and Executive Nursing Director)					

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
	Date ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan		Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed
1	4491	COO	Deputy COO	Business Manager for Chief Operating Office	Safety & Well-being - Patients / Staff / Public	Failure to meet the demand for patient care at all points of the patient journey	IF: The Health Board is unable to meet the demand upon its services at all stages of the patient journey. Then: the Health Board's ability to provide high quality care will be reduced. Resulting in: Potential avoidable harm to patients	Controls are in place and include: • Technical list management processes as follows: - Specialty specific plans are in place to ensure patients requiring clinical review are assessed. - All patients identified will be clinically reviewed which will include an assessment of avoidable harm which will be reported and acted upon accordingly. - A process has been implemented to ensure no new sub specialty codes can be added to an unreported list, this will be refined over the coming months. - All unreported lists that appear to require reporting have been added to the RTT reported lists - All unreported lists that are to remain unreported (as they do not form part of the RTT criteria) are being reviewed and will be visible and monitored going forward. • Patients prioritised on clinical need using nationally defined categories • Demand and Capacity Planning being refined in the UHB to assist with longer term planning. • Outsourcing undertaken when needed. • The UHB will continue to work towards improved capacity for Day Surgery and 23:59 case load. • A Harm Review process is being piloted within Ophthalmology – it will be rolled out to other areas. • The UHB has taken advice from outside agencies especially the DU when the potential for improvement is found. • Appropriate monitoring at ILG and UHB levels via scheduled and formal performance meetings with additional audits undertaken when areas of concern are identified Update November 2021 - the PCH Improvement Programme has significantly accelerated a number of mitigating actions designed to improve flow, reduce risk and improve the quality of care in the unscheduled care pathway. Updates on this are provided through the Quality & Safety Committee including specific actions and measures. There is also a PCH Improvement Board that meets monthly with the COO as the SRO. The Health Board is centralising the operational management and decision making around all elective services with the clear aim of increasing and protecting elective activity as we deal with the pressures of the Covid-19 pandemic and winter. This process commenced in late October 2021 and greater clarity will be provided in the next review. Update September 2022 - Continue delivery of the Planned Care Recovery Actions. Reconfiguration orthopaedic inpatient	April 2026: Risk reviewed by COO 30.4.26 and a request to review the risk overall by care groups. April 2026: The Health Board is delivering a system wide programme of control measures and improvement actions to reduce the risk of failing to meet patient demand at all points of the patient journey, from admission avoidance and urgent access, through inpatient flow, to timely discharge and recovery of planned care. This approach recognises that emergency demand is strongly influenced by performance earlier and later in the pathway and therefore requires co-ordinated action across acute, community and partner services. Urgent care have developed an action plan in collaboration with NHS Wales Performance and Improvement Team utilising recommendations from key documents such as, GIFT, SDEC Review, ambulance patient handover guidance, ED Quality Statement and MAG Report April 2026. Ambulance escalation cards are live and ED 12 hour action plan complete. Six Goals for Urgent and Emergency Care programme remains a key driver in place, aligned to national policy and overseen through established governance arrangements. This includes targeted work on admission avoidance, integrated front door models, acute hospital flow, and integrated discharge, supported by weekly performance tracking and escalation processes. Progress within the Productivity, Improvement and Transformation (PIT) and Planned Care Recovery programmes is directly contributing to reduced pressure on emergency pathways by improving outpatient demand management, theatre productivity, diagnostics, and waiting list control, including expanded insourcing, protected elective units, and regional collaboration. These actions reduce inappropriate emergency attendances linked to delayed diagnosis and treatment Targeted action has been taken to stabilise and improve the Eye Care pathway, recognising its contribution to both elective and urgent demand. Cataract surgery has been consolidated to the Princess of Wales Eye Unit, enabling standardisation, high volume low complexity delivery and improved throughput. This is supported by a Regional Cataract Plan In addition, the Health Board continues to receive enhanced assurance reporting on Ophthalmology, alongside other high pressure specialties, enabling earlier identification of access risks and prioritised mitigation where pathway instability could escalate demand elsewhere in the system Recognising the impact of discharge delays on emergency flow, the Health Board has strengthened integrated discharge governance, expanded alternative bed models, and implemented Discharge to Recover then Assess (D2RA) approaches in partnership with local authorities. This is complemented by the mobilisation and scaling of Hospital at Home, enhanced community response services, and improved digital tools to support safe and timely discharge decisions Regular reporting through the Operational Delivery Committee, Quality, Safety & Experience Committee. Performance dashboards, harm reviews, specialty specific reports (including Eye Care), and escalation mechanisms provide ongoing visibility and enable timely corrective action where pressures remain high	20	C4 x L5	12	↔	11/01/2021	01/04/2026	
2	4664 (Confidential risk)	Director of Digital	Digital	Head of Server Management	Statutory Duty, Regulation, Mandatory Requirements	CYBER: Ransomware/Extortion Resulting in Loss of Critical Services/Data and Possible Extortion	Due to business sensitivities the details of this risk are captured in the closed session of the Committee.				20	C5 x L4	12	↔	03/05/2021	05/05/2026
3	5276	Director of Digital	Digital	Pathology Quality Manager	Service / Business Interruption	Failure to deliver replacement Laboratory Information Management System, LIMS 2.0 Programme within project timeframe	IF: the new Laboratory Information Management System (LIMS) service is not fully deployed before the contract for the current LIMS expires in December 2026. THEN: operational delivery of pathology services and the financial position of the Health Board will be severely impacted RESULTING IN: delays in treatments affecting the quality and safety of a broad spectrum of clinical services, potential of system wide disruption associated with loss of Blood Transfusion services and the ability of the Health Board to deliver its statutory responsibilities in respect of financial management.	Currently LIMS 2.0 Programme reports progress against timeline to LIMS 2.0 Programme Board and Chief Executive Group. Business continuity options are being explored including extending the contract for the current LIMS to cover any short term gap in provisions. An expert stock take review of the LIMS programme has been completed with findings presented to Collaborative Executive Group (CEG) to inform next steps. Options appraisal presented to ELG March 2026	April 2026: Further escalation of concerns raised to SRO, DOO and COO 17th April Unbudgeted and unexpected costs passed onto CTM for LIMS Programme Delays. As advised at LIMS Programme Board April 2026 1. LIMS2 Programme shortfall for delays: CTM HB allocation of costs £0.5m 2. CCNs- Change Control Notifications for Analyser Interface development costs: CTM allocation £72,326.23 (these costs are being challenged) 3. TCL2016 Legacy Data extract and Sunset Viewer Infrastructure: Pending DHCW Work breakdown. Costs to be advised 4. Continued operational support of WLIMS/TCL2016 in the next quarter of 2026: CTM will be billed by the DHCW SLA to continue running TCL2016. Cost breakdown is expected from DHCW for support, licensing and maintenance post Aug/Sep 2026 We are still waiting to hear about the change to Micro Go Live for 18 May. February 2026: There is very real concern within the BT SME community that the BT LIMS 2.0 (TCLx) project will not be delivered within the specified timeframe. This presents both operational and financial risks: Operational: Dedalus have issued an end of life (EOL) notification for the current LIMS system (Telpath) (attached). This means that past the end of March 2027 the current system will no longer be supported. This presents operational risks in that if there is any hardware or software failure then the supplier would not fix the issue and the blood transfusion lab within the health board would not have a functioning IT system. A lack of a supported LIMS is also in direct contrast with the governance requirements for BT. It must also be noted that the current Telpath contract extension expires at the end of December 2026. Financial: An alternative solution would be the DLIMS solution supplied by Dedalus. This would allow us to extend the current Telpath contract up to implementation of the new DLIMS product (as they are both supplied by the same company and Dedalus have confirmed that this is a possibility). The financial risk is significant (quote attached).	20	C5 x L4	5	↔	31/10/2022	01/05/2026	
4	6597	Executive Director of Finance	Finance Directorate	Executive Assistant, Corporate/Finance	Adverse Publicity or Reputation	Failure to achieve the planned break-even position in 2026/27.	IF: The Health Board is not able to plan and deliver expenditure run rates that align with the available funding for 2026/27. THEN: The Health Board will not be able to deliver the planned break-even financial position for 2026/27. RESULTING IN : • Potential short term unsustainable cost reductions with associated risks and potential Welsh Government regulatory action. • Withdrawal of recurrent funding support for Welsh Risk Pool risk of £18.4m. • Failure to deliver the financial plan for 26/27. • Failure to meet the statutory financial duty to break even over a 3 year period resulting in qualification of the Annual Accounts in 26/27. • Potential cash shortfalls in the latter months of 26/27	• Financial Accountability letters from CEO to Executive Leadership Group. • Monthly monitoring arrangements and meetings in place with Care Groups and directorates. • Regular reporting to the Executive Leadership Group, the Operational Delivery Committee and the Board	NEW RISK - opened April 2026 for the new financial year	20	C4 x L5	12	N/A (new risk)	01/04/2026	01/05/2026	
5	6596	Executive Director of Finance	Finance Directorate	Executive Assistant, Corporate/Finance	Financial Stability & Impact of Litigation	Failure to reduce the £9.2m recurrent deficit at the start of 26/27 down to the planned £0.3m recurrent surplus at the end of 26/27	IF: The Health Board is not able to plan and deliver recurrent expenditure run rates that align with the available recurrent funding confirmed for 2026/27. THEN: The Health Board may not be able to deliver a break-even financial position for 2026/27 & beyond. RESULTING IN : • The Health Board not being able to support increase demands within services and/or reduce savings targets from current levels. • Potential short term unsustainable cost reductions with associated risks and potential Welsh Government regulatory action. • WGS not supporting the Health Board's plan for 27/28 • Failure to meet the statutory financial duty to break even over a 3 year period resulting in qualification of the Annual Accounts in 27/28. • Potential cash shortfalls in 27/28.	• Financial Accountability letters from CEO to Executive Leadership Group to be issued. • Monthly monitoring arrangements and meetings in place with Care Groups and directorates. • Regular reporting to the Executive Leadership Group, the Operational Delivery Committee and the Board.	NEW RISK - opened April 2026 for the new financial year	20	C4 x L5	12	N/A (new risk)	01/04/2026	01/05/2026	
6	5554		Diagnostics, Therapeutics, Pharmacy & Specialties Care Group	Clinical and Laboratory Haematology Service Manager	Statutory Duty, Regulation, Mandatory Requirements	Ability to comply with legal responsibilities for containment level 3 facilities	The Health Board previously been served with an improvement notice from the HSE for the management of the CL3 (containment level 3) facility. Currently the CL3 laboratory does not meet sealability requirements as advised with relation to COSHH. If CL3 standards do not comply with COSHH - Then the responsible persons can be prosecuted under section 37 of the Health and Safety at Work etc Act 1974. Resulting in - Potential fines and/or imprisonment and reputational damage for the Health Board. 27/01/26 Fumigation as detailed above is no longer viable as per inspection on 02/12/25 (see attached sealability certificate and report). Where clinical details indicate potential high risk organisms, specimens are not processed on-site and referred to Public Health Wales laboratories (currently Glyn Cwylf Hospital). Glyn Cwylf are only capable of accepting a small number of specimens. TB incidence rate in clinically indicated non-respiratory sites = 1.38% (2024). For respiratory specimens, the positivity rate is 0.39% (2024). It is not safe to send all specimens away as some specimens are clinically urgent and the delay would risk patient harm. Staff training has been updated to include referral of high risk specimens. Ongoing meetings with capital planning to refurbish the laboratory are essential to significantly reduce the associated risk level. The Health Board previously been served with an improvement notice from the HSE for the management of the CL3 (containment level 3) facility. Currently the CL3 laboratory does not meet sealability requirements as advised with relation to COSHH. If CL3 standards do not comply with COSHH - Then the responsible persons can be prosecuted under section 37 of the Health and Safety at Work etc Act 1974. Resulting in - Potential fines and/or imprisonment and reputational damage for the Health Board.	Assurances from Elab that fumigation can be undertaken The facility is still capable of being fumigated under the following conditions - "Should the room require fumigation the areas from both sets of double doors that comprise the corridor should be sealed and all rooms off that corridor evacuated for the duration of the spillage. During fumigation the volume should be increased by 10% to account for any leakage over the course of the fumigation" 27/01/26 Fumigation as detailed above is no longer viable as per inspection on 02/12/25 (see attached sealability certificate and report). Where clinical details indicate potential high risk organisms, specimens are not processed on-site and referred to Public Health Wales laboratories (currently Glyn Cwylf Hospital). Glyn Cwylf are only capable of accepting a small number of specimens. TB incidence rate in clinically indicated non-respiratory sites = 1.38% (2024). For respiratory specimens, the positivity rate is 0.39% (2024). It is not safe to send all specimens away as some specimens are clinically urgent and the delay would risk patient harm. Staff training has been updated to include referral of high risk specimens. Ongoing meetings with capital planning to refurbish the laboratory are essential to significantly reduce the associated risk level.	April 2026: COO reviewed 30.4.26 and has advised the score needs to be reviewed, based on the grounds there are mitigation and consideration if this is to be merged with 3567 April 2026: Risk reviewed and remains the same. Now escalated to the Organisational Risk Register. The refurbishment project has been delayed as the updated detailed quotations have exceeded procurement regulations, and so the project needs to go back to tender. However this has proceeded at pace and is in hand. Met with the COO, Executive Director of AHPs and Health Science, Deputy Director of Allied Health Professions and Health Science, Director of DT/PS, and Pathology Directorate Manager to discuss the current CL3 risks and mitigations. Followed up this meeting with a Teams call with the regional H/S lead for Public Health Wales. I was advised that the HSE have supported PHW with advice in the implementation of mitigations to continue testing specimens in CL3 whilst maximising safety as a temporary measure whilst the CL3 lab is non-sealable. We have adopted these mitigations in CTM as we have the same problems with non-sealability and non-fumigability. See email in document section. March 2026: Risk reviewed and remains the same. Awaiting advice from the Health Board as to whether funding can be provided to make the necessary repairs to the laboratory.	20	C4 x L5	4	↑	19/09/2023	01/05/2026	
7	5753	Executive Director of Nursing	Children & Families Care Group	Senior Nurse Community Children's Nursing Services	Workforce / Organisational Development / Staffing / Competence	Risk to patient safety and children's access to education due to inadequate Special School Nurse Provision	IF: the Health offer towards the current Special Schools Nursing Model is not increased; Bridgend Local Education Authority (LEA) does not contribute financially to the Service Level Agreement (SLA) in Special Schools and education not supporting the use of education staff in delivering delegable tasks to children with health needs Then the 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 Rhonda Cynon Taf (RCT) and Merthyr who are the only LEAs who contribute financially into the SLA 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), children unable to attend school, impact on parents who are having to attend schools to deliver care, 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. Reviewed 19/2/25 due to lack of progress Meetings have been held between Directors of education 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. Community nursing supporting gaps. Service director has asked to meet with education around SLA in January 2026 to agree way forward .	April 2026: The Special School Nursing risk has been reviewed following receipt of national guidance on modernising the school nursing model and improved engagement with education partners. Progress has been made in stabilising the service and clarifying expectations with special schools. An updated SLA with local education authorities is in development, with further assurance anticipated by the end of April. Subject to clinical confirmation, the risk score is expected to reduce from 20 to approximately 15-16, with further reduction dependent on formal SLA agreement and sustained implementation. February 2026: Meeting being arranged for 11th March 2026 - invite to be sent SLA to be redrafted	20	C4 x L5	8	↔	16/04/2024	31/03/2026	
8																

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
	Date ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	
8	5821	Executive Director of Strategy and Transformation	Strategy and Transformation	Assistant Director of Transformation	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; Then: CTM residents will have no access to secondary care immunology provision. Resulting in: unacceptable level of clinical risk for both routine and urgent referrals that are currently without any available referral option. Patient experience will be impacted by delays in onward referral for investigation, diagnosis and definitive treatment/management plan. This could lead to both informal and formal concerns being submitted to the health boards.	Control Measures There is a plan 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. CTM UHB Referral Management Centre currently maintaining database of both urgent and routine referrals received. CMT GPs have been informed of the challenges currently experienced with immunology provision and delays can be expected to continue.	April 2026: Working group continues to meet to look at options. Currently testing to see if any GPs would be interested in developing a special interest as part of service delivery (subject to funding and likely to be paediatric rather than adults). Waiting list is being reviewed to identify any individuals that need review in peri op allergy service as Cardiff and Vale are now accepting referrals via IPR. Discussion on future options to be tabled for exec discussion. December 2026: Internal working group now meeting monthly and will produce paper to go for executive discussion. New outpatient capacity has been secured to bring adult over 52 weeks waiting list down to zero by 31/3/26 but there remains an issue with follow up appointments. Options are being considered for this. Work on paediatrics continues around gaps in service. Awaiting communications from Welsh Government regarding service development across Wales.	20	C4 x L5	4	↔	11/07/2024	30/04/2026	
9	6052	COO	Facilities Directorate	Assistant Director OSS (Facilities)	Statutory Duty, Regulation, Mandatory Requirements	Patient hydration risks associated with the replacement of aged Beverage Trolley fleet (ultrafraks)	Existing fleet of beverage trolleys in CTM UHB require a replacement programme (as per regen trolley). The current fleet (apart from the Seren assets) are 10 plus years old and maximum life is 10 years old if maintained. The Ultrafraks are used for patient breakfast and beverages and then on used on average 5 times a day for beverages so are heavy use. The current models at all district general and community sites are not able to be put on maintenance contracts due to age, hence non-compliant. Several sites are now running with one per two/three wards and the service level is one per ward. VCC have 1 beverage trolley that is non-repairable. If: The patient beverage trolley fleet is not maintained/replaced. Then: Patients are unable to be fed breakfast and beverages. This is an essential part of the patient care. Resulting in: Patient hydration and nutrition non-compliance	April 2025 Update - 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 there is a repair programme in place at each site when equipment is broken. However the beverage trolleys are too old to put on maintenance contracts. Replacement is the only alternative. There is not enough budget in revenue to purchase singularly and the beverage trolleys are manufactured to order (cost decreases with volume). An investment bid has been included in the Facilities IMTP (submitted March 2025) An agreed replacement process has been approved, the risk will remain high until such time we have sufficient spares from replaced carts to maintain the existing equipment. Funding for 2 trolleys has been secured 4 additional trolleys are being purchased with a further 12 trolleys to be purchased in 2026/27. Review in 3 months to enable purchased trolleys to be operational and review risk rating (CM 16/03/26) This risk is being mitigated through the purchase of replacement trolleys as funding is identified. The replaced trolleys will be used for spare parts to further extend the life of the existing fleet pending future purchases. The risk will be reduced when the recently purchased trolleys are delivered - estimated as the end of May. Review date amended (CM 5/5/26)	May 2026: 16 trolleys have been procured via revenue they are not due in until end of May from the nominated supplier. Therefore there is currently no change to the score. The service has concerns on the current condition of the trolley from a food safety, health and safety and IPC perspective (see pictures attached). There is also the customer experience – it is not visually appealing to encourage patients to want to eat/drink from the trolleys (see pictures attached). We received another DATIX on 20/04/2026 105556 in relation to a staff trying to move an ultrafrakt which would not move due to wheels. The procurement status is that the kit is unable to go via Capital due to value and there is not the level of funding in patient feeding budgets to support this level (circa 360k) across the Health Board. Estates have been asked to prepare condition reports on the existing fleet. April 2026: 16 trolleys purchased but as yet no date for delivery. This risk will be reviewed when trolleys are fully operational	20	C4 x L5	8	↔	15/01/2025	05/05/2026	
10	6179	Executive Director of Public Health	Public Health	Assistant Director Public Health	Quality / Complaints / Assurance / Patient Outcomes	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 Then rates of obesity will remain high in CMT. Resulting in increased activity/achy/complexity of patients resulting from obesity, poorer patient outcomes, increasing pressures on services, risk of clinical incidents and continuing financial pressures on the organisation 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 CMT including: 1)Grant funded Whole system approach to healthy weight work- building momentum to influence system wide change in our obesogenic environment. 2)Adult Weight Management Service – the scale of this is vastly insufficient to make a difference to population level rates of obesity 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. 4)Healthy pre- and health schools programmes – working to enable educational settings to be healthy weight environments. Current activities are insufficient for population level impact. 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: -Healthy environments -Healthy settings, -Healthy people -Buddership and enabling change. 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.	April 2026: This risk was reviewed by the LHMT Strategic group on 31st March and also on 21st April Although a positive update was received that the business case to continue the PIPYN service has been approved via the IMTP, as there still remains a significant gap in funding to fully support level 1 and 3 services for children, the risk remains the same. The HW roadmap is awaited and will be submitted to board for approval in early 2026	20	C4 x L5	9	↔	06/05/2025	29/04/2026	
11	3826	Chief Operating Officer	Unscheduled Care Group	Deputy Clinical Service Group Manager - Acute Medicine and ED	Safety & Well-being - Patients / Staff / Public	Emergency Department Overcrowding	Resulting In: Failure to deliver Emergency Department Metrics, Poor patient experience, compromised 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 major cases, ambulance arrivals and self presenters. Filling the last resus space compromises the ability to manage an immediate life threatening emergency. Clinicians taking increasing personal risk in management of clinical cases.	April 2026 - Directorate working closely with NHS P&I Team to establish UEC Plans and 12-Hour Action Plan to help improve flow and ease overcrowding in the ED department. Increased number of nursing staff being rostered over and above establishment. Additional respite mattresses have been purchased with associated equipment. Safe to start meeting twice daily to escalate and make plans for deescalation Updated March 21 All patients are triaged, assessed and treatment started while waiting to offload. - Daily site safety meeting to ensure flow and site safety is maintained. - There is now a daily W&T led call (including weekends) with a senior identified leader from the Health Board representing CMT and taking daily through the plans to reduce offload delays across the 3 DGH sites. - Twice weekly meetings with RDC/RCC to ensure that any delays in discharge are escalated at a senior level to maximise the use of limited care packages/ care home capacity. - Appointment of Clinical Lead and Lead Nurse for Flow appointed Feb 21. Note clinical lead position has been removed in re-structuring 2024. Ongoing significant concern re ED crowding and barriers to flow at discharge / community level. Continued highlighting to senior leadership and exec team of patient safety concerns and risks to patients and staff. Continued significant ambulance offload delays impacting on community response times. Ongoing crowding in ED as above. Continued risk of harm to patients and staff.	April 2026 - CMT was the best performing HB in Wales for 45 Minute Ambulance Handover with the Royal Glamorgan top in Wales at 92%. Whilst improving 12-hour ED performance continues to be a priority, an increase from 1871 in February to 2373 in March was recorded. Sustained system pressure continues to impact on operational performance. To address this; ED 12 Hour Action Plan completed - ready for wider CG/HB input and sign off. CMT Safe Transfer of Patient Policy requires sign off alongside action plan Action Plan to review long waits to be seen in ED in development within the Directorate. Unscheduled Care SMT to attend National Urgent and Emergency Care summit 27th April 2026. Urgent Emergency Care Action Plan has been developed in collaboration with NHS Wales Performance and Improvement Team utilising recommendations from key documents such as: GORT recommendations SDCC Review Ambulance Patient Handover Guidance gQRT Quality Statement M&C Report (April 2026)	20	C4 x L5	12	↔	24/09/2019	07/05/2026	
12	6294	Chief Operating Officer	Planned Care Group	Directorate Manager for General Surgery and Gastrointestinal Services	Workforce / Organisational Development / Staffing / Competence	Insufficient Consultant Workforce - Endoscopy / Gastroenterology	Fragility of Consultant workforce, notably on the POW site. Inability to appoint Consultants to replace Consultants that leave. Only two substantive Consultants at POW currently. If the Consultant posts cannot be filled, it will impact on Service Delivery and affect our ability to deliver both diagnostics and clinical services to patients. If the Consultants that are currently in post were no longer in post, this would significantly affect our ability to deliver both diagnostics and clinical services to patients. Furthermore it would impact on ability to support inpatient services at POW. Fragility of the Consultant workforce is contributing to potential gaps within the on call bleed rota, with little redundancy. This could result in a situation in which the on call bleed rota could not be covered.	No possible mitigation currently. Posts remain out to advert. Locum in post for one of the vacancies however he is due to leave in the near future due to other obligations There has been no interest from agencies. Update December 2025: No possible mitigation. Posts remain out to advert. Locum has now left post as of early December (this was earlier than expected, with significant disruption to Endoscopy). Extremely fragile staffing position in POWH. There has been no interest from agencies. 15.4.26 - Locum has since left, vacancy out continuously to advert and current Consultants raising issues with their health	April 2026: Recruitment advert now live, with ongoing development of plans to sustain and support service provision. Currently working through timeline.	20	C4 x L5	9	↑	07/08/2025	01/05/2026	
13	6318	Chief Operating Officer	Mental Health and Learning Disabilities Care Group	Directorate Manager - CAMHS and Specialist Services (Mental Health and Learning Disabilities)	Safety & Well-being - Patients / Staff / Public	Tier 3 SHED (Severe and High Impact Eating Disorders) Team Service Delivery	If: The level of vacancies continues in the C+V UHB service for high risk eating disorder patients (SHED) Then: The service will be unable to fully deliver assessment and treatment interventions for CTM UHB residents. Resulting in: Patient safety concerns for a number of high risk patients (CTM UHB patients - 16) escalating concerns following meetings with CMHT and Dietetic colleagues, concerns relating to lack of engagement by SHED with CMHTS in relation to discharge and lack of timely assessment service, briefing note developed and forwarded to director of nursing and care group director 24/10/25	There are regular meetings with the SHED team to discuss the caseload. These controls are fragile and could include increased oversight for named pts by CTM CMHT This has been escalated to the MHLT SLT on 29/08/2025, following dialogue with CMHT colleagues increasing concern about communication between SHED and local CMHTS together with lack of timely assessment services and lack of mitigating actions by CVUHB. •The recent appointment of a band 7 practitioner within CTMUHB to help with coordination - Hannah Pritchard would be starting in this role on 15th December for a fixed term until 31st March 2026. The costs for this post would be recharged to CVUHB. •The establishment of fortnightly SHED drop in clinics for adult CMHT staff in CTMUHB. Tracey Larson had helpfully been involved in establishing these regular meetings and initial feedback was positive. •CTMUHB adult CMHT services will continue to provide physical health monitoring arrangements for their patients who have been referred to SHED. •The Consultant lead for SHED, Isabella had agreed to schedule some training sessions for CTMUHB CMHT staff which	April 2026: The Care Group has met with CVUHB colleagues and implemented a series of mitigating actions including, a temporary appointment of a nurse practitioner, drop-in clinics, physical health monitoring and staff training. April 2026: Meetings scheduled with CVUHB on 13th and 14th April to discuss medical cover and the 36 degree report action plan. February 2026: The Care Group has met with CVUHB colleagues and implemented a series of mitigating actions including, a temporary appointment of a nurse practitioner, drop-in clinics, physical health monitoring and staff training.	18	C4 x L4	6	↔	29/08/2025	01/05/2026	
14	6498 NEW RISK	Chief Operating Officer	Diagnostics, Therapies, Pharmacy & Specialties Care Group	Care Group Service Director - Diagnostics, Therapies, Pharmacy and Sciences & Children and Family	Safety & Well-being - Patients / Staff / Public	Lack of Dynamic Mattress Systems in UHB due to over 100 units being condemned and not replaced due to cost.	If: there are insufficient dynamic mattresses available, Then treatment of patients with pressure ulcers or at risk of developing pressure ulcers will be compromised, Resulting in pressure ulcers developing, possible tissue damage, increased risk of infection, possible increased length of stay and long term health effects, RIDDOR reporting event and possible litigation for avoidable pressure ulcer damage.	April 2026: COO reviewed 30.4.26, content to agree escalation but would like a clear plan and actions presented to address risk	18	C4 x L4	1bc	N/A (new risk)	11/02/2026	01/05/2026		
15	6429 NEWLY ESCALATED TO ORR	Executive Director of Therapies and Health Sciences	Diagnostics, Therapies, Pharmacy & Specialties Care Group	Physiotherapy Manager for Rehabilitation	Safety & Well-being - Patients / Staff / Public	Physiotherapy MSK Self Referral Form	The Physiotherapy Self Referral Form for patients to have open access to physiotherapy was put in place in 2019. At the time Primary Care referrals were lower, and physiotherapy service infrastructure supported the quick triage of patients (within 48-72 hours). It has been highlighted by staff over the past 2-3 years that the self referral form is not fit for purpose, with instances of patients waiting for triage, who should have been seeking urgent medical care. As the Demand for Primary Care MSK Physio self referral has increased beyond triage capacity, we are unable to support the ongoing appropriate governance to ensure the	There have been several attempts to amend the referral form to include branching logic within the question format, to allow the appropriate safety/setting of patients self referring. Healthboard decisions were made to block the use of MS forms for this purpose over Information Governance concerns. Further options were explored this year, and the form has been developed. However this is unable to progress due to software issues.	April 2026: The risk was reviewed by the COO following meetings on 24 and 30 April 2026. Approval was given to progress with MS Forms to support physiotherapy self referral, implementation is awaiting action by the Digital team. Clinical incidents continue as the process has not yet changed, therefore the risk score remains unchanged. Further actions include commissioning content via the Keeping Me Well website, consideration of short term measures to address backlog pressures, and escalation to the Primary Care Transformation Board. The risk will be reviewed within one month, or earlier if the self referral system is implemented.	18	C4 x L4	1	↑	24/11/2025	06/05/2026	
16	6417	COO	Depty COO	Assistant Director of Operations MH and LD	Safety & Well-being - Patients / Staff / Public	Management of Security Doors in All Hospital Settings	Following several serious incidents following patients absconding from clinical areas, the HSE have issued an Improvement Notice on Bridgend Integrated Locality Group (see Documents) outlining the following actions: In consultation with employees and involving competent persons: 1. Identify the units, wards and premises where in-patients may be at risk from wandering, absconding or escaping. 2. For each of these, undertake a suitable and sufficient risk assessment of physical and procedural measures to prevent in-patients from wandering, absconding or escaping. 3. Identify the measures needed to protect patients at risk 4. Record the significant findings. Any lessons learned from the above should be formally shared with the other 2 Integrated Locality Groups for action. If: The Health Board do not comply with the notice. THEN: The Health Board may be subject to prosecution by the HSE Resulting in: Large Fines and poor publicity.	clinical areas across the Health Board should have in place local arrangements/procedures to prevent patients from absconding. 29/09/2022 - RTE ILG has recently undertaken a review of all their clinical areas and assessed the risks from patients absconding. An action plan is being developed.	May 2026: COO review 30.4.26, requesting further clarity on progress and actions to date. Business Manager following up with colleagues further. February 2026: The HB are in the process of reviewing incidents reported in the last 6 months, compared to those reported 2 years prior. This will enable the HB to analyse the impact against the original assessment, and review the risk rating.	18	C4 x L4	8	↔	30/09/2020	01/05/2026	
17	4632	Executive Director of Therapies and Health Sciences.	Unscheduled Care Group	Senior Quality & Safety Manager - Unscheduled Care	Safety & Well-being - Patients / Staff / Public	Provision of an effective and comprehensive stroke service across CMT (encompassing prevention, early intervention, acute care & rehabilitation)	If: changes are not made to improve and align stroke prevention initiatives, early intervention campaigns, and acute and rehabilitation stroke care pathways across CMT THEN: avoidable strokes may not be prevented, patients who suffer a stroke may miss the time-window for specialist treatments (thrombolysis, thrombectomy), and patients may not receive timely, high-quality, evidence-based stroke care RESULTING in: higher than necessary demand for stroke services, poorer patient outcomes/increased disability, increased length of stay, and poor patient/carer experience. Impact will extend to the need for increased packages of care, increased demand for community health services, and increased carer burden when discharged to the community. Additionally, the performance targets to monitor improvement of the stroke prevention and care service will be adversely affected, leading to significant challenges for the health board to include noncompliance with Quality Improvement Measures (QIMs).	• Executive-led Stroke Strategy Group in place, with targeted task and finish under development. Membership updated to reflect senior Ops change • Task and membership of Strategy Group updated. • Close working amongst executive team to escalate and address operational and clinical issues in relation to stroke pathway • Board briefing to ensure all aligned to challenges • Quarterly briefings to Quality and Safety Committee • Performance data regularly presented to Performance, Planning and Finance Committee • Strong CMT input to regional and national Stroke Programme Boards • Unified, evidence-based pathway developed for thrombolysis • Preparations progressing to prepare for 24/7 thrombolysis service at Bristol and updated RCP guidance on thrombolysis and thrombectomy • Designated senior operational lead for performance and improvement leadership for stroke pathway	April 2026: Stroke Improvement Programme continuing • Focused KPI improvement work continues at RGH - time to CT and time to Stroke Unit. • Daily multidisciplinary huddles with review of all stroke presentations – breach reasons and actions agreed. • SGP to support clinical pathway • CNS based in ED 6/7. • Daily and weekly performance reporting. Stroke Performance Summary • Stroke performance continues to improve with daily focused huddles ongoing. Next Steps • Roll out improvement programme to PCH and POWH • Engagement with all stakeholders • Review of baseline data	18	C4 x L4	12	↔	11/05/2021	01/05/2026	

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	Date ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	
1	5374	Executive Director of Strategy & Transformation	Strategy and Transformation Directorate	Executive Director of Strategy & Transformation (temporary until Deputy Director role is filled)	Environmental / Estate / Infrastructure	Fulfilling our environmental and social duties	If the health board's decisions fail to reflect our values or consider the long term environmental or social impact Then we will not fulfil our socio-economic duty, our Wellbeing of Future Generations objectives or our value based healthcare principles Resulting in negative environmental and social impacts and loss of trust and confidence among stakeholders	•Integrated Medium Term Planning Process aligned to the seven Welsh wellbeing goals and five ways of working. •CTM 2020' delivery focuses on community developments, employment and local procurement where possible. •CTM becoming established as an Anchor Organisation. •Decarbonisation Action Plan •Established a CTM Environmental Sustainability Group which will have oversight and delivery of CTM's decarbonisation agenda •CTM 2020' seeks to ensure that services take account of the impact on the environment •88-Wales approach to sustainable procurement •Green CTM Staff Forum •Meet emissions reduction programme and trial of electric vehicles •Tree planting initiatives •Waste management – elimination of landfill for foodstuffs •Use of less environmentally impactful anaesthetic gases •CTM representatives attend the Welsh Government Green meeting •DAP updated and signed off by Board March 2024 •Board and Committee cover papers also now include environmental impact against SRs. •Sustainability post appointed to, started July 2024 •Adaptation sub-group established and plan to be produced by March 2026 •Use of SimplyGo platform •Close working with Innovation Team and wider partners to deliver a number of sustainability projects •Solar panels being rolled out •LED lighting fitted in POW as part of roof programme October 2025 update: Additional calls to be answered by March 2025 which will respond to Welsh Government Decarbonisation Strategy Delivery Plan. This	April 2026: Risk reviewed - no change to score or controls	16	C4 x L4	8	↔	21/02/2023	29/04/2026	
10	4671 Confidential Risk	Director of Digital	Digital	Head of Datacentres and Cloud, Digital & Data	Service / Business Interruption	NHS Computer Network Infrastructure unable to meet demand	Due to business sensitivities the details of this risk are captured in the closed session of the Committee.	The Policy for the Development, Review and Approval of Organisational Wide Policies is extant and sets out the process to follow. Policy and Procedure advice and guidance is available from the Clinical Policy lead and the Assistant Director of Governance & Risk for non clinical policies. SharePoint Intranet page acts as document library. A risk assessment approach to the prioritisation of reviewing policies and procedures is available to support functions. A suite of support templates along with the policy is published on the Health Board. Policies and procedures are available centrally on SharePoint although many have passed their 3 year review point. Step by Step guides for clinical and non clinical written control documents issued.	April 2026: The new SharePoint site for Non Clinical Policies is now live. Uploading and archiving access is currently restricted to the Quality Assurance and Compliance team, enabling tight control of approvals and version management. A live master register and shared drive are maintained as a fail safe for all current and archived documents, although this requires significant manual administration. Work is ongoing with Directorates to confirm an accurate baseline of existing policies. Once this is complete, the project will move to the next phase, enabling greater automation and background archiving. Clinical policies remain under development by the clinical team and are not yet ready to migrate to the new SharePoint site.	16	C4 x L4	9	↔	03/05/2021	05/07/2026	
20	4885	Director of Corporate Governance & Board Secretary	Governance	Head of Quality Assurance and Compliance	Quality / Complaints / Assurance / Patient Outcomes	Failure to deliver and sustain effective Policy Management System and Process	If the Health Board fails to maintain an effective policy management process/system to monitor, store and manage the review of policy and procedural documentation Then: there is a risk that staff may act in a manner that is not consistent with strategic and functional expectations. Policies and procedures may not be readily accessible to support decision making and service delivery, and the Health Board may not be protected from litigation if policies and procedures are not regularly reviewed to reflect changes in standards and/or legislation. Resulting in: Policies not being readily available for reference in decision making / emergency situations to support courses of action. Non compliance with new standards and legislative changes leading to possible legal challenge. Limited version control which could impact decision making if there are inconsistent or varying versions of a policy available.	The Policy for the Development, Review and Approval of Organisational Wide Policies is extant and sets out the process to follow. Policy and Procedure advice and guidance is available from the Clinical Policy lead and the Assistant Director of Governance & Risk for non clinical policies. SharePoint Intranet page acts as document library. A risk assessment approach to the prioritisation of reviewing policies and procedures is available to support functions. A suite of support templates along with the policy is published on the Health Board. Policies and procedures are available centrally on SharePoint although many have passed their 3 year review point. Step by Step guides for clinical and non clinical written control documents issued.	April 2026: The new SharePoint site for Non Clinical Policies is now live. Uploading and archiving access is currently restricted to the Quality Assurance and Compliance team, enabling tight control of approvals and version management. A live master register and shared drive are maintained as a fail safe for all current and archived documents, although this requires significant manual administration. Work is ongoing with Directorates to confirm an accurate baseline of existing policies. Once this is complete, the project will move to the next phase, enabling greater automation and background archiving. Clinical policies remain under development by the clinical team and are not yet ready to migrate to the new SharePoint site.	16	C4 x L4	8	↔	26/10/2021	01/05/2026	
21	6451 NEW ESCALATION		Planned Care Group	Clinical Service Group Manager, Surgery & ACCT, POW	Safety & Well-being - Patients / Staff / Public	Orthopaedic pathway	Due to business sensitivities the details of this risk are captured in the closed session of the Committee.			15	C5 x L3	4	↑	15/12/2025	01/05/2026	
22	5045	Chief Operating Officer	Unscheduled Care Group	Directorate Manager Specialty Unscheduled Care	Safety & Well-being - Patients / Staff / Public	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 services provision for the residents of CTM; 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; 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. The waiting lists for RGH and PCH are currently reported by CAUHS and POW by SBUHS but there has been a request for CTM to take over the RGH and PCH reporting. An SRAK has been drafted and tabled at OMB on 19/02/25 which identifies the resources required to take the waiting over in a reasonable position.	Current Control Measures: An additional Locum Consultant working out of RGH providing inpatient and outpatient neurology services support. Plan to appoint 2 consultant neurologists within CTM as part of the Neurology Liaison Plan. Mitigating Action Being Taken: Significant concerns have been raised across CTM and the planning team has engaged with key stakeholders to develop a robust commissioning plan. Any development of the service will require investment. A CTM liaison service model paper has been produced and forms part of the USC Care Group IMTP plan for 2023/26. Provision of neurology services to CTM residents has been highlighted as a key risk in the Medicine CSG IMTP in previous years. Approval has been given to recruit 2x Consultant Neurologists; one post was successfully recruited with a planned start date of April 26. the RGH locum has been extended to end of Dec 26. Once the new appointee starts the risk can be reviewed again and potentially be adjusted to reflect the additional capacity within the neurology service for CTM.	April 2026: • The care group have successfully appointed a Consultant Neurologist (currently working in a neighbouring health board), with a planned start date of 6th May 2026; options for filling the remaining Consultants position are being reviewed in discussion with the new appointement. • The reporting of the neurology waiting list in PCH & RGH will be taken over by CTM on 1st April 2026. The end of March position was 82 patients waiting over 52 weeks for 1st OPA. • Conversations are ongoing with CAU regarding delivery of the commissioned capacity within the Neurology LIA. The risk score will be reviewed following consultant commencing appointment in May.	16	C4 x L4	8	↔	09/03/2022	30/04/2026	
31	5579	Executive Director of Public Health	Diagnostics, Therapies, Pharmacy & Specialties Care Group	Interim Head of Dietetics	Quality / Complaints / Assurance / Patient Outcomes	Rising childhood obesity rates resulting in an increase in obesity related conditions and poorer health outcomes.	If there is no children and young persons weight management service... Then the Health Board will be unable to support children and young people to manage their overweight and obesity. Resulting in non compliance with national standards and pathways, significant risk to patients with increases in childhood obesity rates, obesity related conditions, healthcare costs and no improvement in the health of the most disadvantaged.	Non-finance dependant controls: 1) Level 1 service via PIPYN continues to be delivered in Merthyr via PHW budget and pan HB roll out due from April 26 onwards, this will be a phased approach 2) Written first line advice and guidance on the management of referrals available and provided to referrers and shared with families and carers 3)Business case developed submitted and submitted for IMTP consideration. BC includes phased approach at levels 1 and 3 and was developed in collaboration with stakeholders. Budget agreed for Level 1 PIPYN 26 and onwards. L3 service submitted again as part of this cycle of IMTP. Finance dependant controls: 1) Set up PIPYN and expand to ages 3-10 (from 3-7) from March 26 onwards.	Feb 2026: Risk reviewed. No change. Budget confirmed for HB role out of L1 PIPYN 3-10 from March 26 onwards. L3 still significant gap and put forward again as part of IMTP planning process.	16	C4 x L4	8	↔	13/10/2023	10/04/2026	
34	5761	Executive Medical Director	Medical Directorate	Medical Directorate Manager, YMH	Safety & Well-being - Patients / Staff / Public	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 Then... Clinical staff across CTM will be unable to provide the safe and effective care to patients using transparent, available data Resulting in... Potential harm to the patients of CTM due to the lack of clinical information available to clinicians when making clinical assessments	Update May 2026 - Same update as Oct 2025. It is raised at the relevant forums (All Wales Medical Director Meetings) regularly.	May 2026: Risk reviewed; no change	16	C4 x L4	8	↔	26/04/2024	05/05/2026	
25	5877	Chief Operating Officer	Primary and Community Care Group	Development Manager - Out of Hours	Service / Business Interruption	NEW WORKER CONTRACT FOR OUT OF HOURS GPs - WTR Risk	If the new worker contract for out of hours GPs is implemented (ambition is for Dec 2025) it will require the application of Working Time Regulations. THEN there will be a significant impact on shift fill rates, RESULTING in the Health Boards ability to fill shifts across the whole roster having a negative impact on both WAST and ED departments.	CTM to consider a local activity threshold to avoid local absenteeism, unnecessary prolonged length of stay, patient decondition and adverse outcomes to enable an immediate transfer for definitive care.	April 2026- waiting NHS Employers and BMA to conclude their negotiations. Regular oversight of the GP rota's, liaising with pool for additional shifts where possible.	16	C4 x L4	8	↔	07/08/2024	01/05/2026	
26	6232	Executive Director of Nursing	Executive Nurse Directorate	Deputy Executive Director of Nursing	Stability of the Legal Services Function	If the Health Board fails to adequately equip the Legal Services Function with the resources and support to fulfil the requirements of the function. Then: there is a risk to staff turnover and retention, wellbeing and morale. Risk to the reputation of the function and the Health Board as an employer of choice. Lack of resilience and capacity to fulfil the obligations under the relevant legislation surrounding the activity of the function. Resulting in: an adverse impact to the wellbeing and morale of staff leading to increased sickness absence and staff turnover. Lack of job satisfaction. Increasing risk of breaching relevant legislation due to lack of sustainable resources and resilience of the existing function. Loss of Trust and Confidence in the Legal Service Function / Reputation.	Current Control Measures: Review initiated to understand CTMUBH's position in terms of the number of inquests underway and the response to requests. Current controls: OCP underway to consider structures of the function. Benchmarking and learning from other organisations. Mitigating Action Plan: Legal Services Recovery Plan in place which will consider if there is sufficient capacity to manage cases effectively, if internal processes and systems need to be revisited to make changes and identify areas for further improvement. July 2025: The Organisational Change Process is near completion, with feedback from team members now catalogued. The benchmarking exercise is complete, and the senior leadership team is reviewing the structure against known demand. Additional workforce in place through recruitment and redeployment to support immediate service needs and overall recovery. September 2025: The recovery programme continues to make progress in standardising and stabilising processes and work plans. The OCP remains delayed as a result of the prioritisation of work and gaps in senior leadership owing to non-work-related absence. April 2026: The OCP is now complete and will be implemented on 5 May 2026. As part of the OCP, additional posts within the Legal Services Team have been approved, with recruitment underway to strengthen capacity and resilience. A new Lead for Legal Services has been recruited to the role. Recruitment of other members of the team is expected to be complete by 31 July 2026. 30/04/26-Executive Director Nursing, Midwifery & Patient Care Richard Hughes reviewed and approved.	April 2026: The risk to remain at its current level until above recruitment (RE OCP) is concluded and the revised staffing arrangements for the Legal Team are fully in place. Progress will continue to be monitored through routine governance and risk reporting.								
27	6231	Executive Director of Nursing	Executive Nurse Directorate	Deputy Executive Director of Nursing	Statutory Duty, Regulation, Mandatory Requirements	Proactive management and compliance with cases that qualify for consideration under the NHS (Concerns, Complaints and Redress Arr	If the Health Board fails to comply and proactively manage cases that qualify for consideration under NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. Then: there will be a missed opportunity to deal with concerns under a single and consistent method for grading, investigating and to actively involve the person raising the concern in an open and engaged manner to put things right. Resulting in: Delays in improving patient safety and experience as a result of identifying how services may have improved as a result of concerns notified and dealt with under these arrangements. Early resolution of cases which provide an opportunity for closure for families and staff as well as effective and efficient learning to be implemented. Avoidable costs should a case proceed to litigation due to failure to comply proactively with the arrangements. Reputational impact of the Health Board in terms of trust and confidence in the service and assurance that lessons have been learned	April 2026: The risk to remain at its current level until above recruitment (RE OCP) is concluded and the revised staffing arrangements for the Legal Team are fully in place. Progress will continue to be monitored through routine governance and risk reporting.	15	C3 x L5	8	↔	03/07/2025	02/05/2026		
28	6235	Executive Director of Finance	Finance Directorate	Head of Governance Estates	Environmental / Estate / Infrastructure	Insufficient funding to address backlog maintenance across the estate. Then: there is a risk that it may not be able to maintain an estates infrastructure that keeps services functioning, meets statutory compliance regulations and provide enhancements/ improvements for patient care and staff well being RESULTING IN: An inability to deliver its services efficiently and effectively. Poor environment and experience for patients, visitors and staff. Estate infrastructure problems. Unable to replace failing/ ageing plant and equipment. Poor estate regulatory compliance. High carbon footprint. Loss of service and productivity. Increased backlog maintenance	Added to Internal Care Group commissioning meeting 19.11.2025	April 2026: No change. This risk is being tolerated for the foreseeable future. Backlog maintenance funding is a recognised national issue across NHS Wales, and while there has been significant investment in major hospital developments, this does not address backlog maintenance across the wider estate. Mitigation on high risks is being carried out through the use of Discretionary capital funding, and schemes such as Targeted Estates Funding (TEF) stream, or additional maintenance to prolong the life of assets reaching end of life, but this only addresses a small % of the total backlog maintenance figure and a % of the high risk items.	16	C4 x L4	9	↔	04/07/2025	07/05/2026		
29	6280	Executive Medical Director	Executive Medical Directorate	Directorate Manager for General Surgery and Gastrointestinal Services	Safety & Well-being - Patients / Staff / Public	Suspension of the Regional Hepato-Pancreato-Biliary service model	If... the commissioning of this service is not prioritised as part of the regional commissioning arrangements Then... there will be no Regional service for Severe Acute Pancreatitis Resulting in... sub optimal care for this group of acutely unwell patients	Each case NOW has to be discussed on a case by case basis between neighbouring Health Board Medical Directors which will add delays to an already complex and time sensitive treatment pathway	April 2026: Risk reviewed; no change	16	C4 x L4	9	↔	06/08/2025	24/04/2026	
30	6397	Chief Operating Officer	Primary and Community Care Group	Development Manager - Out of Hours	Service / Business Interruption	RECRUITMENT - SHORTAGE OF GPs TO DELIVER URGENT PRIMARY CARE SERVICES	If the decision to have a 'hold' on the recruitment of GPs into GP OOH and Navigation Hub continues, or if engagement and contractual status of Out of Hours GPs THEN there will be a continued reduction in shift fill rates, RESULTING in shifts remaining unfilled (specifically home visiting shifts) and this will lead to more patients (palliative and end of life) being conveyed into the Emergency departments.	Explore alternative engagement routes such as bank and salaried contracting although there are challenges as these do not offer flexible engagement for GPs who have permanent day time and other employment. There are GPs who wish to work GP OOHs and if the recruitment freeze was lifted we may be able to fill some of the shifts to off set the risk.	April 2026: No change with the risk, remains to be closely monitored by the care group. The Care group are reviewing the position to share an appropriate update and mitigation to executives.	16	C4 x L4	12	↔	31/10/2025	01/05/2026	
31	6424	Director of Digital	Digital Directorate	Information Governance Manager	Statutory Duty, Regulation, Mandatory Requirements	Mental Health Subject Access Requests (SARs) (IG/15)	If... SARs in the Mental Health Team are not processed efficiently due to lack of staff and resources. THEN... we may not be compliant with the law, RESULTING IN... enforcement action from the regulator (ICO), plus increased complaints from requesters and affected parties, adverse press and loss of faith in the organisation	All relevant Exec leads and senior managers have been made aware of the issues faced by the Mental Health Admin Team and the backlog of requests due to staff shortages. The SAR process is in place as it has been for years. Extra recruitment is needed to ensure there are enough staff to process the requests and handle the redaction/checking process.		16	C4 x L4	16	↔	20/11/2025	01/05/2026	
32	6426	Director of Digital	Digital Directorate	Information Governance Manager	Statutory Duty, Regulation, Mandatory Requirements	IG17 Access to e-whiteboards	Due to business sensitivities the details of this risk are captured in the closed session of the Committee.			16	C4 x L4	16	↔	20/11/2025	01/05/2026	
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	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
	Date ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	
1	6475 NEW	COO and Executive Director of Nursing	Children & Families Care Group	Head of Nursing CYP	Service / Business Interruption	Industrial action of Health Visiting staff members of UNITE Union	IF there is sustained industrial action across a long period of time THEN there will be sustained disruption to the expected service offer for the Healthy Child Wales Programme, Flying Start programme and CWTCH programme RESULTING IN reduced health visiting contacts, breach of ALN requirements, reduced opportunity for robust and accurate health needs assessment, reduced data submission to Welsh Government and Local Authority. During Industrial Action (IA), the absence of provision will create immediate risks for: •Exhausted babies and mothers in the first 42 days post-birth. The first 1,000 days from conception to a child's second birthday represent a critical window for early intervention. Optimal nutrition, nurturing and responsive caregiving, and a safe environment during this period are essential to preventing lifelong and potentially irreversible health, cognitive, and developmental inequalities. Health visiting services play a vital role during this time. •Reduced essential universal services as well as targeted support to meet the needs of	1. Caseload planning in areas where there are staff members taking industrial action 2. Robust risk assessment during caseload planning to ensure those identified as most vulnerable are in receipt of health visiting support 3. Maximising skill mix workforce to support essential services 4. Students without a PSPA will be supported to complete their training by CPE's 5. Informed WG and LA of the industrial action and the impact on data submission 6. Regular close monitoring of the staffing and service delivery plan by the Deputy Senior Nurses to ensure caseload planning reflects the current service position and actions required to maximise service reach to families and children 7. Regular and close monitoring of empty caseloads, caseload numbers and complexity 8. Allocation of vulnerable families to staff taking industrial action, this will support the universal delivery of the service to non striking staff 9. Commenced weekly communications updates to all Health Visiting staff (and wider CTM workforce) wef 23rd April to increase transparency and accuracy of information	April 2026: Risk reviewed, no change Feb 2026: The following actions were confirmed at OMB: High risk families are prioritised Mitigation plans focus specifically on families and children with the highest level of need or risk. Daily "strike action cell" Runs every morning from 8:30am, starting Monday 23 February led by senior leaders Reviews staffing attendance and reallocates available capacity Additional afternoon cells may be stood up if required Communications Formal communications to Local Authorities are being issued Wider internal and external comms are supported corporately FACs are being used to clarify staff responsibilities and expectation	18	C4 x L4	12	N/A (new risk)	21/01/2026	05/05/2026	
34	6604 NEW	Director of Digital	Digital Directorate	Information Governance Officer	Statutory Duty, Regulation, Mandatory Requirements	IG 18 Misdirected clinical correspondence - NHS to GP	IT..... system errors continue to send clinical correspondence to the wrong GP systems due to patient demographic misalignment. Then..... there is potential for clinical risk for the patients due to incorrect or missing data. Resulting in..... Potential non-compliance with the Data Protection Act 2018. Significant manual reprocessing by NWSPP, including RPA and scanning intervention. Delayed communication leading to inefficiencies and increased demand on GP and secondary care services. Systemic duplication of effort across Health Boards. Material Risk to Reputation	•CTM IHR: • detailed analysis of misdirection causes • reinforcement of demographic update responsibilities for PAS users • API onboarding to enable real-time demographic synchronisation • collaboration with DHCW to mitigate legacy demographic risks • implementation of real-time API consumption of WDS/EMPI/NPIX demographic updates • reduction of reliance on warehouse refresh cycles • event-driven demographic synchronisation • investigation and resolution of Myriad PAS correspondence routing issue • reconciliation of historic demographic records	May 2026: New Risk Opened following discussion by the IG Group	18	C4 x L4	6	N/A (new risk)	01/05/2026	01/05/2026	
35	6605	Director of Digital	Digital Directorate	Information Governance Officer	Statutory Duty, Regulation, Mandatory Requirements	IG20 Legal compliance with access to records requests	IT..... the health board does not improve the compliance for access to medical records requests. Then..... there will be excessive complaints from patients, Resulting in..... complaints to the regulator, potential regulatory action against the health board including investigations or fines. Potential for claims for late records impacting on	Medical Records Team are informing patients that there is an 8 week backlog with the requests. Issues with backlog is due to amount of requests coming in, not enough staff dedicated to access requests only to assist with the work.	May 2026: New Risk Opened following discussion by the IG Group	18	C4 x L4	16	N/A (new risk)	01/05/2026	01/05/2026	
36	3337	COO and Director of Digital	Mental Health and Learning Disabilities Care Group	Service Director, Mental Health and Learning Disability	Safety & Well-being - Patients / Staff / Public	Lack of a Single Electronic Patient Record in Mental Health Services inc CAMHS	IF: Mental Health Services do not have a single integrated clinical information system that captures all patients details. Then: Clinical staff may make a decision based on limited patient information available that could cause harm. Resulting in: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace.	1. To ensure teams are able to access patient information in all localities, a matrix has been developed that informs teams of who they should contact to obtain current information from any of the multiple systems being used. This was introduced to mitigate risk to meet the HTW recommendation. 2. Process in place for clinical teams to access information via local authority and health board teams. 3. Clinical teams will only use historical information as part of their current risk assessment and if this is not available they will judge the risk accordingly. 4. Merthyr and Cynon and Bridgend COS leads have confirmed that WCCIS is on their CSG risk register and their update have been provided within this this section, therefore aligned. 5. WCCIS Programme Board establishment for CTM was finalised by the 30th June 2021, Merthyr and Cynon COS Lead will Chair this group. The Chair of this group will report to the Senior Responsible Officer. The Task and Finish Groups is established and aligned to this Programme board Programme and is now established. 6. Local Authority have recently developed reports for Mental Health which identifies practitioner caseloads, admissions and discharges and care plan for compliance. 7. Community Drug and Alcohol Team in Bridgend have now moved over to WCCIS, early implementation learning continues to take place. 06.09.2023 8. New WCCIS Programme Board and Operational Group established for CTM. The Digital Director and Deputy COO are SROs for the Programme. 9. Project manager has been recruited. This role is leading on the PID and will support the wider project plan. 10. Business Case refresh is underway with a view to present to Board for approval. 11. Workforce capacity impacts on programme deliverables and proposal has been submitted to HEIW for support. 12. Director of Digital, CTM/MB has undertaken a review confirming that WCCIS remains the best solution to progress for CTM/MB in general and for Mental Health specifically. 13. WCCIS will become non functional in 2025 therefore, its name has now been removed from the Programme and replaced with Connections as a DHCW acronym. All Wales digital section: this is currently assessed as 2.2-2A).	April 2026: Risk Reviewed no change March 2026 newsletter attached The Recommendation Report is still with WG for approval therefore the contract award is delayed. Feb 2026: The procurement evaluation has been completed and the Recommendation Report has been drafted and escalated to WG for approval. The contract award is now imminent. Recruitment for key programme roles such as Project Manager, Programme Manager and Business Analyst are complete. It is anticipated that the contract will start in April 2026 and the transition to the system can begin. Giffiths, Mr Lloyd - Head of Nursing - Mental Health (Bridgend ICG) 02/02/2026 10:21:13 Risk reviewed no change, see attached Jan 26 Newsletter for progress. The post of MH&LD Nursing Information Officer has been appointed to	15	C5 x L3	6	↔	07/11/2018	01/05/2026	
37	4672	Director of Digital	Digital Directorate	Head of Server Management	Business objectives or Projects	Absence of coded structured data & inability to improve our delivery of the national clinical coding targets and standards	IF: The Health Board is not able to record information accurately and reliably & does not address the 35000 backlog of uncoded FCS Then: the data informing the clinical, regional and organisational decisions we and our partners (including WG) make, will be inaccurate, out of date or incomplete. Resulting in: Degradation in our delivery of the quadruple aim and strategic objectives and damage to our reputational standing with our population and partners. Further we will be prevented from driving forward our ambitions to become a digital organisation, an exemplar for R&D and Value etc.	Operational controls: Coding key performance indicators covering productivity, demand and backlog robustly monitored DHWC annual coding quality audit. 2020/21 funding addressed backlog and proposals made to extend this into 2021/22. Tactical controls: Digital element of the strategic programme - Culture to digitalise the EPR, our communications, how we do business National Architecture Review - encompassing (NDR /CDR & Sharing arrangements) Coding transformation programme Information and Technical Standards Clinical audit Gaps in controls Workforce skills & development programme Insufficient resource available to address backlog Digital solutions not yet using snomed-CT/ structurally coded data	May 2026: Our strategic partners Tekstology have now started an activity to map Digital and Data activities to meet IMTP initiatives, this work is currently underway and will be reporting to the CTM/MB Board in September.	15	C3 x L5	9	↔	05/06/2021	05/05/2026	
38	4601	Chief Operating Officer	Mental Health and Learning Disabilities Care Group	Service Director, Mental Health and Learning Disability	Safety & Well-being - Patients / Staff / Public	The Provision of Safe and Appropriate Estate for Inpatient MH Care	IF: Mental health inpatient environments fall short of the expected design and standards. Then: Care delivered may be constrained by the environment, which is critical to reducing patient frustration and incidents as well as presenting more direct risk as a result of compromised observations. Resulting In : Compromised safety of patients , potential avoidable harm , compromised safety for staff in the workplace and extended lengths of stay.	A Quality Improvement programme in relation to inpatient care has started and a work stream in relation to Safe and Therapeutic Environments has been established with the aim of optimising the patient experience. Inaugural workshop took place on the 26th April. Assistant Director of Strategic Transformation - Mental Health has commenced in post. This new role will lead a range of strategic programmes including recommending a capital business case for a new Mental Health Unit. Annual revisiting of all patient litigation risks and completion of Statement of Needs via capital process for any litigation risks assessed as needing resolution. All and litigation works planned for 2022 - 2023 have now been completed. A scoping document case is to be prepared and submitted to WG. Inpatient Improvement Programme established April 2023. The inpatient review and remodelling programme continues to progress, with Safe Wards interventions and enhanced therapeutic input positively received by staff, patients, and external reviewers. The inpatient renaming of the wards to align with the new model remains paused pending resolution of governance and safety compliance requirements	March 2026: Risk title changed April 2026: The inpatient mental health service review and remodelling programme continues under MHLD governance, with no change to current controls or risk scoring.	15	C3 x L5	6	↔	15/06/2021	01/05/2026	
39	4958	Executive Director for People	People Directorate	Deputy Locality Manager - Primary Care and Communities	Safety & Well-being - Patients / Staff / Public	Fire Safety #1	Due to business sensitivities the details of this risk are captured in the closed session of the Committee.			15	C5 x L3	6	↔	16/12/2021	23/04/2026	
40	4933	Executive Director for People	People Directorate	Deputy Directorate Manager - Community Services	Safety & Well-being - Patients / Staff / Public	Fire Safety #2	Due to business sensitivities the details of this risk are captured in the closed session of the Committee.			15	C5 x L3	6	↔	07/12/2021	23/04/2026	
41	5040	Director of Digital	Digital Directorate	Head of Server Management	Business objectives or Projects	DHCW Interdependencies	IF: The Health Board can not integrate new applications into its digital architecture in a timely fashion Then: there could be a detriment to patient care, inefficiencies in care provision and loss of confidence by Health Board staff in the technology provided to them leading to them using alternative software and bespoke systems (including paper based systems) to carry out their duties which are not integrated and major strategic priorities for the organisation (e.g. Bridgend aggregation and the deployment of the new Emergency Department system) not being delivered Resulting in: delays in clinical decisions and consequently treatment which may affect clinical outcomes, reduced levels of productivity and thus poorer access to services, staff appetite to work digitally and in accordance with the digital standards required to realise the full strategic benefits of an integrated record and repository not being realised. Other consequences include: 1. Loss of information integrity and accessibility as multiple copies of clinical records 2. Failure and delay of digital system deployments (e.g. WEDS) 3. Possible breaches to the GDPR, safeguarding and information governance risks. 4. Mistrust by staff of the ICT systems and services they are	Update 06/03/2024: Tactical controls: DHWC digital programme seeks to map out programmes and key phases for delivery over the forthcoming 24 months DHWC group and Digital Directors peer group provide steer to the programme at strategic level Majority of the programme is directly funded by WG into DHWC Gaps in controls: No overall governance structure in place that enables Health Boards to prioritise digital developments and adequately assure their delivery and value generation DHWC operate autonomously to meet their own objectives and priorities as determined by their board, rather than by the provider organisations that they are there to support and enable. Expenditure priorities for digital are often taken in isolation of wider NHS prioritisation process Previous Update: A Myriad strategic programme group has been established, chaired by the CEO of DHWC to map out how the constraints can be overcome SLAs are in place between DHWC and NHS Wales organisations, however their fulfilment has been exposed by demand pushing the waiting times for developments to start (not complete) to over 12 months	May 2026: Following a delay the feeds related to test results and administrative data are now successfully tested and deployed enabling the ePMA programme to progress to an early adopter phase.	15	C3 x L5	9	↔	07/02/2022	05/05/2026	
42	6232	Executive Director of Nursing	Nursing Directorate	Deputy Executive Director of Nursing	Safety & Well-being - Patients / Staff / Public	Stability of the Legal Services Function	IF: the Health Board fails to adequately equip the Legal Services Function with the resources and support to fulfil the requirements of the function. Then: there is a risk to staff turnover and retention, wellbeing and morale. Risk to the reputation of the function and the Health Board as an employer of choice. Lack of resilience and capacity to fulfil the obligations under the relevant legislation surrounding the activity of the function. Resulting in: an adverse impact to the wellbeing and morale of staff leading to increased sickness absence and staff turnover. Lack of job satisfaction. Increasing risk of breaching relevant legislation due to lack of sustainable resources and resilience of the existing function. Loss of Trust and Confidence in the Legal Service Function / Reputation.	Current Control Measures: Review initiated to understand CTM/MB's position in terms of the number of inquests underway and the response to requests. Current controls: OCP underway to consider structures of the function. Benchmarking and learning from other organisations. Mitigating Action Plan: Legal Services Recovery Plan in place which will consider if there is sufficient capacity to manage cases effectively, if internal processes and systems need to be revisited to make changes and identify areas for further improvement. July 2025: The Organisational Change Process is near completion, with feedback from team members now catalogued. The benchmarking exercise is complete, and the senior leadership team is reviewing the structure against known demand. Additional workforce in place through recruitment and redeployment to support immediate service needs and overall recovery. September 2025: The recovery programme continues to make progress in standardising and stabilising processes and work plans. The OCP remains delayed as a result of the prioritisation of work and gaps in senior leadership owing to non-work-related absence. April 2026: The OCP is now complete and will be implemented on 5 May 2026. As part of the OCP, additional posts within the Legal Services Team have been approved, with recruitment underway to strengthen capacity and resilience. A new Lead for Legal Services has been recruited to the role. Recruitment of other members of the team is expected to be complete by 31 July 2026.	April 2026: The risk to remain at its current level until above recruitment (RE: OCP) is concluded and the revised staffing arrangements for the Legal Team are fully in place. Progress will continue to be monitored through routine governance and risk reporting.	15	C3 x L5	6	↔	03/07/2025	02/05/2026	
43	5820	Executive Director of Public Health	Public Health Directorate	Assistant Director Public Health	Safety & Well-being - Patients / Staff / Public	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. 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 NHF. The health board response to infectious disease or environmental hazards will also be significantly hindered and work to address gaps in equity of access will be limited. RESULTING IN avoidable harm to patients in vulnerable groups and harm to the public as a result of insufficient health protection interventions delivered. This also poses a reputational risk as a consequence	Control Measures: Governance structure agreed in Health Protection. Health Protection Board establishment. Recruitment underway to Health Protection structure. A series of planning workshops with partners agreed to review resources available, develop Health Protection strategy and highlight ongoing gaps Action Plan: A workforce structure has been approved by ELG and work to identify gaps is ongoing which will be reviewed once recruitment is complete. Work with partners is ongoing to reduce inefficiencies and develop A collaborative Health Protection (HP) plan based on all resources available to ensure priorities can be clearly defined and delivered. 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. Update Feb 2025 This risk has been reviewed by the LPHT Strategic Group meeting on Tues 11th Feb 2025. As the uplift in HP funding for 25/26 still does not bring parity to the funding across Wales and is insufficient to deliver the HP 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.	April 2026: This risk was reviewed in the LPHT strategic group meeting on 31st March and 21st April. The uplift in HP funding for 25/26 still does not bring parity to the funding across Wales and is insufficient to deliver the HP strategic plan, there remains a funding gap. A submission to Welsh Government was made in December 2025 highlighting the remaining funding gap and areas this is impacting. Therefore the risk is to remain unchanged and for review upon confirmation of the funding allocation for 26/27	12	C4 x L3	8	↔	10/07/2024	29/04/2026	
44																

Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	De-escalation Rationale
4973	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety 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 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 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. Substantive jobs which are new posts are being developed and advertised Rehabilitation service is at a critically low level with urgent closure of one service needed. Redeployment from inpatients to Rehabilitation of locum has had knock on effect on inpatients. 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 given by Executive Medical Director and the necessary paperwork submitted. Weekly cover rota going out to inpatients and rehab wards to ensure all are aware of the cover arrangements.	Substantive jobs which are new posts are being developed and advertised. Substantive and significant programme of work running alongside this in the Medical Workforce Productivity in place. International recruitment drive looking to recruit two Specialty Doctors to Inpatients and Rehab in August 2025. Update December 2025 Risk reviewed, no change in the risk rating Due to ongoing respect and resolution related issues medical staffing in RGH has been further pressured in December, to mitigate this further control measures have been implemented. Two Interim Clinical Directors have been appointed. Dr Sally Bolt is also supporting the MHLD Care Group with sessions as Interim	Quality, Safety & Experience Committee Operational Delivery Committee	16		A number of Nationally reportable incidents have been raised since February 2025 within Obstetrics / Maternity. De-escalated and removed from the ORR in February 2026 following internal and external assurance and Care Group agreement.
1793	Chief Operating Officer	Improving Care	Safety & Well-being - Patients / Staff / Public	Lack of isolation facilities available-negative pressure rooms	If there are no negative pressure isolation facilities available then there will be no appropriate isolation facilities to manage patients with infections transmitted via the airborne route resulting in an increased risk of infection to other patients/ staff/visitors. There are 2 positive pressure ventilated lobby rooms available at PCH. Non compliant with national guidance/ WG expectation.	12/02/2026 - A/W for capital project team to start project 23/10/2025 - No changes, A/W for capital project team Update 19/05/2025 - Capital funding approved for 2 negative pressure rooms, one at RGH and other POW, risk will change once rooms are built Update 13/10/23 - Awaiting executive steer for placement of isolation rooms. Further information required to progress the discussions re. air cleaners. Update 14/04/24 - ongoing. Air purification unit SBAR to be presented in the upcoming IPCC meeting. Two air purification units have been trialled on a ward in POW. Update 24/06/24 - ongoing with regards to executive steer. T&F group set up to operationalize the air purification units. Update - HCID plan being developed with evaluation of capacity on A&E. POW has negative pressure room in A&E but it's location makes it unsafe to deal with HCID. PCH has negative pressure in A&E that can be used in those cases, this capcity does not exist in RGH A&E			12		Feb 2026: A/W for capital project team to start project. Score reduced with care group agreement
6229	Executive Nurse Director		Quality / Complaints / Assurance / Patient Outcomes	Timely development of, management and response to Learning From Event Reports (LFERs)	If: the Health Board fails to achieve timely completion of LFERs, respond promptly to the questions from the Welsh Risk Pool Learning Advisory Panel and provide assurance that learning has been implemented and shared. Then: there is a risk that improvement to quality and safety in healthcare aligned to learning which flows from case investigations, and the LFER (Learning From Event Report)s is not acted upon. Resulting in: reputational impact of the Health Board in terms of trust and confidence in the service and assurance that lessons have been learned. Missed opportunities to improve patient care and safety following identification of areas for improvement. Financial penalties if the Welsh Risk Pool consider withholding reimbursements due to being dissatisfied with the learning and actions taken in a case.	April 2026: An Organisational Change Process across the Quality & Safety and Legal portfolio is now complete and will be implemented on 5 May 2026, strengthening capacity and clarity of accountability for incident investigation and learning processes. LFER Panels have now been established, with the Assistant Director of Quality & Safety chairing the panels from 23 April 2026. Liaison with Welsh Risk Pool continues on a weekly basis in relation to individual LFERs and the overall LFER position, providing ongoing oversight, assurance on timeliness, and support in addressing learning and actions required. 30/04/26-Executive Director Nursing, Midwifery & Patient Care Richard Hughes reviewed and approved.	May 2026: Initial score of 20 but with the immediate control measures in place and collaborative working with the Welsh Risk Pool the likelihood score has reduced to a 4.	Quality, Safety & Experience Committee	12		May 2026: Initial score of 20 but with the immediate control measures in place and collaborative working with the Welsh Risk Pool the likelihood score has reduced to a 4.
5576	Chief Operating Officer	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. Then.. there will be a 60% gap in palliative medicine consultant cover. This is in addition to an already understaffed consultant compliment. 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. 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. Recruitment in specialist agencies being sought. Additional middle grade cover sought but will have limited impact as not meeting national standards	Update December 2025 The status for the SPC in YCC has been temporarily changed and removed as a result of implementation of admission criteria for end of life and complex care. This is an interim measure whilst the engagement process is complete around the long term future of the centre enabling the Care Group to commence a redesign of PEoLC across the CTM wide footprint. This will be under review as the care group continue the process around the long term future of the centre.	Quality, Safety & Experience Committee Operational Delivery Committee	6		Risk score reduced following interim mitigation, including a temporary change to the YCC unit's designation and admission criteria, and alternative medical cover arrangements due to ongoing vacancies. These measures support current safety but are not a long-term solution. Consideration of the longer term, future service model is being considered by Board at its meeting on 21 May 2026.
2713	Chief Operating Officer	Sustaining Our Future	Workforce / Organisational Development / Staffing / Competence	Backlog of Reporting Radiology Examinations	If there is consistent backlog of Radiology reports THEN there will a delay in patient diagnosis and treatment, which could lead to poorer patient outcomes Resulting in impact on patient outcomes, delay in diagnosis of patient condition and any additional interventions/treatment that may be required following diagnosis due to an excessive backlog and increasing demand in imaging services. There is also a risk of damage to the reputation of the Organisation due to the failure to meet performance targets. There is also risk of work related stress due to pressure placed on existing Radiologist workforce to meet the demands of the service	Radiologists performing extra reporting sessions in addition to their normal working hours. Radiographers trained to report accident & emergency images. Up to date job plans for all Radiologists. Datix incident and concerns procedures in place.	There is a significant backlog of reporting radiology examinations, with just over 10,000 X-rays pending. Current mitigation measures include rostering SPRs for extra reporting, outsourcing MSK cases, utilising training posts and the returning from parental leave. We are aiming to address the backlog in the more likely clinical urgent cases (chest x rays) by December as a priority. January 2026 Note: Due to site pressures with capacity and flow this risk was not updated at the time of the Organisational Risk Register for January being finalised. The Chief Operating Officers Business Team are seeking an update and this will be reflected in the next iteration of the Organisational Risk Register. Updates prior to this can be sought from the COO Business Team.	Quality, Safety & Experience Committee. Operational Delivery Committee	12		Improvements in radiology reporting have reduced the risk score from 16 to 12 and removed it from the ORR, however the position remains fragile as additional funding ends and is being actively monitored for potential re emergence.
6039	Director of Digital		Business objectives or Projects	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 THEN nearly every clinical service (e.g. Pathology, ICU) will be affected RESULTING IN the health board being unable to access local clinical systems	Alternative hardware technologies chosen - Dell PowerEdge (instead of VXRail) Production server acquired through WG slippage 2025/2026 to replace 4 nodes (EOL Feb 2026) and 6 nodes (EOL Jun 2026). Project to implement underway, expected closure end of summer 2026. Additional 18 nodes (EOL Jan 2027) to be considered.	May 2026: Two investment bids submitted to Welsh Government were approved. This funding allows the procurement of 10 nodes to replace the existing 10 nodes that are due to reach end of life in 2026. Deployment of the replacement technology is scheduled for completion by the end of Quarter 3 2026. Planning is under way to address the funding and procurement of the remaining 18 nodes which are due to go end of life in January 2027 March 2026: Phase 1 & Phase 2 hardware acquired. Implementation plan underway. ETA summer 2026 for full installation and migration completed.	Operational Delivery Committee	8		Please see under "Action Plan"

Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	De-escalation Rationale
6234	Executive Director of Finance (Executive Lead for Estates)	Sustaining Our Future	Environmental / Estate / Infrastructure	National skills shortage in Estates Roles (Private sector salaries are impacting the CTMUHB's ability to be competitive in the recruitment market) resulting in recruitment and retention challenges throughout the department.	IF: A UK skills shortage coupled with the demand for labour in the private sector has caused recruitment and retention issues throughout the department, this has affected the ability to fill all WTE posts in a timely manner. THEN: The Health Board is at risk of being unable to complete all statutory, mandatory preventative maintenance tasks and help desk request. There is also a risk of being unable to support the delivery of capital projects, and departmental virement works. RESULTING IN: Insufficient staff to deliver the service, significant delays in replacement of staff. Increased revenue costs for overtime and contractor costs to supplement shortfalls. Inability to complete all Statutory and mandatory maintenance activities which could potentially breach legislation requirements Decrease in the maintenance performance figures. Failing estates affecting patient safety and service. Increased risk of claims. Reputational damage.	Performance levels monitored monthly at SMT and weekly at operational estate management level Overtime worked and contractors employed when key risks identified.	Vacancies reviewed at Senior Management team (SMT) meetings on a monthly basis. Age profile developed to manage succession planning. Update January 2026 Risk score reviewed and whilst recognising that there continues to be a National UK skills shortage the Health Board has had recent success in appointing to two Senior Estate Manager roles, and due to robust succession planning filled other gaps within the team which has provided stability. Ongoing activity continues with the support of the People Directorate to explore routes to further promote and attract candidates to roles advertised particularly around the Band 6 opportunities within the team as it is acknowledged that recruiting to these roles continues to be a challenge. On the basis of this review the risk likelihood score has been reduced to a 3 and the risk de-escalated from the Organisational Risk Register. The risk will continue to be monitored by the Capital and Estates Directorate.	Operational Delivery Committee & Health, Safety & Fire Sub Committee	12 C4xL3 (Reduced from a 16)	9 (C3xL3)	Risk score reviewed and whilst recognising that there continues to be a National UK skills shortage the Health Board has had recent success in appointing to two Senior Estate Manager roles, and due to robust succession planning filled other gaps within the team which has provided stability. Ongoing activity continues with the support of the People Directorate to explore routes to further promote and attract candidates to roles advertised particularly around the Band 6 opportunities within the team as it is acknowledged that recruiting to these roles continues to be a challenge. On the basis of this review the risk likelihood score has been reduced to a 3 and the risk de-escalated from the Organisational Risk Register. The risk will continue to be monitored by the Capital and Estates Directorate.
5417	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Paediatric Dentistry - General Anaesthetic (GA) theatre list	If... Regular additional GA theatre lists (necessary to meet current and future demand) are not made available to the Community Dental Service team for paediatric GA. Then... the number of children waiting list for assessment and treatment will continue to increase beyond 1000 by March 2024. Resulting in... 1. children waiting increased times for assessment/treatment who have high levels of dental caries and painful teeth requiring extraction, 2. a further increase in the number of children requiring GA, due to long waits for assessment more children need GA when assessed, conversion rate has jumped from 48% to 80%. Children can only wait 8 wks from assessment to treatment therefore there is a large backlog of assessments due to limited GA lists to provide treatment.	Current theatre lists are run on Monday mornings and Friday afternoons and are likely to be cancelled due to bank holidays. This impacts the running of the service, no additional lists are available when lists are missed. There are currently 800+ patients waiting for appointments, with some already waiting for 17 months. Patients are advised to return to their General Dental Practitioner (GDP) if they experience pain, some children are being prescribed multiple courses of antibiotics to ease dental infections that can only be alleviated by tooth extraction. There is a risk these patients will require the removal of more teeth/more require GA when assessed/children will present as an urgent case in Accident and Emergency if left untreated.	Update December 2025 Prince Charles Hospital additional theatre lists have commenced and now beginning to see the positive impact on the waiting list. October figures show 443 children waiting for assessment for GA. There are also 516 children waiting for a PMBA assessment which may increase the number of children requiring GA once assessed. Following a delayed start to the RGH lists they are now due to commence the 1st week of January, with all lists in place, this should start addressing the backlog issue, however winter pressures does lead to dental GA lists being cancelled so the decrease in numbers may take time to be seen. As a result of the progress being noted to lists, the care group have reviewed and reduced the score to a 12 but will keep under review to ensure there is no notable impact to the lists to change position. (Action plan submitted to Board September 2025 to outline the HB plans to mitigate risk, as a result of the progress against the plan the HB were able to reduce this risk).	Quality, Safety & Experience Committee Operational Delivery Committee	12 Decreased from a 20	9 (C3xL3)	As a result of the progress being noted to lists, the care group have reviewed and reduced the score to a 12 (Likelihood reduced to a 3) but will keep under review in the Care Group to ensure there is no notable impact to the lists to change position. (Action plan submitted to Board September 2025 to outline the HB plans to mitigate risk, as a result of the progress against the plan the HB were able to reduce this risk).
6228	Executive Director of Nursing	Improving Care	Quality, Complaints, Assurance / Patient Outcomes	Effective and efficient management of requests from the HM Coroner	If: the Health Board fails to effectively respond and manage requests from the HM Coroners Office in a timely manner. Then: there is a risk that the Health Board will breach 'The Coroners (Investigations) Regulations 2013' in failing to provide documentation on time and take required action in a timely manner to ensure lessons have been learned. Resulting in: poor experience and the wellbeing impact for the families and staff members involved in inquests, reputational impact of the Health Board in terms of trust and confidence in the service, an increase in the number of Regulation 28 / 29 reports on actions to prevent future deaths, an increase in potential enactment of the Coroners powers, including under Schedule 5 - "Power to require evidence to be given or produced".	Review initiated to understand CTMUHB's position in terms of the number of inquests underway and the response to requests. Review and remap internal processes in the management of inquest cases within the organisation. Weekly coronial meetings with the Senior Coroner's Officer to discuss operational progress and individual cases. Weekly oversight meetings and briefings on cases of concern for discussion at ELG as well as performance review.	Update January 2026 The review of inquest management has been completed, and new processes are now operational with SOPs in place. Weekly meetings with the Senior Coroner's Officer continue to monitor progress, supported by internal briefings for ELG oversight. These improvements have strengthened governance and reduced the likelihood rating to 3. Risk now 12	Quality, Safety & Experience Committee Audit, Risk & Assurance Committee	12 Decreased from a 16	8 (C4xL2)	The review of inquest management has been completed, and new processes are now operational with SOPs in place. Weekly meetings with the Senior Coroner's Officer continue to monitor progress, supported by internal briefings for ELG oversight. These improvements have strengthened governance and reduced the likelihood rating to 3. Risk now 12

	A	B	C	D	E	F	G	H	I	J	K
	Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Month Closed on Org RR	Closure Rationale
1											
2											
3											
4	6372	Director for Digital	Sustaining our Future	Financial Risk	Cost escalation risk – Microsoft Enterprise Agreement renewal	Due to business sensitivities the details of this risk are captured in the closed session of the Committee.			Operational Delivery Committee	Risk closed May 2026	
5	6217	Executive Medical Director	Improving Care	Quality / Complaints / Assurance / Patient Outcomes	A number of Nationally reportable incidents have been raised since February 2025	If - the safeguards and quality systems and processes are not robust Then - mothers and babies may not receive the best evidence based care Resulting in - Potentially less than ideal or negative outcomes.	Rapid reviews have been undertaken on all cases with findings and learning from each. Meetings held with Care Group and executive team to decide on way forward. External review commissioned of the 4 cases. Action plan put in place by the clinical teams and care group. (details of all actions within that action plan) Further review once external report received	February 2026: External review received from Cons Obstetrician. No additional issues raised so risk is closed.	Quality, Safety & Experience Committee	Feb-26	February 2026: External review received from Cons Obstetrician. No additional issues raised so risk is closed.
6	5688	Chief Operating Officer		Service / Business Interruption	Aging Equipment	If a replacement steam steriliser is not purchased Then, the department is at risk of not being able to decontaminate medical devices Resulting in patients' operations being cancelled	April 2026: received installed and commissioned.		Quality, Safety & Experience Committee	Apr-26	April 2026: received installed and commissioned.
7	6239	Executive Director of Finance	Sustaining Our Future	Financial Risk	Failure to reduce the £7.8m recurrent deficit at the start of 25/26 down to the planned £1.7m recurrent surplus at the end of 25/26	IF: The Health Board is not able to plan and deliver recurrent expenditure run rates that align with the available recurrent funding for 2025/26. THEN: The Health Board may not be able to deliver a break-even financial position for 2026/27. RESULTING IN : • The Health Board not being able to increase investments in services and/or reduce savings targets from current levels. • Potential short term unsustainable cost reductions with associated risks and potential Welsh Government regulatory action. • WG not supporting the Health Board's plan for 26/27 • Failure to meet the statutory financial duty to break even over a 3 year period resulting in qualification of the Annual Accounts in 26/27. • Potential cash shortfalls in 26/27.	• Financial Accountability letters from CEO to Executive Leadership Group. • Monthly monitoring arrangements and meetings in place with Care Groups and directorates. • Regular reporting to the Executive leadership Group, the Operational Delivery Committee and the Board.	Update December 2025 The Month 8 Year To Date (YTD) position is a £4.0m deficit and this position presents a risk to both the In year forecast and the recurrent forecast. The forecast recurrent position at the end of 25/26 has deteriorated from the planned £1.7m surplus to a £10.2m deficit due to lower than anticipated financial allocations for Pay awards and National Insurance along with under achievement of Savings Targets and operational cost pressures. The recurrent impact of Welsh Risk Pool contributions and the recurrent impact of Band 2/3 Healthcare Support Workers settlement remain a risk to this forecast position pending confirmation of WG financial settlements for 2026/27. 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 26/27 as well as schemes in delivery for 25/26.	Operational Delivery Committee	Risk closed April 2026	Risk closed at year-end; superseded by new Risk 6596 for 2026/27
8	6379	Chief Operating Officer	Improving Care	Safety & Wellbeing Patients / Staff and Public	CT Scanners at RGH damaged by power outage and manual generator/UPS switch over	IF the manual switch over following a power outage is not rectified. THEN the CT scanners/tubes may become damaged RESULTING IN no CT service on site, causing significant delay in patient outcomes, and significant cost to repair (circa £350k per tube)	Discussion with manufacturer and All Wales procurement Discussion with estates team Estates will ensure CT is switched on first, for generator to kick in Regular weekly meeting with GE and estates to monitor	Action plan required urgently to show regular monitoring. If a separate or modified UPS is required then a statement of need for Capital consideration will be required. January 2026 Note: Due to site pressures with capacity and flow this risk was not updated at the time of the Organisational Risk Register for January being finalised. The Chief Operating Officers Business Team are seeking an update and this will be reflected in the next iteration of the Organisational Risk Register. Updates prior to this can be sought from the COO Business Team.	Quality, Safety & Experience Committee Operational Delivery Committee	Risk closed February 2026	Risk closed and removed from the ORR in February 2026 following completion of CT scanner switch replacements.
9	6240	Executive Director of Finance	Sustaining Our Future	Financial Risk	Failure to achieve the planned break-even position in 2025/26.	IF: The Health Board is not able to plan and deliver expenditure run rates that align with the available funding for 2025/26. THEN : The Health Board will not be able to deliver the planned break-even financial position for 2025/26. RESULTING IN : • Potential short term unsustainable cost reductions with associated risks and potential Welsh Government regulatory action. • Failure to deliver the financial plan for 25/26. • Failure to meet the statutory financial duty to break even over a 3 year period resulting in qualification of the Annual Accounts in 25/26. • Potential cash shortfalls in the latter months of 25/26	• Financial Accountability letters from CEO to Executive Leadership Group. • Monthly monitoring arrangements and meetings in place with Care Groups and directorates. • Regular reporting to the Executive leadership Group, the Operational Delivery Committee and the Board.	Update December 2025 The M8 Year To Date (YTD) position is a £4.0m deficit, which includes a £5.6m shortfall in savings delivery. The Health Board is continuing to forecast a break even position for 25/26. The key risks to the forecast have improved following confirmation of non recurrent WG funding for the Welsh Risk Pool contributions together with Band 2/3 settlements in 2025/26. There remains a requirement to achieve further mitigation actions of £1m in maintaining our breakeven forecast. The following actions are to support savings plan identification, development and delivery: • Develop a more project and programmatic approach to planning and delivery of efficiency savings schemes, with a focus on pipeline schemes for 26/27 as well as schemes in delivery for 25/26. • Disseminate the learning from the Health Board's Value Based Healthcare projects to drive service planning and improvement going forward. • Develop the Value & Efficiency Programme with a focus on 'Enabling schemes' to support savings identification and delivery.	Operational Delivery Committee	Risk Closed January 2026	The Health Board is continuing to forecast a break even position for 25/26. The key risks to the forecast have improved following confirmation of non recurrent WG funding for the Welsh Risk Pool contributions together with Band 2/3 settlements in 2025/26. The Finance Function have therefore closed this risk as the target score of 12 has been achieved.



Agenda Item

7.1a

Audit, Risk & Assurance Committee

AUDIT RECOMMENDATIONS TRACKER UPDATE REPORT

Dyddiad y Cyfarfod / Date of Meeting	19 th May 2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Claire Jones, 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	5 th May 2026	Management sign off

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

Internal Audit Activity Limited Assurance Overdue Activity Comparison.

Internal Audit Areas of suggested focus

The following pie charts relate to **Limited Assurance** reports only and highlights the total 'overdue' actions based on the originally assigned due date. The position as at the last ARAC in February is included as a comparator for the May 2026 ARAC position. The actions are also split by the priority of High, Medium and Low as assigned at the finalisation of the Audit Review.

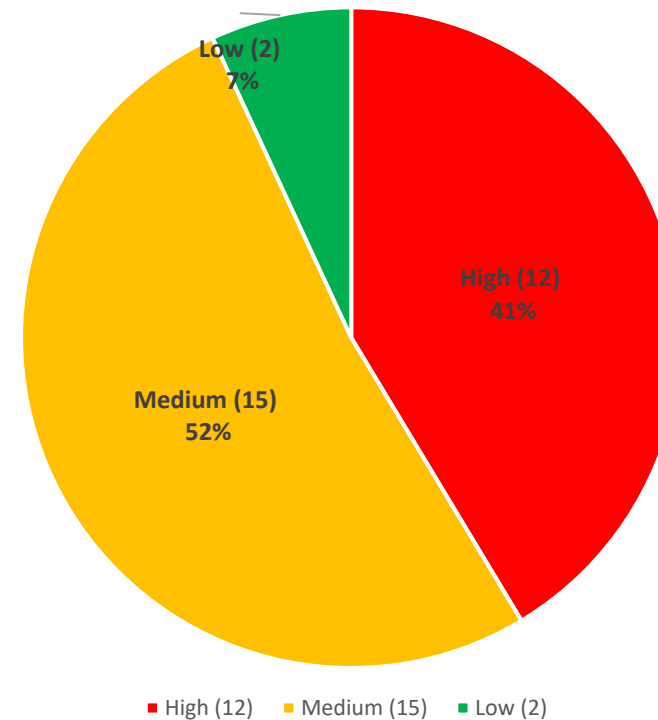
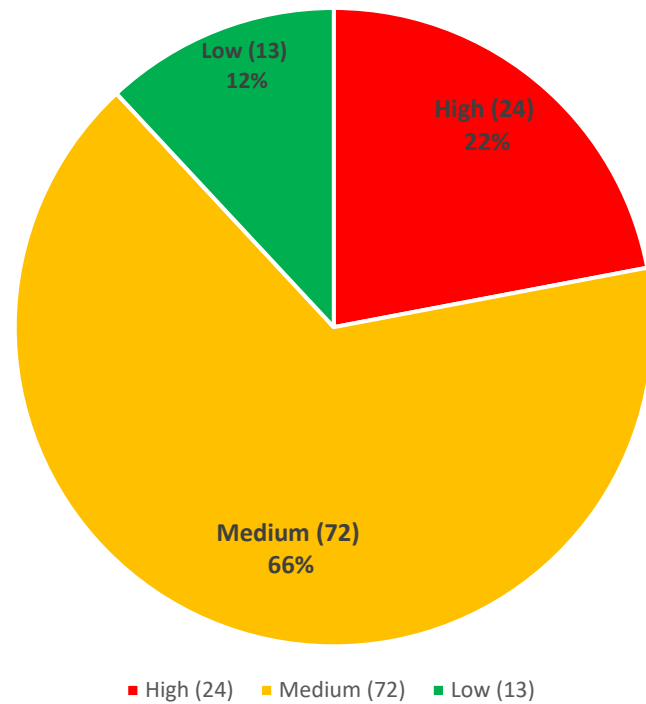
The following Internal Audit Reviews have the longest overdue audit actions against the original due date for Limited Assurance rated reports:

January 2026

April 2026

Limited Assurance reports. Overall overdue Internal Audit open inspection actions by action priority as at 13th January 2026

Limited Assurance reports. Overall overdue Internal Audit open inspection actions by action priority as at 27th April 2026



Internal Audit/2023/146. Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023.

6 open actions overdue for between 787-865 days. (Reduction of 2)

Internal Audit/2024/162. 4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024.

2 open actions overdue by 695 days

Internal Audit/2024/170. Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024.

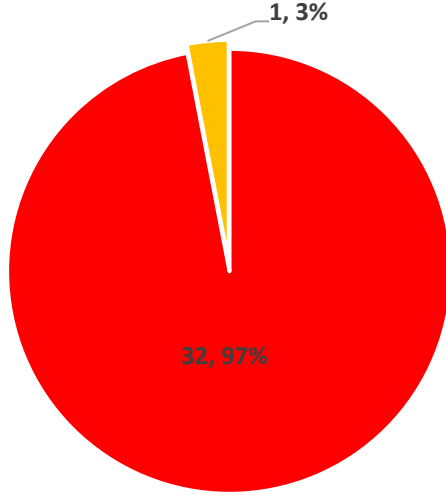
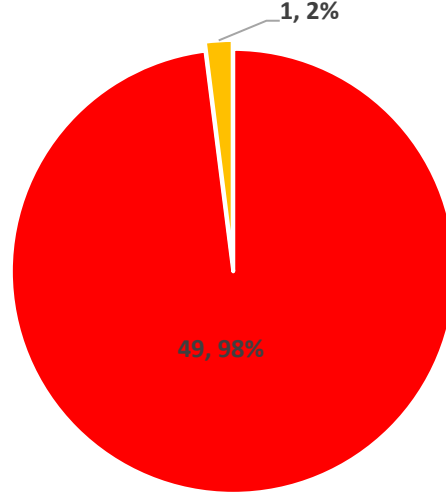
5 Open actions overdue by between 378 and 666 days. (Reduction of 2)

Whilst these audits remain on the dashboard as areas of suggested focus, there has been updates provided and some audit recommendations completed and awaiting approval for closure.

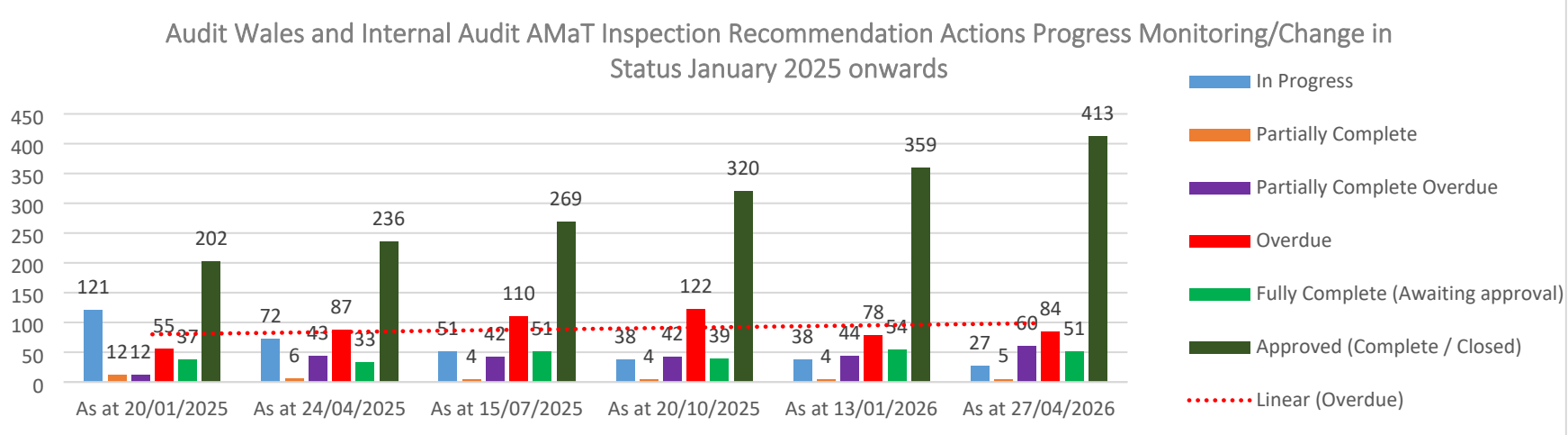
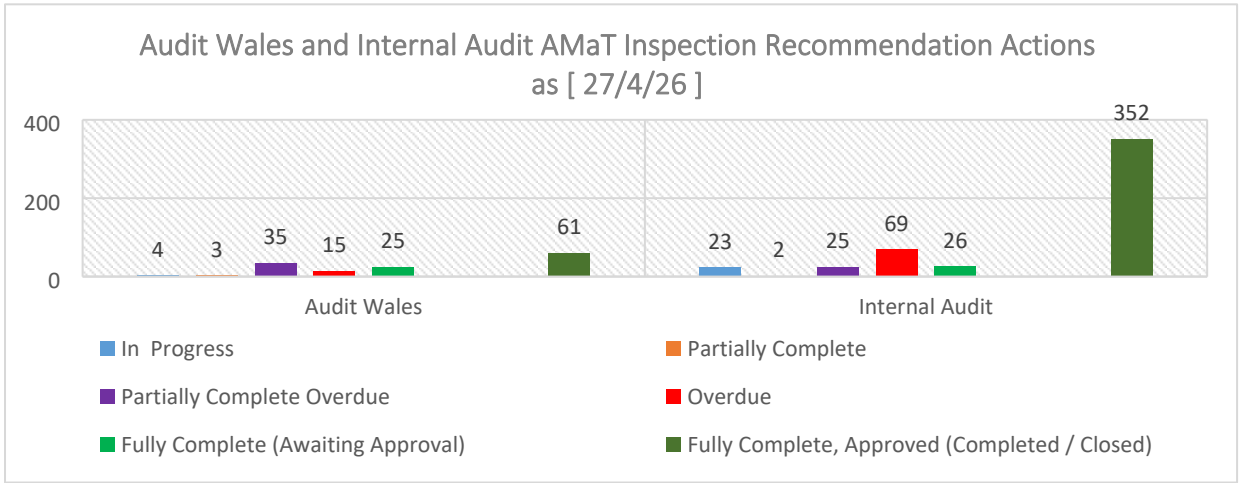
Narrative Commentary – There has been a notable increased effort by most teams in the number of updates being provided this period as well as notable increase in the actions updated and marked as fully complete and awaiting approval. The overall number has seen a dramatic reduction in the overall number of option actions since last report – 29 down from 109 in January.

Overdue Limited Assurance Actions – Breakdown by Executive Portfolio

Overdue actions that fall within the portfolio of the Chief Operating Officer	19
Overdue actions that fall within the portfolio of the Executive Director of Finance	4
Overdue actions that fall within the portfolio of the Strategy and Transformation	3
Overdue actions that fall within the portfolio of the Executive Medical Director	2
Director of Digital	1

Audit Wales Activity Limited Assurance Overdue Activity Comparison		Audit Wales Areas of suggested focus
The following pie charts relate to 'overdue' actions from Audit Wales reviews. The position presented at the last ARAC in February 2026 is included as a comparator for the May 2026 ARAC position. The actions are also split by the priority of High, Medium and Low as assigned at the finalisation of the Audit Review.		The following Audit Reviews have the longest overdue audit actions against the original due date for Audit Wales Reports:
January 2026	April 2026	
Overall overdue Audit Wales open Inspection Recommendation Actions by Action priority as at 13/01/2026  ■ High (32) ■ Medium (1) ■ Low (0)	Overall overdue Audit Wales open Inspection Recommendation Actions by Action priority as at 27/04/2026  ■ High (49) ■ Medium (1) ■ Low (0)	Audit Wales/2021/144 - Audit Wales Quality Governance Follow Up Review. 1 open action overdue by 1669 days from original due date Audit Wales/2022/12 - Transformational Leadership Programme Board – Baseline Governance Review. 1 Open action overdue by 1123 days Audit Wales/2023/18 Structured Assessment 2022 – CTMUHB 2022_February 2023 1 open action remains overdue by 1032 No updates provided for Audit Wales/2021/144 for the past 6 reporting periods. Audit Wales/2022/12- Discussion ongoing with Audit Wales to negotiate closure. Audit Wales/2023/18- Discussions with Audit Wales in progress.
Narrative Commentary – This period there has been work to close historic audit recommendations. Talks continue with Audit Wales colleagues to re-evaluate those which are still outstanding.		

Overall position summary of all outstanding actions for Internal Audit and Audit Wales



1. Background

- 1.1 The main purpose of this report is to present an update to the Audit, Risk & Assurance Committee on reported progress of audit report recommendations with an increased focus on overdue actions with a Limited Assurance rating.
- 1.2 The scope of this report relates to both Internal Audit and Audit Wales review recommendations. Inspections and reviews conducted by Healthcare Inspectorate Wales are presented at the Quality, Safety and Experience Committee.

2. Specific Matters for Consideration

- 2.1 This report continues to highlight the areas of focus within the "Overdue Actions Tracker" with increased focus on those actions with a Limited Assurance rating. The 'Overdue Actions Tracker' is included as *Appendix 1*, however please note if members would like to view the full tracker this will be made available to all members for scrutiny in the supplementary folder available on Admincontrol.
- 2.2 Since AMaT is a live system, please note that the data presented in this report was captured and analysed up to April 27th 2026.
- 2.3 The dashboard found at the front of this report has been designed to evidence any progress and highlight areas that need an increased focus. This written report will add some narrative to the graph data to add context to the data. All reports are presented by the **original due date**. Revised due dates are noted in the narrative of the tracker.
- 2.4 *Graph 1* shows a direct comparison on the Health Board's position between reporting periods of overdue, Limited Assurance Internal Audit Reports. As evidenced in the graphs, this period there has been a notable increase in effort within teams to provide updates and close overdue actions with an increased focus on the highest priority can be noted.
- 2.5 *Graph 3* in both performance dashboards focus on audits that require further attention, which in this case due to the length of days past their original due date. The areas of focus highlighted in both performance dashboards indicate those audits of which actions have the longest number of overdue days based on their original implementation date. There has been increased work ongoing this period to complete and close historic overdue actions and in doing so we can see that a long overdue Audit Wales action has now been completed/closed. This highlighted focus to audits and actions is the first step to triangulating the data and raising awareness of those actions that may pose higher risk to the organisation.



- 2.6 As can be seen in the table **Overdue Limited Assurance Actions – Breakdown by Executive Portfolio**, there has been a notable reduction in the number of overdue Limited Assurance Actions. **In January there were 109 overdue in total in the April report that number is down to 29 which, notwithstanding the fluctuating nature of these numbers with a live system, this demonstrates significant progress in the numbers outstanding.**
- 2.7 In our last report it was indicated that the Quality Assurance and Compliance Team had implemented focussed, individualised Audit Performance meetings with business managers and the wider team. The engagement this period as a result has been very encouraging and the evidence shows in the turnover of action updates and actions moving to closure.
- 2.8 **51 recommendations actions are proposed for closure this month. This follows on from 54 last month which is encouraging.** The format and target level of the Audit Performance Meetings appears to be working well so far and the team will continue to encourage this level of engagement through the prescribed meetings in order to sustain momentum whilst encouraging independent checking and updating of AMaT in between meetings.
- 2.9 Progress on this work continues to be reported to this Committee following appropriate Executive approval at Executive Leadership Group before closure on the system Across both Audit Wales and Internal Audit, there have been **51 total completed actions** proposed for **closure** with **10 fully completed audits**.
- 2.10 The current position on the status of recommendation actions which are overdue can be viewed in **Appendix 1**, with the most recent updates provided in red.

3. Tracker Updates

- 3.1 **Internal Audit (NWSSP)** - Since the last meeting the following changes and updates are noted:
- **5 New** Internal Audit Reviews have been added to the Audit Recommendations Tracker including **24** new actions.
 - **8** Internal Audit Reviews have been completed and **26** audit recommendation actions are proposed for **CLOSURE**.
- 3.2 **External Audit (Audit Wales)** Since the last meeting the following changes and updates are noted:
- **2 New** External Audit Reviews have been added to the Audit Recommendations Tracker with **41** new actions.

- **2** Audit Wales Reviews have been completed and **25** audit recommendations actions which are proposed for **CLOSURE**.

3.3 **Health Inspectorate Wales (HIW)** – Position reports for HIW are presented to Quality, Safety and Experience Committee data is being processed for the next meeting scheduled for **June 3rd 2026**. Highlights from this report will be shared in the next Audit, Risk and Assurance Committee for members to note.

4. Key Risks / Matters for Escalation

- 4.1 The Quality, Assurance and Compliance Team will continue to work closely with teams via Audit Performance meetings as well as day to day queries to continue momentum in updating and evidencing the ongoing improvement and effort to address outstanding audit actions. Teams will be encouraged to provide updates to the original audit recommendation rather than updating from the previous tracker update.
- 4.2 The audit tracker will continue to be updated with a targeted focus on actions with Limited Assurance and are overdue from original due date. As previously mentioned, this report and tracker are continuously evolving with the aim of providing a transparent and assurance focus account of the Health Board's position.

5. 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)) /	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 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 CTMUIB 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.	

6. Recommendation

- 6.1 The Audit, Risk & Assurance Committee are being asked to **NOTE** the report and **AGREE** that where applicable the progress updates provide Members with sufficient assurance, particularly in relation to closed recommendations.

AMoT Inspection Code	Title	Type	Date of Inspection	Executive Lead	Overall Assurance Rating	Recommendations	Action	Parent Inspection
Audit Wales/2023/144	Audit Wales Quality Governance Follow up Review, Audit and Risk Committee Update – CTMUHB August 2022 (Document reference: 12342017)	New	01/08/2023	Richard Hughes, Interim Executive Director of Nursing, Midwifery & Patient Care	N/A	7	7	
Audit Wales/2023/12	Transformational Leadership Programme Board – Baseline Governance Review – CTM Regional Partnership Board 2021-22, August 2022 (Document reference: 298442022)	New	01/08/2023	Claire Thompson, Executive Director of Strategy & Transformation	N/A	5	5	
Audit Wales/2023/149	Structured Assessment 2023 – CTMUHB 2023, October 2023 (Document reference: 43942023)	New	01/10/2023	Gareth Watts, Director of Corporate Governance & Board Secretary / Claire Thompson, Executive Director of Strategy & Transformation / Stuart Morris, Director of Digital	N/A	6	6	
Audit Wales/2023/118	Structured Assessment 2022 – CTMUHB 2022, February 2023 (Document reference: 31334023)	New	01/02/2023	Gareth Watts, Director of Corporate Governance & Board Secretary / Sally May, Executive Director of Finance / Claire Thompson, Executive Director of Strategy & Transformation / Stuart Morris, Director of Digital	N/A	8	8	
Audit Wales/2023/123	Orthopaedic Services in Wales – Tackling the Waiting List Backlog, Report of the Auditor General for Wales, March 2023	New	01/02/2023	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: 415242024)	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 Ybiky Cwm Cynon Minoir Injuries Unit – Cwm Taf Morgannwg University Health Board (Document reference: 43642024)	New	01/07/2024	Richard Hughes, Interim Executive Director of Nursing, Midwifery & Patient Care	N/A	1	2	
Audit Wales/2024/205	CONFIDENTIAL, Audit of Accounts Report Addendum, CTMUHB 2023-24, October 2024 (Document reference: 439542024)	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: 440542024)	New	30/11/2024	Gethin Hughes, Chief Operating Officer	N/A	6	12	
Audit Wales/2025/234	Structured Assessment 2024, CTMUHB 2024, November 2024 (Document reference: 457942024)	New	23/01/2025	Gareth Watts, Director of Corporate Governance & Board Secretary / Sally May, Executive Director of Finance / Claire Thompson, Executive Director of Strategy & Transformation / Richard Hughes, Interim Executive Director of Nursing, Midwifery & Patient Care / Gethin Hughes, Chief Operating Officer / Philip Daniels, Executive Director for Public Health	N/A	13	14	
Audit Wales/2025/271	CONFIDENTIAL Audit of Accounts Report Addendum, CTMUHB 2024-25, July 2025 (Document reference: 459942025)	New	01/07/2025	Sally May, Executive Director of Finance / Gareth Watts, Director of Corporate Governance & Board Secretary	N/A	5	5	
Audit Wales/2025/280	Tackling the Planned Care Challenges, June 2025 (Document reference: 466642025)	New	01/08/2025	Gethin Hughes, Chief Operating Officer	N/A	6	9	
Audit Wales/2026/287	Eye Care Review, Cwm Taf Morgannwg University Health Board, November 2025	New	01/11/2025	Gethin Hughes, Chief Operating Officer	N/A	6	30	
Audit Wales/2025/288	Urgent and Emergency Care: Arrangements for Managing Demand, October 2025 (Document reference: 471342025)	New	01/10/2025	Gethin Hughes, Chief Operating Officer	N/A	9	9	
Internal Audit/2020/65	Directorate review: Acute Medicine and A&E Directorate, Final Internal Audit Report July 2020 (Review reference: CTMU 2020-23)	New	29/07/2020	Gethin Hughes, Chief Operating Officer	Reasonable Assurance	2	2	
Internal Audit/2020/74	IT Infrastructure, Final Internal Audit Report July 2020 (Review reference: CTMU 2020-458)	New	24/01/2020	Gethin Hughes, Chief Operating Officer	Reasonable Assurance	1	1	
Internal Audit/2021/200	Welsh Risk Pool Claims, Final Internal Audit Report May 2023 (Review reference: CTMUHB-2223-48)	New	31/05/2023	Richard Hughes, Interim Executive Director of Nursing, Midwifery & Patient Care	Reasonable Assurance	3	3	
Internal Audit/2021/203	Decarbonisation, Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-48)	New	08/08/2023	Richard Hughes, Interim Executive Director of Nursing, Midwifery & Patient Care	Reasonable Assurance	5	5	
Internal Audit/2021/113	National Incident Framework, Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-061)	New	08/08/2023	Richard Hughes, Interim Executive Director of Nursing, Midwifery & Patient Care	Reasonable Assurance	8	8	
Internal Audit/2021/117	Performance Reporting – Integrated Performance Report, Internal Audit Report July 2023 (Review reference: CTMUHB-2223-15)	New	28/07/2023	Claire Thompson, Executive Director of Strategy & Transformation / Stuart Morris, Director of Digital	Reasonable Assurance	2	2	
Internal Audit/2021/124	Follow-up: Concerns, Final Internal Audit Report May 2023 (Review reference: CTM 22/23-29)	New	31/05/2023	Richard Hughes, Interim Executive Director of Nursing, Midwifery & Patient Care	Reasonable Assurance	4	4	
Internal Audit/2021/146	Interventions Not Normally Undertaken (NNU), Final Internal Audit Report October 2023 (Review reference: CTMUHB-2224-15)	New	11/10/2023	Gethin Hughes, Chief Operating Officer / Dom Hurford, Executive Medical Director	Limited Assurance	8	8	
Internal Audit/2021/148	IT Infrastructure, Final Internal Audit Report October 2023 (Review reference: CTMUHB-2224-15)	New	09/10/2023	Stuart Morris, Director of Digital	Reasonable Assurance	5	5	
Internal Audit/2021/162	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/2024/169	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-2324-58)	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/2024/188	Welsh Risk Pool Claims, Final Internal Audit Report, June 2024 (Review reference: CTMUHB-2324-14)	New	11/06/2024	Richard Hughes, Interim Executive Director of Nursing, Midwifery & Patient Care	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/2024/199	Intelligent 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	Richard Hughes, Interim Executive Director of Nursing, Midwifery & Patient Care	Reasonable Assurance	7	8	
Internal Audit/2024/202	Follow-up: Reasonable Offer, Final Internal Audit Report, October 2024 (Review reference: CTM-2324-20)	Re-inspection	02/10/2024	Gethin Hughes, Chief Operating Officer	Reasonable Assurance	4	4	Reasonable Offer Process, Internal Audit Report April 2023 (Review reference: CTMUHB-2223-041)
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/2025/232	Medical Job Planning, 2024/25 (Review reference: CTM-2425-17)	New	21/01/2025	Dom Hurford, Executive Medical Director	Limited Assurance	9	6	
Internal Audit/2025/250	Duty of Candour, March 2025 (Review reference: CTMUHB-2324-10)	New	31/03/2025	Richard Hughes, Interim Executive Director of Nursing, Midwifery & Patient Care	Reasonable Assurance	10	11	
Internal Audit/2025/251	Cancer Tracking Process, 2024/25 (Review reference: CTM-2425-02)	New	22/05/2025	Gethin Hughes, Chief Operating Officer	Reasonable Assurance	7	7	
Internal Audit/2025/252	Service User Experience, 2024/25 (Review reference: CTM-2425-13)	New	09/05/2025	Richard Hughes, Interim Executive Director of Nursing, Midwifery & Patient Care	Reasonable Assurance	1	1	
Internal Audit/2025/253	New Care Group Model, 2024/25 (Review reference: CTM-2425-01)	New	12/05/2025	Gethin Hughes, Chief Operating Officer	Reasonable Assurance	1	1	
Internal Audit/2025/257	Capital Systems, 2024/25 (Review reference: CTM-SSU-2425-18)	New	12/04/2025	Sally May, Executive Director of Finance	Limited Assurance	7	7	
Internal Audit/2025/258	Digital Benefits Realisation, 2024/25 (Review reference: CTM-242508)	New	15/05/2025	Stuart Morris, Director of Digital	Limited Assurance	4	4	
Internal Audit/2025/259	Follow-up: 4-hour Emergency Department Performance, March 2025 (Review reference: CTM-2425-18)	Re-inspection	27/03/2025	Gethin Hughes, Chief Operating Officer	Reasonable Assurance	6	6	4-hour Emergency Department Performance Reporting, Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)
Internal Audit/2025/263	Electronic Whiteboards, 2024/25 (Review reference: CTM-2425-11)	New	15/05/2025	Gethin Hughes, Chief Operating Officer	Reasonable Assurance	10	10	
Internal Audit/2025/266	Welsh Risk Pool, 2024/25 (Review reference: CTM-2425-14)	New	30/06/2025	Richard Hughes, Interim Executive Director of Nursing, Midwifery & Patient Care	Reasonable Assurance	6	6	
Internal Audit/2025/267	End of Life Care Management, 2024/25 (Review reference: CTM-2425-04)	New	13/06/2025	Gethin Hughes, Chief Operating Officer	Limited Assurance	4	4	
Internal Audit/2025/270	Decarbonisation (Follow up), 2025/26 (Review reference: CTM-2526-30)	Re-inspection	14/08/2025	Claire Thompson, Executive Director of Strategy & Transformation	Limited Assurance	4	4	Decarbonisation Internal Audit Report, April 2024 (Review reference: CTMUHB-2324-23)
Internal Audit/2025/279	Follow-up: Vaccination Policy Implementation, 2025/26 (Review reference: CTM-2526-28)	Re-inspection	13/11/2025	Philip Daniels, Executive Director of Public Health	Limited Assurance	1	1	Vaccination Policy Implementation, 2024/25 (Review reference: CTM-2425-22)
Internal Audit/2025/282	Clinical Coding, 2025/26 (Review reference: CTM-2526-09)	New	23/12/2025	Stuart Morris, Director of Digital	Reasonable Assurance	2	2	
Internal Audit/2025/283	Substance Management, 2025/26 (Review reference: CTMUHB-SSU-2526-20)	New	19/01/2026	Sally May, Executive Director of Finance	Reasonable Assurance	2	2	
Internal Audit/2025/284	Operational Response to Critical Incident, 2025/26 (Review reference: CTM-2526-04)	New	28/11/2025	Gethin Hughes, Chief Operating Officer / Claire Thompson, Executive Director of Strategy & Transformation	Reasonable Assurance	6	6	
Internal Audit/2026/285	Stroke Services, 2025/26 (Review reference: CTM-2526-16)	New	31/01/2026	Lauren Edwards, Executive Director of A&Ps and Health Science	Reasonable Assurance	3	3	
Internal Audit/2026/286	Discharge Planning, 2025/26 (Review reference: CTM-2526-31)	New	21/12/2025	Gethin Hughes, Chief Operating Officer / Julie Denby, Deputy Chief Operating Officer – Mental Health, Primary Care and Community Services	Limited Assurance	11	11	

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.

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Audit Wales/2024/212	02/11/2024	Primary Care Follow-Up Review - CTMA108 2024, November 2024 (Document reference: A68A0201)	84 - 2024 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 demonstrate their funding. The Health Board should: • 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; • internally collate evaluations of new ways of working and share the learning by publishing the key message across all clusters; • work with the public to promote successful new ways of working; • 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/ND01/5	84a - Evaluation templates have been introduced for clusters to use to demonstrate outcomes and support continued investment/implementation.	Chief Operating Officer	31/03/2025	31/03/2025	High	Partially complete (Ongoing)	April 2025 Update - New process for approving evaluations is in place and reporting this PECT Board. Cluster initiatives already monitored by Board. Evaluation framework in place. Regular ring with cluster leads to share learning. Evidence of monitoring successful initiatives with a final Cluster Plan for 2024/25 and the delivery monitoring and continuous improvement for selected 5 care programs. Consider if evidence can be shared to close the action for next iteration update. January 2025 Update - Further completed. Action in the single communications officer post was evaluated and not felt to be good value for money. Instead funding is being made available to the central communications team to add additional resources into the team. This will give milestones. Action A to B - Single evaluation form has been introduced for clusters to use. A process for considering cluster initiatives is due to be finalised in January 2025. The other actions are still work in progress as part of the wider Transformation Programme.
Audit Wales/2024/212	02/11/2024	Primary Care Follow-Up Review - CTMA108 2024, November 2024 (Document reference: A68A0201)	84 - 2024 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 demonstrate their funding. The Health Board should: • 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; • internally collate evaluations of new ways of working and share the learning by publishing the key message across all clusters; • work with the public to promote successful new ways of working; • 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/ND01/5	84a - 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 offering prioritisation during the year.	Chief Operating Officer	31/03/2025	31/03/2025	High	Partially complete (Ongoing)	April 2025 Update - Work is ongoing with communication colleges to progress this, with consideration of an appropriate agreed ID. January 2025 Update - requires further review of actions and proposed closure April 2025 updates, update to be provided ahead of the next committee.
Audit Wales/2024/212	02/11/2024	Primary Care Follow-Up Review - CTMA108 2024, November 2024 (Document reference: A68A0201)	85 - 2024 Open Recommendation: We found variation in the maturity of primary care clusters, and scope to improve cluster membership and leadership. The Health Board should: • review the relative maturity of clusters, to develop and implement a plan to strengthen its support for clusters where necessary.	Audit Wales/2024/212/ND01/5	85a - Each IPB will have a role to review and develop the clusters maturity and to report this to Primary Care and Community Transformation Board.	Chief Operating Officer	31/03/2025	31/03/2025	High	Ongoing	April 2025 Update - The IPBs have been suspended and are under review. January 2025 Update - S01 remains as work in progress. To be reviewed ahead of next update to demonstrate progress.
Audit Wales/2024/218	21/01/2025	Structured Assessment 2024 - CTMA108 2024, November 2024 (Document reference: A73NA0201)	81 - 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/2024/218/ND01/5	81 - A detailed Project Initiation Document for a review of Non-Clinical Policy Management process has been developed. The project objectives are: 1. To establish a smaller compliance position for Non-Clinical Written Control Documents 2. To ensure that Non-Clinical Written Control Documents are appropriately defined - policy, procedure, guideline etc. 3. To explore an automated approach for the management of Written Control Documents to support monitoring, review prompts, version control and document storage. 4. To review the policy pages on the internal and external websites to ensure ease of access for users when searching for documents. 5. To review the "Policy enforcer" and develop a simplified Document supported with clear process maps. Progress on the Project will be monitored via the Executive Leadership Group. Once completed this will generate improved monitoring through the appropriate Board Committees.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategic & Transformation Executive Director of Nursing, Midwifery & Patient Care	21/12/2024	21/12/2024	High	Partially complete (Ongoing)	April 2025 Update - A baseline compliance position was established in relation to Non-Clinical Policies, which now forms the Non-Clinical Policies Master Library. All documents are appropriately defined, Policy, Procedure or Guideline. Exploration in relation to an automated approach has been carried out with Digital colleagues however, due to ongoing early embedding of the new SharePoint site and related automation process (described under February 2025 Update) together with capacity challenges, this remains ongoing. Governance collaboration between Corporate Governance and Digital colleagues and early collaboration with document management has ensured that the new SharePoint site is easy to access and user friendly and incorporate relevant "search" terms. January 2025 Update - An update against this recommendation has not been provided at this occasion.
Audit Wales/2024/218	21/01/2025	Structured Assessment 2024 - CTMA108 2024, November 2024 (Document reference: A73NA0201)	82 - The Health Board should establish arrangements for identifying and monitoring actions arising from its Learning and Learning Standards.	Audit Wales/2024/218/ND01/5	82 - Any actions from Learning & Learning Standards Board & Committee meetings should be identified, monitored and completed prior to the Learning & Learning Standards Board presentation, monitoring of any action following the presentation of Learning & Learning Standards at Board Committee will be provided through the Clinical Governance Group and the Patient Experience Forum. The governance process for any action arising from the presentation of these actions is currently being worked through. As this will be a new revised arrangement, with this work being in its infancy, a full review of the required governance arrangements will be undertaken for assurance. The Health Board will ensure that each strategy to inform Board members on Staff Experiences are included within the Library of Learning & Learning stories being built up for wider sharing, this work will be monitored through the Patient experience forum.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategic & Transformation Executive Director of Nursing, Midwifery & Patient Care	31/03/2025	31/03/2025	High	Ongoing	June, October 2025, January, April 2026 Update - An update against this recommendation has not been provided on these occasions.
Audit Wales/2024/218	21/01/2025	Structured Assessment 2024 - CTMA108 2024, November 2024 (Document reference: A73NA0201)	84 - The Health Board should strengthen its integrated Performance Dashboard by clearly articulating whether actions to improve underperformance are achieving their intended impact.	Audit Wales/2024/218/ND01/5	84 - The performance report routine will be stripped back to focus on remedial actions and their impact, this update on impact.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategic & Transformation Executive Director of Nursing, Midwifery & Patient Care	31/03/2025	31/03/2025	High	Fully complete (Awaiting approval)	April 2025 Update - The IPB was updated in 2024/25 to reflect this action and requirements (prior to revised IPB 21 onwards) and there is a further Board working 22/04/25 to discuss and consider further arrangements for 2027 including IPC training and use of control charts. This action is recommended for closure on the basis of this evidence as the IPB will always continue to iterate but this audit recommendation has been addressed. December 2025 Update - Progress to close. The revised committee structure supports a robust approach for reporting on the CTMA030: Building Healthier Communities Together strategy with being a key focus of the Strategic Development Committee. The NHTF delivery is also a routine focus at Operational Delivery Committee. **Pending agreement with Audit Wales colleagues and therefore status currently remains unchanged.
Audit Wales/2024/218	21/01/2025	Structured Assessment 2024 - CTMA108 2024, November 2024 (Document reference: A73NA0201)	85.1 - The Health Board should strengthen its reporting on the Quality of Safety and Care by: 85.1.1 ensuring that future annual reports are clearer around the challenges it is experiencing in embedding the requirements.	Audit Wales/2024/218/ND01/5	85.1 - Future Annual Reports will include details in respect of the health board reporting mechanisms and in particular include clear revision around the challenges experienced in embedding the requirements.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategic & Transformation Executive Director of Nursing, Midwifery & Patient Care	31/03/2025	31/03/2025	High	Ongoing	June, October 2025, January, April 2026 Update - An update against this recommendation has not been provided on these occasions.
Audit Wales/2024/218	21/01/2025	Structured Assessment 2024 - CTMA108 2024, November 2024 (Document reference: A73NA0201)	85.2 - The Health Board should strengthen its reporting on the Quality of Safety and Care by: 85.2.1 ensuring that future annual reports are clearer around the challenges it is experiencing in embedding the requirements.	Audit Wales/2024/218/ND01/5	85.2 - Future Annual Reports will include details in respect of the health board reporting mechanisms and in particular include clear revision around the challenges experienced in embedding the requirements.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategic & Transformation Executive Director of Nursing, Midwifery & Patient Care	31/03/2025	31/03/2025	High	Ongoing	June, October 2025, January, April 2026 Update - An update against this recommendation has not been provided on these occasions.
Audit Wales/2024/218	21/01/2025	Structured Assessment 2024 - CTMA108 2024, November 2024 (Document reference: A73NA0201)	85.3 - The Health Board should strengthen its reporting on the Quality of Safety and Care by: 85.3.1 ensuring that future annual reports are clearer around the challenges it is experiencing in embedding the requirements.	Audit Wales/2024/218/ND01/5	85.3 - Future Annual Reports will include details in respect of the health board reporting mechanisms and in particular include clear revision around the challenges experienced in embedding the requirements.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategic & Transformation Executive Director of Nursing, Midwifery & Patient Care	31/03/2025	31/03/2025	High	Ongoing	June, October 2025, January, April 2026 Update - An update against this recommendation has not been provided on these occasions.
Audit Wales/2024/218	21/01/2025	Structured Assessment 2024 - CTMA108 2024, November 2024 (Document reference: A73NA0201)	86 - The Health Board should develop and report on population outcome measures to demonstrate the impact of its strategy delivery.	Audit Wales/2024/218/ND01/5	86 - 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 reporting meaningful however, both strategic and operational data sets will need to be developed using data from a number of different internal and external resources. In addition to this, CTMA018 are working with IPB to develop a data dashboard with Data Centre and close collaboration with Swansea and NHTF. Once developed, this will provide an early data dashboard across the wide range of themes with around 100 indicators. Due date to be confirmed - initial meeting with IPB and CTMA018 to discuss the options around accessing the required data by December 2025. After this a draft timeline for options and system development can be produced. Timeline for IPB dataset to be confirmed.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategic & Transformation Executive Director of Nursing, Midwifery & Patient Care	31/03/2025	31/03/2025	High	Fully complete (Awaiting approval)	April 2025 Update - The performance reporting has been approved by Creating Health Programme Board and reports will be available annually. There is also a monthly schedule of "Snap shot" reports that are programme specific on a rolling basis. This enables us to monitor progress using operational and strategic data sets. The Public Services User (PSU) dataset is also due and will be provided on request to feed into the CTMA 018 website. January 2025 Update - An update against this recommendation has not been provided on these occasions.
Audit Wales/2024/218	21/01/2025	Structured Assessment 2024 - CTMA108 2024, November 2024 (Document reference: A73NA0201)	88 - The Health Board should develop and report on population outcome measures to demonstrate the impact of its strategy delivery.	Audit Wales/2024/218/ND01/5	88 - 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 reporting meaningful however, both strategic and operational data sets will need to be developed using data from a number of different internal and external resources. In addition to this, CTMA018 are working with IPB to develop a data dashboard with Data Centre and close collaboration with Swansea and NHTF. Once developed, this will provide an early data dashboard across the wide range of themes with around 100 indicators. Due date to be confirmed - initial meeting with IPB and CTMA018 to discuss the options around accessing the required data by December 2025. After this a draft timeline for options and system development can be produced. Timeline for IPB dataset to be confirmed.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategic & Transformation Executive Director of Nursing, Midwifery & Patient Care	30/04/2025	30/04/2025	High	Partially complete (Ongoing)	April 2025 Update - The governance for the 18 committees has been introduced through the 2027 forward plan to reflect the responsibility for the strategic goals in CTMA 2025. We have introduced a strategic alignment framework that directly links the goals to the work of the 18 organisations. December 2025 Update - Progress to close. The revised committee structure supports a robust approach for monitoring CTMA030: Building Healthier Communities Together strategy with being a key focus of the Strategic Delivery Committee. The NHTF delivery is also a routine focus at the Operational Delivery Committee. **Pending agreement with Audit Wales colleagues and therefore status currently remains unchanged.
Audit Wales/2024/218	21/01/2025	Structured Assessment 2024 - CTMA108 2024, November 2024 (Document reference: A73NA0201)	89 - The Health Board should develop and report on population outcome measures to demonstrate the impact of its strategy delivery.	Audit Wales/2024/218/ND01/5	89 - There are three components to CTMA 2020: Building Healthier Communities - this reports in the new Strategic Development Committee (SDC) and activities will be ongoing as we work with internal and external partners to ensure the outcomes of the work is supported and delivered. Integrated community and primary care - a specific plan that will report to Operational Delivery Committee (ODC) with clear timelines and performance metrics.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategic & Transformation Executive Director of Nursing, Midwifery & Patient Care	30/04/2025	30/04/2025	High	Partially complete (Ongoing)	April 2025 Update - Work continues on the 5 year "No nothing scenario" which is being used to inform a draft "Plan for change" shared with Board on 21/04/25. This will allow the development of interventions that can be based on a longer time scale. December 2025 Update - Work continues on the 5 year "No nothing scenario" which is being used to inform a draft "Plan for change" shared with Board on 21/04/25. This will allow the development of interventions that can be based on a longer time scale.
Audit Wales/2024/218	21/01/2025	Structured Assessment 2024 - CTMA108 2024, November 2024 (Document reference: A73NA0201)	90 - The Health Board should develop and report on population outcome measures to demonstrate the impact of its strategy delivery.	Audit Wales/2024/218/ND01/5	90 - There are three components to CTMA 2020: Building Healthier Communities - this reports in the new Strategic Development Committee (SDC) and activities will be ongoing as we work with internal and external partners to ensure the outcomes of the work is supported and delivered. Integrated community and primary care - a specific plan that will report to Operational Delivery Committee (ODC) with clear timelines and performance metrics.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategic & Transformation Executive Director of Nursing, Midwifery & Patient Care	30/04/2025	30/04/2025	High	Partially complete (Ongoing)	April 2025 Update - Work continues on the 5 year "No nothing scenario" which is being used to inform a draft "Plan for change" shared with Board on 21/04/25. This will allow the development of interventions that can be based on a longer time scale. December 2025 Update - Work continues on the 5 year "No nothing scenario" which is being used to inform a draft "Plan for change" shared with Board on 21/04/25. This will allow the development of interventions that can be based on a longer time scale.
Audit Wales/2024/218	21/01/2025	Structured Assessment 2024 - CTMA108 2024, November 2024 (Document reference: A73NA0201)	91.1 - The Health Board should develop and report on population outcome measures to demonstrate the impact of its strategy delivery.	Audit Wales/2024/218/ND01/5	91.1 - The Quality Governance Team will review the Quality Impact Assessment (QIA) having from its recent use in the response to the NDSM Clinical Incident, to ensure that any improvements are addressed and that QIA is routinely completed where there is a risk to quality and performance where investment in services is required. Consideration will also be given to how such instances routinely available through the appropriate stages of the Quality Governance Framework.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategic & Transformation Executive Director of Nursing, Midwifery & Patient Care	30/04/2025	30/04/2025	High	Ongoing	June, October 2025, January, April 2026 Update - An update against this recommendation has not been provided on these occasions.
Audit Wales/2024/218	21/01/2025	Structured Assessment 2024 - CTMA108 2024, November 2024 (Document reference: A73NA0201)	91.2 - The Health Board should develop and report on population outcome measures to demonstrate the impact of its strategy delivery.	Audit Wales/2024/218/ND01/5	91.2 - The Quality Governance Team will review the Quality Impact Assessment (QIA) having from its recent use in the response to the NDSM Clinical Incident, to ensure that any improvements are addressed and that QIA is routinely completed where there is a risk to quality and performance where investment in services is required. Consideration will also be given to how such instances routinely available through the appropriate stages of the Quality Governance Framework.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategic & Transformation Executive Director of Nursing, Midwifery & Patient Care	30/04/2025	30/04/2025	High	Ongoing	June, October 2025, January, April 2026 Update - An update against this recommendation has not been provided on these occasions.
Audit Wales/2024/218	21/01/2025	Structured Assessment 2024 - CTMA108 2024, November 2024 (Document reference: A73NA0201)	91.3 - The Health Board should develop and report on population outcome measures to demonstrate the impact of its strategy delivery.	Audit Wales/2024/218/ND01/5	91.3 - The Quality Governance Team will review the Quality Impact Assessment (QIA) having from its recent use in the response to the NDSM Clinical Incident, to ensure that any improvements are addressed and that QIA is routinely completed where there is a risk to quality and performance where investment in services is required. Consideration will also be given to how such instances routinely available through the appropriate stages of the Quality Governance Framework.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategic & Transformation Executive Director of Nursing, Midwifery & Patient Care	30/04/2025	30/04/2025	High	Ongoing	June, October 2025, January, April 2026 Update - An update against this recommendation has not been provided on these occasions.
Audit Wales/2024/218	21/01/2025	Structured Assessment 2024 - CTMA108 2024, November 2024 (Document reference: A73NA0201)	91.4 - The Health Board should develop and report on population outcome measures to demonstrate the impact of its strategy delivery.	Audit Wales/2024/218/ND01/5	91.4 - The Quality Governance Team will review the Quality Impact Assessment (QIA) having from its recent use in the response to the NDSM Clinical Incident, to ensure that any improvements are addressed and that QIA is routinely completed where there is a risk to quality and performance where investment in services is required. Consideration will also be given to how such instances routinely available through the appropriate stages of the Quality Governance Framework.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategic & Transformation Executive Director of Nursing, Midwifery & Patient Care	30/04/2025	30/04/2025	High	Ongoing	June, October 2025, January, April 2026 Update - An update against this recommendation has not been provided on these occasions.
Audit Wales/2024/218	21/01/2025	Structured Assessment 2024 - CTMA108 2024, November 2024 (Document reference: A73NA0201)	91.5 - The Health Board should develop and report on population outcome measures to demonstrate the impact of its strategy delivery.	Audit Wales/2024/218/ND01/5	91.5 - The Quality Governance Team will review the Quality Impact Assessment (QIA) having from its recent use in the response to the NDSM Clinical Incident, to ensure that any improvements are addressed and that QIA is routinely completed where there is a risk to quality and performance where investment in services is required. Consideration will also be given to how such instances routinely available through the appropriate stages of the Quality Governance Framework.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategic & Transformation Executive Director of Nursing, Midwifery & Patient Care	30/04/2025	30/04/2025	High	Ongoing	June, October 2025, January, April 2026 Update - An update against this recommendation has not been provided on these occasions.
Audit Wales/2024/218	21/01/2025	Structured Assessment 2024 - CTMA108 2024, November 2024 (Document reference: A73NA0201)	91.6 - The Health Board should develop and report on population outcome measures to demonstrate the impact of its strategy delivery.	Audit Wales/2024/218/ND01/5	91.6 - The Quality Governance Team will review the Quality Impact Assessment (QIA) having from its recent use in the response to the NDSM Clinical Incident, to ensure that any improvements are addressed and that QIA is routinely completed where there is a risk to quality and performance where investment in services is required. Consideration will also be given to how such instances routinely available through the appropriate stages of the Quality Governance Framework.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategic & Transformation Executive Director of Nursing, Midwifery & Patient Care	30/04/2025	30/04/2025	High	Ongoing	June, October 2025, January, April 2026 Update - An update against this recommendation has not been provided on these occasions.
Audit Wales/2024/218	21/01/2025	Structured Assessment 2024 - CTMA108 2024, November 2024 (Document reference: A73NA0201)	91.7 - The Health Board should develop and report on population outcome measures to demonstrate the impact of its strategy delivery.	Audit Wales/2024/218/ND01/5	91.7 - The Quality Governance Team will review the Quality Impact Assessment (QIA) having from its recent use in the response to the NDSM Clinical Incident, to ensure that any improvements are addressed and that QIA is routinely completed where there is a risk to quality and performance where investment in services is required. Consideration will also be given to how such instances routinely available through the appropriate stages of the Quality Governance Framework.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategic & Transformation Executive Director of Nursing, Midwifery & Patient Care	30/04/2025	30/04/2025	High	Ongoing	June, October 2025, January, April 2026 Update - An update against this recommendation has not been provided on these occasions.
Audit Wales/2024/218	21/01/2025	Structured Assessment 2024 - CTMA108 2024, November 2024 (Document reference: A73NA0201)	91.8 - The Health Board should develop and report on population outcome measures to demonstrate the impact of its strategy delivery.	Audit Wales/2024/218/ND01/5	91.8 - The Quality Governance Team will review the Quality Impact Assessment (QIA) having from its recent use in the response to the NDSM Clinical Incident, to ensure that any improvements are addressed and that QIA is routinely completed where there is a risk to quality and performance where investment in services is required. Consideration will also be given to how such instances routinely available through the appropriate stages of the Quality Governance Framework.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategic & Transformation Executive Director of Nursing, Midwifery & Patient Care	30/04/2025	30/04/2025	High	Ongoing	June, October 2025, January, April 2026 Update - An update against this recommendation has not been provided on these occasions.
Audit Wales/2024/218	21/01/2025	Structured Assessment 2024 - CTMA108 2024, November 2024 (Document reference: A73NA0201)	91.9 - The Health Board should develop and report on population outcome measures to demonstrate the impact of its strategy delivery.	Audit Wales/2024/218/ND01/5	91.9 - The Quality Governance Team will review the Quality Impact Assessment (QIA) having from its recent use in the response to the NDSM Clinical Incident, to ensure that any improvements are addressed and that QIA is routinely completed where there is a risk to quality and performance where investment in services is required. Consideration will also be given to how such instances routinely available through the appropriate stages of the Quality Governance Framework.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategic & Transformation Executive Director of Nursing, Midwifery & Patient Care	30/04/2025	30/04/2025	High	Ongoing	June, October 2025, January, April 2026 Update - An update against this recommendation has not been provided on these occasions.
Audit Wales/2024/218	21/01/2025	Structured Assessment 2024 - CTMA108 2024, November 2024 (Document reference: A73NA0201)	91.10 - The Health Board should develop and report on population outcome measures to demonstrate the impact of its strategy delivery.	Audit Wales/2024/218/ND01/5	91.10 - The Quality Governance Team will review the Quality Impact Assessment (QIA) having from its recent use in the response to the NDSM Clinical Incident, to ensure that any improvements are addressed and that QIA is routinely completed where there is a risk to quality and performance where investment in services is required. Consideration will also be given to how such instances routinely available through the appropriate stages of the Quality Governance Framework.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategic & Transformation Executive Director of Nursing, Midwifery & Patient Care	30/04/2025	30/04/2025	High	Ongoing	June, October 2025, January, April 2026 Update - An update against this recommendation has not been provided on these occasions.
Audit Wales/2024/218	21/01/2025	Structured Assessment 2024 - CTMA108 2024, November 2024 (Document reference: A73NA0201)	91.11 - The Health Board should develop and report on population outcome measures to demonstrate the impact of its strategy delivery.	Audit Wales/2024/218/ND01/5	91.11 - The Quality Governance Team will review the Quality Impact Assessment (QIA) having from its recent use in the response to the NDSM Clinical Incident, to ensure that any improvements are addressed and that QIA is routinely completed where there is a risk to quality and performance where investment in services is required. Consideration will also be given to how such instances routinely available through the appropriate stages of the Quality Governance Framework.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategic & Transformation Executive Director of Nursing, Midwifery & Patient Care	30/04/2025	30/04/2025	High	Ongoing	June, October 2025, January, April 2026 Update - An update against this recommendation has not been provided on these occasions.
Audit Wales/2024/218	21/01/2025	Structured Assessment 2024 - CTMA108 2024, November 2024 (Document reference: A73NA0201)	91.12 - The Health Board should develop and report on population outcome measures to demonstrate the impact of its strategy delivery.	Audit Wales/2024/218/ND01/5	91.12 - The Quality Governance Team will review the Quality Impact Assessment (QIA) having from its recent use in the response to the NDSM Clinical Incident, to ensure that any improvements are addressed and that QIA is routinely completed where there is a risk to quality and performance where investment in services is required. Consideration will also be given to how such instances routinely available through the appropriate stages of the Quality Governance Framework.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategic & Transformation Executive Director of Nursing, Midwifery & Patient Care	30/04/2025	30/04/2025	High	Ongoing	June, October 2025, January, April 2026 Update - An update against this recommendation has not been provided on these occasions.
Audit Wales/2024/218	21/01/2025	Structured Assessment 2024 - CTMA108 2024, November 2024 (Document reference: A73NA0201)	91.13 - The Health Board should develop and report on population outcome measures to demonstrate the impact of its strategy delivery.	Audit Wales/2024/218/ND01/5	91.13 - The Quality Governance Team will review the Quality Impact Assessment (QIA) having from its recent use in the response to the NDSM Clinical Incident, to ensure that any improvements are addressed and that QIA is routinely completed where there is a risk to quality and performance where investment in services is required. Consideration will also be given to how such instances routinely available through the appropriate stages of the Quality Governance Framework.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategic & Transformation Executive Director of Nursing, Midwifery & Patient Care	30/04/2025	30/04/2025	High	Ongoing	June, October 2025, January, April 2026 Update - An update against this recommendation has not been provided on these occasions.
Audit Wales/2024/218	21/01/2025	Structured Assessment 2024 - CTMA108 2024, November 2024 (Document reference: A73NA0201)	91.14 - The Health Board should develop and report on population outcome measures to demonstrate the impact of its strategy delivery.	Audit Wales/2024/218/ND01/5	91.14 - The Quality Governance Team will review the Quality Impact Assessment (QIA) having from its recent use in the response to the NDSM Clinical Incident, to ensure that any improvements are addressed and that QIA is routinely completed where there is a risk to quality and performance where investment in services is required. Consideration will also be given to how such instances routinely available through the appropriate stages of the Quality Governance Framework.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategic & Transformation Executive Director of Nursing, Midwifery & Patient Care	30/04/2025	30/04/2025	High	Ongoing	June, October 2025, January, April 2026 Update - An update against this recommendation has not been provided on these occasions.
Audit Wales/2024/218	21/01/2025	Structured Assessment 2024 - CTMA108 2024, November 2024 (Document reference: A73NA0201)	91.15 - The Health Board should develop and report on population outcome measures to demonstrate the impact of its strategy delivery.	Audit Wales/2024/218/ND01/5	91.15 - The Quality Governance Team will review the Quality Impact Assessment (QIA) having from its recent use in the response to the NDSM Clinical Incident, to ensure that any improvements are addressed and that QIA is routinely completed where there is a risk to quality and performance where investment in services is required. Consideration will also be given to how such instances routinely available through the appropriate stages of the Quality Governance Framework.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategic & Transformation Executive Director of Nursing, Midwifery & Patient Care	30/04/2025	30/04/2025	High	Ongoing	June, October 2025, January, April 2026 Update - An update against this recommendation has not been provided on these occasions.
Audit Wales/2024/218	21/01/2025	Structured Assessment 2024 - CTMA108 2024, November 2024 (Document reference: A73NA0201)	91.16 - The Health Board should develop and report on population outcome measures to demonstrate the impact of its strategy delivery.	Audit Wales/2024/218/ND01/5	91.16 - The Quality Governance Team will review the Quality Impact Assessment (QIA) having from its recent use in the response to the NDSM Clinical Incident, to ensure that any improvements are addressed and that QIA is routinely completed where there is a risk to quality and performance where investment in services is required. Consideration will also be given to how such instances routinely available through the appropriate stages of the Quality Governance Framework.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategic & Transformation Executive Director of Nursing, Midwifery & Patient Care	30/04/2025	30/04/2025	High	Ongoing	June, October 2025, January, April 2026 Update - An update against this recommendation has not been provided on these occasions.
Audit Wales/2024/218	21/01/2025	Structured Assessment 2024 - CTMA108 2024, November 2024 (Document reference: A73NA0201)	91.17 - The Health Board should develop and report on population outcome measures to demonstrate the impact of its strategy delivery.	Audit Wales/2024/218/ND01/5	91.17 - The Quality Governance Team will review the Quality Impact Assessment (QIA) having from its recent use in the response to the NDSM Clinical Incident, to ensure that any improvements are addressed and that QIA is routinely completed where there is a risk to quality and performance where investment in services is required. Consideration will also be given to how such instances routinely available through the appropriate stages of the Quality Governance Framework.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategic & Transformation Executive Director of Nursing, Midwifery & Patient Care	30/04/2025	30/04/2025	High	Ongoing	June, October 2025, January, April 2026 Update - An update against this recommendation has not been provided on these occasions.
Audit Wales/2024/218	21/01/2025	Structured Assessment 2024 - CTMA108 2024, November 2024 (Document reference: A73NA0201)	91.18 - The Health Board should develop and report on population outcome measures to demonstrate the impact of its strategy delivery.	Audit Wales/2024/218/ND01/5	91.18 - The Quality Governance Team will review the Quality Impact Assessment (QIA) having from its recent use in the response to the NDSM Clinical Incident, to ensure that any improvements are addressed and that QIA is routinely completed where there is a risk to quality and performance where investment in services is required. Consideration will also be given to how such instances routinely available through the appropriate stages of the Quality Governance Framework.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategic & Transformation Executive Director of Nursing, Midwifery & Patient Care	30/04/2025	30/04/2025	High	Ongoing	June, October 2025, January, April 2026 Update - An update against this recommendation has not been provided on these occasions.
Audit Wales/2024/218	21/01/2025	Structured Assessment 2024 - CTMA108 2024, November 2024 (Document reference: A73NA0201)	91.19 - The Health Board should develop and report on population outcome measures to demonstrate the impact of its strategy delivery.	Audit Wales/2024/218/ND01/5	91.19 - The Quality Governance Team will review the Quality Impact Assessment (QIA) having from its recent use in the response to the NDSM Clinical Incident, to ensure that any improvements are addressed and that QIA is routinely completed where there is a risk to quality and performance where investment in services is required. Consideration will also be given to how such instances routinely available through the appropriate stages of the Quality Governance Framework.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategic & Transformation Executive Director of Nursing, Midwifery & Patient Care	30/04/2025	30/04/2025	High	Ongoing	June, October 2025, January, April 2026 Update - An update against this recommendation has not been provided on these occasions.
Audit Wales/2024/218	21/01/2025	Structured Assessment 2024 - CTMA108 2024, November 2024 (Document reference: A73NA0201)	91								

Audit Wales/2025/280	01/06/2025	Tackling the Planned Care Challenges, June 2025 (Document reference: A68A2025)	Efficiency and productivity 84. Our work has identified there are opportunities for further efficiency and productivity improvements. The Health Board should: 4.1 Address the causes of short notice surgical cancellations to improve use of theatre resources. As part of this, set a clear reduction target for short notice surgical cancellations. 4.2 Improve theatre utilisation rates, with the aim of achieving the GBT recommended level of 85%. 4.3 Increase day surgery rates to the GBT recommended level of 85%. 4.4 Increase job planning compliance to the 85% target. Use job planning as a means to drive improved productivity and to help shape and transform efficient services.	Audit Wales/2025/280/MDA/5	4.1 – Theatre improvement group to focus on cancellations in Q4 of 2026. Baseline and target to be reviewed and set in Q2.	Chief Operating Officer	31/07/2026	31/07/2026	High	In progress	April 2026 Update - The actions are rolled up as part of the PTT programme and regularly updated via PTT and medical workforce effectiveness and productivity group. Working towards the trajectory of 85%. December 2025 Update - In progress, all efficiency and productivity is monitored by the PTT programme.
Audit Wales/2025/280	01/06/2025	Tackling the Planned Care Challenges, June 2025 (Document reference: A68A2025)	Efficiency and productivity 84. Our work has identified there are opportunities for further efficiency and productivity improvements. The Health Board should: 4.1 Address the causes of short notice surgical cancellations to improve use of theatre resources. As part of this, set a clear reduction target for short notice surgical cancellations. 4.2 Improve theatre utilisation rates, with the aim of achieving the GBT recommended level of 85%. 4.3 Increase day surgery rates to the GBT recommended level of 85%. 4.4 Increase job planning compliance to the 85% target. Use job planning as a means to drive improved productivity and to help shape and transform efficient services.	Audit Wales/2025/280/MDA/2	4.2 – Priority for theatre improvement group • Target set and monitoring of target to improvement group and reported to the PTT board. • Partner team to all Consultant on the instruction of short times • 4.2.2 The measure that all list are booked in full at least one and a half weeks of last week. • Specialist escalation to the Theatre Improvement group on the specialities that are underperforming theatre sessions.	Chief Operating Officer	31/05/2026	31/05/2026	High	Partially complete (Overdue)	April 2026 Update - Reports monthly to the productivity, improvement and transformation board. 1. 4.2.2 - in place to diagnose short notice cancellations 2. Theatre utilisation rates are increasing with many specialities above 85% 3. day surgery rates consistently above 85% DCO agreed update 23.4.26 January 2026 Update - An update against this recommendation has not been provided on this occasion.
Audit Wales/2025/280	01/06/2025	Tackling the Planned Care Challenges, June 2025 (Document reference: A68A2025)	Efficiency and productivity 84. Our work has identified there are opportunities for further efficiency and productivity improvements. The Health Board should: 4.1 Address the causes of short notice surgical cancellations to improve use of theatre resources. As part of this, set a clear reduction target for short notice surgical cancellations. 4.2 Improve theatre utilisation rates, with the aim of achieving the GBT recommended level of 85%. 4.3 Increase day surgery rates to the GBT recommended level of 85%. 4.4 Increase job planning compliance to the 85% target. Use job planning as a means to drive improved productivity and to help shape and transform efficient services.	Audit Wales/2025/280/MDA/3	4.3 – day surgery rates already greater than 85%. Target set in theatre utilisation group to be monitored monthly.	Chief Operating Officer	31/05/2026	31/05/2026	High	Partially complete (Overdue)	April 2026 Update - Reports monthly to the productivity, improvement and transformation board. 1. 4.2.2 - in place to diagnose short notice cancellations 2. Theatre utilisation rates are increasing with many specialities above 85% 3. day surgery rates consistently above 85% DCO agreed update 23.4.26 December 2025 Update - Monitored regularly in Theatre Utilisation Group meetings. Progress note to fully complete on receipt of evidence to demonstrate increase in theatre, day surgery rates aligned to GBT, job planning compliance and sign off by DCO.
Audit Wales/2025/280	01/06/2025	Tackling the Planned Care Challenges, June 2025 (Document reference: A68A2025)	Efficiency and productivity 84. Our work has identified there are opportunities for further efficiency and productivity improvements. The Health Board should: 4.1 Address the causes of short notice surgical cancellations to improve use of theatre resources. As part of this, set a clear reduction target for short notice surgical cancellations. 4.2 Improve theatre utilisation rates, with the aim of achieving the GBT recommended level of 85%. 4.3 Increase day surgery rates to the GBT recommended level of 85%. 4.4 Increase job planning compliance to the 85% target. Use job planning as a means to drive improved productivity and to help shape and transform efficient services.	Audit Wales/2025/280/MDA/9	4.4 – Medical workforce group focusing on and inspecting by directors board in. All specialities excluding	Chief Operating Officer	30/04/2027	30/04/2027	High	Partially complete (Overdue)	April 2026 Update - Reports monthly to the productivity, improvement and transformation board. 1. 4.2.2 - in place to diagnose short notice cancellations 2. Theatre utilisation rates are increasing with many specialities above 85% 3. day surgery rates consistently above 85% There are a working progress and regularly monitored training progress against target January 2026 Update - An update against this recommendation has not been provided on this occasion.
Audit Wales/2025/280	01/06/2025	Tackling the Planned Care Challenges, June 2025 (Document reference: A68A2025)	Treat in turn 85. The Health Board needs to strengthen its actions to achieve its treat in turn target of 85% within the next 12 months.	Audit Wales/2025/280/MDA/5	• Wales Patient Administration system (WPAS) merger completed in May 2025. • Subordinate to be established as a specialty unit. • Expectations to be set for each specialty.	Chief Operating Officer	30/11/2026	30/11/2026	High	Partially complete (Overdue)	April 2026 Update - Performance work ongoing to focus on sub specialty treat in turn rates. December 2025 Update - Actions across now all in place following evidence to demonstrate the Health Board has strengthened its actions to achieve its treat in turn rate target of 85% within the next 12 months and sign off by DCO.
Audit Wales/2025/280	01/06/2025	Tackling the Planned Care Challenges, June 2025 (Document reference: A68A2025)	Managing clinical risks associated with long waits 86. The Health Board needs to strengthen its monitoring and reporting processes associated with managing clinical risks associated with long waits. 4.1 Building on the harm review arrangements in ophthalmology services, develop and implement a consistent methodology across all specialties to assess the risk of, or actual harm, to patients caused by long waits. 4.2 Report the risks and actual incidence of harm resulting from delays in access to treatment to the Quality, Safety and Experience Committee.	Audit Wales/2025/280/MDA/5	4.1 - SATS process followed and investigated, and action taken accordingly. Incidents on DATX are reviewed and presented monthly at Care Group Quality, Safety and Experience Committee. 4.2 - Reviewed on Planned Care Quality, Safety and Experience Committee and escalated as appropriate.	Chief Operating Officer	31/08/2025	31/08/2025	High	Fully complete (Awaiting approval)	April 2026 Update - Evidence can be requested from the Planned Care Q&E meetings, suggest closure. December 2025 Update - All recommendations now in place. Will progress to fully complete on receipt of evidence to CDO business team for sign off by DCO and closure.
Audit Wales/2025/287	01/11/2025	Eye Care Review, Care T&F Merginsing University Health Board, November 2025	81. To increase the pace of delivery, regional partners should spend up decision making processes for agreeing business cases.	Audit Wales/2025/287/MDA/5	The Regional Joint Committee (RJC) that will come into existence towards the end of 2025 will streamline regional decision making for all regional programmes.	Chief Operating Officer	31/12/2025	31/12/2025	High	Partially complete (Overdue)	April 2026 Update - Regional internet pathway agreed. Discussion taken place with CTR in implementation. Pathway available and shared the Eye Care Collaboration meeting 16.4.26.
Audit Wales/2025/287	01/11/2025	Eye Care Review, Care T&F Merginsing University Health Board, November 2025	82. Regional partners should develop a resource plan, to better understand operational and clinical commitment needed from each partner organisation to realistically deliver each phase of the strategy.	Audit Wales/2025/287/MDA/2	The Regional Programme Plan for 2026 includes a regional workforce review along with the ongoing demand and capacity reviews for each sub specialty.	Chief Operating Officer	31/08/2026	31/08/2026	High	Overdue	April 2026 Update - Ongoing internal Eye Care Measures meetings with regional partners and CTR. T&F and minutes available.
Audit Wales/2025/287	01/11/2025	Eye Care Review, Care T&F Merginsing University Health Board, November 2025	83. Regional partners should agree realistic but appropriately ambitious timescales for the three phases of the South East Wales Regional Ophthalmology Strategy.	Audit Wales/2025/287/MDA/5	The Regional Ophthalmology Strategy brings down the National Clinical Strategy for Ophthalmology. As a result the Regional Strategy will be viewed as part of the programme plan in 2026, with separate planning and performance against to programme priorities.	Chief Operating Officer	31/05/2026	31/05/2026	High	Overdue	April 2026 Update - seeking an update from the regional lead to inform this update.
Audit Wales/2025/287	01/11/2025	Eye Care Review, Care T&F Merginsing University Health Board, November 2025	84. The Health Board should urgently develop an eye care plan, writing to address current and future challenges. The Health Board should ensure the plan is: - based on current and projected future demand for services; - includes capacity plans based on realistically ambitious levels of productivity; - coded, as a minimum, for the medium term (3-5 years), supported by resource plans in financial, workforce (particularly medical staffing) and infrastructure, reflecting sustainable service models; - supported by clear delivery actions and milestones, and approved by the Board	Audit Wales/2025/287/MDA/5	Review and implement the Eye Care Plan based on demand and capacity analysis.	Chief Operating Officer	31/12/2025	31/12/2025	High	Partially complete (Awaiting approval)	April 2026 Update - Full demand and capacity undertaken on planning partners. Cap identified. Brought to bring established for cataracts. Virtual clinics established. WQDS plan being rolled out. Collectively the above will increase available capacity.
Audit Wales/2025/287	01/11/2025	Eye Care Review, Care T&F Merginsing University Health Board, November 2025	84. The Health Board should urgently develop an eye care plan, writing to address current and future challenges. The Health Board should ensure the plan is: - based on current and projected future demand for services; - includes capacity plans based on realistically ambitious levels of productivity; - coded, as a minimum, for the medium term (3-5 years), supported by resource plans in financial, workforce (particularly medical staffing) and infrastructure, reflecting sustainable service models; - supported by clear delivery actions and milestones, and approved by the Board	Audit Wales/2025/287/MDA/2	Complete demand and capacity review for cataract, 3, 4 and 4 address gaps by subspecialty.	Chief Operating Officer	30/09/2025	30/09/2025	High	Overdue	April 2026 Update - An update against this recommendation has not been provided on this occasion.
Audit Wales/2025/287	01/11/2025	Eye Care Review, Care T&F Merginsing University Health Board, November 2025	84. The Health Board should urgently develop an eye care plan, writing to address current and future challenges. The Health Board should ensure the plan is: - based on current and projected future demand for services; - includes capacity plans based on realistically ambitious levels of productivity; - coded, as a minimum, for the medium term (3-5 years), supported by resource plans in financial, workforce (particularly medical staffing) and infrastructure, reflecting sustainable service models; - supported by clear delivery actions and milestones, and approved by the Board	Audit Wales/2025/287/MDA/3	Review and update job plans and clinic templates to increase activity and ensure sustainability.	Chief Operating Officer	31/05/2026	31/05/2026	High	Partially complete (Overdue)	April 2026 Update - Job plans ongoing, will monitor progress of reviews at next update.
Audit Wales/2025/287	01/11/2025	Eye Care Review, Care T&F Merginsing University Health Board, November 2025	84. The Health Board should urgently develop an eye care plan, writing to address current and future challenges. The Health Board should ensure the plan is: - based on current and projected future demand for services; - includes capacity plans based on realistically ambitious levels of productivity; - coded, as a minimum, for the medium term (3-5 years), supported by resource plans in financial, workforce (particularly medical staffing) and infrastructure, reflecting sustainable service models; - supported by clear delivery actions and milestones, and approved by the Board	Audit Wales/2025/287/MDA/9	Complete contract review to RMBN from 1 Sept 2025 and deliver higher volumes through H&C bus.	Chief Operating Officer	30/06/2026	30/06/2026	High	Fully complete (Awaiting approval)	April 2026 Update - All contracts have been reviewed to RMBN from 1st Sept 26. Agreed updates by DCO. Moved to complete waiting approval.
Audit Wales/2025/287	01/11/2025	Eye Care Review, Care T&F Merginsing University Health Board, November 2025	84. The Health Board should urgently develop an eye care plan, writing to address current and future challenges. The Health Board should ensure the plan is: - based on current and projected future demand for services; - includes capacity plans based on realistically ambitious levels of productivity; - coded, as a minimum, for the medium term (3-5 years), supported by resource plans in financial, workforce (particularly medical staffing) and infrastructure, reflecting sustainable service models; - supported by clear delivery actions and milestones, and approved by the Board	Audit Wales/2025/287/MDA/5	Implement brought to lighting from Sept 2025 to increase outpatient capacity.	Chief Operating Officer	30/09/2025	30/09/2025	High	Partially complete (Overdue)	April 2026 Update - Completed in September 2025. Suggested in Feb 2026 following request from regional team as new internet pathway being implemented on regional.
Audit Wales/2025/287	01/11/2025	Eye Care Review, Care T&F Merginsing University Health Board, November 2025	84. The Health Board should urgently develop an eye care plan, writing to address current and future challenges. The Health Board should ensure the plan is: - based on current and projected future demand for services; - includes capacity plans based on realistically ambitious levels of productivity; - coded, as a minimum, for the medium term (3-5 years), supported by resource plans in financial, workforce (particularly medical staffing) and infrastructure, reflecting sustainable service models; - supported by clear delivery actions and milestones, and approved by the Board	Audit Wales/2025/287/MDA/6	Continue virtual clinics for medical retina and macular patients to expand outpatient access.	Chief Operating Officer	31/12/2026	31/12/2026	High	Partially complete (Overdue)	April 2026 Update - Increased virtual clinic capacity and in process of setting up further virtual clinics.
Audit Wales/2025/287	01/11/2025	Eye Care Review, Care T&F Merginsing University Health Board, November 2025	84. The Health Board should urgently develop an eye care plan, writing to address current and future challenges. The Health Board should ensure the plan is: - based on current and projected future demand for services; - includes capacity plans based on realistically ambitious levels of productivity; - coded, as a minimum, for the medium term (3-5 years), supported by resource plans in financial, workforce (particularly medical staffing) and infrastructure, reflecting sustainable service models; - supported by clear delivery actions and milestones, and approved by the Board	Audit Wales/2025/287/MDA/7	Reduce contract waiting times to 86 weeks stage 1 cataract by end of Sept 25.	Chief Operating Officer	30/09/2025	30/09/2025	High	Fully complete (Awaiting approval)	April 2026 Update - Completed. Contract cabinet waiting list down to 76 weeks.
Audit Wales/2025/287	01/11/2025	Eye Care Review, Care T&F Merginsing University Health Board, November 2025	84. The Health Board should urgently develop an eye care plan, writing to address current and future challenges. The Health Board should ensure the plan is: - based on current and projected future demand for services; - includes capacity plans based on realistically ambitious levels of productivity; - coded, as a minimum, for the medium term (3-5 years), supported by resource plans in financial, workforce (particularly medical staffing) and infrastructure, reflecting sustainable service models; - supported by clear delivery actions and milestones, and approved by the Board	Audit Wales/2025/287/MDA/8	Continue Medical Consultant surgeries using the Surgicare at POWN.	Chief Operating Officer	30/09/2025	30/09/2025	High	Partially complete (Overdue)	April 2026 Update - Completed Sept 2025 - Substantal eye underperform when clinically deemed appropriate.
Audit Wales/2025/287	01/11/2025	Eye Care Review, Care T&F Merginsing University Health Board, November 2025	84. The Health Board should urgently develop an eye care plan, writing to address current and future challenges. The Health Board should ensure the plan is: - based on current and projected future demand for services; - includes capacity plans based on realistically ambitious levels of productivity; - coded, as a minimum, for the medium term (3-5 years), supported by resource plans in financial, workforce (particularly medical staffing) and infrastructure, reflecting sustainable service models; - supported by clear delivery actions and milestones, and approved by the Board	Audit Wales/2025/287/MDA/9	Increased virtual clinics for medical retina and macular patients again increasing outpatient capacity.	Chief Operating Officer	28/02/2026	28/02/2026	High	Partially complete (Overdue)	April 2026 Update - Virtual clinics set up. Plan to establish a further 2 MBW virtual clinics to support H&C and MB WQDS pathways.
Audit Wales/2025/287	01/11/2025	Eye Care Review, Care T&F Merginsing University Health Board, November 2025	84. The Health Board should urgently develop an eye care plan, writing to address current and future challenges. The Health Board should ensure the plan is: - based on current and projected future demand for services; - includes capacity plans based on realistically ambitious levels of productivity; - coded, as a minimum, for the medium term (3-5 years), supported by resource plans in financial, workforce (particularly medical staffing) and infrastructure, reflecting sustainable service models; - supported by clear delivery actions and milestones, and approved by the Board	Audit Wales/2025/287/MDA/10	Redesign waiting list cards for better planning and high risk case identification.	Chief Operating Officer	30/09/2025	30/09/2025	High	Fully complete (Awaiting approval)	April 2026 Update - Working for red redesigned as part of the contract consultation. This incorporates risk stratification as per GBT recommendations. Completed. Agreed updates DCO 23.4.26.
Audit Wales/2025/287	01/11/2025	Eye Care Review, Care T&F Merginsing University Health Board, November 2025	84. The Health Board should urgently develop an eye care plan, writing to address current and future challenges. The Health Board should ensure the plan is: - based on current and projected future demand for services; - includes capacity plans based on realistically ambitious levels of productivity; - coded, as a minimum, for the medium term (3-5 years), supported by resource plans in financial, workforce (particularly medical staffing) and infrastructure, reflecting sustainable service models; - supported by clear delivery actions and milestones, and approved by the Board	Audit Wales/2025/287/MDA/11	Implement Medical Consultant SOP.	Chief Operating Officer	30/09/2025	30/09/2025	High	Fully complete (Awaiting approval)	April 2026 Update - Completed - attached. Also been agreed at Board level. Agreed updates DCO 23.4.26.

Audit Wales/2023/287	01/11/2025	Eye Care Review, Cwm Taf Morgannwg University Health Board, November 2025	R4. The health board should urgently develop an eye care plan, setting to address current and future challenges. The health board should ensure the plan is based on current and projected future demand for services. The report should include: - comprehensive overview of current ophthalmology waiting times; - information on avoidable harm suffered by patients as a result of waiting for treatment; - mitigating actions in place; and - outline of longer-term plans for eye care services.	Audit Wales/2023/287/MDA/12	Implementation of Service Improvement Group with focus on theatre utilisation, FHU / IOS and DNA visits.	Chief Operating Officer	30/06/2025	30/06/2025	High	Fully complete (Awaiting approval)	April 2026 update - Completed. Collective SSI for specialised services implemented July 2025. FHU, IOS and DNA monitored monthly on RCT outpatient programme. Agreed update QCOO 23.6.26.
Audit Wales/2023/287	01/11/2025	Eye Care Review, Cwm Taf Morgannwg University Health Board, November 2025	R5. Due to ongoing risks from long ophthalmology waits, an updated ophthalmology 'spiglit' report should be provided to the Quality, Safety and Experience Committee and/or the Operational Delivery Committee to support continued oversight and action. The report should include: - comprehensive overview of current ophthalmology waiting times; - information on avoidable harm suffered by patients as a result of waiting for treatment; - mitigating actions in place; and - outline of longer-term plans for eye care services.	Audit Wales/2023/287/MDA/15	Produce a Planned Care Report for the Quality, Safety & Experience Committee, covering waiting times, harm, mitigation, and long-term plans.	Chief Operating Officer	31/10/2025	31/10/2025	High	Partially complete (Overdue)	April 2026 update - Ophthalmology is featured as part of regular reporting within eye care group governance reporting structure, including updates requested and shared with QSEC, sharing updates with members of committees for their oversight, with one planned for June 2026.
Audit Wales/2023/287	01/11/2025	Eye Care Review, Cwm Taf Morgannwg University Health Board, November 2025	R5. Due to ongoing risks from long ophthalmology waits, an updated ophthalmology 'spiglit' report should be provided to the Quality, Safety and Experience Committee and/or the Operational Delivery Committee to support continued oversight and action. The report should include: - comprehensive overview of current ophthalmology waiting times; - information on avoidable harm suffered by patients as a result of waiting for treatment; - mitigating actions in place; and - outline of longer-term plans for eye care services.	Audit Wales/2023/287/MDA/17	Continue regular updates to SPO meetings with Welsh Government.	Chief Operating Officer	31/10/2025	31/10/2025	High	Partially complete (Overdue)	April 2026 update - SPO meetings currently under review following HSC framework review. However, the team have close engagement and support from MG colleagues to work towards the pathway and development to improve position and complete any WGO2. An update was formally shared with MG at the February 2025 SPO2 Panel on the shared framework.
Audit Wales/2023/287	01/11/2025	Eye Care Review, Cwm Taf Morgannwg University Health Board, November 2025	R5. Due to ongoing risks from long ophthalmology waits, an updated ophthalmology 'spiglit' report should be provided to the Quality, Safety and Experience Committee and/or the Operational Delivery Committee to support continued oversight and action. The report should include: - comprehensive overview of current ophthalmology waiting times; - information on avoidable harm suffered by patients as a result of waiting for treatment; - mitigating actions in place; and - outline of longer-term plans for eye care services.	Audit Wales/2023/287/MDA/19	Monitor reporting of harm and incidents through the Harm Review Panel, ensuring RCA and Duty of Candour processes are followed.	Chief Operating Officer	31/10/2025	31/10/2025	High	Partially complete (Overdue)	April 2026 update - The team have provided an update on the incidents reported and what was in progress to the review of the updates, noting that this is monitored and mitigated by the team.
Audit Wales/2023/287	01/11/2025	Eye Care Review, Cwm Taf Morgannwg University Health Board, November 2025	R5. Due to ongoing risks from long ophthalmology waits, an updated ophthalmology 'spiglit' report should be provided to the Quality, Safety and Experience Committee and/or the Operational Delivery Committee to support continued oversight and action. The report should include: - comprehensive overview of current ophthalmology waiting times; - information on avoidable harm suffered by patients as a result of waiting for treatment; - mitigating actions in place; and - outline of longer-term plans for eye care services.	Audit Wales/2023/287/MDA/14	Full implementation of WGO2 pathways (Gynaecoma, VMC, Independent Prescribing, HCO2) and monitor performance.	Chief Operating Officer	21/01/2026	21/01/2026	High	Partially complete (Overdue)	April 2026 update - Gynaecoma implemented 1st Feb - planning on going the May 24, HCO2 pathway agreed. DR further discussions for implementation taking place. IF cannot go ahead until open eyes rolled out in primary care.
Audit Wales/2023/287	01/11/2025	Eye Care Review, Cwm Taf Morgannwg University Health Board, November 2025	R5. Due to ongoing risks from long ophthalmology waits, an updated ophthalmology 'spiglit' report should be provided to the Quality, Safety and Experience Committee and/or the Operational Delivery Committee to support continued oversight and action. The report should include: - comprehensive overview of current ophthalmology waiting times; - information on avoidable harm suffered by patients as a result of waiting for treatment; - mitigating actions in place; and - outline of longer-term plans for eye care services.	Audit Wales/2023/287/MDA/15	Recruit the band 3 admin post to support WGO2 pathway implementation.	Chief Operating Officer	31/08/2025	31/08/2025	High	Overdue	April 2026 update - Appointed into but has handed in resignation. Job plan for coordinator with job matching panel. Interim staff will overtime agreed to support WGO2 pathways until substantive person is post.
Audit Wales/2023/287	01/11/2025	Eye Care Review, Cwm Taf Morgannwg University Health Board, November 2025	R5. Due to ongoing risks from long ophthalmology waits, an updated ophthalmology 'spiglit' report should be provided to the Quality, Safety and Experience Committee and/or the Operational Delivery Committee to support continued oversight and action. The report should include: - comprehensive overview of current ophthalmology waiting times; - information on avoidable harm suffered by patients as a result of waiting for treatment; - mitigating actions in place; and - outline of longer-term plans for eye care services.	Audit Wales/2023/287/MDA/16	Appointment of clinical lead in Ophthalmology and Ophthalmologist to lead on implementation of WGO2 pathways.	Chief Operating Officer	31/05/2025	31/05/2025	High	Fully complete (Awaiting approval)	April 2026 update - Complete - Phyllis fitted for substantiated lead and Ophthalmologist lead.
Audit Wales/2023/287	01/11/2025	Eye Care Review, Cwm Taf Morgannwg University Health Board, November 2025	R5. Due to ongoing risks from long ophthalmology waits, an updated ophthalmology 'spiglit' report should be provided to the Quality, Safety and Experience Committee and/or the Operational Delivery Committee to support continued oversight and action. The report should include: - comprehensive overview of current ophthalmology waiting times; - information on avoidable harm suffered by patients as a result of waiting for treatment; - mitigating actions in place; and - outline of longer-term plans for eye care services.	Audit Wales/2023/287/MDA/17	Launch HCO2 pathway and ensure transfer of identified patients to primary care.	Chief Operating Officer	30/11/2025	30/11/2025	High	Partially complete (Overdue)	April 2026 update - Pathway agreed. Awaiting update from primary care re practice, equipment, opportunities to undertake virtual clinics, agreed numbers.
Audit Wales/2023/287	01/11/2025	Eye Care Review, Cwm Taf Morgannwg University Health Board, November 2025	R5. Due to ongoing risks from long ophthalmology waits, an updated ophthalmology 'spiglit' report should be provided to the Quality, Safety and Experience Committee and/or the Operational Delivery Committee to support continued oversight and action. The report should include: - comprehensive overview of current ophthalmology waiting times; - information on avoidable harm suffered by patients as a result of waiting for treatment; - mitigating actions in place; and - outline of longer-term plans for eye care services.	Audit Wales/2023/287/MDA/18	Implement Gynaecoma pathway and manage referrals to ophthalmology practices.	Chief Operating Officer	31/10/2025	31/10/2025	High	Fully complete (Awaiting approval)	April 2026 update - Complete. Patient lists are sent from secondary care to ophthalmology practices weekly.
Audit Wales/2023/287	01/11/2025	Eye Care Review, Cwm Taf Morgannwg University Health Board, November 2025	R5. Due to ongoing risks from long ophthalmology waits, an updated ophthalmology 'spiglit' report should be provided to the Quality, Safety and Experience Committee and/or the Operational Delivery Committee to support continued oversight and action. The report should include: - comprehensive overview of current ophthalmology waiting times; - information on avoidable harm suffered by patients as a result of waiting for treatment; - mitigating actions in place; and - outline of longer-term plans for eye care services.	Audit Wales/2023/287/MDA/19	Continue weekly internal RRT meeting to monitor high risk subspecialties and monitor 10k week targets. Complete and activated.	Chief Operating Officer	31/12/2024	31/12/2024	High	Fully complete (Awaiting approval)	April 2026 update - Complete - ongoing weekly RRT meetings and achieving 10k weeks for all stages and all sub-specialties.
Audit Wales/2023/287	01/11/2025	Eye Care Review, Cwm Taf Morgannwg University Health Board, November 2025	R5. Due to ongoing risks from long ophthalmology waits, an updated ophthalmology 'spiglit' report should be provided to the Quality, Safety and Experience Committee and/or the Operational Delivery Committee to support continued oversight and action. The report should include: - comprehensive overview of current ophthalmology waiting times; - information on avoidable harm suffered by patients as a result of waiting for treatment; - mitigating actions in place; and - outline of longer-term plans for eye care services.	Audit Wales/2023/287/MDA/10	Validation of list of all high numbers of cataract patients are inappropriately categorised as R1. Internally agreed vetting prioritisation to mitigate against this risk.	Chief Operating Officer	31/12/2025	31/12/2025	High	Fully complete (Awaiting approval)	April 2026 update - Completed 2025. Validation of the waiting list is being undertaken and appropriate action taken by the team to ensure appropriate coding, allowed and added.
Audit Wales/2023/287	01/11/2025	Eye Care Review, Cwm Taf Morgannwg University Health Board, November 2025	R5. Due to ongoing risks from long ophthalmology waits, an updated ophthalmology 'spiglit' report should be provided to the Quality, Safety and Experience Committee and/or the Operational Delivery Committee to support continued oversight and action. The report should include: - comprehensive overview of current ophthalmology waiting times; - information on avoidable harm suffered by patients as a result of waiting for treatment; - mitigating actions in place; and - outline of longer-term plans for eye care services.	Audit Wales/2023/287/MDA/11	Update risk register as Risk to patients due to volume, waiting list and service demand is captured on the HSB generic Risk Register.	Chief Operating Officer	30/11/2025	30/11/2025	High	Partially complete (Overdue)	April 2026 update - Risk register updated and reviewed regularly, this can be reported from Data the risk management system.
Audit Wales/2023/287	01/11/2025	Eye Care Review, Cwm Taf Morgannwg University Health Board, November 2025	R5. Due to ongoing risks from long ophthalmology waits, an updated ophthalmology 'spiglit' report should be provided to the Quality, Safety and Experience Committee and/or the Operational Delivery Committee to support continued oversight and action. The report should include: - comprehensive overview of current ophthalmology waiting times; - information on avoidable harm suffered by patients as a result of waiting for treatment; - mitigating actions in place; and - outline of longer-term plans for eye care services.	Audit Wales/2023/287/MDA/12	Ensure Planned Care Group provides incident overview and NMs to the Quality, Safety & Experience Committee.	Chief Operating Officer	31/10/2025	31/10/2025	High	Fully complete (Awaiting approval)	April 2026 update - NM's duty of candour, UDR's, Rights of access through weekly and discussed at planned care governance meeting monthly. Agendas and incident available.
Audit Wales/2023/287	01/11/2025	Eye Care Review, Cwm Taf Morgannwg University Health Board, November 2025	R5. Due to ongoing risks from long ophthalmology waits, an updated ophthalmology 'spiglit' report should be provided to the Quality, Safety and Experience Committee and/or the Operational Delivery Committee to support continued oversight and action. The report should include: - comprehensive overview of current ophthalmology waiting times; - information on avoidable harm suffered by patients as a result of waiting for treatment; - mitigating actions in place; and - outline of longer-term plans for eye care services.	Audit Wales/2023/287/MDA/13	Develop and finalise SOP for Medical Review pathways and commence filtering once approved.	Chief Operating Officer	31/01/2025	31/01/2025	High	Partially complete (Overdue)	April 2026 update - SOP written colleagues. Awaiting feedback from primary care. Plan to go live with filtering pathway May 2026.
Audit Wales/2023/287	01/11/2025	Eye Care Review, Cwm Taf Morgannwg University Health Board, November 2025	R6. The health board should provide routine updates to an appropriate committee on its progress with implementing the ophthalmology GRIET recommendations.	Audit Wales/2023/287/MDA/15	Provide regular progress updates on GRIET implementation at Quality, Safety & Experience and Operational Delivery Committees.	Chief Operating Officer	31/10/2025	31/10/2025	High	Partially complete (Overdue)	April 2026 update - A highlight will be shared at the Improving Care Board in April 2026 and will feature here on a cycle of business as the reporting board for next oversight and evaluation. The updates will be shared as directed by members to QSEC.
Audit Wales/2023/288	01/10/2025	Urgent and Emergency Care: Arrangements for Managing Demand, October 2025 (Document reference: 4713A2025)	R1. Future Six Goals plans should clearly the use of the entirety of financial allocations.	Audit Wales/2023/288/MDA/17	Continue to track actions via the Operational Management Group, ensuring alignment with IMFP progress.	Chief Operating Officer	30/11/2025	30/11/2025	High	Partially complete (Overdue)	April 2026 update - Ongoing. Ophthalmology GRIET also sharing updates on Service Improvement Group.
Audit Wales/2023/288	01/10/2025	Urgent and Emergency Care: Arrangements for Managing Demand, October 2025 (Document reference: 4713A2025)	R2. To support the urgent delivery of Six Goals related initiatives, the health board should ensure that its Six Goals plans identify any funding needs beyond the current annual allocation.	Audit Wales/2023/288/MDA/15	Six Goals financial allocation covers various service provision across urgent and emergency care pathway. Detailed plans and financial allocation are produced annually and shared with both Performance and Improvement and subsequently with Welsh Government via national Six Goals Programme team.	Chief Operating Officer	31/01/2026	31/01/2026	High	Partially complete (Overdue)	April 2026 update - R1. 21/25 plans had detailed financial breakdowns of investment. Those investments have carried over to the 2027 allocation but are being reviewed by the QCOO and Programme Lead to ensure they are delivering against objectives of the programme. Financial breakdown can be shared if required as evidence.
Audit Wales/2023/288	01/10/2025	Urgent and Emergency Care: Arrangements for Managing Demand, October 2025 (Document reference: 4713A2025)	R2. To support the urgent delivery of Six Goals related initiatives, the health board should ensure that its Six Goals plans identify any funding needs beyond the current annual allocation.	Audit Wales/2023/288/MDA/15	Funding needs to support current Six Goals funding to ensure sustainable delivery of transformation across urgent and emergency pathway should be identified and described within care group Integrated Medium Term Plan (IMTP).	Chief Operating Officer	31/01/2026	31/01/2026	High	Overdue	April 2026 update - As per spreadsheet additional funding requirements should be detailed in the IMTP, where possible throughout 21/25 bid was made to the national team for further investment to enhance the work of the Six Goals. The investment: - 4x Capital Hospital flow fluctuations band 1-3 - 4x Additional points for high frequency releases - 4x Additional funding for 7 day GP coverage New Hub - 4x Hub equipment - 4x Hub training - 4x Hub contract extensions - 4x Hub review for the hub
Audit Wales/2023/288	01/10/2025	Urgent and Emergency Care: Arrangements for Managing Demand, October 2025 (Document reference: 4713A2025)	R3. To support achievement of the ambitions of its urgent and emergency care plans, the health board should clearly set out the current and future workforce requirements.	Audit Wales/2023/288/MDA/15	The Emergency and Acute Medicine Department are undertaking a comprehensive assessment of the current workforce capacity with the aim of outlining the additional roles, skills and staffing levels required to meet current and future service needs. A workforce review for emergency medicine in PCH was undertaken in November 2025, with review of PCH and R&G in quarter 4.	Chief Operating Officer	31/01/2026	31/01/2026	High	Partially complete (Overdue)	April 2026 update - R3. Workforce review has been undertaken for all 3 sites. A detailed output from this will be sought for the next update.
Audit Wales/2023/288	01/10/2025	Urgent and Emergency Care: Arrangements for Managing Demand, October 2025 (Document reference: 4713A2025)	R4. To ensure patient care is secure, relevant information quality and confidence, the health board should improve the visibility and accessibility of urgent and emergency care information on its main website homepages. This could include adding a clearly labelled, prominently positioned link to banners.	Audit Wales/2023/288/MDA/15	We will liaise with CTH Communications department to ensure that appropriate and clear information is accessible and visible to the public.	Chief Operating Officer	28/02/2026	28/02/2026	High	Overdue	April 2026 update - 12 MDT interim team discussion planned to review and either support closure or confirm the required further action with termed banners, desktop.
Audit Wales/2023/288	01/10/2025	Urgent and Emergency Care: Arrangements for Managing Demand, October 2025 (Document reference: 4713A2025)	R5. To ensure compliance with the national SDEC referral criteria and guidance, the health board should conduct an audit of its SDEC data and report the results to the appropriate committee.	Audit Wales/2023/288/MDA/15	The health board will utilise SAMRA platform to conduct SDEC audit across all three distinct general hospitals. In addition to this, national performance and improvement team conduct separate audits to provide a benchmarking analysis of findings and data. Recent audit was conducted in November 2025. CTH UHB is awaiting outcomes of the review.	Chief Operating Officer	31/01/2026	31/01/2026	High	Partially complete (Overdue)	April 2026 update - SDEC Action plan developed for delivery throughout Q3 & Q4, to be monitored through the Six Goals, Action Plan can be viewed as required.
Audit Wales/2023/288	01/10/2025	Urgent and Emergency Care: Arrangements for Managing Demand, October 2025 (Document reference: 4713A2025)	R6. To inform decision making, the health board should enhance its data collection to capture the clinical impact of alternative services, such as those accessed via the Navigation Hub.	Audit Wales/2023/288/MDA/15	The health board regularly (monthly) captures and analyses data from community services such as Navigation Hub to consider further service developments and implementation of new pathways. As a result of each review and analysis, new pathways: - Navigation Pathways and virtual care for patients with chronic COVID - Primary Pathways supporting GMS and presenting in community - Path Response Pathway - clinical assessment of people who feel in community and collaborative approach with local authorities' mobile responder teams	Chief Operating Officer	28/02/2026	28/02/2026	High	Partially complete (Overdue)	April 2026 update - Navigation Hub has developed a dashboard to capture all of the pathway's KPIs, updated regularly when additional work is included in their scope. This data is presented at each Programme Board, the dashboard and programme board pack will be evidence of this action.

Audit Wales/2023/208	01/10/2023	Urgent and Emergency Care: Arrangements for Managing Demand, October 2023 (Document reference: 031A2023)	R7: The Health Board should review and regularly validate the data that is currently available for urgent and emergency care, so more assurance can be taken when making decisions based on the data available.	Audit Wales/2023/208/MC1/5	The Health Board regularly reviews and validates urgent and emergency care data collected locally and nationally i.e. SICAT/GARF. As a result of such review and validation, an Urgent Treatment Centre was set up in Prince Charles Hospital, Merthyr Tydfil to support high demand of self-presenting patients with lower acuity who would be suitable to be seen by GPs. The service is based in proximity to ED which enables timely care and breast response and reduces number of patients waiting in ED.	Chief Operating Officer	03/02/2024	03/02/2024	High	Fully complete (standing approval)	Added to tracker February 2024. As per the report, this action is marked as Complete and will therefore be presented to the Audit, Risk & Assurance Committee in May 2024 as fully complete, awaiting approval.
Audit Wales/2023/208	01/10/2023	Urgent and Emergency Care: Arrangements for Managing Demand, October 2023 (Document reference: 031A2023)	R8: To ensure the Health Board is building on feedback from staff and patients, plans for urgent and emergency care should demonstrate how they have considered staff and patient feedback.	Audit Wales/2023/208/MC6/5	Reporting on PREMS is a key priority using QR Codes and an update on the analysis of the results is provided in Unscheduled Care Sixmonthly Quality, Safety, Risk and Patient Experience. The detail reports on updates from previous findings. The clinical areas include "Appointments boards", and "Triage staff" and "See and" and "See and". The allow is reported in the quarterly Progress to Excellence. Reported on the Local patient care meetings on Unscheduled Care discussing any improvement work. This was based on these areas and provide detailed feedback for practice and any issues that require immediate attention so that there is a proactive response from the MCT. Close working relationship with NHS and L&HC, where any issues identified are formally responded to with evidence of validated improvements. GARP Survey is key and Unscheduled Care compliance is the highest it has been over recent years currently at 28%.	Chief Operating Officer	21/03/2024	21/03/2024	High	Partially complete (Ongoing)	April 2024 Update - GARP has all been based on delivering against staff feedback of how they would like their services developed. The mode of delivery included workshops with the trade (product, nursing, A&E, How, right to design the service, throughout implementation daily touch point meetings are used to embed the changes and report out sessions are used to present back progress to all stakeholders to understand the impact of the changes, to hear any feedback. Staff feedback is ongoing as evidence.
Audit Wales/2023/208	01/10/2023	Urgent and Emergency Care: Arrangements for Managing Demand, October 2023 (Document reference: 031A2023)	R9: To strengthen its ability to join up strategic plans and service changes for its urgent and emergency care services, the Health Board should include WAST as a member of its SA South Delivery Board.	Audit Wales/2023/208/MC5/5	Six Sixmo Programme Board and its Terms of Reference produced at the inception of the programme had always taken a collaborative and partnership based approach to delivery of programme objectives with inclusion of stakeholders external to CMA L&HC such as WAST.	Chief Operating Officer	03/02/2024	03/02/2024	High	Fully complete (standing approval)	Added to tracker February 2024. As per the report, this action is marked as Complete and will therefore be presented to the Audit, Risk & Assurance Committee in May 2024 as fully complete, awaiting approval.

Inspection Code	Inspection Date	Inspection Title	Overall Assurance Rating	Recommendation	Reference Number	Action	Executive Lead	Original Due Date	Current / Revised Due	Action Rating	Progress Status	Comments/Updates
Internal Audit/2023/020	14/03/2023	Duty of Candour_March 2023 (Review reference: CTRM-008 2023-03)	Reasonable Assurance	1. Information and a link to the GSB Duty of Candour training module should be included on the Duty of Candour Intranet pages. Consideration should be given to identifying those staff that would most benefit from attending Duty of Candour training and direct communications to encourage participation. 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.	Internal Audit/2023/020/M00/L1	1.40 Duty of Candour Intranet pages to be updated to include links to training programmes.	Executive Director of Nursing, Midwifery & Patient Care	31/03/2023	31/03/2023	Low	Overdue	late October 2023, January, April 2024 update - No update against this recommendation has not been provided on their accounts.
Internal Audit/2023/020	14/03/2023	Duty of Candour_March 2023 (Review reference: CTRM-008 2023-03)	Reasonable Assurance	1. Information and a link to the GSB Duty of Candour training module should be included on the Duty of Candour Intranet pages. Consideration should be given to identifying those staff that would most benefit from attending Duty of Candour training and direct communications to encourage participation. 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.	Internal Audit/2023/020/M00/L2	1.40 Consideration of Duty of Candour training to be included in training plan for implementation of revised Putting Things Right regulations.	Executive Director of Nursing, Midwifery & Patient Care	31/10/2023	31/10/2023	Low	Overdue	late October 2023, January, April 2024 update - No update against this recommendation has not been provided on their accounts.
Internal Audit/2023/020	14/03/2023	Duty of Candour_March 2023 (Review reference: CTRM-008 2023-03)	Reasonable Assurance	2.2a 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 oversteering of harm levels is predominantly related to certain care groups or departments.	Internal Audit/2023/020/M00/L3	Monthly assessment of variations in harm levels to be undertaken and feedback provided monthly Care Group reports.	Executive Director of Nursing, Midwifery & Patient Care	30/06/2023	30/06/2023	Moderate	Overdue	late October 2023, January, April 2024 update - No update against this recommendation has not been provided on their accounts.
Internal Audit/2023/020	14/03/2023	Duty of Candour_March 2023 (Review reference: CTRM-008 2023-03)	Reasonable Assurance	2.2b 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.	Internal Audit/2023/020/M00/L3	Training in relation to assessment of harm to be included in training programme for implementation of revised Putting Things Right Regulations.	Executive Director of Nursing, Midwifery & Patient Care	31/10/2023	31/10/2023	Moderate	Overdue	late October 2023, January, April 2024 update - No update against this recommendation has not been provided on their accounts.
Internal Audit/2023/020	14/03/2023	Duty of Candour_March 2023 (Review reference: CTRM-008 2023-03)	Reasonable Assurance	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 Matrix stringing)	Internal Audit/2023/020/M00/L3	The Incident Management Framework to be updated to include information and guidance in relation to harm assessment and its application to Duty of Candour.	Executive Director of Nursing, Midwifery & Patient Care	31/05/2023	31/05/2023	Moderate	Overdue	late October 2023, January, April 2024 update - No update against this recommendation has not been provided on their accounts.
Internal Audit/2023/020	14/03/2023	Duty of Candour_March 2023 (Review reference: CTRM-008 2023-03)	Reasonable Assurance	3.2a Detailed operating procedures should be developed to set staff in ensuring the correct application of the Duty of Candour and the capture of essential information within the Data system. 3.2b Once produced, the procedures should be made accessible to staff via the Duty of Candour Intranet pages.	Internal Audit/2023/020/M00/L3	3.2a The Incident Management Framework to be updated to include flow charts in appendices to support the implementation of Duty of Candour and accurate completion of Data Cycles. 3.2b 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 Data.	Executive Director of Nursing, Midwifery & Patient Care	31/05/2023	31/05/2023	High	Overdue	late October 2023, January, April 2024 update - No update against this recommendation has not been provided on their accounts.
Internal Audit/2023/020	14/03/2023	Duty of Candour_March 2023 (Review reference: CTRM-008 2023-03)	Reasonable Assurance	3.2 A review of the current forms used within Data Cycles by the Health Board should take place with a view to reformatting the workstream approved forms in the system that have mandatory elements to both and prevent fields being left unpopulated.	Internal Audit/2023/020/M00/L3	Review of Data Cycles forms allocated to be undertaken and updated as required.	Executive Director of Nursing, Midwifery & Patient Care	30/06/2023	30/06/2023	High	Overdue	late October 2023, January, April 2024 update - No update against this recommendation has not been provided on their accounts.
Internal Audit/2023/020	14/03/2023	Duty of Candour_March 2023 (Review reference: CTRM-008 2023-03)	Reasonable Assurance	4.2 As part of the development of an SOP to provide clarity to staff on the capture of information, staff should be reminded of the importance of comprehensively and accurately completing the required fields in Data and using copies of relevant documents to the Data record. Staff should also be reminded of the timeframe of when key letters should be issued. (Though any appropriate achievement of the 30-day timeframe in complex investigations is difficult).	Internal Audit/2023/020/M00/L3	The Incident Management Framework to be updated to include flow charts in appendices to support the implementation of Duty of Candour and accurate completion of Data Cycles.	Executive Director of Nursing, Midwifery & Patient Care	31/05/2023	31/05/2023	Moderate	Overdue	late October 2023, January, April 2024 update - No update against this recommendation has not been provided on their accounts.
Internal Audit/2023/020	14/03/2023	Duty of Candour_March 2023 (Review reference: CTRM-008 2023-03)	Reasonable Assurance	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 delay.	Internal Audit/2023/020/M00/L3	Consult with Duty of Candour Network to identify best practice for management of complex cases and incorporate into Standard Operating Procedures.	Executive Director of Nursing, Midwifery & Patient Care	30/06/2023	30/06/2023	Low	Overdue	late October 2023, January, April 2024 update - No update against this recommendation has not been provided on their accounts.
Internal Audit/2023/020	14/03/2023	Duty of Candour_March 2023 (Review reference: CTRM-008 2023-03)	Reasonable Assurance	6.1 The Health Board should ensure the reports it allows for monitoring of Duty of Candour are in line with the standard reports produced by the GPF Central Team.	Internal Audit/2023/020/M00/L3	Review of reports produced in relation to Duty of Candour are in line with Once for Wales templates and reports.	Executive Director of Nursing, Midwifery & Patient Care	31/03/2023	31/03/2023	Moderate	Overdue	late October 2023, January, April 2024 update - No update against this recommendation has not been provided on their accounts.
Internal Audit/2023/020	14/03/2023	Duty of Candour_March 2023 (Review reference: CTRM-008 2023-03)	Reasonable Assurance	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 GPF Central Team. A regular review/built 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.	Internal Audit/2023/020/M00/L3	Review of 2023 / 2024 data to be completed and having identified to inform improvement action. Weekly review of closed records to be implemented and monitored via the weekly Quality & Safety data meeting.	Executive Director of Nursing, Midwifery & Patient Care	31/03/2023	31/03/2023	Moderate	Overdue	late October 2023, January, April 2024 update - No update against this recommendation has not been provided on their accounts.

AMaT Inspection Code	Title	Type	Date of Inspection	Executive Lead	Overall Assurance Rating	Recommendations	Action	Parent Inspection
Audit Wales/2023/144	Audit Wales Quality Governance Follow up Review, Audit and Risk Committee Update – CTMUHB August 2022 (Document reference: 12342017)	New	01/08/2023	Richard Hughes, Interim Executive Director of Nursing, Midwifery & Patient Care	N/A	7	7	
Audit Wales/2023/12	Transformational Leadership Programme Board – Baseline Governance Review – CTM Regional Partnership Board 2021-22, August 2022 (Document reference: 298442022)	New	01/08/2023	Claire Thompson, Executive Director of Strategy & Transformation	N/A	5	5	
Audit Wales/2023/149	Structured Assessment 2023 – CTMUHB 2023, October 2023 (Document reference: 43942023)	New	01/10/2023	Gareth Watts, Director of Corporate Governance & Board Secretary / Claire Thompson, Executive Director of Strategy & Transformation / Stuart Morris, Director of Digital	N/A	6	6	
Audit Wales/2023/118	Structured Assessment 2022 – CTMUHB 2022, February 2024 (Document reference: 43942023)	New	01/08/2023	Gareth Watts, Director of Corporate Governance & Board Secretary / Sally May, Executive Director of Finance / Claire Thompson, Executive Director of Strategy & Transformation / Stuart Morris, Director of Digital	N/A	8	8	
Audit Wales/2023/123	Orthopaedic Services in Wales – Tackling the Waiting List Backlog, Report of the Auditor General for Wales, March 2023	New	01/02/2024	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: 415242024)	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 Ybely Cwm Cynon Minor Injuries Unit – Cwm Taf Morgannwg University Health Board (Document reference: 41642024)	New	01/07/2024	Richard Hughes, Interim Executive Director of Nursing, Midwifery & Patient Care	N/A	1	2	
Audit Wales/2024/205	CONFIDENTIAL, Audit of Accounts Report Addendum, CTMUHB 2023-24, October 2024 (Document reference: 43942024)	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: 440642024)	New	30/11/2024	Gethin Hughes, Chief Operating Officer	N/A	6	12	
Audit Wales/2025/234	Structured Assessment 2024, CTMUHB 2024, November 2024 (Document reference: 457942024)	New	23/01/2025	Gareth Watts, Director of Corporate Governance & Board Secretary / Sally May, Executive Director of Finance / Claire Thompson, Executive Director of Strategy & Transformation / Richard Hughes, Interim Executive Director of Nursing, Midwifery & Patient Care / Gethin Hughes, Chief Operating Officer / Philip Daniels, Executive Director for Public Health	N/A	13	14	
Audit Wales/2025/271	CONFIDENTIAL Audit of Accounts Report Addendum, CTMUHB 2024-25, July 2025 (Document reference: 459942025)	New	01/07/2025	Sally May, Executive Director of Finance / Gareth Watts, Director of Corporate Governance & Board Secretary	N/A	5	5	
Audit Wales/2025/280	Tackling the Planned Care Challenges, June 2025 (Document reference: 466642025)	New	01/08/2025	Gethin Hughes, Chief Operating Officer	N/A	6	9	
Audit Wales/2026/287	Eye Care Review, Cwm Taf Morgannwg University Health Board, November 2025	New	01/11/2025	Gethin Hughes, Chief Operating Officer	N/A	6	30	
Audit Wales/2025/288	Urgent and Emergency Care: Arrangements for Managing Demand, October 2025 (Document reference: 471342025)	New	01/10/2025	Gethin Hughes, Chief Operating Officer	N/A	9	9	
Internal Audit/2020/65	Directorate review: Acute Medicine and A&E Directorate, Final Internal Audit Report July 2020 (Review reference: CTMUH 2020-23)	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: CTMUH 2020-23)	New	24/01/2020	Gethin Hughes, Chief Operating Officer	Reasonable Assurance	1	1	
Internal Audit/2021/200	Welsh Risk Pool Claims, Final Internal Audit Report May 2023 (Review reference: CTMUHB 2223-18)	New	31/05/2023	Richard Hughes, Interim Executive Director of Nursing, Midwifery & Patient Care	Reasonable Assurance	3	3	
Internal Audit/2021/203	Decarbonisation, Final Internal Audit Report August 2023 (Review reference: CTMUHB 2223-18)	New	08/08/2023	Richard Hughes, Interim Executive Director of Nursing, Midwifery & Patient Care	Reasonable Assurance	5	5	
Internal Audit/2021/213	National Incident Framework, Final Internal Audit Report August 2023 (Review reference: CTMUHB 2223-18)	New	08/08/2023	Richard Hughes, Interim Executive Director of Nursing, Midwifery & Patient Care	Reasonable Assurance	8	8	
Internal Audit/2021/217	Performance Reporting – Integrated Performance Report, Internal Audit Report July 2023 (Review reference: CTMUHB 2223-15)	New	28/07/2023	Claire Thompson, Executive Director of Strategy & Transformation / Stuart Morris, Director of Digital	Reasonable Assurance	2	2	
Internal Audit/2021/214	Follow-up: Concerns, Final Internal Audit Report May 2023 (Review reference: CTM 22/23-29)	New	31/05/2023	Richard Hughes, Interim Executive Director of Nursing, Midwifery & Patient Care	Reasonable Assurance	4	4	
Internal Audit/2021/246	Interventions Not Normally Undertaken (NNU), Final Internal Audit Report October 2023 (Review reference: CTMUHB 2223-15)	New	11/10/2023	Gethin Hughes, Chief Operating Officer / Dom Hurford, Executive Medical Director	Limited Assurance	8	8	
Internal Audit/2021/248	IT Infrastructure, Final Internal Audit Report October 2023 (Review reference: CTMUH 2224-18)	New	09/10/2023	Stuart Morris, Director of Digital	Reasonable Assurance	5	5	
Internal Audit/2021/262	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/2024/169	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 2324-08)	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/2024/188	Welsh Risk Pool Claims, Final Internal Audit Report, June 2024 (Review reference: CTMUHB 2324-14)	New	11/06/2024	Richard Hughes, Interim Executive Director of Nursing, Midwifery & Patient Care	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/2024/199	Intelligent 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	Richard Hughes, Interim Executive Director of Nursing, Midwifery & Patient Care	Reasonable Assurance	7	8	
Internal Audit/2024/202	Follow-up: Reasonable Offer, Final Internal Audit Report, October 2024 (Review reference: CTM 2324-20)	Re-inspection	02/10/2024	Gethin Hughes, Chief Operating Officer	Reasonable Assurance	4	4	Reasonable Offer Process, Internal Audit Report April 2023 (Review reference: CTMUHB 2223-04)
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/2025/232	Medical Job Planning, 2024/25 (Review reference: CTM 2425-17)	New	21/01/2025	Dom Hurford, Executive Medical Director	Limited Assurance	9	6	
Internal Audit/2025/250	Duty of Candour, March 2025 (Review reference: CTMUHB 2324-10)	New	31/03/2025	Richard Hughes, Interim Executive Director of Nursing, Midwifery & Patient Care	Reasonable Assurance	10	11	
Internal Audit/2025/251	Cancer Tracking Process, 2024/25 (Review reference: CTM 2425-02)	New	22/05/2025	Gethin Hughes, Chief Operating Officer	Reasonable Assurance	7	7	
Internal Audit/2025/252	Service User Experience, 2024/25 (Review reference: CTM 2425-13)	New	09/05/2025	Richard Hughes, Interim Executive Director of Nursing, Midwifery & Patient Care	Reasonable Assurance	1	1	
Internal Audit/2025/253	New Care Group Model, 2024/25 (Review reference: CTM 2425-01)	New	12/05/2025	Gethin Hughes, Chief Operating Officer	Reasonable Assurance	1	1	
Internal Audit/2025/257	Capital Systems, 2024/25 (Review reference: CTM 2425-18)	New	12/04/2025	Sally May, Executive Director of Finance	Limited Assurance	7	7	
Internal Audit/2025/258	Digital Benefits Realisation, 2024/25 (Review reference: CTM 2425/08)	New	15/05/2025	Stuart Morris, Director of Digital	Limited Assurance	4	4	
Internal Audit/2025/259	Follow-up: 4-hour Emergency Department Performance, March 2025 (Review reference: CTM 2425-18)	Re-inspection	27/03/2025	Gethin Hughes, Chief Operating Officer	Reasonable Assurance	6	6	4-hour Emergency Department Performance Reporting, Final Internal Audit Report February 2024 (Review reference: CTMUHB 2324-03)
Internal Audit/2025/263	Electronic Whiteboards, 2024/25 (Review reference: CTM 2425-11)	New	15/05/2025	Gethin Hughes, Chief Operating Officer	Reasonable Assurance	10	10	
Internal Audit/2025/266	Welsh Risk Pool, 2024/25 (Review reference: CTM 2425-14)	New	30/06/2025	Richard Hughes, Interim Executive Director of Nursing, Midwifery & Patient Care	Reasonable Assurance	6	6	
Internal Audit/2025/267	End of Life Care Management, 2024/25 (Review reference: CTM 2425-04)	New	13/06/2025	Gethin Hughes, Chief Operating Officer	Limited Assurance	4	4	
Internal Audit/2025/270	Decarbonisation (Follow up), 2025/26 (Review reference: CTM 2526-30)	Re-inspection	14/08/2025	Claire Thompson, Executive Director of Strategy & Transformation	Limited Assurance	4	4	Decarbonisation Internal Audit Report, April 2024 (Review reference: CTMUHB 2324-23)
Internal Audit/2025/279	Follow-up: Vaccination Policy Implementation, 2025/26 (Review reference: CTM 2526-28)	Re-inspection	13/11/2025	Philip Daniels, Executive Director of Public Health	Limited Assurance	1	1	Vaccination Policy Implementation, 2024/25 (Review reference: CTM 2425-22)
Internal Audit/2025/282	Clinical Coding, 2025/26 (Review reference: CTM 2526-09)	New	23/12/2025	Stuart Morris, Director of Digital	Reasonable Assurance	2	2	
Internal Audit/2025/283	Substance Management, 2025/26 (Review reference: CTMUHB-SSU-2526-20)	New	19/01/2026	Sally May, Executive Director of Finance	Reasonable Assurance	2	2	
Internal Audit/2025/284	Operational Response to Critical Incident, 2025/26 (Review reference: CTM 2526-04)	New	28/11/2025	Gethin Hughes, Chief Operating Officer / Claire Thompson, Executive Director of Strategy & Transformation	Reasonable Assurance	6	6	
Internal Audit/2026/285	Stroke Services, 2025/26 (Review reference: CTM 2526-16)	New	31/01/2026	Lauren Edwards, Executive Director of A&Ps and Health Science	Reasonable Assurance	3	3	
Internal Audit/2026/286	Discharge Planning, 2025/26 (Review reference: CTM 2526-31)	New	21/12/2025	Gethin Hughes, Chief Operating Officer / Julie Denby, Deputy Chief Operating Officer – Mental Health, Primary Care and Community Services	Limited Assurance	11	11	

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 Date	Inspection Title	Recommendation	Reference Number	Action	Executive Lead	Original Date	DATE OVERDUE	Current / Revised Date	Action Rating	Progress Status	Comments/Updates
Auth WtW/2021/04	08/06/2021	Auth WtW/2021/04 Quality Governance Follow Up Review 13.5 Issue three is evidence responsible for quality and patient safety across the executive team and clearly defined roles for professional leads. a) Strengthening of the role of the Medical Director and Clinical Director in relation to quality and patient safety b) Clarify the roles, responsibilities, accountability, and engagement in relation to quality and patient safety within the directorates c) Ensure there is sufficient capacity and support, in corporate and directorate level, dedicated to quality and patient safety	Auth WtW/2021/04/MD/01	Quality metrics including a greater breadth of HR services and functions, including paediatric health measures, have been agreed and reviewed at the TLO performance meeting. Quality & Safety Committee and Board. The new measures will allow, where possible, controls, targets and indicators to be developed and support the H&B benchmark against other sites.	Executive Director of Nursing, Midwifery & Patient Care	01/01/2021	14/09/2021	14/09/2024	High	Partially complete (Download)	Auth WtW/2021/04/MD/01 - An update against this recommendation has not been provided on these occasions. January 2025 Update - An Executive Director for quality and patient safety has taken place with the plan. With the Medical Quality Officer's expansion a greater breadth of the services and functions, including paediatric assessment of quality and patient safety information, patient safety reviews, compliance and outcomes and patient safety.
Auth WtW/2021/02	08/06/2021	Transformational Leadership Programme Board - Executive Governance Review 14 Our work focused areas of risk management that require 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 ongoing actions are robust and clearly articulated.	Auth WtW/2021/02/MD/01	Agreed within the new governance structure there will be an integrated resource group which will be tasked to develop the risk management framework.	Executive Director of Nursing, Midwifery & Patient Care	14/09/2021	11/12/2021	11/12/2024	High	Partially complete (Download)	Auth WtW/2021/02 - This is pending alignment with Audit Wales for closure and the update remains in place. The R&B is undertaking a full risk assessment of all schemes in 2027 and will hold a risk register. January 2025 Update - Progress is on track. Since this review was undertaken in 2021 there has been significant strengthening of regional working for example which is the approval of the Regional Partnership Agreement for Services and Support for Older People, Progress on with Frailty and their Centres of the Board meeting in July 2023, which required risk management arrangements/engagements. Our focus this work clearly with local areas, Integrated Services, Clinical and Professional Services, which are the programme and support the regional working. "Planning agreement with Audit Wales colleagues and therefore status currently remains unchanged. We anticipate that with the development of a shared risk register, the progress to risk management of the regional integration fund and the other mechanisms and in place since this was formalised by the Senior UK Agreement and strengthening of regional strategy and governance generally under the last round of plans, as well as the forthcoming cycle of regional Population Boards and Area Plans we will have addressed this recommendation and be able to close this at the next update cycle.
Auth WtW/2021/08	08/06/2021	Stratified Assessment 2021 - CTM408 22 February 2023 (Document reference: 4134204)	Auth WtW/2021/08/MD/01	a) HR plans and strategies will contain an essential summary writing out the information, a set of sub-headers, work is ongoing around outcome measures. b) Regional work will ensure that they responsible for the delivery of the plan will be clear and it is more visible. c) Regions will be reviewed to ensure they responsible for the delivery of the plan will be clear and it is more visible. d) Report will be reviewed to ensure they responsible for the delivery of the plan will be clear and it is more visible.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategic & Transformation Director of Digital	20/06/2021	10/02/2021	10/02/2024	High	Partially complete (Download)	Auth WtW/2021/08 - This is pending alignment with Audit Wales for closure and the update remains in place. The R&B is undertaking a full risk assessment of all schemes in 2027 and will hold a risk register. January 2025 Update - Progress is on track. Since this review was undertaken in 2021 there has been significant strengthening of regional working for example which is the approval of the Regional Partnership Agreement for Services and Support for Older People, Progress on with Frailty and their Centres of the Board meeting in July 2023, which required risk management arrangements/engagements. Our focus this work clearly with local areas, Integrated Services, Clinical and Professional Services, which are the programme and support the regional working. "Planning agreement with Audit Wales colleagues and therefore status currently remains unchanged. We anticipate that with the development of a shared risk register, the progress to risk management of the regional integration fund and the other mechanisms and in place since this was formalised by the Senior UK Agreement and strengthening of regional strategy and governance generally under the last round of plans, as well as the forthcoming cycle of regional Population Boards and Area Plans we will have addressed this recommendation and be able to close this at the next update cycle.
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Audit Wides/2025/287	03/1/2025	Eye Care Review, Cam Tef Morganwg University Health Board, November 2025	85. Due to ongoing info from long ophthalmology with, an updated ophthalmology "spotlight" report should be provided to the Quality, Safety and Experience Committee and/or the Operational Delivery Committee to support continued oversight and action. The report should include: - comprehensive overview of current ophthalmology waiting times - information on available from referred-by patients as a result of waiting for treatment; - mitigating actions in place, and - quality of longer-term plans for eye care services.	Audit Wides/2025/201/MSU/13	Develop and finalise SOP for Media pathway and commence filtering once approved.	Chief Operating Officer	31/01/2025	601	31/01/2025	High	Partially complete (Overdue)	April 2026 Update: SOP written colleagues. Awaiting feedback from primary care. Plan to go live with filtering pathway May 2026.
Audit Wides/2025/288	03/1/2025	Urgent and Emergency Care: Arrangements for Managing Demand, October 2025 (Document reference: 4713A3025)	82. To support the ongoing delivery of Six Goals related initiatives, the Health Board should ensure that its Six Goals plans identify any funding needs beyond the current annual allocation.	Audit Wides/2025/208/MSU/1	Funding needs to support current Six Goals funding to ensure sustainable delivery of transformation across urgent and emergency pathway should be identified and described within care group's "Integrated Medium-Term Plan (IMTP)".	Chief Operating Officer	31/09/2026	27	31/09/2026	High	Overdue	April 2026 Update: As per spreadsheet additional funding requirements should be detailed in the IMTPs. Where possible throughout 24/25 beds were made to the national team for further investment to enhance the work of the Six Goals. This included: - 48 Optimal Hospital Flow Facilities boards a 3 - additional staff for high frequency arrivals. - additional funding for 7 Day GP coverage from hubs (which is required) - 6000s funding
Audit Wides/2025/288	03/1/2025	Urgent and Emergency Care: Arrangements for Managing Demand, October 2025 (Document reference: 4713A3025)	83. To support achievement of the ambitions of its urgent and emergency care plans, the Health Board should clearly set out the current and future workforce requirements.	Audit Wides/2025/208/MSU/1	The Emergency and Acute Medicine Directorate are undertaking a comprehensive assessment of the current workforce capacity with the aim of enabling the additional roles, skills and staffing/beds required to meet current and future service needs. A workforce review for emergency medicine in FCI was undertaken in November 2025, with reviews of EDW and R&D aspects in quarter 4. Acute medicine workforce requirements are being reviewed as part of the Strategic Transformation of Acute Medicine Programme (STAMP).	Chief Operating Officer	31/09/2026	37	31/09/2026	High	Partially complete (Overdue)	April 2026 Update: 83. Workforce reviews have been undertaken for all 3 sites. A detailed output from this will be sought for the next update.
Audit Wides/2025/288	03/1/2025	Urgent and Emergency Care: Arrangements for Managing Demand, October 2025 (Document reference: 4713A3025)	85. To ensure compliance with the national SDEC referral criteria and guidance, the Health Board should conduct an audit of its SDEC data and report the results to the interpretation committee.	Audit Wides/2025/208/MSU/1	The Health Board will utilise SMMB platform to conduct SDEC audit across all three distinct general hospitals. In addition to this, national performance and improvement team conducts separate audits to provide a benchmarking analysis of findings and data. Recent audit was conducted in November 2025, CTM Unit is awaiting outcomes of the review.	Chief Operating Officer	31/09/2026	27	31/09/2026	High	Partially complete (Overdue)	April 2026 Update: SDEC Action plan developed for delivery throughout Q2 & Q3, to be monitored through the Six Goals, Action Plan can be viewed at request.
Audit Wides/2025/288	03/1/2025	Urgent and Emergency Care: Arrangements for Managing Demand, October 2025 (Document reference: 4713A3025)	86. To ensure the Health Board is building on feedback from staff and patients, plans for urgent and emergency care should demonstrate how they have considered staff and patient feedback.	Audit Wides/2025/208/MSU/1	Reporting on PRIDE is a key priority using QR Codes and an update on the analysis of the results is provided in Unscheduled Care Monthly Quality, Safety, Risk and Patient Experience. The detailed report on updates from previous findings. The critical areas include: Appointment Booking, and "You don't feel like you're being listened to" and "You don't feel like you're being listened to". The actions to respond to the quality, Patient's Experience, Reported via the Local partnership meeting, with Unscheduled Care de-identified improvement work. PRIDE can assist in these areas and provide detailed feedback from patients and staff across their reported immediate experiences that come in a structured manner from the MET. Close working relationship with HRH and L&AS, where any issues identified are formally responded to with evidence of sustained improvements. Staff survey is key and Unscheduled Care compliance is the highest it has been over recent years currently at 98%.	Chief Operating Officer	31/09/2026	27	31/09/2026	High	Partially complete (Overdue)	April 2026 Update: STAMP has all been based on delivering against staff feedback of how they would like their services developed. The needs of delivery included workshops with the beds (medical, nursing, admin, flow, etc) to design the service, throughout implementation daily touch point meetings are used to embed the changes and report out sessions are used to present back progress to all stakeholders to understand the impact of the changes, to hear any feedback, staff feedback is captured as evidence.
Audit Wides/2025/288	03/1/2025	Urgent and Emergency Care: Arrangements for Managing Demand, October 2025 (Document reference: 4713A3025)	84. To ensure that patients can locate relevant information quickly and confidently, the Health Board should improve the visibility and accessibility of urgent and emergency care information on its main website homepage. This could include adding a clearly labelled, prominently positioned link or banner.	Audit Wides/2025/208/MSU/1	We will liaise with CSM Communications department to ensure that appropriate and clear information is accessible and visible to the public.	Chief Operating Officer	28/02/2026	18	28/02/2026	High	Overdue	April 2026 Update: 83 MET senior team discussion planned to review and either suggest issues or confirm the required further action with named deadlines identified.
Audit Wides/2025/288	03/1/2025	Urgent and Emergency Care: Arrangements for Managing Demand, October 2025 (Document reference: 4713A3025)	86. To inform decision making, the Health Board should enhance its data collection to capture the clinical impact of alternative services, such as those accessed via the Navigation Hub.	Audit Wides/2025/208/MSU/1	The Health Board regularly monitors outcomes and analyses data from community services such as Navigation Hub to consider further service developments and implementation of new pathways. As a result of such review and analysis, new pathway: Respiratory pathway and virtual care for patients with chronic COPD. Podiatry pathway supporting GPs and providing in community. Early Response pathway - critical assessment of people who did in community and collaborative approach with local authorities' mobile responder teams.	Chief Operating Officer	28/02/2026	18	28/02/2026	High	Partially complete (Overdue)	April 2026 Update: Navigation Hub has developed a dashboard to capture all of the pathway it develops, updated regularly when additional work is included in their scope. This data is presented at each Programme Board, the dashboard and programme board pack will be evidence of this action.
Audit Wides/2025/288	03/1/2025	Urgent and Emergency Care: Arrangements for Managing Demand, October 2025 (Document reference: 4713A3025)	85. Future Six Goals plans should clarify the use of the entirety of financial allocations.	Audit Wides/2025/208/MSU/1	Six Goals financial allocation covers various service provision across urgent and emergency care pathways. Detailed plans and financial allocations are produced annually and shared with local Performance and Improvement and subsequently with Welsh Government via national Six Goals Programme team. 2025/2026 delivery plans and financial allocation are currently subject to WSG review and decision on future planning and delivery of ministerial priorities. Updated requirements for delivery of urgent and emergency care priorities will be released on 28th December 2025.	Chief Operating Officer	31/01/2026	86	31/01/2026	High	Partially complete (Overdue)	April 2026 Update: As 2026 plans had detailed financial breakdowns of resources. These requirements have spread over to the 2027 allocation but are being reviewed by the SCSO and Programme Lead to ensure they are delivering against objectives of the programme. Financial breakdown can be shared if required as evidence.

[illegible]

[illegible]

[illegible]

Internal Audit/0000346	12/02/2024	Recommendation Not Necessarily Underpinned (NNU), Final Internal Audit Report (October 2023) (Review reference: 1704000-223-01)	Control Assurance	Implementations of Necessarily Underpinned 1.5 The policy, and an associated SOP, should provide greater clarity on whether the SOPs can be used for those interventions that are listed as 'Not Met' and the related process to follow.	Internal Audit/0000346/NNU/1	Aggregation of the above actions	Executive Medical Director Chief Operating Officer	01/01/2024	807	01/01/2024	On track	Overdue	April 2024 update - regional and national policy is being updated as part of a national group policy will be discussed once approved. One group medical director has ensured all services are compliant with current policy in the interim.
Internal Audit/0000348	06/06/2024	National Incident Framework, Post-incident Audit Report (April 2023) (Review reference: 1704000-223-05)	Process Assurance	National Incident Framework 2.5 The staff training needs analysis should be formal and staff or care teams should be requested to identify who needs to attend incident management training and PCA training. As part of the process of identifying staff training needs, consideration should be given to whether training on BME is required.	Internal Audit/0000348/NNU/1	A training strategy to be developed which outlines all levels of training in relation to incident and disaster management for different staff groups across the health board. The board should reference to BME topics requirements. Following approval of the strategy, a training needs analysis will be undertaken and a training programme established.	Executive Director of Nursing, Midwifery & Patient Care	01/01/2024	808	26/01/2024	On track	Partially complete (Overdue)	December 2023 update - following implementation of the aggregate policy there will be a review of this compliance. June, October 2024, January, April 2025 update - to update against this recommendation has not been provided on these occasions.
Internal Audit/0000349	06/06/2024	Decontamination, Final Internal Audit Report August 2023 (Review reference: 1704000-223-06)	Process Assurance	Decontamination 5.1 Management plan to ensure that there is a dedicated Microbiologist (Decontamination) update for Processes of Waste site as soon as practically possible.	Internal Audit/0000349/NNU/1	Decontamination is the responsibility of the Medical Director and escalated to the first PMR Executive meeting (17/01/2024). The dedicated microbiologist has been assigned to the role. The dedicated microbiologist will ensure the programme of work required to meet an appropriate reduction outcome. The dedicated microbiologist will ensure the programme of work required to meet an appropriate reduction outcome. The dedicated microbiologist will ensure the programme of work required to meet an appropriate reduction outcome.	Executive Director of Nursing, Midwifery & Patient Care	01/01/2024	809	01/01/2024	On track	Overdue	April 2024 update - An update against this recommendation has not been provided on these occasions. January 2024 update - in response to the following action as of 01/01/24 the management will be put in place to ensure that there is a dedicated Microbiologist (Decontamination) in place for Processes of Waste site as soon as practically possible. This action has been escalated up the chain and will be the dedicated Microbiologist for Processes of Waste hospital when resources in progress. January 2024 update - Decontamination Decontamination will start in 2024 for PMR provision of decontamination services. + PMR provision of decontamination services will start in 2024 for PMR provision of decontamination services. + PMR provision of decontamination services will start in 2024 for PMR provision of decontamination services.
Internal Audit/0000350	29/07/2024	Decontamination Review Audit Medicines & A&B Directorate, Final Internal Audit Report July 2023 (Review reference: 1704000-223-07)	Process Assurance	Decontamination Review Audit Medicines & A&B 5.1 An overview of the impact of the decontamination review audit, detailing their assets, which fit under the definition of inventory as described within the Patient Control Procedures	Internal Audit/0000350/NNU/1	It is accepted that this is an on-going process and this will need to be provided by the C&G general manager during 2024. The review supporting staffing structure are in place.	Chief Operating Officer	01/01/2024	810	01/01/2024	High	Overdue	April 2024 update - To have this during the year group will link with their clinical governance team to ensure a risk of all care capital equipment and a further review will be shared with the PM of decontamination to provide a process update. January 2024 update - An update against this recommendation has not been provided on this occasion.
Internal Audit/0000352	01/07/2024	Follow up Controls, Post-incident Audit Report May 2023 (Review reference: 1704000-223-08)	Process Assurance	Controls Follow Up Review 5.1 In order for the Controls Follow Up Review to be completed, the following needs analysis work should be completed in order to identify the training requirements across the Health Board, including effective training for those that have been previously completed training on previous policies and procedures. 5.2 An overview of the impact of the Controls Follow Up Review audit, detailing their assets, which fit under the definition of inventory as described within the Patient Control Procedures	Internal Audit/0000352/NNU/1	It is Training Needs Analysis to be developed and sent to all Care Manager to identify staff which require training. It is to ensure the training needs analysis has been completed, the staff will be identified and the training programme will be developed and sent to all Care Manager to identify staff which require training. It is to ensure the training needs analysis has been completed, the staff will be identified and the training programme will be developed and sent to all Care Manager to identify staff which require training.	Executive Director of Nursing, Midwifery & Patient Care	01/01/2024	811	01/01/2024	On track	Partially complete (Overdue)	June, October 2024, January, April 2025 update - to update against this recommendation has not been provided on these occasions.
Internal Audit/0000358	01/07/2024	Watch Risk Post Closure, Final Internal Audit Report May 2023 (Review reference: 1704000-223-10)	Process Assurance	Watch Risk Post 1.1 Management should ensure that staff are aware of accurately recording date information within data to allow the calculation of target dates and monitoring.	Internal Audit/0000358/NNU/1	It is to staff will be reminded of importance in next meeting in regard of closure. It is to Management should ensure that staff are aware of accurately recording date information within data to allow the calculation of target dates and monitoring.	Executive Director of Nursing, Midwifery & Patient Care	01/01/2024	812	01/01/2024	On track	Partially complete (Overdue)	April, June, October 2024, January, April 2025 update - An update against this recommendation has not been provided on these occasions. January 2024 update - An audit tool for validation of open report dates has been developed and run as a weekly task. Clinical and medical databoards are being developed to support the timely identification of open reports on date. Further audits of open and closed cases will commence in February 2024. Revised implementation date aligned to date of audit for assurance.
Internal Audit/0000359	01/07/2024	Watch Risk Post Closure, Final Internal Audit Report May 2023 (Review reference: 1704000-223-11)	Process Assurance	Watch Risk Post 1.2 Management should ensure that staff are aware of accurately recording date information within data to allow the calculation of target dates and monitoring.	Internal Audit/0000359/NNU/1	Staff will be reminded of the importance of accurately recording date information within data and ensuring it is reflected on documents submitted to WMP. The recording of WMP information will be included in the audit and data validation programme described in action 1.6.	Executive Director of Nursing, Midwifery & Patient Care	01/01/2024	813	01/01/2024	On track	Partially complete (Overdue)	April, June, October 2024, January, April 2025 update - An update against this recommendation has not been provided on these occasions. January 2024 update - and following, due to operational demands, and staff availability, the Medical Databoards yet to be completed. Anticipated date value for completion is now 15 March 2024.
Internal Audit/0000360	29/07/2024	Decontamination Review Audit Medicines & A&B Directorate, Final Internal Audit Report July 2023 (Review reference: 1704000-223-07)	Process Assurance	Decontamination Review Audit Medicines & A&B 5.1 An overview of the impact of the decontamination review audit, detailing their assets, which fit under the definition of inventory as described within the Patient Control Procedures	Internal Audit/0000360/NNU/1	The review of patient and procedures needs to be undertaken on each audit site and it is acknowledged that this is an area of concern with focused attention needed over the next months. There also needs to be clear guidance from the C&G on the process for the approval of policies and procedures in the new operating model.	Chief Operating Officer	01/01/2024	814	01/01/2024	On track	Overdue	April 2024 update - Clinical policies/OP procedures have been developed and the care group have been advised of this. January 2024 update - An update against this recommendation has not been provided on this occasion.

Cwm Taf Morgannwg University Health Board

Audit, Risk & Assurance Committee Internal Audit Progress Report

May 2026

NWSSP Audit and Assurance Services

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Appendix A – Tables showing detailed progress against audit plans



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

Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit, Risk and Assurance 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 13 May 2026. This report provides information on the status of progress of our reviews.
- 1.2 We report the progress made to date against individual assignments both for the Health Board and Joint Commissioning Committee (JCC), along with details regarding the delivery of the plans and any required updates.

2 Report summary

- 2.1 The current position of our programme of work for the Health Board and the JCC is summarised as:

Table 1: Summary of position

Status	CTM Number	JCC Number	Note
Final	17	1	-
Draft	4	1	-
Work in progress	8	1	CTM – Two are concluding.
Planning /Planned	-	-	-
Not started	-	-	-
Defer	7	-	-
Total	36	3	-

- 2.2 A summary of the position of the reports finalised since the last Committee, including a summary of number of recommendations, is provided in Table 2 below.

Table 2: Summary of finalised reports

Assignments	High	Medium	Total	Assurance rating
Princess of Wales - Roof replacement	-	3	3	Substantial
Long terms strategy	1	3	4	Reasonable
Speaking up Safely	-	3	3	Reasonable
Bridgend disaggregation	1	1	2	Reasonable

Assignments	High	Medium	Total	Assurance rating
Cyber security	-	2	2	Reasonable
PCH Phase 2 (section 7) – Target cost	-	3	3	Reasonable
Falls prevention management	-	4	4	Reasonable
Savings – Centrally led programmes	3	3	6	Limited
Medical Variable Pay – Additional Duty Hours – follow up	-	4	4	N/A
Estates condition - follow up	1	1	2	N/A

3 Summary of finalised substantial, reasonable or non-opinion audit reports included in Audit Committee papers

3.1 In this section of the report, we summarise our key findings from the finalised reports identified above in table 2 that have been given either a substantial or reasonable assurance opinion. We have also summarised our follow up reports.

Princess of Wales roof replacement

The Health Board declared a critical incident as a result of leakages in the roof coverings at PoW hospital. The first floor of PoW was decanted, closing multiple areas including operating theatres, intensive care, endoscopy facilities, and multiple wards. Due to the nature of the critical incident the Health Board in conjunction with its advisers, quickly costed the roof replacement works and multiple other work packages including the upgrade to the Intensive care unit, and refurbishment of theatres. We made three medium priority key findings and issued a substantial assurance opinion, primarily reflecting the project’s strong overall performance.

Long term strategy

The message and branding of CTM2030 (the long term strategy) has been at the heart of the Health Board’s strategic direction and is considered to be broadly understood both internally and externally, although there is no single document that portrays the future vision of CTM2030 in more detail. Instead, CTM2030 is underpinned and supported by a number of strategic delivery plans. We identified one high priority key finding in relation to the development of an overarching or summary document. We also made three medium priority recommendations. Overall, we issued a reasonable assurance opinion.

Speaking up safely

The framework was issued by Welsh Government in September 2023 and states that ‘organisations, departments and teams are required to follow in order to establish and sustain a culture where no individual will suffer victimisation or

detrimental treatment as a result of speaking up, and where organisations learn and improve as a result of listening and responding to concerns raised’. Having effective arrangements which enable staff to speak up (also referred to as ‘raising a concern’) helps to protect patients, the public and the NHS workforce, as well as helping to improve the population’s experience of healthcare. We concluded reasonable assurance on this area with three medium priority matter requiring management attention.

Bridgend disaggregation

We have concluded reasonable assurance on this area. We identified one high priority finding in relation to duplicated patient records within the merged Welsh Patient Administration System (WPAS), and one medium priority finding. A post implementation review has been undertaken, along with a transition into business as usual. The review included identification of lessons which have been communicated within Digital. The Health Board now has a single WPAS with all appropriate data transferred following full testing, and the project considered and reduced operational variations in practice.

Cyber security

We confirmed that risks are being managed appropriately, we highlighted that gaps in controls identified through the Cyber Assessment Framework (CAF) risk assessment could indicate distinct risks to the organisation that are not being recorded in line with the organisation’s risk management procedure. We saw that work to strengthen the organisation’s cyber security posture was progressing. We identified two medium priority recommendations and issued reasonable assurance opinion.

PCH Phase 2 (section 7) – Target cost

Section 7 of the works was added within Phase 2 to aid the development of a Full Business Case (FBC) for Phase 3. This section included the establishment of a target cost under the contract, which is central to the justification and financial planning for the FBC. We made three medium priority findings and issued a reasonable assurance opinion.

Falls prevention management

We have concluded reasonable assurance on this area and identified four medium priority findings. We confirmed that there are good governance arrangements in place for overseeing falls prevention work. Actions have been agreed in relation to the falls policy, training participation, the completion of falls risk assessments and lessons learnt.

Follow up – Additional duty hours

In December 2024 we issued a ‘limited assurance’ opinion in relation to Additional Medical Pay and covered Additional Duty Hours (ADH) and Waiting List Initiatives (WLI). Our follow up as focussed on ADH where eight high or medium priority findings were identified, with 15 actions to address the matters arising. (A separate re-audit is being in relation to the WLI elements). Our follow-up review, undertaken

in February 2026 confirmed that the majority of actions had been implemented or partially implemented, with four residual actions to be implemented.

Follow up - Estates condition

In May 2025 we issued a 'limited assurance' opinion related to the Health Board's arrangements to manage risks associated with its estate. Our report identified six high or medium priority findings, and management agreed actions to address the risks associated with our findings. Our follow up review, undertaken in March 2026, confirmed that four of the agreed actions had been appropriately implemented, with ongoing work for the other two agreed actions.

4 Performance reporting

- 4.1 We monitor aspects of the Internal Audit service and report this information in our annual report. We also report performance during the year at Audit Committee.
- 4.2 Our agreed performance indicators, as at the time of this progress report, are set out in table 3 below:

Table 3 – Performance Indicators 2025/26 (ex. JCC)

Indicator	Status	Actual	Target	Red	Amber	Green
Report turnaround: time from fieldwork completion to draft reporting [10 days]	Green	100% (21/21)	95%	v>20%	10%<v ≤20%	v≤10%
Report turnaround: time taken for management response to draft report [15 days per Internal Audit Charter]	Red	35% (6/17)	80%	v>20%	10%<v ≤20%	v≤10%
Report turnaround: time from management response to issue of final report [10 days]	Green	100% (17/17)	95%	v>20%	10%<v ≤20%	v≤10%

5 Other activity

Joint Commissioning Committee (JCC)

- 5.1 We have agreed a programme of work for 2025/26 with officers of the JCC (Appendix A – Table 6). We have finalised one review, one review is in draft, and we have ongoing fieldwork for a third review.

Meetings

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

Appendix A – Programme of work**Table 4: Core programme of work**

Plan Ref.	Review	Rating	Review period	AC	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
30	Follow up - Decarbonisation	N/A	Q2	Aug	Final	Y	Y	-
29	Follow up – Vaccination policy implementation	N/A	Q2	Nov	Final	Y	Y	-
N/A	Discharge planning	Limited	Q1	~~Aug~~ Feb	Final	Y	N	-
9	Clinical coding	Reasonable	Q1	~~Aug~~ Feb	Final	Y	N	-
4	Operational response to critical incident	Reasonable	Q1	~~Aug~~ Feb	Final	Y	N	-
16	Stroke	Reasonable	Q2	~~Nov~~ Feb	Final	Y	N	-
20	Estates assurance – Asbestos Management	Reasonable	Q2	~~Nov~~ Feb	Final	Y	N	-
15	Long term strategy	Reasonable	Q4	Feb	Final	Y	N	-

Plan Ref.	Review	Rating	Review period	AC	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
19	PoW roof replacement	Substantial	Q3	~~Nov~~ May	Final	Y	Y	-
18	Savings	Limited	Q2	~~Nov~~ May	Final	Y	N	-
10	Cyber security	Reasonable	Q3	May	Final	Y	N	-
11	Digital – Bridgend disaggregation	Reasonable	Q3	May	Final	Y	N	-
6	Speaking up safely	Reasonable	Q4	May	Final	Y	Y	-
27	Estates assurance - follow up	N/A	Q4	May	Final	Y	Y	-
24	Follow up – Medical Variable Pay – Additional Duty Hours	N/A	Q3	~~Feb~~ May	Final	Y	N	-
13	Falls prevention management	Reasonable	Q3	~~Feb~~ May	Final	Y	Y	-
1	Individually commissioned packages of care	Reasonable	Q1	~~Nov~~ May	Draft	Y	-	Draft issued 27.03.26

Plan Ref.	Review	Rating	Review period	AC	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
7	Risk management	Reasonable	Q3	~~Feb~~ May	Draft	Y	-	Draft issued 18.03.26, revised draft 08.05.26
2	Outpatient booking process	Reasonable	Q3	May	Draft	Y	-	Draft issued 07.05.26
5	Medical sickness records (Advisory)	-	Q2	~~Nov~~ May	Draft	Y	-	Fieldwork completed and file reviewed. Draft report to be issued imminently.
12	Welsh risk pool	-	Q4	May	WIP	-	-	Auditor capacity due to delays in other reviews.
14	Ward audits	-	Q4	May	WIP	-	-	Auditor capacity
23	Medical job planning - re-audit	-	Q4	May	WIP	-	-	Auditor capacity. Fieldwork completed and file being reviewed.
25	Interventions not normally used (INNU) re-audit	-	Q4	May	WIP	-	-	Delays in receiving data required to undertake audit.
	Additional Medical Pay – Waiting List Initiatives - re-audit	-	Q4	May	WIP	-	-	Auditor capacity. Additional work due to change in system.

Plan Ref.	Review	Rating	Review period	AC	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
26	Capital systems – follow up	-	Q4	-	Defer	-	-	As at May, a number of the agreed actions were open so unable to follow up.
17	Financial systems	-	Q4	-	Defer	-	-	Proposed brief required involvement from People directorate who did not have capacity to support the audit at current time
22	Re-audit - Gastro-Intestinal demand management	-	Q3	-	Defer	-	-	CTM advise can't support the audit until at least April.
3	Medical annual leave and rostering	-	Q4	-	Defer	-	-	Held scoping meeting on 08.01.26. Scope overlap with Medical Sickness audit
08	Establishment of new committee structure	-	Q4	-	Defer	-	-	Audit Wales have considered as part of their structured assessment. Remove to avoid duplication.
21	End of life care management re-audit	-	Q4	-	Defer	-	-	Agreed actions not due until 2026/27. So defer until actions complete.

Plan Ref.	Review	Rating	Review period	AC	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
28	Digital benefits realisation – follow up	-	Q4	-	Defer	-	-	Agreed actions not due until 2026/27. So defer until actions complete.

Table 5: PCH programme of work for 2025/26

Plan Ref.	Review	Rating	Review period	AC	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
1	Section 7 – Development of target cost	Reasonable	Q3	May	Final	Y	N	-
2	Assessment of community benefits	-	Q4	May	WIP	-	-	Awaiting further information.
3	Deep dive into the final account	-	Q4	May	WIP	-	-	-
4	Annual assessment	-	Q4	May	WIP	-	-	-

Table 6: Joint Commissioning Committee (JCC) 2025/26

Ref.	Review	Rating	Status	Notes
1	High cost drugs	-	WIP	Fieldwork has commenced
2	Individual Patient Funding Requests (IPFR)	Substantial	Final	-
3	Strategic planning	-	Defer	To form part of the 26/27 plan
4	Budget management	Reasonable	Draft	Draft report issued 11.05.26

Savings - centrally led programmes

Final Internal Audit Report

2025/26

Cwm Taf Morgannwg University Health Board



Limited Assurance

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Review Reference

CTM-2526-18

Fieldwork

October – January 2026

Executive Sign Off

April 2026

Audit Committee

May 2026

Executive Lead

Hywel Daniel, Executive Director of People

Audit Team

Paul Dalton, Head of Internal Audit

Emma Samways, Deputy Head of Internal Audit



Executive Summary

Purpose

Our audit review of the centrally led savings programmes has been undertaken in line with the 2025/26 Internal Audit plan for Cwm Taf Morgannwg University Health Board (the 'Health Board' or CTM).

The Health Board continues to face significant financial pressures as it works to deliver high-quality care within a constrained funding environment. For the 2025/26 financial year, the Health Board has set a savings target of £31.3 million to achieve a balanced financial position, reflecting the growing need for sustainable cost reduction and operational efficiency.

To support delivery of this target, the Health Board established four centrally led savings programmes that will be responsible for achieving £9.6m of the overall target. The programmes focus on:

- Medical workforce.
- Nursing workforce.
- Internal service reconfiguration.
- Patient-centred contact through digital enablement.

We understand a fifth savings programme relating to procurement has recently started, but at the time of our fieldwork, it was in its infancy.

Recent reviews by us and Audit Wales have highlighted challenges in embedding a consistent approach to savings planning and implementation. We have previously reported inconsistent documentation practices including gaps in project planning, risk and quality impact assessments, and the application of savings guidance.

For this review, we tested the governance, planning, and monitoring arrangements for two of the Health Board's savings programmes: the medical workforce productivity programme; and the nursing workforce productivity programme. The medical workforce productivity programme comprises of eight workstreams including Additional Duty Hours and agency spend, rota reviews and compliance and job planning completion. The nursing workforce productivity programme is structured around two workstreams, though these are broken down into five sub-workstreams including absence management, shift pattern alignment and bank operating model.

Overview

We have concluded Limited assurance on this area. The matters requiring management attention are:

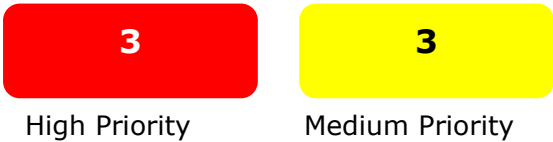
- Programme delivery plans, risk registers, and core planning documents are incomplete, reducing accountability and assurance over savings delivery.
- Centrally led savings programmes were mobilised late and without a documented methodology, limiting early planning and delivery. Identified savings schemes fall short of programme targets, leaving significant gaps unlikely to be closed in-year.
- There is insufficient alignment between operational workstreams of each programme and financial targets, limiting the ability to track and demonstrate savings delivery.
- Data integrity and timeliness issues across workforce and finance systems undermine confidence in reported savings and decision-making.
- Centrally led savings workstreams rely on Care Group delivery, but unclear ownership and savings attribution reduce accountability and limit assurance over their delivery.
- Operational improvements are not consistently translated into financial savings, creating a risk of double counting and no single source of truth.

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

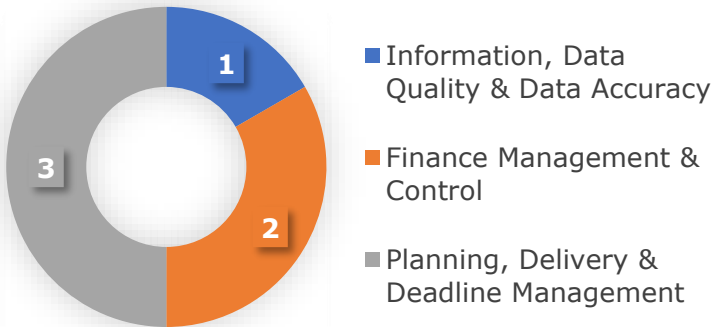
Scope & Assurance Summary

Objectives	The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.	Related Findings	Assurance
1	Governance arrangements are in place that support the planning, delivery and monitoring of the centrally led savings programmes. Updated guidance and documentation requirements for savings schemes are in place and have been embedded and applied consistently across the Health Board.	1	Limited
2	Agreed work plans are in place for the centrally led programmes, setting out the desired achievements, leads and timeframes. Suitable data is available to allow effective decisions to be made in relation to action plan implementation.	2, 3, & 4	Limited
3	Care group savings schemes are aligned with and contribute to the centrally led programmes in a coordinated approach.	5 & 6	Limited
4	Appraisal and monitoring of the delivery of progress against each programme takes place, with effective scrutiny and remedial actions taken where targets are not on track.	4	Reasonable

Management Actions



Themes



Risk Types

Financial Loss
Quality or Safety Issues

Findings & Agreed Action Plan

Objective 1: Governance arrangements are in place that support the planning, delivery and monitoring of the centrally led savings programmes. Updated guidance and documentation requirements for savings schemes are in place and have been embedded and applied consistently across the Health Board.

Limited

We confirmed that the Health Board has established a formal governance framework to oversee the delivery of centrally led savings programmes. The Savings Delivery Programme Oversight Group (SDPOG) meet monthly and provide assurance and escalate matters to the Executive Management Board (EMB) and the Health Board’s Operational Delivery Committee (ODC). The EMB receives programme updates alongside monthly finance reports, while the ODC undertakes quarterly scrutiny through formal savings presentations that include information on targets, risks, and assurance ratings relating to the programmes.

The medical and nursing workforce productivity programmes each have dedicated boards that provide programme level oversight. The boards meet each month to review progress against agreed trajectories. In addition, fortnightly operational huddles support the programmes by bringing together relevant operational, workforce and finance leads to review performance and agree remedial actions for programme slippage. They provide a mechanism for maintaining momentum in-between the formal board meetings. Roles and responsibilities are clearly defined, with Senior Responsible Officers (SROs), finance leads, workforce leads, and Project Management Office (PMO) support embedded within the structure.

While these arrangements provide the oversight of programmes once operational, there appears to have been delays in mobilising the programme workstreams, with key governance, data and performance enablers not in place at the start of the year and still maturing during the year. Furthermore, we saw no documentation setting out the planning process that programmes should follow when identifying and evaluating potential workstreams to produce savings targets. **(Key Finding 1)**

At the time of our fieldwork, the identified workstreams fell significantly short of the savings target set for the year for each programme. The medical savings programme identified viable saving schemes of £623k against a £3m year-end target, and the nursing programme had identified savings of £547k against a £4m target. While remedial actions are agreed and tracked through action logs and the fortnightly huddles, their impact had not closed the gap.

We understand that the Health Board is reviewing and refining the governance framework to streamline reporting lines and further clarify accountability with an aim to strengthen oversight and improve responsiveness to delivery risks.

Key Findings		Risk & Impact	Agreed Management Action
1	Governance arrangements for planning and under identification of savings schemes The medical and nursing workforce savings programme boards were not operational at the start of the financial year. Governance structures were established later, with the programme boards’ terms of reference not approved until the summer of 2025. However, from the start of the year, programme teams were required to begin identifying key leads and gather relevant data. This reactive approach constrained	Late mobilisation and unclear allocation approach reduce planning time, increasing risk of under-delivery and failure to meet savings targets.	Agreed Action: Ensure that centrally led savings programmes are in a position to mobilise at the start of the financial year. This should include: - Establishing and formally approving programme boards, terms of reference, and key roles in advance of the financial year. - Developing and implementing documented guidance for programme boards on the identification, appraisal, and prioritisation of savings workstreams.

early planning activity and meant there was initially a lack of clarity on the approach to identifying savings. We also note the lack of formally documented guidance for programme boards to follow when identifying and evaluating potential workstreams, further reducing consistency, transparency, and clarity of expectations for operational teams during the early planning stages. At the time of our review, the medical programme had identified approximately £623k against a target of £3m. However, only £243k of savings had been delivered. The nursing programme had identified around £547k of schemes against a target of £4m, with approximately £224k of savings delivered to date.	High Priority	Expected Evidence of Implementation: Documented governance timelines, ratified terms of reference, and complete delivery plans available by April for all centrally led programmes. Guidance in place for programmes to follow to aid the identification and appraisal of potential workstreams.
Theme: Planning, Delivery & Deadline Management		Officer: Hywel Daniel - Executive Director for People Target Implementation Date: May 2026

There is no documented planning method for programmes to follow when appraising potential workstreams. As such, we saw no evidence to explain the rationale for the eight medical and five nursing workstreams as being the most suitable workstreams to meet savings targets. This includes documentation such as Project Initiation Documents (PID) or quality impact assessments for the chosen workstreams. Without these documents, it is unclear how viability and impact were assessed prior to mobilisation, or how individual workstreams were intending to contribute to savings targets. **(Key Finding 2)**

The requirements of the workstreams are set out in programme work plans, but the work plans for medical and nursing workforce productivity were not complete or consistent. We saw differences between the workstreams captured in the work plans and those reported in board papers. The work plans we saw lacked key details, such as task ownership, progress updates, and defined start and end dates. **(Key Finding 2)**

Both programmes set out objectives focused on workforce efficiency and cost reductions, but the financial targets for the individual workstreams were not always captured and there were inconsistencies in key documents. **(Key Finding 3)**

While finance and workforce teams provide enabling support, reliance on data sourced from multiple systems (HealthRoster, ESR, Allocate, Locums Nest) that do not fully integrate, alongside delays in data provision, could undermine confidence in reported savings and decision-making. **(Key finding 4)**

Whilst monthly programme boards review progress and operational huddles provide a mechanism for addressing slippage, the absence of fully populated plans and inconsistent reporting limits assurance that milestones are achievable within the remaining timeframe.

Key Findings		Risk & Impact	Agreed Management Action
2	Missing programme and workstream planning documentation Our review identified gaps in programme documentation across both the medical and nursing workforce programmes. There was limited documentation setting out the rationale for the selection of individual workstreams or how these aligned to the overall programme objectives and savings trajectories. While workstreams had been identified and progressed, there was no consolidated record evidencing option appraisal, prioritisation criteria, or assessment of deliverability. In addition, we did not see evidence of workstream specific Project Initiation Documents (PIDs), Quality Impact Assessments (QIAs), and risk assessments. These documents typically define scope, objectives, governance, and financial targets for workstreams.	Unclear objectives, weak accountability, and difficulty evidencing how savings targets will be achieved. Limited assurance that programmes were properly scoped and assessed for viability and impact, increasing the likelihood of under-delivery.	Agreed Action: Ensure that programme documentation is complete and consistent, including: • Document and approve the rationale for the selection and prioritisation of programme workstreams, including the criteria used, consideration of alternative options, assessment of deliverability. • Fully populated delivery plans with task owners, timelines, and progress status. • Comprehensive risk registers with trend indicators, mitigation actions, and escalation routes. • Workstream-specific PIDs, QIAs, and risk assessments developed and approved prior to mobilisation, setting out scope, objectives, workstream structure with indicative monetary targets, governance arrangements, and quality impact considerations.

	Delivery plans contained gaps such as missing task owners, progress status, and start/end dates, making it difficult to track accountability and timelines. Risk registers were incomplete, as they lacked trend indicators, mitigation actions, and escalation routes for several high-impact risks.		Expected Evidence of Implementation: • Documented rationale for the selection and prioritisation of programme workstreams, including alignment to programme objectives and savings trajectories, and evidence of approval through the appropriate programme governance route. • Updated delivery plans and risk registers presented in programme board packs, showing full details and regular progress updates. • Approved PID, QIA, and risk assessment documents for workstreams of each programme. • Evidence of review and ratification by programme boards and SDPOG before programme go-live.
		High Priority	Officer: Programme Senior Responsible Officers Target Implementation Date: May 2026
	Theme: Planning, Delivery & Deadline Management	Control Operation	
3	Lack of clarity and alignment between workstreams and financial targets We saw inconsistencies in programme documentation for the medical workforce programme. The delivery plan lists six workstreams (excluding governance), while the 'plan on page' presented to SDPOG references eight, with two workstreams, Workforce Systems and SAS, not appearing in the delivery plan. We were unable to confirm the monetary savings target for each workstream within either programme. While overall programme targets are set (£3m for medical and £4m for nursing), there is no documented breakdown showing how individual workstreams are expected to contribute to these totals.	Risk that programmes cannot demonstrate how planned actions will achieve savings. This reduces accountability and makes monitoring progress against targets difficult.	Agreed Action: Ensure programme documentation includes: • A complete and consistent list of workstreams. • Defined monetary savings targets for each workstream. • Alignment between operational plans and financial plans, reviewed and ratified by programme boards. Expected Evidence of Implementation: Updated Delivery Plans and Plan on Page documents showing consistent workstream lists. Documented financial breakdown by workstream. Evidence of review and approval by programme boards and SDPOG.
		Medium Priority	Officer: Hywel Daniel - Executive Director for People Target Implementation Date: June 2026
	Theme: Planning, Delivery & Deadline Management	Control Operation	

4	Data reliability and timeliness We understand that data reliability and timeliness of data provision remain significant challenges for both the Medical and Nursing Workforce Productivity Programmes. Programme boards rely on accurate workforce and financial data to monitor progress and make informed decisions. However, that data is sourced from multiple systems, including HealthRoster, ESR, Allocate and Locums Nest, where integration gaps affect data reliability. Delays in data provision were repeatedly highlighted in productivity board packs as missing or late updates for key metrics such as bank shifts, agency usage, and rate card compliance. For example, as of December 2025, the Medical Workforce Programme was awaiting a series of workforce related reports that had been requested in late September.	Poor data quality and delays reduce decision-making effectiveness, increasing risk of inaccurate reporting and failure to achieve savings targets.	Agreed Action: Implement a data assurance plan, including system integration improvements, timeliness standards, and validation checks, to ensure accurate and complete workforce and financial data is available for programme monitoring and decision-making.
			Expected Evidence of Implementation: Documented data assurance plan, agreed timeliness standards, and evidence of validated, complete datasets presented in programme board reporting packs.
		High Priority	Officer: Andrew Jones (Acting Deputy Director of Finance), Natalie Price (Assistant Director, Strategic Workforce Planning)
	Theme: Information, Data Quality & Data Accuracy	Control Design	Target Implementation Date: July 2026

While programme boards provide oversight of centrally led workstreams, delivery of these schemes is largely reliant on care groups. At the same time, care groups are responsible for delivering their own local savings schemes, some of which appear to overlap with centrally led programmes. The governance structures provide mechanisms for alignment where there is an overlap between the care groups savings schemes and the centrally led programmes, as care groups submit monthly highlight reports to the medical and nursing workforce programme boards. These reports detail workforce metrics, financial performance and action plans, which are consolidated into programme level reports. Programme boards review the reports alongside workstream updates and finance summaries, showing care group activity within the broader savings context. However, the savings targets for workstreams delivered by the care groups and the centrally led programmes are not clearly defined. We found that arrangements to clearly define ownership, accountability and attribution of savings between care groups and centrally led programmes were not consistently documented, making it difficult to determine where savings were delivered and how they contributed to programme targets. **(Key Finding 5)**

Furthermore, although some operational measures, such as job planning compliance and establishment gap reductions, are tracked, these have not been assigned financial savings values. This means programme boards cannot accurately determine what proportion of savings will be delivered through these improvements or assess their contribution to overall targets. Programme boards monitor and escalate issues, but they do not directly control delivery; accountability for achieving savings rests with care groups. **(Key Finding 6)**

Data quality issues compound these challenges. Delays and inconsistencies in workforce reporting make it difficult to assess whether care group actions are contributing effectively to programme objectives. **(See Key Finding 5)**

Key Findings		Risk & Impact	Agreed Management Action
5	Lack of clarity over ownership and accountability for savings delivery Although the savings workstreams within both programmes are centrally led, delivery of these schemes is largely dependent on implementation at care group level. Care groups are responsible for enacting changes required to realise savings arising from centrally defined workstreams, alongside delivering locally developed savings schemes aligned to their own financial targets. Our review found that the respective roles of centrally led programmes and care groups in the delivery and ownership of savings are not clearly defined or consistently documented. In particular, where care group led schemes overlap with or support centrally led workstreams, there is limited clarity over which	Absence of a single source of truth and financial linkage reduces transparency, increasing risk of inaccurate reporting and missed savings targets.	Agreed Action: Clarify and document accountability arrangements for the delivery and reporting of savings arising from centrally led workforce productivity workstreams implemented at Care Group level. This should include: - Clearly defining ownership for delivery and financial reporting purposes where workstreams span centrally led programmes and Care Group activity. - Agreeing how savings will be attributed, validated and reported to avoid duplication or omission. - Ensuring Care Group delivery responsibilities and contribution to centrally led priorities are explicitly reflected within programme reporting and governance processes.

	programme or care group is accountable for delivery and where realised savings should be attributed and reported. This lack of clarity makes it difficult for programme boards to accurately assess progress, understand the true contribution of care groups to centrally led priorities, and obtain assurance that savings are being fully captured without duplication or omission. It also reduces accountability for delivery, as responsibility for outcomes is dispersed across multiple forums and reporting routes.		Expected Evidence of Implementation: • Documented allocation of ownership for delivery and reporting of savings for centrally led workstreams, including where delivery occurs at Care Group level. • Agreed and applied approach to savings attribution, demonstrating how Care Group-led activity supporting centrally led schemes is recorded, validated and reported. • Updated programme and Care Group reporting packs showing consistent attribution of savings and clear linkage between centrally led workstreams, Care Group actions and financial outcomes.
		Medium Priority	Officer: Hywel Daniel Target Implementation Date: July 2026
	Theme: Finance Management & Control	Control Design	
6	Financial links between operational metrics and savings targets Our review found that while operational metrics such as job planning compliance and establishment gap reductions are tracked within programme reporting, these measures have not been translated into financial savings values. This creates a disconnect between operational improvements and their contribution to overall savings targets. Programme boards can see progress in workforce efficiency indicators, but without assigning monetary values, it is unclear what proportion of the savings will come from these changes. Additionally, attribution rules between care groups and centrally led programmes are not defined, and there is no formal process for validating or reconciling reported savings against baseline positions.	Absence of a single source of truth and financial linkage reduces transparency, increasing risk of inaccurate reporting and missed savings targets.	Agreed Action: Develop a benefits modelling framework that assigns financial values to key operational metrics and implement clear attribution rules, supported by a single reconciled source of truth for savings reporting.
		Medium Priority	Expected Evidence of Implementation: Documented benefits modelling framework and consolidated reporting process, with financial values linked to operational metrics and reconciled savings data.
	Theme: Finance Management & Control	Control Design	Officer: Andrew Jones Target Implementation Date: July 2026

Objective 4: Appraisal and monitoring of the delivery of progress against each programme takes place, with effective scrutiny and remedial actions taken where targets are not on track.

Reasonable

We confirmed that there are forums in place for reporting on the delivery of progress against each of the programmes. The arrangements include the fortnightly huddles, monthly programme board meetings, monthly Savings Delivery Programme Oversight Group meetings and quarterly Operational Delivery Committee meetings.

Our review of the updates taken to both the medical and nursing productivity programme boards confirmed that both contain information from the care group relating to the respective workstreams and progress in meeting targets. The updates also contain action logs of matters raised in previous meetings. The logs set out the actions required to enable the workstreams to make progress in achieving their targets.

In September and October 2025, the SDPOG recognised the delivery challenges facing both programmes and commissioned deep-dive reviews. These deep dives identified a range of challenges and remedial actions which are tracked through action logs and reviewed at programme huddle meetings. The work undertaken to perform the deep dives also highlighted the issues with data integrity and timeliness, which undermines confidence in the reported progress. Without accurate, timely data, programme boards cannot fully appraise delivery or prioritise interventions. **(See Key Finding 5)**

In summary, while governance structures and reporting mechanisms exist, the gaps in scheme identification, benefit modelling and data reliability, reduce the effectiveness of monitoring and remedial action.

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

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

Disclaimer

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

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.



Internal Audit Plan

2026/27

Cwm Taf Morgannwg University Health Board

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1. Introduction

This document sets out the Internal Audit Plan for 2026/27 (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. 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 2026/27. 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). 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 2026/27

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 apprised 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.

In addition, we are in discussion with the NHS Wales Joint Commissioning Committee about a programme of work for 2026/27. When agreed, an appendix to this plan will be produced and presented to the Audit Committee.

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 2026/27 and:

- approve the Internal Audit Plan for 2026/27;
- 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 2026/27

Planned output, Outline scope, Review reference		Risk reference	Executive Lead/Responsible Director	Planned quarter to start
1	Neurodevelopment services: To consider governance and oversight of pathways (children and/or adults). Demand, capacity and waiting list controls; referral management and prioritisation. Quality standards and outcomes measurement; patient experience and feedback. Reporting: accuracy and completeness of ND performance and risk reporting.	SR2	Chief Operating Officer	Q1
2	Urgent and Acute medicine - application of standard model: To consider the application of the standard operating model across sites. Governance: arrangements performance monitoring.	SR1b	Chief Operating Officer	Q2
3	Trauma pathway - Possible areas to consider: pathway governance and compliance with agreed standards (pre/post-operative). Timeliness and coordination: referral, transfer, theatre access, bed management. Safety controls: handover, consent documentation governance, peri-operative risk controls. Outcome monitoring: complications, readmissions, length of stay, patient experience. Interface with orthopaedics/anaesthetics/theatres and discharge/rehab pathways.	SR1b	Chief Operating Officer	Q2
4	Primary care – Dentistry: To consider delivery against improvement plans and key performance indicators.	SR11	Chief Operating Officer	Q3
5	IMTP delivery: To consider governance for IMTP delivery: ownership, controls, reporting and assurance. Milestone and benefits tracking: accuracy of progress reporting, exception management. Risk and issue management: escalation routes to committees/Board. To sample review a small number of IMTP programmes from plan → delivery evidence.	SR1	Director of Strategy and Transformation / Chief Operating Officer	Q3

Planned output, Outline scope, Review reference		Risk reference	Executive Lead/Responsible Director	Planned quarter to start
6	Care Group and Corporate directorate Governance arrangements: To consider governance structure effectiveness. Clarity of accountabilities, escalation pathways and assurance reporting. Consistency of governance across a sample of agreed directorates.	SR2/ ORR 6217	Director of Strategy and Transformation	Q4
7	Estates assurance: Focus to be agreed.	SR6	Director of Finance	Q3
8	Finance – Budgetary control and governance: To consider budget setting, accountability letters, reporting lines, escalation. Budgetary control: forecasting, variance management.	SR9	Director of Finance	Q2
9	Staff overpayments: To consider controls relating to prevention, recovery, and governance and accountability.	-	Director of Finance / Director of People	Q2
10	Medical sickness – policy compliance: To consider compliance with policy, including triggers and referrals to OH. Governance and reporting arrangements.	SR3	Medical Director / Director of People / Chief Operating Officer	Q3
11	Software development: To consider governance (approvals, requirements capture, clinical input and sign off process), Security, data governance, benefits and performance monitoring post release.	SR5 / ORR 5040	Director of Digital	Q1
12	Electronic Prescribing Medicines Administration: To consider governance, clinical safety, access and control medicines workflow, access, training, data integrity, benefits realisation.	SR5 / ORR 5040	Director of Digital	Q2
13	Risk management: To consider alignment of committee structure with strategic risks and key assurances. Ensuring terms of reference and committee reporting meets the requirements of the Board Assurance Framework and the associated strategic risks.	Cross cutting	Director of Governance	Q4

Planned output, Outline scope, Review reference		Risk reference	Executive Lead/Responsible Director	Planned quarter to start
14	Harm free governance: Possible areas of focus to include governance arrangements for harm-free care programmes. Data and reporting: definitions, quality of incident coding, and dashboards. Oversight and learning: how actions are identified, implemented, and tracked; spread of learning. Reporting of assurance. Compliance with relevant national standards and policy.	SR2	Director of Nursing, Midwifery and Patient Care	Q2
15	Welsh Risk Pool: Annual review	ORR 6229	Director of Nursing, Midwifery and Patient Care	Q4
16	Nurse staff rostering: To consider governance arrangements such as, approvals, safe staffing controls, audit trails. Establishment control: funded vs actual, shift fill, bank/agency usage triggers. Data quality: roster-to-pay integrity, exceptions, and error correction controls. Training and adoption: user competence, super-user model, system controls.	SR3	Director of Nursing, Midwifery and Patient Care	Q1
17	Mortality – governance arrangements: To consider governance arrangements: committee oversight, roles, escalation, reporting, and policies and procedures. To consider interactions with medical examiner service. Learning and improvement: action tracking, thematic reporting, sharing learning across sites	SR2	Medical Director	Q4
Follow up work				
18	Follow up – Gastro-Intestinal demand management re-audit: Previous year limited assurance report.	-	Chief Operating Officer	Q1
19	Follow up - Patient pathways - re-audit: Previous year limited assurance report.	-	Chief Operating Officer	Q1

Planned output, Outline scope, Review reference		Risk reference	Executive Lead/Responsible Director	Planned quarter to start
20	Follow up – Digital benefits realisation: Previous year limited assurance report.	-	Director of Digital	Q2
21	Follow up - End of life care management re-audit: Previous year limited assurance report.	-	Chief Operating Officer	Q2
22	Follow up – Savings re-audit: Previous year limited assurance report.	-	Director of People	Q3
23	Follow up – Discharge planning re-audit: Previous year limited assurance report.	-	Chief Operating Officer	Q3
24	Follow up - Capital systems: Previous year limited assurance report.	-	Director of Finance	Q3
Other activity				
NHS Wales - Joint Commissioning Committee (JCC) We have worked with the JCC to identify a programme of work for 2026/27 (see Annex)		-	-	-
Integrated Audit and Assurance plans				
Management of Prince Charles Hospital capital project Part of separate Integrated Audit & Assurance Plan (IAAP).		-	Director of Finance	Q1-Q4
Management of Llantrisant Health Park capital project Part of separate Integrated Audit & Assurance Plan (IAAP).		-	Director of Finance	Q1-Q4

Appendix B: Key performance indicators (KPI)

KPI	SLA required	Target 2026/27
Audit plan 2026/27 agreed/in draft	✓	To deliver plan
Audit opinion 2025/26 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, insight and foresight.

- 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 requirements 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 2026

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.

Annex to the Cwm Taf Morgannwg University Health Board Annual Internal Audit Plan 2026/27

May 2026

NHS Wales Joint Commissioning
Committee (JCC)



GIG
CYMRU
NHS
WALES

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



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Disclaimer notice – Please Note

This annex to the annual internal audit plan has been prepared for internal use only.

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1. Introduction

The NHS Wales Joint Commissioning Committee ('the JCC') is a hosted body of Cwm Taf Morgannwg University Health Board ('the Health Board') and was established in April 2024.

This document sets out an annex to the NHS Internal Audit risk-based Plan for the Health Board in 2026/27 (the 'Plan'), detailing the work to be undertaken. This document should be read in conjunction with the Health Board's Internal Audit plan for 2026/27. The Plan will be delivered in accordance with the Internal Audit Mandate and Charter.

2. The Internal Audit Plan

The NHS Internal Audit work related to the JCC is made up of:

1. Audits agreed directly with the JCC

This year we plan to look at:

1. Strategic planning – To consider the approach to the development of the IMTP. Work to be undertaken between October and December 2026.
2. Risk management arrangements – To consider the new assurance framework. Work to be undertaken between July and September 2026.
3. Escalation processes – To consider the process and quality assurance arrangements for managing the escalation process. Work to be undertaken between July and September 2026.
4. Contract monitoring arrangements – To consider management of performance in relation to long term agreements (LTAs). Work to be undertaken between May and June 2026.

The scope, objectives and timing will be refined in each area as identified when developing the audit scope in discussion with the responsible director and operational management.

2. Audits undertaken as part of NWSSP's Internal Audit plan that will include testing of the JCC.

The Plan includes assurance audits on some services that are provided by NWSSP on behalf of NHS Wales, for example accounts payable and payroll. These audits are part of the risk-based programme of work for NWSSP, but the results are reported to the relevant organisations.

The audits that will be relevant for the JCC will be identified when the NWSSP audit plan has been agreed.

For each of these audits a sample will be picked for the Health Board, and that sample will include the JCC.

These audits are reported to the Velindre Audit Committee for NWSSP and

then shared more widely with NHS Wales organisations. They are also listed as part of the Head of Internal Audit Opinion and Annual Report for the Health Board.

3. Action required

The Audit, Risk and Assurance Committee is invited to consider and approve the annex to the Health Board's Internal Audit Plan for the JCC for 2026/27.

Paul Dalton

Head of Internal Audit (Cwm Taf Morgannwg University Health Board)
Audit & Assurance Services
NHS Wales Shared Services Partnership

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

Date issued: May 2026



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

Introduction

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 2026 Audit Plan to the Committee on 19 May 2026.

We also provide additional information on:

- other relevant examinations and studies published by the Auditor General; and
- relevant corporate documents published by Audit Wales (e.g., fee schemes, annual plans, annual reports), as well as details of any consultations underway.

Accounts audit update

Audit of the 2025-26 Annual Report and Accounts

- **Executive Lead:** Executive Director of Finance
- **Focus of the work:** to provide an audit opinion on the Health Board's 2025-26 Annual Report and Accounts.
- **Status:** in progress.
- **Expected committee dates:** ARAC on 24 June 2026 and Board on 25 June.
- **Audit certification:** scheduled for 26 June 2026, being ahead of the Welsh Government's deadline of 30 June.

Audit of the Health Board's Charity's 2025-26 Annual Report and Accounts

- **Executive Lead:** Executive Director of Finance
- **Focus of the work:** to provide an audit opinion on the Health Board's Charity's 2025-26 Annual Report and Accounts
- **Status:** Scheduled to be certified by 31 January 2027.

Expected committee dates: to be determined, the Charitable Funds Committee and then the Board will consider the accounts in January 2027, with certification due by the Charity Commission's deadline of 31 January 2027.

Performance audit update

Structured assessment 2024 - deep dive review of investment in digital systems

- **Executive Lead:** Director of Digital
- **Focus of the work:** This work will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.
- **Status:** Complete – final report in today's papers.
- **Expected committee date:** May 2026

Review of Unscheduled Care (Part 1)

- **Executive Lead:** Chief Operating Officer
- **Focus of the work:** 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.
- **Status:** Report being drafted
- **Expected committee date:** August 2026

Review of Follow-Up Outpatients (Local Work)

- **Executive Lead:** Chief Operating Officer
- **Focus of the work:** This work will examine whether the Health Board is taking appropriate action to strengthen its management of follow-up outpatient appointments. In doing so, we will assess whether it has fully addressed the audit recommendations from our follow-up outpatient reviews in 2015 and 2017.
- **Status:** Fieldwork
- **Expected committee date:** August 2026

Structured assessment 2025 - deep dive review of the arrangements to manage estates

- **Executive Lead:** Executive Director of Finance
- **Focus of the work:** This work will examine the effectiveness of corporate arrangements to manage the Health Board's estate with a particular focus on how it is prioritising resources to meet strategic priorities whilst also ensuring the current estate remains fit for purpose.
- **Status:** Planning
- **Expected committee date:** August 2026

Review of Cancer Services

- **Executive Lead:** Chief Operating Officer
- **Focus of the work:** This work will follow on from the review of national leadership arrangements for cancer services. This work will evaluate whether the Health Board is taking effective action to ensure timely and equitable access to cancer treatment in line with national targets and quality standards.
- **Status:** Planning
- **Expected committee date:** August 2026

Structured Assessment 2026

- **Executive Lead:** Director of Corporate Governance
- **Focus of the work:** The 2026 structured assessment will examine proper arrangements for the efficient, effective, and economical use of resources and track progress against previous audit recommendations. It will also inform our thinking on whether to undertake future work on hosted bodies' governance arrangements, particularly the Joint Commissioning Committee (JCC) and the NHS Wales Shared Services Partnership (NWSSP).
- **Status:** Planning
- **Expected committee date:** December 2026

Review of the management and prevention of diabetes

- **Executive Lead:** Director of Public Health
- **Focus of the work:** Review of the management and prevention of diabetes
- **Executive Lead:** Director of Public Health
- **Focus of the work:** This work will examine the extent to which NHS bodies are improving the management and prevention of diabetes across Wales. The exact focus of this work is still to be determined, but it will focus on the ambitions set out in the Tackling Diabetes Together Programme and is likely to consider the extent to which NHS bodies are implementing initiatives such as the All-Wales Diabetes Prevention Programme, and the high value impact pathway of diabetes.
- **Status:** Planning
- **Expected Committee Date:** TBC

Other relevant publications

Since the last committee update, the Auditor General has not published other outputs relevant to the NHS.

Since the last committee update, Audit Wales has published the following corporate documents.

<u>Annual Plan for 2026-27</u>	April 2026

There are no relevant Audit Wales consultations currently underway.

Further information

Audit Wales has a range of other information to support the scrutiny of Welsh public bodies and to continue to improve the services provided to the people of Wales.

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



Digital Transformation

Cwm Taf Morgannwg University Health Board

May 2026



About us

We have prepared and published this report under section 61(3) (b) of the Public Audit Wales Act 2004.

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Audit snapshot

What we looked at

- 1 We looked at how Cwm Taf Morgannwg University Health Board's (the Health Board) approach to digital transformation is supporting service improvement. This included the approach to strategy, leadership and skills development. And we considered how the organisation manages risks around digital infrastructure, cyber resilience and artificial intelligence.

Why this is important

- 2 Digital technology is a key enabler to many of the aims of A Healthier Wales. That plan says that new technologies and digital approaches will be an important part of the future whole system approach to health and care.
- 3 However, achieving digital transformation is challenging. It requires investment, the right infrastructure, and staff engagement and training. Systems need to communicate with one another and organisations must manage ever-growing risks around cyber resilience.
- 4 Digital transformation isn't just about technology, it's about culture and leadership. The boards of NHS bodies have a key role in approving and owning the organisation's digital strategy. Boards also need assurance that digital transformation is being managed safely and effectively, and that investment is securing the intended benefits.

What we have found

- 5 The Health Board has clear digital ambitions and strong leadership, but its Digital and Data Plan does not include clear milestones, resources or an up-to-date view of digital maturity. Digital priorities are not yet fully linked to workforce, estates, finance, or its strategic clinical service planning. The partnership with Tektology is helping to strengthen digital foundations, but the Health Board still lacks the detail needed to show that its digital plans are realistic or achievable.
- 6 The Board receives regular updates on digital work, but these reports mainly describe activity rather than progress or results. The Health Board has improved its cyber security work, but several important gaps remain. While the Health Board is developing and testing AI, the governance around this needs to be stronger.
- 7 The Health Board's commitment to developing digital skills within its workforce needs to be accompanied by a stronger approach to digital skills assessment, staff training, and workforce planning. Staff and service users are involved in some major digital projects, but not consistently across all programmes. Digital exclusion is recognised as an issue, but there is no clear plan in place to address this.
- 8 The Health Board is delivering a range of digital projects locally, regionally, and nationally, but oversight is fragmented and updates do not always include timelines, milestones, or information on partnership working. Future investment needs are unclear, and the benefits framework is still being developed, meaning the Health Board cannot yet show whether its digital plans are affordable or will deliver value.

- 9 The Health Board is delivering a range of digital projects locally, regionally and nationally, but oversight is fragmented, and updates do not always include timelines, milestones or information on partnership working. This is made more difficult by ongoing delays to national digital programmes, which are largely outside the Health Board's direct control. These delays limit the Health Board's ability to plan confidently, manage digital risks, and progress wider digital transformation that depends on national delivery. Separately, future investment needs are unclear, and the benefits framework is still being developed, meaning the Health Board cannot yet show whether its digital plans are affordable or will deliver value.

What we recommend

- 10 We have made nine recommendations to the Health Board which focus on:
- Strengthening the digital strategy with clearer milestones and alignment to wider plans.
 - Improving digital performance reporting with clearer measures and risks.
 - Developing a costed infrastructure plan with timelines and asset data.
 - Introducing formal AI governance for oversight of all AI use.
 - Building digital workforce capability through skills assessment and training.
 - Strengthening user engagement and digital inclusion.
 - Clarifying long-term digital investment needs and decision points.
 - Coordinating oversight of digital projects.
 - Embedding a benefits framework to show whether digital investments deliver value.

Key facts and figures

Of the Health Board's workforce of approximately 12,000 employees, only 245 have completed the Health Education and Improvement Wales (HEIW) interactive self-evaluation tool as part of the Digital Capability Framework.

Since March 2025, the Health Board has had two reportable cyber incidents per the Network and Information Systems Regulations 2018.

16 serious cyber incidents were reported in quarter 3 2025-26, although none were reportable under the Network and Information Systems Regulations 2018.

In 2022, the Health Board was assessed at Stage 0 of the Health Information and Management Systems Society (HIMSS) Electronic Medical Records Adoption Model (EMRAM) meaning only early digital capabilities were in place.

The Health Board now considers itself to be at Stage 1 of HIMMS EMRAM meaning core digital systems are in place.

From 2021-22 to 2024-25, the Health Board invested approximately £68 million in digital revenue and £25 million in capital.

Our findings

Strategy, Planning and Leadership

There is a clear strategic direction for digital transformation supported by strong leadership and partnering with external experts. However, a more consistent approach to the reporting and oversight of digital developments is needed.

Digital strategy and plans

11 The Health Board has not created a separate digital strategy. Instead, its Digital and Data Plan is set out within the Integrated Medium-Term Plan (IMTP) 2025-28. The Digital and Data Plan outlines the Health Board's aim to become a leading digital organisation in NHS Wales, by using new digital technologies to improve care, involve patients more, and support sustainable services. To deliver this vision, the Health Board has set out eight clear digital and data themes¹, which link to its four overarching strategic goals² within its long-term strategy - CTM 2030: Building Healthier Communities Together. The plan aligns to national priorities, including the Welsh Government's digital agenda, A Healthier Wales, and the NHS Wales Digital and Data Strategy.

¹ Its eight digital and data themes are: Digital Health Board, Insights-Driven Healthcare, Single Patient View, Intelligently Integrated Healthcare, Digital Workforce, Adoption and Exploitation, Managing Innovation, and Digital Enablers.

² Its four goals are: Creating Health, Improving Care, Sustaining Our Future, and Inspiring People, focus on prevention, equity, and sustainability.

- 12 The Digital and Data Plan explains that digital transformation is important for providing joined-up care focused on the patient. It also highlights how better information can help the Health Board understand the value and impact of different interventions on the health and wellbeing of people in Cwm Taf Morgannwg. It focuses on seamless working across hospital and community boundaries, with joined up services between health, social care, and other professionals. By setting out these aims, the plan shows a clear ambition to use digital tools and better data to improve communication, reduce duplication, and strengthen decision-making. It also highlights a desire to use data more effectively to support prevention and early intervention.
- 13 The Health Board has created a workplan and roadmap to deliver its Digital and Data Plan, covering both national and local priorities. While the workplan includes both important improvements and forward-looking initiatives, it would be more effective if it had clearer milestones, more details about resources, and specific ways to measure progress. This would help make sure the plan is managed well and can be properly monitored.
- 14 The Health Board has a good process for developing its IMTP, which involves feedback from staff, patients, and stakeholders. However, it is not clear how this feedback influenced the Digital and Data Plan. This makes it harder to be confident that the digital priorities match what people actually need. Furthermore, while the Digital and Data Plan suggests digital maturity is an important goal through the areas it focuses on, it does not set out the Health Board's actual level of digital maturity. A HIMSS EMRAM assessment completed in 2022 shows the Health Board was at Stage 0 at that time, meaning only early digital capabilities were in place. The Health Board now considers itself to be at Stage 1, meaning core digital systems are in place. However, this has not yet been confirmed through a further formal reassessment. Without a clear view of the Health Board's current digital maturity, it is hard to understand the size of the digital gaps, why certain priorities were chosen, or how progress will be measured.

- 15 The Digital and Data Plan in the IMTP connects to some clinical services, for example maternity, mental health, and diagnostics, but its alignment with the Health Board's emerging Strategic Clinical Services Plan is only at a high level. This reflects the fact that the Strategic Clinical Services Plan is still being developed. As both plans progress, further work will be needed to show clearly how digital priorities will support and integrate with future clinical service developments across the organisation. Additionally, links to workforce, estates, and finance remain under-developed, meaning digital requirements are not yet fully embedded across all planning areas.
- 16 The Health Board is working with a strategic partner – Tektology - to develop a digital and data strategic roadmap and help deliver its long-term digital and data goals. This partnership supports the organisation by strengthening its digital foundations, improving the way data is managed and shared, and helping staff use new systems more effectively. It also brings extra skills and capacity at a time when the Health Board is delivering several major digital programmes.

Board ownership of digital transformation

- 17 The Board has a reasonable understanding of the Digital and Data Plan and supports its aims. Senior leaders recognise that digital transformation is important for delivering the Health Board's long-term strategy. There is evidence of digital matters being discussed at committees (see paragraph 29) and during a recent Board development session with the Health Board's strategic digital partner, Tektology. However, while Board members recognise and discuss digital risks, they would benefit from more focused digital training and awareness so they can provide stronger challenge, scrutiny and strategic leadership as the Health Board continues its digital transformation journey.

Roles, responsibilities and accountability

- 18 The Health Board has strong digital leadership. It includes a Director of Digital who has overall responsibility for the digital strategy. Day-to-day delivery is led by four assistant directors, covering Digital Intelligence, Data Science and Compliance, Digital Systems, Digital Delivery and Digital Transformation. The Health Board has recently appointed a new Independent Member for Digital after the previous independent member's term ended. Both take part in Board and various internal and external committees and groups relevant to their respective roles. The Health Board also continues to take part in the All-Wales Directors of Digital and IM Digital Network meetings, which allows organisations to share learning, good practice, and take part in national digital discussions that support the Health Board's digital transformation.
- 19 The Board has a reasonable understanding of how digital work is progressing. In January 2025, the Health Board introduced a new committee structure that reduced the number of committees and closed the Digital and Data Committee. Digital updates are now provided every quarter through highlight reports to the Operational Delivery Committee and the Strategic Development Committee, which respectively oversee both operational and strategic digital work.
- 20 The reports are reasonably clear and provide regular updates, but they mostly describe activities rather than explaining what has been achieved. Key information, such as progress against milestones, changes in risk, and whether programmes are on track is not always included. Some areas are covered in detail while others are brief, making it hard to get a complete picture of progress. Using clearer measures, consistent reporting, and simple visuals would help the Health Board monitor delivery more effectively.

Identifying and managing risks

The Health Board is managing a number of significant digital risks but it needs to report progress more clearly and urgently strengthen its governance around the use of AI.

Strategic digital risks

- 21 The Health Board's Board Assurance Framework includes one digital-related risk: delivering the digital and information infrastructure needed for transformation. This risk is rated high at 16 and is regularly reviewed by the Board and its key committees. Overall, the Board has reasonable visibility of the digital risk, but it would benefit from clearer reporting on how well controls and actions are working, and what impact they are having on managing the risk.

Digital infrastructure risks

- 22 While the Digital and Data Plan recognises the need to keep technology up to date, it does not set out clear timelines, milestones, or costed plans for doing so. This potentially limits the plan's usefulness as a tool for prioritising actions in response to digital risks.
- 23 As discussed in paragraph **16**, the Health Board has begun developing a digital and data delivery roadmap with support from its strategic partner. This work remains in the early stages, and as a result, formal delivery plans have not yet been produced. The Health Board recognises that several core elements need to be in place first, including a reliable network, secure data storage, strong security measures, stable power and environmental controls, and improved integration between systems. Completing this initial work will help the Health Board set out a clearer plan for strengthening its digital foundations and supporting future digital transformation.

- 24 The Health Board is making some progress in modernising parts of its digital infrastructure. There have been updates to Citrix software, the Wi-Fi network, Windows 10, and the move to a single Welsh Patient Administration System (WPAS). However, several weaknesses remain. There is still no clear, combined view of the main infrastructure gaps and no plan showing how these will be fixed. Asset management is also not yet developed enough to give the Board a single, reliable list of equipment or a clear plan for replacing and updating it.
- 25 The Operational Risk Register shows that the Health Board understands the main risks linked to its digital infrastructure and the pressures these create. It has several controls in place, such as established governance boards, an improvement programme for service and asset management, and regular oversight from the Risk, Audit, Governance and Cyber Security Board. Recent updates also show progress in identifying capital needs and securing Welsh Government funding for important end-of-life systems. However, ageing equipment, limited capital, workforce shortages, weak disaster recovery plans, and a reliance on short-term fixes are all risks which will need continued management and mitigation.

Cyber resilience

- 26 The Health Board has appropriate arrangements in place to manage its cyber security risks. In October 2024, the Health Board was audited by the Welsh Government's Cyber Resilience Unit (CRU), using the Cyber Assessment Framework (CAF) which found several principles had either partially or not met the required maturity level. Following the assessment, the Health Board agreed an improvement plan with the CRU. It also meets monthly with the CRU to discuss progress and address issues raised in the audit. Updates on the Health Board's cyber security improvement plan are provided regularly to the Operational Delivery Committee in private.

- 27 In October 2025, the CRU re-audited the Health Board. The review highlighted that it has made considerable progress in resolving and closing past audit issues. However, it also found key gaps in threat monitoring, responsiveness, and back-up arrangements. The Health Board recognises these weaknesses and is taking a range of mitigating actions to address them.
- 28 The Digital and Data Highlight Reports to the Operational Delivery Committee also cover day-to-day cyber issues. In January 2026, the committee was told that there had been 16 serious cyber incidents in the last quarter, and that all of them were being dealt with properly. None of these incidents were notifiable to the CRU under the Network and Information Systems (NIS) Regulations.
- 29 While these reports appropriately set out day-to-day cyber incidents, the technical language used means many Board members may struggle to understand the risks or challenge the actions being taken. Terms such as “ransomware artefacts”, “software deployment controls”, and “endpoint management” may require a level of technical expertise to interpret. Without clearer, plain-English explanations, non-experts may find it hard to grasp the key risks or why certain actions matter, which in turn can limit effective scrutiny. Our observations of the meetings show that although cyber resilience is discussed, there was little questioning of the detail in the reports, suggesting that the complexity of the subject may be a barrier.

Artificial intelligence

- 30 The Health Board knows that Artificial Intelligence (AI) could offer important benefits, such as supporting clinical decisions, helping with early diagnosis and screening, and making administrative tasks more efficient. But in its current Digital and Data Plan, AI is only mentioned in one area, digital pathology, where it could help improve how test results are analysed. There is no wider plan yet for how AI could be used across other Health Board’s services. However, the Health Board’s emerging digital and data strategic roadmap (see paragraph 16) recognises that AI will need to be considered more fully in the future, suggesting that wider plans may develop as the organisation strengthens its core digital foundations.

- 31 Despite this, the Health Board is already developing and testing a range of AI tools. However, none of this AI activity is reflected in the Board Assurance Framework or the Organisational Risk Register. As a result, the Health Board is using AI within operational practice without formally recording or assessing the associated risks. This limits the organisation's ability to demonstrate that AI use is safe, that it protects patient confidentiality, and that it meets required standards. The lack of documented oversight also reduces the Board's ability to identify potential issues at an early stage or provide effective scrutiny and challenge regarding the deployment of AI technologies.

Digital skills

Further action on skills assessment, training, and workforce planning is needed to ensure Health Board staff are adequately prepared for digital transformation.

Assessing digital skills

- 32 Although the Health Board recognises the importance of digital skills, it does not yet make consistent or comprehensive use of available tools, such as the HEIW Digital Capability Framework, to assess the digital skills, capacity, and capability of its workforce. At the time of our review, only 245 staff had completed the HEIW Digital Capability Framework, which is a very small number for an organisation of approximately 12,000 staff. However, the tool measures basic IT confidence and does not assess the wider digital skills needed to support digital transformation. There is no evidence that the Health Board has carried out its own assessment of these broader skills. Without a good understanding of its digital capability, the Health Board risks slowing down its digital transformation because it cannot accurately target training, allocate resources, or plan organisational change.

Developing digital skills

- 33 The Health Board is committed to developing a digitally skilled workforce but lacks a comprehensive digital skills training programme to achieve this. While the Digital and Data Plan and the People Plan 2025-2030 recognise that many staff still need to improve their digital and data skills, there are only limited arrangements in place to achieve this. For example, the Health Board is working with universities to offer some cyber security e-learning courses and AI focused training modules to staff.
- 34 At the time of our work, the Health Board reported 188.37 whole time equivalent staff in digital roles, with additional short-term posts in place for specific projects and workstreams. We were also told that the digital structure had been strengthened in recent years through appointments to key roles, such as the Assistant Director of Digital Transformation and Head of Digital Business Change and Benefits. However, without a baseline or a strategic workforce plan, it is unclear whether staffing levels are sufficient to meet the Health Board's digital needs.

Collaboration and involvement

While the Health Board engages users in some digital programmes, involvement is inconsistent and there is no clear, organisation-wide approach to digital inclusion.

Staff and service user involvement

- 35 The Health Board engages with staff and services users in the design of some major programmes and services, for example, the patient centred contact programme and electronic prescribing and medicines administrations system (ePMA). It also shares regular updates on digital and data topics at the Cwm Taf Morgannwg (CTM) Leadership Forum and staff Q&A sessions and has engaged external groups like Llais and the Welsh Centre for Deaf People. However, these were the only examples provided, and this level of involvement does not appear to happen across all digital projects. The Board recognises that it needs to understand more about what service users think of digital transformation and plans to develop its approach further with support from its strategic partner.

Reducing digital exclusion

- 36 The Health Board's Digital and Data Plan sets an aim to prevent digital exclusion and ensure that its online services are accessible to all users. The plan also highlights a project that supports pregnant women and families who may struggle to access digital technology. This work forms part of the Health Board's wider goal to strengthen its digital systems, including introducing a new digital maternity record and expanding virtual care. Together, these developments are intended to make digital services easier to use, fair, and responsive to the needs of all service users.

- 37 Whilst this represents a clear commitment to improving digital inclusion and some initial targeted activity, there is limited evidence that digital exclusion is being reduced in practice. While digital inclusion is part of the Assistant Director for Digital Transformation's role, the Health Board has not yet developed a dedicated digital inclusion plan to set out its objectives, actions, and measures of success in this area. The Board Assurance Framework mentions digital inclusion and accessibility, but provides very little detail, so it is hard to understand what activity is actually taking place. The Digital and Data Highlight Reports make only brief reference to digital exclusion as a risk, and do not describe any actions or progress. The Board has said that digital exclusion is discussed regularly, especially when developing new services like the patient centred contact programme, but there is little evidence that these discussions lead to clear actions. As a result, it is unclear if digital exclusion is being addressed in a consistent and meaningful way across the Health Board.

Using digital developments to support service transformation

The Health Board is progressing digital developments, but unclear funding, national programme delays and limited benefits evaluation create uncertainty over whether digital plans are affordable and deliver value.

Investment in digital transformation

- 38 The Digital and Data Plan includes some funded programmes, such as the digital maternity system, ePMA, and the single clinical record for mental health services. However, most of the wider digital ambitions in the plan do not yet have confirmed funding. The plan highlights that further investment will be needed for the Health Board to deliver its full digital vision, but it does not set out the expected costs or when key investment decisions will be made. This makes it difficult to judge whether the plan is achievable within the Health Board's financial position.

39 **Exhibits 1 and 2** show that the Health Board’s digital spending has increased over recent years. Capital expenditure varies between financial years, rising and falling between £2.5 million and £9.4 million; largely reflecting changes in discretionary capital allocations, and annual increases and decreases in other Welsh Government capital funding streams. The Health Board's 2026-27 IMTP includes a planned IT discretionary capital spend of £2.068m, out of a total of £13.274m. Revenue investment has grown each year and is expected to continue to remain high in future years. The Health Board's Discretionary Capital allocation is issued annually by Welsh Government. Therefore, capital allocations for 2027/28 and beyond have not yet been notified. The Health Board has an established capital planning formula which allocates available discretionary capital across priority headings, including digital. However, the lack of confirmed future discretionary allocations and uncertainty in respect of other Welsh Government capital funding streams, makes it difficult to assess whether future digital plans are affordable, or whether the Health Board will have enough funding to replace ageing systems and invest in the improvements it expects to deliver.

Exhibit 1: Annual capital and revenue investment in digital (2021–22 to 2024–25)

Financial Year	Capital (£m)	Revenue (£m)
2021-22	6.6m	14.8m
2022-23	2.5m	16.7m
2023-24	6.5m	17.8m
2024-25	9.4m	19.0m

Source: Health Board supplied data

Exhibit 2: Planned levels of capital and revenue investment in digital (2025-26 to 2027–28).

Financial Year	Capital (£m)	Revenue (£m)
2025-26	3.5m	24.3m
2026-27	TBC	23.2m
2027-28	TBC	23.0m
2028-29	TBC	23.1m

Source: Health Board supplied data

Local digital projects

- 40 The Health Board is working on several local digital projects to make services easier to use, more efficient, and productive. These projects include the patient centred contact programme, medical record digitisation, emergency department huddle application, creating a digital consent form for school vaccination, and as discussed in **paragraph 31** developing and using AI tools.
- 41 However, despite the positive momentum, the Health Board does not have a coordinated approach to oversee and monitor delivery of local digital projects. Updates to the Operational Delivery Committee show what has been done and what is planned, but they don't always give clear delivery schedules and dates. This makes it hard to see when these digital projects will be finished or to track their progress against set milestones.

Adopting national digital systems

- 42 The Health Board is actively adopting national digital solutions as part of the 'Once for Wales' approach. It works closely with key partners including Digital Health and Care Wales (DHCW), Welsh Government, and neighbouring Health Boards. The Health Board is involved in major digital projects such as Digital Maternity Cymru, diagnostics systems such as the radiology informatics system (RISP), and the Welsh patient referral system.

- 43 At a regional level, the Health Board is working with neighbouring Health Boards on shared national projects. This includes using the 'open eyes' digital ophthalmology system to improve eye care across South-East Wales and introducing the laboratory information management system (LIMS) for Cellular Pathology.
- 44 Despite this, the Health Board has raised concerns that roles and responsibilities are not always clear between itself, DHCW and Welsh Government, especially when it comes to how national digital programmes are delivered and supported. The Digital and Data Highlight Reports to the Operational Delivery Committee show that delays to national digital programmes are ongoing and significant. These delays make it harder for the Health Board to manage digital risks and move forward with wider digital transformation.
- 45 The reports show delays in key national programmes, including LIMS, and ePMA. The reports also show pressure on other all-Wales programmes, such as Digital Maternity Cymru, where competing national priorities are affecting delivery times. Many of these delays are outside the Health Board's direct control and depend on national partners and system-wide capacity. As a result, the Health Board's progress in modernising digital services and delivering wider digital transformation depends heavily on how quickly and effectively national programmes are delivered.
- 46 While the highlight reports give a reasonable overview of progress and risks for national digital programmes, they do not always include clear timelines or detailed plans for dealing with challenges. This makes it hard to understand when projects will be finished or how risks will be addressed if they arise. The reports reference partnership working on individual programmes but provide only limited insight into how effectively these arrangements operate overall. Because of this, it is difficult for the Board to see if partnership issues might slow down progress, or to be sure that joint working is strong enough to support major digital programmes.

Evaluating digital solutions

- 47 At the time of our review, the Health Board did not have a benefits framework and an Internal Audit review in May 2025 gave only limited assurance in this area. By January 2026, a draft benefits framework and toolkit had been developed, with new benefits registers for major digital projects. It is important for the Health Board to finish this work at pace so it can clearly show if digital investments are making a difference and delivering value for money. This will also help the Board use resources better, make informed decisions based on reliable evidence, and show the impact of its digital investments to stakeholders.

Recommendations

49 The following table details the recommendations arising from our work.

- R1** The Health Board should strengthen the Digital and Data Plan by setting clear milestones and resource requirements, defining and tracking digital maturity, and fully integrating digital priorities across workforce, estates, finance, and clinical service planning. **(Paragraphs 12-14)**
- R2** The Health Board should strengthen its digital performance reporting by including clear milestones, progress measures, risk updates and consistent information across programmes, supported by simple visuals to improve Board oversight. **(Paragraph 20)**
- R3** The Health Board should develop a comprehensive, costed infrastructure replacement plan that includes clear timelines, milestones, asset information and long-term investment needs, supported by clearer reporting on the effectiveness of controls and actions. **(Paragraph 24)**
- R4** The Health Board should develop a clear AI governance framework, ensuring all AI activity is formally recorded, risk-assessed and reported through the Board Assurance Framework and Organisational Risk Register. **(Paragraph 31)**

- R5 The Health Board should develop a structured approach to understanding and building its digital workforce capability by:
- R5.1 maximising the use of HEIW's Digital Capability Framework to understand the basic IT confidence of staff and developing a local assessment tool to understand the wider digital transformation skills needed to deliver its digital ambitions. **(Paragraph 32)**
 - R5.2 developing a digital skills training programme, ensuring staff have access to targeted, role-specific learning beyond basic e-learning, including data skills, digital change capability, and transformation skills. **(Paragraph 33)**
 - R5.3 creating a strategic digital workforce plan that sets out required staffing levels, roles, competencies, and future capacity needs, informed by a clear baseline of current digital workforce capability. **(Paragraph 34)**
- R6 The Health Board should develop an organisation-wide approach to user engagement and digital inclusion by:
- R6.1 introducing an engagement framework to ensure staff and service users are routinely involved in the design and development of all digital programmes. **(Paragraph 35)**
 - R6.2 creating a digital inclusion plan setting out priorities, actions, measures and how digital exclusion risks will be addressed across all service areas. **(Paragraph 37)**
 - R6.3 ensuring that digital inclusion and user engagement activity is clearly reported, with regular updates on actions, progress, and impact to support better oversight and accountability. **(Paragraph 37)**

- R7 The Health Board should set out clear, costed investment requirements, including capital needs beyond 2026-27, timelines for key decisions, and the affordability of major digital priorities. This will allow the Board to judge whether its digital ambitions are realistic within its financial position. **(Paragraphs 38-39)**
- R8 The Health Board should introduce a coordinated approach to overseeing all digital projects to clearly assess progress and dependencies across local, regional and national work. **(Paragraphs 41 and 46)**
- R9 The Health Board should complete and embed its benefits framework, ensuring that benefits registers are routinely maintained and reported to demonstrate whether digital investments are delivering improvements, value for money and better use of resources. **(Paragraph 47)**

Appendices

1 About our work

Scope of the audit

The goal of this audit is to find out if the Health Board is using digital technology to support service modernisation and efficiency. This included the approach to strategy, leadership and skills development for digital transformation, and how risks around digital infrastructure, cyber resilience and artificial intelligence are being managed.

Audit questions and criteria

Questions

Our audit addressed the following questions:

- Does the Health Board have a well-led and appropriately resourced approach to digital transformation?
- Is the Health Board developing the digital skills, capacity, and capability of its workforce?
- Does the Health Board have a clear plan for managing its cyber resilience arrangements and digital infrastructure and how they will need to change to support its digital transformation ambitions?
- Does the Health Board engage effectively with staff, partners, patients / service users to deliver its digital transformation ambitions and minimise digital exclusion risks?
- Is the Health Board actively utilising new digital technology and data solutions to enhance the accessibility, quality, efficiency, and productivity of its services?

Criteria

Our audit questions were shaped by:

- External reference input from the Welsh Government, all-Wales NHS Directors of Digital, and Digital Health & Care Wales.
- Relevant Welsh Government strategies and plans.
- Relevant NHS Digital Transformation review reports completed by the National Audit Office and House of Commons Health and Social Care Committee.
- NHS England Department of Health & Social Care: A plan for digital health and social care policy paper.
- NHS England Transformation Directorate: What good looks like framework.

Methods

We asked Cwm Taf Morgannwg University Health Board (the Health Board) to:

- Complete a self-assessment to help us understand how the organisation is undertaking digital transformation.
- Give us facts and figures about its spending on digital technology, staff digital skills, cyber resilience, and how it involves people in digital transformation.

We reviewed a range of documents, including:

- Board and committee papers and minutes.
- Key governance documents, including Digital and Data Highlight Reports, and the Cyber Improvement Plan
- Key strategies and plans, including the Digital and Data Plan, and IMTP
- Key risk management documents, including the Board Assurance Framework and Organisational Risk Register.
- Relevant policies and procedures.
- Reports prepared by other relevant external bodies, including the HIMSS EMRAM Assessment (2022), and Cyber Security Assurance Report (October 2025)

We interviewed the following key stakeholders:

- Director of Digital
- Chief Executive

- Assistant Director, Data and Digital Transformation
- Senior Finance Manager

We observed Board meetings as well as meetings of the following committees:

- Operational Delivery Committee
- Strategic Development Committee

2 Key terms in this report

Term	Description
Integrated Medium Term Plan	An Integrated Medium-Term Plan is a three-year plan that sets out how the organisation will deliver its services, manage its workforce, and meet its financial duties to break even. The organisation submits its plan to the Welsh Government for approval.
Health Information and Management Systems Society (HIMSS)	The Healthcare Information and Management Systems Society (HIMSS) is a global non-profit organisation dedicated to improving health through the best use of information technology and management systems
Electronic Medical Records Adoption Model (EMRAM) Assessment	The Electronic Medical Record Adoption Model (EMRAM) is a strategic, eight-stage (0–7) framework developed by HIMSS to measure, benchmark, and improve a hospital's digital maturity. It guides organizations from paper-based systems to a fully electronic, paperless environment, aiming to enhance patient safety, clinical outcomes, and efficiency.
Tektology	Tektology is an international consulting organisation that specialises in digital health, innovation, strategy, and operational improvement.
Board Assurance Framework	A Board Assurance Framework (BAF) in the NHS is a structured, strategic tool used by boards to monitor risks that threaten the achievement of corporate objectives
Organisational Risk Register	A Organisational Risk Register sets out the organisation's significant risks (either those with high scores or organisation-wide impact) and the actions in place to manage them.

Term	Description
Citrix Software	Citrix allows staff to work from home or different sites without storing sensitive data on laptops. Everything stays inside the organisation's secure network.
Welsh Patient Administration System (WPAS)	WPAS is the national hospital administration system used across Wales to manage patient pathways and core administrative processes in secondary care.
Cyber Resilience Unit (CRU)	The NHS Wales Cyber Resilience Unit (CRU), established in 2021 and hosted by Digital Health and Care Wales (DHCW), is an independent team responsible for implementing and monitoring NIS regulations to boost cybersecurity across the Welsh health sector
Cyber Assessment Framework (CAF)	The Cyber Assessment Framework (CAF) is a National Cyber Security Centre (NCSC) tool designed to help organisations, particularly those in critical infrastructure like energy, health, and transport, assess their cyber resilience.
National and Information (NIS) Regulations 2018	The National and Information (NIS) Regulations 2018 aim to improve the cybersecurity and resilience of systems that provide essential services.
Artificial Intelligence	Artificial intelligence (AI) is the ability of machines, computer systems, or robots to mimic human intelligence, learning, and decision-making to perform specific tasks.
HEIW's Digital Capability Framework	A national model outlining the digital skills, behaviours and confidence health and care staff need, organised into six capability domains with a self-assessment tool for development

Term	Description
Patient Centred Contact Programme	The Patient Centred Contact Programme is a digital initiative aimed at making patient communication more efficient and personalised, using digital tools and data-driven redesign to improve both patient and staff experience as part of the Health Board's wider digital transformation strategy.
Electronic Prescribing and medicines administration (ePMA)	The Electronic Prescribing and Medicines Administration System is designed to improve patient safety through better documentation, streamlined workflows, and more efficient access to medication records as part of NHS Wales' Digital Medicines Programme.
Llais	Llais is the national citizens voice body for health and social care in Wales.
Open Eyes	Electronic patient record (EPR) system designed specifically for ophthalmology services.
Laboratory Information Management System (LIMS)	The Laboratory Information Management System (LIMS) in NHS Wales is a unified digital system designed to manage pathology data and sample workflows across all health boards and hospitals.
Once For Wales	National approach in NHS Wales where a digital system, process or standard is designed, procured and implemented once at a national level, rather than each Health Board creating its own version.
Digital Maternity Cymru	Digital Maternity Cymru is a national digital programme to replace paper maternity notes with a single electronic maternity record used across all Health Boards in Wales.
Radiology Informatics System Procurement (RISP)	Radiology Informatics System Procurement (RISP) is a national digital programme designed to replace and modernise all core radiology informatics systems across every Health Board.

Term	Description
Welsh Patient Referral System	The Welsh Patient Referral System is a national digital system that supports the electronic management of patient referrals in NHS Wales

About us

The Auditor General for Wales is independent of the Welsh Government and the Senedd. The Auditor General's role is to examine and report on the accounts of the Welsh Government, the NHS in Wales and other related public bodies, together with those of councils and other local government bodies. The Auditor General also reports on these organisations' use of resources and suggests ways they can improve.

The Auditor General carries out his work with the help of staff and other resources from the Wales Audit Office, which is a body set up to support, advise and monitor the Auditor General's work.

Audit Wales is the umbrella term used for both the Auditor General for Wales and the Wales Audit Office. These are separate legal entities with the distinct roles outlined above. Audit Wales itself is not a legal entity.



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

Cwm Taf Morgannwg University Health Board – Audit Plan 2026

Reference: 5301A2026

Date issued: April 2026



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[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 2026 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 5) sets out how we will ensure those standards of quality are met. Our latest annual [audit quality report](#) 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.

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 2026-27](#) 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 standards 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 UK's Whole of Government Accounts.

There have been no limitations imposed on me in planning the scope of this audit.

Financial statements materiality

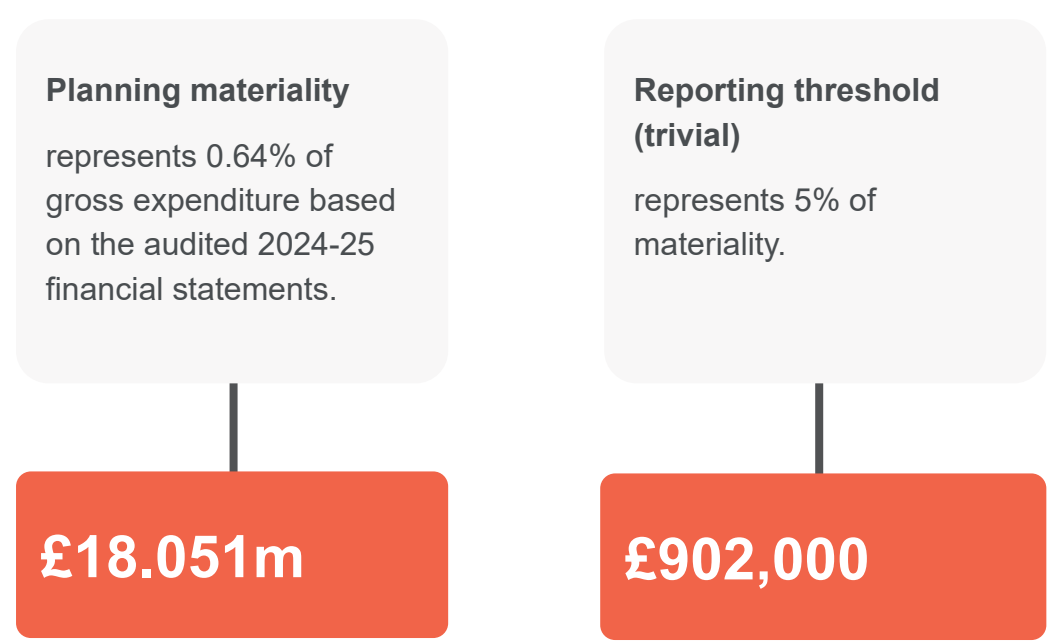
I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material and correct misstatements, that is, those that might result in a reader of the accounts being misled. Materiality applies 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.



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 these:

Remuneration report £1,000	Related party disclosures £10,000 (individuals) £15.56m (other bodies)

My audit team will assess materiality levels throughout the audit.

¹ Excluding the pension element of remuneration report.

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.

Our planned response

My audit team will:

- 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 March, the Health Board's month 11 financial reporting to the Welsh Government set out a forecast break even position for 2025-26 against the revenue resource limit. This outcome would result in a surplus of £205,000 for the three years to 31 March 2026.

The month 11 financial reporting to the Welsh Government also set out the position for the capital resource limit, commenting on schemes at risk of not spending in line with the current financial allocations; and that all risks

are currently planned to be managed across the programme, with a balanced position against the current capital resource limit. This outcome would result in a surplus of £96,000 for the three years to 31 March 2026.

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 2025-26 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

My audit team will:

- monitor the Health Board's financial position for 2025-26 and the cumulative three-year position to 31 March 2026.
- consider the cumulative impact of any relevant uncorrected misstatements over the three years to 31 March 2026; and
- undertake appropriate classification testing across revenue and capital expenditure, including the review of significant capital projects.

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 interests and/or relationships, there is likely to be less transparency.

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 and/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

I continue to judge the remuneration report disclosures to be of high interest and material by nature, as set out at page 8. Therefore, there is a risk that even low value errors in the disclosure could result a material misstatement.

An error may arise, for example, where there has been a change in senior officers and members during the year, which is inaccurately reported in the remuneration report.

Also, for 2025-26 the Welsh Government's Manual for Accounts has a new requirement for the NHS Wales Joint Commissioning Committee's senior officers to be disclosed within the remuneration report (including the prior year's comparative figures).

Our planned response

My audit team will:

- understand the movements in the senior management team during 2025-26;
- 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
- ensure that disclosures are complete and prepared in accordance with the reporting 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 2026.

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; and
- 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 increases 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 Welsh Government's Manual for Accounts.

Remedial works to the Princess of Wales hospital

Since 2024-25 the Health Board has been undertaking significant remedial works to its Princess of Wales Hospital, at a cost of some £28 million. The works were completed during summer 2025. There is a risk that the works are not accounted for correctly, for example some of the classifications of revenue and capital costs being incorrect.

Our planned response

My audit team will:

- review the nature, in accounting terms, of the contracted works; and review and test the 2025-26 transactions.

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 February to March 2026	Planning meeting High level risk assessment procedures Fraud risk assessment Accounting estimates planning IT environment risk assessment Indicative audit fee Audit Plan
Interim March to April 2026	Information flows Detailed risk assessment procedures IT controls review Develop testing strategy Early sample testing Audit Plan
Fieldwork and reporting May to June 2026	Update risk assessment Audit of financial statements to include narrative report and annual governance statement Complete audit testing Evaluate audit findings Audit closure meeting Audit of Accounts Report Present findings to those the Audit, Risk and Assurance Committee and the Board Submission of certified accounts to the Welsh Government Auditor General’s certification Laying of accounts with Senedd Cymru

 Reporting	Recommendations for improvement Post project learning
July 2026	

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	 Asset management
 Financial planning	 Collaborative working
 Performance and risk management	 Overall governance.
 Workforce planning	

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.

The **Sustainable development principle** is defined as acting in a manner...

...which seeks to ensure that the needs of the present are met without compromising the ability of future generations to meet their own needs.'

To do this, they must take account of the '**five ways of working**'.



Long-term



Prevention



Integration



Collaboration



Involvement

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 planned performance audit work.

Structured assessment

Scope of the work

Structured assessment will continue to form a key part of the audit work my audit teams do at each NHS body.

My 2026 structured assessment will examine proper arrangements for the efficient, effective, and economical use of resources.

This work will also review how the audited body tracks progress against previous audit recommendations. This helps the audit team check that improvements identified in earlier audits are being addressed. It also helps us measure the impact of our work more clearly.

My 2026 Structured Assessment work will also inform our thinking on whether we should undertake future work on hosted bodies' governance arrangements, particularly the Joint Commissioning Committee (JCC) and the NHS Wales Shared Services Partnership (NWSSP).

Indicative timescales

Fieldwork to commence between June and August 2026 and reporting by the end of December 2026.

All-Wales thematic review of the management and prevention of diabetes

Scope of the work

I plan to undertake work to examine the extent to which NHS bodies are improving the management and prevention of diabetes across Wales.

Whilst the exact focus of this work is still to be determined, it will focus on the ambitions set out in the Tackling Diabetes Together Programme and is likely to consider the extent to which NHS bodies are implementing initiatives such as the All-Wales Diabetes Prevention Programme, and the high value impact pathway for diabetes.

Indicative timescales

Fieldwork to commence between September and October 2026 and reporting by the end of March 2027.

Local project work – review of workforce planning arrangements follow-up

Scope of the work

My audit team will also undertake performance audit work that reflects issues specific to the Health Board. The local performance audit work will focus on following up the recommendations made as part of my 2023 Review of Workforce Planning Arrangements at the Health Board. As part of this work, my audit team will also examine whether the Health Board is taking effective action to reduce agency staffing use and expenditure.

Indicative timescales

Fieldwork to commence between June and July 2026 and reporting by December 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 progress will be communicated regularly through our quarterly Audit, Risk, and Assurance Committee update. My auditors aim to substantially complete the performance audit work set out in this plan by the end of March 2027.

Audit fee

In January 2026 we published our 2026-27 Fee Scheme following approval by the Senedd Finance Committee which details the average increase to fee rates of 5.3%.

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.

Your estimated total audit fee: £511,199

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 Finance. **Exhibit 2** sets out a further breakdown of your estimated audit fee.

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 2026 (and 2025 for comparison)

Estimated fee for 2026 (£) ²		Actual fee for 2025 (£)	
Audit of financial statements ³	Performance audit work ³	Audit of financial statements	Performance audit work
£308,808	£202,391	£293,146	£192,220
Total fee: £511,199		Total fee: £485,366	

² The fees shown in this document are exclusive of VAT

³ Payable November 2025 to October 2026

Audit team

My audit team will continue to work and engage remotely using technology, but some on-site audit work will resume where it is appropriate to do so. 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	Richard Harries richard.harries@audit.wales	
	Financial Audit	Performance Audit
Engagement Lead	Richard Harries richard.harries@audit.wales	Tom Haslam tom.haslam@audit.wales
Audit Manager	Mark Jones mark.jones@audit.wales	Darren Griffiths darren.griffiths@audit.wales
Audit Lead	Steve Stark steve.stark@audit.wales	Nathan Couch nathan.couch@audit.wales

I can confirm that my team members are all independent of the Health Board / NHS Wales Joint Commissioning Committee, and your officers. I am not aware of any potential conflicts of interest that I need to bring to your attention.

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 Annual Report](#).



Our People

- Selection of right team
- Use of specialists
- Supervisions and review



Arrangements for achieving audit quality Selection of right team

• Audit platform	• Learning and development
• Ethics	• Leadership
• Guidance	• Technical support
• Culture	



Independent assurance

• EQRs	• Peer review
• Themed reviews	• Audit Quality Committee
• Cold reviews	• External monitoring
• Root cause analysis	

Further information

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.



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





Agenda Item

5.10

Audit, Risk & Assurance Committee

Clinical Audit Update Report

Dyddiad y Cyfarfod / Date of Meeting	19/05/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Mark Townsend – Head of Clinical Audit & Quality Informatics
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	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
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
ARAC	Audit, Risk & Assurance Committee



NCA	National Clinical Audit
AMaT	Audit Management and Tracking System
NELA	National Emergency Laparotomy Audit
NEIRT	National Early Inflammatory Autoimmune Diseases Audit
DMARDs	disease-modifying anti-rheumatic drugs
CEC	Clinical Effectiveness Committee



1. Situation / Background

- 1.1 The purpose of this paper is to provide the ARAC with assurance regarding CTMUHB's compliance with National Clinical Audits, Clinical Outcome Reviews and Organisation Priority audits for the 2025/26 reporting period, as at 31/03/2026.
- 1.2 During the period, a total of 40 clinical audits or clinical outcome reviews were applicable to CTMUHB services. Of these, 40 audits were due for completion and were submitted in line with national requirements. Three audits were delayed / not completed within the required timeframe.
- 1.3 The audits delayed / not completed relate to capacity constraints within clinical teams and national delays to data submissions. Based on the review undertaken, these issues do not present an immediate or unmitigated patient safety risk, and alternative sources of assurance are in place.
- 1.4 Overall, this position provides reasonable assurance, with appropriate mitigating actions and oversight arrangements established.
- 1.5 Participation in National Clinical Audit programmes is a key component of quality assurance, enabling benchmarking of care against national standards and supporting service improvement.
- 1.6 CTMUHB coordinates participation via the Clinical Audit function, with delivery responsibilities held by individual clinical services. Compliance is monitored through AMaT and reported through internal governance arrangements.

1.7 Summary Position for National Clinical Audits and Reviews

Status	Number
Completed / On track	37
Not completed / Delayed	3
Total applicable audits	40

2. Specific Matters for Consideration

2.1 Summary National Clinical Audits Not Completed / Delayed

National Clinical Audit	Directorate / Service	Reason Not Completed / Delayed	Risk / Impact	Mitigating Actions	Expected Completion
NELA	Surgery / Anaesthetics	Workforce capacity constraints led to delays in post-operative case note validation and clinician input of audit data into the national web-based system at the time of operation.	Limited national benchmarking and delayed comparative performance reporting.	- Local performance indicators monitored routinely - Incident data reviewed monthly - Escalation to Clinical Lead for oversight and prioritisation - NELA Activity for discussion in May CEC	31/05/2026
NELA No Lap Audit (Non-laparotomy)	Surgery / Anaesthetics	Identification of eligible non-laparotomy cases requires clinical review; delays occurred pending nomination of a clinical lead to oversee case identification.	Limited national comparison and reduced assurance on pathway compliance for non-laparotomy patients.	- Appointment of a Clinical Lead to oversee identification and data submission - Agreed process for case identification implemented - NELA No Lap Audit (Non-laparotomy) Activity for discussion in May CEC	31/05/2026



NEIRT	Rheumatology	Workforce capacity constraints affected clinicians' ability to identify patients for follow-up review, resulting in potential for missed six-week review points for patients commencing DMARD therapy.	• Limited national benchmarking • Clinical outliers identified • Potential risk of delayed follow-up for a small number of patients.	• Working with clinicians to improve patient identification and data capture • Review of local follow-up processes • Service review required to address capacity and pathway compliance	NEIAA 2025/26 data capture has ended, focus now on 2026/27



3. Key Risks / Matters for Escalation

- 3.1 The audits delayed during the reporting period reflect operational and capacity challenges rather than systemic disengagement from national audit processes.
- 3.2 Where national audit participation has not been fully achieved or delayed, assurance has been obtained through:
- Local audit work aligned to national standards
 - Routine performance dashboards
 - Incident reporting and review processes
 - Oversight through Directorate, Speciality and Care Group governance forums
- 3.3 The current position does not indicate a material risk to patient safety; however, continued monitoring is required until full national audit submission is achieved.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Enablers of Quality (<i>Duty of Quality Statutory Guidance (gov.wales)</i>)	Learning, Improvement & Research
	If more than one applies please list below:
Dolen i Feysydd Ansawdd (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Domains of Quality	Effective
	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: 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): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: 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 The Audit, Risk & Assurance Committee is asked to:

- Note the current position regarding National Clinical Audit compliance
- Accept the reasons provided for audits delayed

- Take assurance from the mitigating actions and governance arrangements in place

6. Next Steps

- 6.1 The Health Board continues to engage with National Clinical Audit programmes, with the majority completed in line with requirements. Where audits have not been completed or have been delayed, proportionate mitigating actions and alternative assurance mechanisms are in place.

Agenda Item

6.1.1

Unconfirmed Minutes of the Audit Risk and Assurance Committee

Date and Time of Meeting	Tuesday 3 rd February 2026 at 9:00 am- 12:00 pm
Venue	Virtual via Microsoft Teams

Members Present	Patsy Roseblade	Committee Chair
	Dilys Jouvenat	Committee Vice Chair
	Kath Palmer	Independent Member
	Kathy Mason	Independent Member
In Attendance	Sally May	Executive Director of Finance
	Gethin Hughes	Chief Operating Officer (in-part)
	Gareth Watts	Director of Corporate Governance/Board Secretary
	Paul Dalton	Head of Internal Audit NWSSP
	Emma Samways	Deputy Head of Internal Audit NWSSP
	Owen James	Head of Corporate Finance
	Martyn Lewis	IT Audit Manager (in-part)
	Murray Guard	Audit Manager
	Nathan Couch	Audit Wales
	Andrew Doughton	Audit Wales (in-part)
	Fflur Jones	Audit Wales (in-part)
	Mark Townsend	Head of Clinical Audit & Quality Informatics (in-part)
	David Morgan	Consultant Trauma and Orthopaedics (in-part)
	Kathrine Davies	Corporate Governance Manager
	Sharon Edwards	Corporate Governance Officer
Meeting Observers	Claire Jones	Head of Quality Assurance and Compliance
	Kelly Eddington	Quality, Assurance & Compliance Officer

Agenda Item	Meeting Business
1.	PRELIMINARY MATTERS
1.1	Welcome and Introductions

	P. Roseblade, Committee Chair welcomed everyone to the meeting, particularly those joining for the first time, those observing and colleagues joining for specific agenda items. The format of the proceedings in its virtual form were also noted. Members noted that the meeting would be recorded to aid the Committee Secretariat in ensuring the accuracy of scrutiny related discussions and decisions made during the meeting. Members noted that the recording would be destroyed once the minutes had been confirmed as accurate. Members confirmed they were happy to proceed. The Committee Chair advised that at the end of the meeting, she would be seeking Members views as to how the meeting went.
1.2	Apologies for Absence
	Apologies were received from: • Dom Hurford – Executive Medical Director • Matthew Evans – Local Counter Fraud Officer • Helen Lentle – Independent Member
1.3	Declarations of Interest
	There were no interests to declare.
2.	CONSENT AGENDA BUSINESS
2.1	The Committee 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 no items raised
3.	MATTERS ARISING
3.1	Action Log
	G Watts presented the action log and provided a summary of key matters • The open action relating to negotiations with Microsoft had been updated with a new narrative • The open action regarding the discussions about risk management, heat maps and other tracking tools is delayed due to the risk lead being on an extended period of leave. • The open action in relation to discussions with the Local Counter Fraud team had not taken place as yet and an update would be brought back to the next meeting of the Committee. • The JAG accreditation should be closed on the action log but agreed to schedule for review on the Forward Plan within the next six to twelve months. O. James provided an update on the action in relation to redress thresholds increasing and advised that he had received an update from the team and would share the email outside of the meeting. P Roseblade queried whether the thresholds for recovery of payments remain unchanged and if more cases are

	processed locally under redress, whether this would have an impact on CTM's workload. O James acknowledged that although there will be a reduction in legal spend, there will be a significant operational impact. O James suggested that he would confirm with the service and provide a response but also suggested that it might be helpful inviting someone from the Patient Care & Safety team to the next meeting to answer further questions.
Resolution:	The Committee DISCUSSED and NOTED the Action Log
Action:	To circulate the redress threshold email, clarify the impact of local redress management and invite someone from Patient, Care & Safety to the next meeting.
Action	To schedule a further update on the Forward Plan for JAG Accreditation for 6-9 months' time.
3.2	Matters Arising Not Captured on the Action Log
	No matters were raised
4.	RISK MANAGEMENT
4.1	Organisational Risk Register
	G Watts presented the Organisational Risk Register noting that there had been an impact on the Risk Team due to the absence of the Assistant Director of Governance and Risk. However, a new risk had been added regarding Emergency GP Service while the Paediatric Dentistry risk score decreased. G Watts confirmed that the risk register had been recently reviewed and discussed at the Quality, Safety & Experience Committee and Operational Delivery Committee which was confirmed by P Roseblade. G. Watts highlighted that in addition to the established risks, there were emerging risks on the horizon which were now being captured and flagged within the register. Following feedback from Members G. Watts confirmed that these emerging risks would be refined for future meetings with a clearer explanation, stronger content, context and better differentiation between current risks. As Members had made comments at other Committee meetings, there were no further questions raised.
Resolution:	The Committee REVIEWED and CONSIDERED the Organisational Risk Register
Action:	To review the reporting format for emerging risks.
4.2	Response to the updated HM Treasury Audit & Risk Assurance Committee Handbook
	G Watts presented the report on the updated HM Treasury Audit & Risk Assurance Committee handbook which covered Committee practices, Speaking Up Safely, Accountable Officer attendance and the self-assessment process. K Palmer and D Jouvenat sought clarification on whether the Speaking Up Safely issues would be reported to Audit Risk and Assurance Committee (ARAC),

	Quality, Safety & Experience Committee (QSEC) or the Operational Delivery Committee (ODC). G Watts confirmed that an internal audit will be taking place to provide an extra source of assurance over this new process. The Committee discussed the governance structure, committee responsibilities and how actions and learning should flow between QSEC, ODC and ARAC. G. Watts confirmed that he would produce a Board level briefing paper to confirm the intended governance model. The Committee discussed whether the Chief Executive (as Accountable Officer (AO)) should attend ARAC routinely as suggested in the Treasury Handbook. P. Roseblade emphasised her long-held view that the AO should not be required to routinely attend so that the Committee could escalate issues to the AO without compromising their independence. In response, both G. Watts and S. May confirmed that the current CTM arrangement remained appropriate in that the AO attends for the Annual Report and Accounts and only when required at other times. The Committee agreed this should be recorded as "approved" within the response. The Committee discussed the recommendation of private meetings of the Committee with Internal and External Audit and agreed that the current flexible approach of meeting every other meeting was currently working and did not require a new standing meeting. With regard to meetings with the Chair and Director of Finance, P. Roseblade confirmed that a practical arrangement already existed where either one could request a 1:1 meeting as and when needed P Roseblade and K Palmer raised concerns about the length and detail of the self-assessment questions. G Watts advised that he was happy to streamline the questions. There was consensus that the Board Assurance Framework should be regularly reported to the Committee, and that future arrangements for Speaking Up Safely and Terms of Reference would be finalised after further review. The Committee approved the proposals regarding Accountable Officer attendance, Private meetings, and existing processes for meetings with Finance leads (subject to re-wording) while requesting further work on the terms of reference and the self-assessment process.
Resolution	The Committee • Approved the proposals outline in sections 2.1.1-2.12 • Approved the proposed future role of ARAC in relation to the Board Assurance Framework (Strategic Risks) • Agreed that the following items would not be approved pending revision: - Changes to the Terms of Reference - Self-Assessment Questionnaire (to be streamlined and tailored)

	- Speaking Up Safely
Action:	Further action is requested for: - Item 2.1.3, concerning meetings between the Chair and the Director of Finance, it was noted that it does not reflect current practice and that this section be reworded to align with the process already in place. - The proposed changes to the ARAC Terms of Reference relating to Speaking Up Safely, noting that amendments are required to ensure clarity of role, and outline governance responsibilities. - The proposed self-assessment process and the need to streamline and review the intended target audience, agreeing that the current version is overly detailed.
5.	FINANCIAL GOVERNANCE ACTIVIT
5.1	Losses and Special Payments Report
	S May and O James presented the report which focussed on the rising number of Welsh Risk Pool (WRP) cases, significant reimbursement delays affecting cash flow noting that high-value cases can take up to ten years to settle. K Palmer queried how CTM's WRP patterns compared to other Health Boards. O James advised that the risk share fluctuates but CTM's share had recently decreased. O. James advised that NHS Wales Shared Services Partnership (NWSSP) comparative data will be sourced to help identify trends and potential learning. P Roseblade queried which Committee should review the underlying clinical causes of negligence claims. S May and G Watts clarified that QSEC should handle clinical themes and ARAC should focus on assurance with the process.
Resolution:	The Committee NOTED the losses and special payments made for the period 1 October 2025 to 31 December 2025. NOTED the key risks for escalation on the increasing net provision value.
Action:	To explore where thematic/clinical trends behind claims should be reported into
Action:	Committee Chair and Director of Corporate Governance to discuss with Chair of Quality & Safety Committee (or Quality Lead) how to ensure themes (e.g., obstetrics, high-cost cases) are reviewed at the appropriate Committee to ensure operational learning is not lost and that ARAC continues to receive assurance on the financial process.
5.2	Procurement and Scheme of Delegation report
	S. May and O. James presented the report on procurement compliance looking at retrospective procurement file notes. P Roseblade queried whether catering was the main driver of retrospective receipting issues. O James confirmed that catering was one of the key areas driving retrospective receipting issues due to high ordering volume combined



	with receipting delays, making it difficult for invoices to be receipted in a timely manner. P Roseblade referred to Arjo and queried why they were repeatedly appearing as a problematic supplier. O. James assured the Committee that procurement is working directly with Arjo and the service area to resolve issues. P Roseblade asked if future reports could provide clearer explanations of why each supplier appears in the top problem areas. O. James agreed that future reports will include summary narrative notes for each supplier, explaining the issue and the mitigating actions. P Roseblade enquired about what action is being taken regarding the top recurring suppliers causing retrospective receipting delays. O. James confirmed that procurement is undertaking deep dives, and they will continue to have regular meetings with payments and service teams.
Resolution:	The Committee • NOTED the position on procurement matters for the period 01.10.2025 to 31.12.2025 • NOTED the update regarding Purchase to Pay and achievement of Public Sector Payment Performance (PSPP) target up to Month 9 of 2025/26 • APPROVED the updated Financial Control Procedures (FCPs) and associated Standard Operating Procedures (SoP)
Action:	To include a brief narrative summary in future procurement reports explaining why each of the top suppliers appears on the retrospective receipting list, the current actions being taken, and levels of progress.
6.	COUNTER FRAUD ACTIVITY
6.1	Local Counter Fraud Report
	S May presented the report in M Evans absence, noting there are no specific risks or matters for escalation. P Roseblade questioned the apparent inconsistency between reported increases in counter fraud training and the detailed attendance figures. S May advised that she would follow up with M Evans and the Counter Fraud team for clarification outside of the meeting
Resolution:	The Committee NOTED and REVIEWED the report.
Action:	To highlight the discrepancies relating to training attendance figures with the Counter Fraud Team and seek clarification.
7.	GOVERNANCE AND CONTROL ENVIRONMENT
7.1	Audit Recommendation Tracker
	G Watts presented the audit recommendations tracker, highlighting significant progress in clearing historic recommendations. P. Roseblade noted that although improvements have been made, this is not easily identifiable within the report. She emphasised that going forward



	progress should be clearly highlighted and acknowledged, to ensure that improvements are more visible. K. Palmer noted that the Audit Tracker was showing that the latest Healthcare Inspectorate Wales (HIW) position was reported to the Committee on 20 January 2026, and queried whether this date should actually be 2025. G Watts agreed to check the date and amend the tracker if incorrect.
Resolution:	The Committee NOTED and AGREED the assurances provided
Action:	G Watts to confirm the dates and amend the tracker if incorrect.
7.2	NWSSP Internal Audit Progress Report
	P Dalton presented the report on the current status of the internal audit programme. K Palmer and P Roseblade queried the 29% report turnaround figure, raising concern that this was significantly below the 80% target and sought assurances on what further action could be taken to improve performance. P Dalton acknowledged that turnaround performance was below expected levels and confirmed there was still a large body of work to complete. G Watts agreed to take the Committee's concerns back to the Executive Leadership Group, highlighting the need for improved timeliness from those areas being audited.
Resolution:	The Committee NOTED the report
Action:	G Watts to raise audit delays with Executive colleagues.
7.2.1	IA Review – Clinical Coding
	M. Lewis presented the report on clinical coding audit, which provided Reasonable Assurance. S. May stated that she was surprised Internal Audit reviewed the detail of individual staffing establishments, given that Digital & Data has had the single largest increase in corporate headcount. She queried whether this was the appropriate focus for audit scrutiny. However, it was noted that the report highlighted the risk of future retirement affecting resilience, but staff levels were for budget holders to determine. P. Roseblade queried who was responsible for long-term planning for coding capacity and how CTM is mitigating the risks of an ageing workforce and limited resilience. M. Lewis explained that it was the responsibility of the Chief Information Officer and the Director of Digital. However, recruitment of additional trainee coders is already underway and there are plans in place to increase developer support to sustain the auto-coder and reduce pressure on human coders.
Resolution:	The Committee NOTED the report
Action:	None identified
7.2.2	IA Review – Asbestos Management Audit – Final



	M. Gard presented the report on asbestos management that had received a Reasonable Assurance rating. S. May and K. Palmer queried why the internal audit did not receive a Substantial Assurance rating, given that five findings were strong and only one was weaker. M Gard explained that the overall assurance rating reflects the combined control environment and the presence of remaining control gaps. Although the majority of findings were positive, the inconsistent use of Authority to Proceed documentation and the low training compliance represented material weaknesses. Therefore, Reasonable Assurance was appropriate.
Resolution:	The Committee NOTED the report
Action:	None identified
7.2.3	IA Review – Response to Critical Incident - Final
	E. Samways presented the report of the organisation’s response to the Princess of Wales Hospital roof Critical Incident (October 2024) which received an overall rating of Reasonable Assurance. It was noted within the report that there was strong command and control response during the incident with clear communications both internally and externally and the appropriate adherence to delegated authority during the incident. E. Samways advised that business continuity policies and procedures had not been updated post-incident with several local continuity plans outdated or still in draft and that some appointed business continuity leads lacked clarity on their responsibilities. K. Palmer queried whether the longer-term business continuity and emergency planning issues should sit with Audit Risk & Assurance Committee (ARAC), Operational Delivery Committee (ODC), or Strategic Development Committee (SDC). G Watts advised that the matter had been discussed with the Executive Lead, and it was felt that SDC was the appropriate Committee for overseeing strategic business continuity planning going forward. However, G. Watts advised that he would clarify with the Executive Lead as to which Committee the longer-term business continuity and emergency planning issues should be received.
Resolution:	The Committee NOTED the report
Action:	To clarify with the Executive Lead whether the longer-term business continuity and emergency planning issues should sit with Audit Risk & Assurance Committee (ARAC), Operational Delivery Committee (ODC), or Strategic Development Committee (SDC).
7.2.4	IA Review – Stroke Services – Final
	E Samways presented the report on Stroke Services which received an overall rating of Reasonable Assurance. They have a single amalgamated action plan, drawing together actions from HIW inspection reports, clinical audits, operational meetings, Stroke Programme Board oversight. E Samways advised that whilst consolidation of actions is positive, there was inconsistent closure of actions, poorly defined target dates, weak audit trails



	linking actions to originating reports, and a need to link actions more clearly to Stroke Quality Improvement Measures.
Resolution:	The Committee NOTED the report
Action:	None identified
7.2.5	IA Review – Discharge Planning – Final
	E. Samways presented the report regarding Discharge Planning which received an overall rating of Limited Assurance. K. Palmer queried why, in certain Internal Audit reports (particularly Discharge Planning), some governance improvements were not listed as formal recommendations. E. Samways clarified that these were management-raised suggestions, not audit-identified gaps, and therefore they were not formal recommendations requiring follow-up. D. Jouvenat queried whether the responsible officer named in internal audit follow-up reports (particularly in Discharge Planning) had sufficient capacity to oversee the high number of actions. P Dalton explained that actions were phased over time, reducing pressure on the responsible officer. P. Dalton explained that there was increased operational pressures across departments which had delayed responses from management but that more reviews would be completed ahead of the next Committee in May 2026. P Roseblade noted in the report that an internally developed “Transfer Portal” became unusable after the developer had left, and queried whether any governance was in place to prevent staff creating unsupported digital tools. G Watts agreed this was a risk and committed to raising the issue with Digital Services team and the Executive Director to ensure stronger governance and prevent unsupported systems from being developed in future.
Resolution:	The Committee NOTED the report
Action:	To discuss governance arrangements with the Executive Director in relation to preventing unsupported systems from being developed in the future.
7.3	Audit Wales Progress Update
	N. Couch presented the Audit Wales Progress Update report K Mason queried why the Digital Transformation deep-dive review, although originally planned in 2024, was not reporting until May 2026. She queried whether there was a specific reason for the delay and whether work had been undertaken. N Couch confirmed that the fieldwork had not commenced in 2024 due to capacity constraints within Audit Wales. However, the actual fieldwork had commenced in September 2025, which caused the reporting timetable to move. The report is now due for completion and submission to the Health Board by end of March 2026, to be presented to ARAC in May 2026.
Resolution	The report was NOTED .
Action	None identified



7.3.1	Audit Wales Review – Eye Care Services A. Doughton presented the report. P. Roseblade raised concerns on reading the report with regard to quality and performance issues which were highlighted as requiring urgent attention and given the nature of the concerns she recommended that a formal cross Committee referral should be made to the Quality, Safety & Experience Committee in relation to the following: - Deteriorating eye-care performance - Potential patient harm - That the management responses did not appear to strongly accept all of the recommendations. - There was no clear explanation where recommendations were not accepted as to whether they were reasonable, deliverable and had evidence based-justification. G. Watts confirmed that he would take the matter forward and refer to the Quality, Safety & Experience Committee to provide assurances and an outcome back to the Committee.
Resolution:	The Committee NOTED the report
Action:	To make a formal cross Committee referral of the concerns raised in the Audit Wales Eye Care Services report to QSEC.
7.3.2	Audit Wales Report – Urgent and Emergency Care: Arrangements for Managing Demand F. Jones presented the report which identified new initiatives such as the navigation hub having a positive impact. F. Jones advised that same Day Emergency Care (SDEC) is performing well, but it was noted that low conveyance rates from the Welsh Ambulance Services Trust (WAST) to alternatives in the Emergency Department (such as Minor Injury Units and SDEC).
Resolution:	The Committee NOTED the report
Action:	None identified
7.4	Clinical Audit Annual Forward Plan & Monitoring M Townsend delivered the presentation which detailed the monitoring process, committee structure, and improvements in compliance and engagement. P Roseblade noted that the presentation and forward work plan addresses any concerns that she has raised previously regarding the responsibilities around clinical audit and thanked M. Townsend for the presentation
Resolution:	The Committee NOTED the report
Action:	None identified
7.5	JAG Accreditations Update

	G Hughes presented the report on JAG accreditation which focussed on four key areas, clinical governance arrangements associated with the delivery of endoscopy, waiting times, the competence of the workforce and the environment. G Hughes explained that there are currently no JAG accredited endoscopy services due to facility non-compliance. However, actions have been taken to address waiting times and governance requirements. He went on to outline timelines for accreditation at each site with Prince Charles Hospital hoping to be the first site to achieve accreditation. K Palmer asked whether the plan had built in the seven-day service provision to which G Hughes clarified that the seven-day service is not required for JAG but that the main pressure is surveillance backlog capacity which the Team are working on. P. Roseblade raised a point of clarification on the wording in the paper which stated that there were no significant resource requirements associated with the JAG Accreditation plan. She advised that the wording was potentially misleading, given the discussion about, surveillance backlogs, workforce pressures and estates dependencies (including the decontamination facility) and asked that the recommendation be revised, so that: • It does not imply ARAC acceptance of a “no resource impact” position • It reflects that this is an assurance update, not a resourcing decision G. Hughes agreed to revise the wording accordingly.
Resolution:	The Committee NOTED the presentation
Action:	To revise the wording within the report.
8.	CONSENT AGENDA
8.1	Items for Approval
8.1.1	Unconfirmed minutes of the meeting held in 13 November 2025 were APPROVED .
8.1.2	Unconfirmed minutes of the In Committee meeting held on 13 November 2025 Were APPROVED .
8.2	ITEMS FOR NOTING
8.2.1	Committee Forward Work Plan was NOTED .
8.2.2	Annual Report Timetable 2025 /2026 was NOTED .
9.	CLOSE OF BUSINESS
9.1	Any Other Urgent Business None identified
9.2	Committee Highlight Report



	The Committee Chair advised that this would be drafted outside the meeting by the Governance Team
9.3	How did we do in this meeting? The Committee Chair advised that if Committee Members had any comments to raise as to how the meeting went today, then they could share these with herself and the Corporate Governance Team outside the meeting.
10.	PRIVATE IN COMMITTEE SESSION • Organisational Risk Register - Business Sensitive Risks • Financial Control Procedure - Medical Variable pay - Summary of Authorised Breaches • Local Counter Fraud Report – Cases Report • Counter Fraud Service in NHS Wales Operational Performance Report 2025/2026 Quarter 1
11.	DATE AND TIME OF NEXT MEETING
	19 th May 2026 at 12.30p.m



Agenda Item

6.1.2

Unconfirmed Minutes of the CLOSED CTMUHB Audit, Risk & Assurance In Committee

Date and Time of Meeting	Tuesday 3 rd February 2026 at 12:30pm
Venue	Virtual via Microsoft Teams

Members Present	Patsy Roseblade	Independent Member (Committee Chair)
	Kathy Mason	Independent Member
	Kath Palmer	Health Board Vice Chair
	Dilys Jouvenat	Independent Member
In Attendance	Emma Samways	NWSSP Deputy Head of Internal Audit
	Paul Dalton	NWSSP Head of Internal Audit
	Anthony Gibson	Deputy Medical Director for Acute Services
	Nathan Couch	Audit Wales
	Owen James	Head of Corporate Finance
	Gareth Watts	Director of Corporate Governance/Board Secretary
	Kathrine Davies	Corporate Governance Manager
Meeting Observers	Sharon Edwards	Corporate Governance Officer

Agenda Item	Meeting Business
1.	PRELIMINARY MATTERS
1.1	Welcome and Introductions
	P. Roseblade, Committee Chair welcomed everyone to the meeting.
1.2	Apologies for Absence
	Apologies were received from: - Helen Lentle, Independent Member - Dom Hurford, Executive Medical Director (A. Gibson Deputising) - Sally May, Executive Director of Finance - Matthew Evans, Local Counter Fraud Officer
1.3	Declarations of Interest
	No declarations were identified.



2. MAIN AGENDA	
2.1	Organisational Risk Register – Business Sensitive Risks
	G. Watts presented the business sensitive risks captured on the Organisational Risk Register which had been subject to review with detailed updates provided. P Roseblade noted that a full discussion on the risk register was held in Operational Delivery Committee at its recent meeting.
Resolution	The Organisational Risk Register was REVIEWED and DISCUSSED.
Action	No actions identified.
2.2	Financial Control Procedures - Medical Variable Pay - Summary of Authorised Breaches
	A Gibson presented the report which provided a summary of instances where bank and agency workers had been paid outside of the agreed rate card. Members were advised that the matter had been reviewed at the Management Board in February 2023, where initial controls were strengthened. Approval processes had since been tightened so that Care Groups could authorise payments within defined limits, with any higher exceptions escalated appropriately. A monthly Care Group Delivery Group meeting is now held to review high-cost locums and plans for transitioning to permanent staffing solutions. It was noted that areas with consistently high locum expenditure included Stroke and Mental Health services, as well as a temporary gap in Urology due to sickness absence, which was now resolving. Work was ongoing to develop more sustainable and substantive workforce models. P. Roseblade echoed the need for more concise reporting, noting that the current level of detail (approximately 50 pages) was excessive for Committee requirements. She requested trend data in areas such as expenditure over the preceding three months and clearer explanation of “so what” impacts, actions, and anticipated changes. A. Gibson acknowledged the limitations of the current system, particularly around authorisation processes for long-term locums, and agreed that future reports would present information by Care Group with clearer actions and more meaningful narrative for the Committee
Resolution:	The Committee NOTED the report.
Action	A revised and more concise report, including trend data and Care Group-specific actions, to be presented at future Committee meetings.
2.3	Local Counter Fraud Report
	As no representative was available to present the report, it was agreed to take any questions back to the Counter Fraud team. The item was being considered in the CLOSED session due to the presence of potentially identifiable information within the Open Investigation Cases report.

	P. Roseblade requested that existing "red comments" remain visible for discussion at the next meeting, with any new comments highlighted in a different colour for ease of reference.
Resolution	The report was NOTED and DISCUSSED.
Action	To keep the existing red comments visible for discussion at the next meeting.
2.4	Counter Fraud Services in NHS Wales Operational Performance Report 2025-26 Quarter 1 No representative to present the report
Resolution:	The report was NOTED.
Action:	None identified.
3.	ANY OTHER BUSINESS
	No further items were identified.
4.	DATE AND TIME OF NEXT MEETING
	3 February 2026 at 12:00 pm
5.	CLOSE

Cwm Taf Morgannwg University Health Board – Annual Audit Summary 2025

Date issued: March 2026



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Foreword



Adrian Crompton

Auditor General for
Wales

I am pleased to share my Annual Audit Summary for Cwm Taf Morgannwg University Health Board (the Health Board). It summarises the main findings from my 2025 audit work undertaken to fulfil my responsibilities under the Public Audit (Wales) Act 2004 and the Well-Being of Future Generations (Wales) Act 2015.

I provided opinions on whether the accounts were properly prepared and gave a true and fair view, in all material aspects, and whether expenditure and income have been used for the purposes intended and in accordance with the authorities which govern you.

My audit team has also assessed whether the Health Board has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources, and acted in line with the sustainable development principle. In doing so, my audit team has undertaken my annual structured assessment work and reviewed planned care services, urgent and emergency care services, digital transformation, and eye care services. As set out in my audit plan, these reviews have been carried out in line with the [International Organisation of Supreme Audit Institutions \(INTOSAI\) standards](#).

At the time of publishing this summary, the Health Board was subject to Level 3 for performance and outcomes relating to planned care and cancer and Level 4 for performance and outcomes relating to urgent and emergency care under the [Welsh Government's escalation and intervention arrangements](#).

The detailed audit findings for each of my reviews are set out in the respective reports which my audit team have presented to the Audit, Risk and Assurance Committee throughout the year. The performance audit reports are available on the [Audit Wales website](#) and further links are available in the summary.

The Annual Audit Summary should be shared with the Board. I will then make the summary available to the public on the [Audit Wales website](#).

I would like to extend my gratitude to the Health Board's staff for their help and cooperation throughout my audits.

Your audit at a glance



I received the draft accounts in line with the statutory deadline of 2 May 2025. The quality of the draft accounts and working papers was good.



In advance of the statutory deadline of 30 June 2025, on 27 June I issued an unqualified true and fair opinion, and a qualified regularity opinion. There were no uncorrected misstatements in the accounts. There were no other significant issues to report.



My performance audit work found that the Health Board has sound corporate governance arrangements, a clear long-term strategy, and a balanced IMTP. However slow progress on the Strategic Clinical Services Plan is limiting the pace of transformation. Financial planning is robust, and the Health Board has a good track record of delivering against its financial plan. However, savings gaps, along with other financial risks will make achievement of financial targets challenging.

Long waits and planned care backlogs are reducing, though recovery was impacted by the October 2024 critical incident with the roof at the Princess of Wales hospital. Urgent and emergency care performance is still challenging and requires further improvement. Ophthalmology waits have fallen, but recovery targets are unmet, and poor eye care performance increases the risk of avoidable harm.



My audit team made several recommendations to the Health Board focused on strengthening risk management, service planning, and strategic coordination, while improving governance, clinical oversight, and operational efficiency to support transformation, enhance patient safety, and ensure sustainable performance.

My audit team made five recommendations to the Health Board regarding the 2024-25 accounts; four of which were accepted by management and are to be implemented for the 2025-26 accounts.



There is still some work outstanding from my Audit Plan dated April 2025. My team expects to complete this work by summer 2026.

Audit of accounts findings

Preparing annual accounts is an essential part of demonstrating the stewardship of public money. The accounts show the organisation's financial performance and set out its net assets, net operating costs, gains and losses, and cash flows. My annual audit of those accounts provides opinions on whether the accounts are properly prepared and give a true and fair view, in all material aspects, and the proper use ('regularity') of public monies.

My responsibilities in auditing the accounts are described in my [Statement of Responsibilities](#) publications, which are available on the [Audit Wales website](#).

The draft accounts were presented for audit on 2 May 2025, being the Welsh Government's deadline. The quality of the draft accounts presented for audit was generally good.

My audit opinions

I must report issues arising from my work to those charged with governance for consideration before I issue my audit opinion on the accounts. I reported these issues within my Audit of Accounts Report to the Audit, Risk and Assurance Committee on 25 June 2025, and then to the Board on 26 June.

True and fair

A relatively small number of changes were made to the draft accounts arising from my audit work. There were no uncorrected misstatements and no significant matters to report.

I concluded that the Health Board's accounts were properly prepared and materially accurate and issued an unqualified audit opinion on them.

Regularity

The Health Board is only allowed to receive income and incur expenditure in ways that follow the rules set by the authorities that govern it.

Further, where a Health Board does not achieve financial balance, its expenditure exceeds its powers to spend and so I must qualify my regularity opinion.

For revenue expenditure, the Health Board did not meet its financial duty to achieve financial balance for three-year period 2022-2023 to 2024-2025. For the three-year period the Health Board exceeded its revenue resource limit by £24.276 million and I therefore qualified my regularity opinion.

For capital expenditure, over the same three-year period the Health Board did achieve financial balance, with a surplus of £139,000.

All other material financial transactions were in accordance with authorities and used for the purposes intended, so I issued an unqualified opinion on the regularity of the financial transactions within Health Board's accounts. The Health Board met its second financial duty to have an approved three-year plan in place for the period 2024-2025 to 2026-2027.

Alongside my audit opinion, I placed a substantive report on the Health Board's accounts to highlight the failure to achieve financial balance

Whole of Government Accounts

I also undertook a review of the Health Board's Whole of Government Accounts return to Welsh Government for 2024-25. My audit results were satisfactory.

Performance audit findings

Structured assessment

My team looked at how well the Health Board is governed and whether it makes the best use of its resources.

I found that the Board operates well, supported by good governance arrangements. The new committee structure is embedding well. The Board engages with staff, patients, and service users but must improve how it monitors and tracks actions arising from listening and learning stories. While risk management is generally effective, there is a need to strengthen performance management to address persistent challenges in meeting key targets, particularly in urgent and planned care, cancer, and diagnostics. The Health Board needs to focus on maintaining improvements to service quality. It also needs to respond to some longstanding overdue audit recommendations.

The Health Board has a clear long-term strategy, and a financially balanced Integrated Medium-Term Plan that has been approved by Welsh Government. Work is also underway to develop the Strategic Clinical Services Plan, supported by the appropriate financial modelling. However, the Health Board is slow in progressing this work, impacting the Board's ability to drive forward service transformation at pace. Financial planning is strong, and the Health Board has a good track record of delivering against its financial plan. But gaps in savings plans, along with other financial risks, will still make achievement of financial targets challenging.

I made six recommendations focused on:

- reporting the impact of actions taken to mitigate organisational risks;
- taking urgent and sustained action to reduce risks identified by the Welsh Risk Pool;
- ensuring that implementation of audit recommendations is a key part of its new accountability framework;
- developing and implementing a strategy deployment framework to coordinate all strategic programs;
- standardising the IMTP 'Plans on a Page' to ensure consistency, clarity, and enable easier comparison of priorities and progress; and

- strengthening quarterly IMTP reporting by clearly demonstrating the impact of plan delivery across all required domains.

Managing Planned Care

My team looked at the progress the Health Board is making in tackling its planned care challenges and reducing its waiting list backlog.

I found that the Health Board is reducing the numbers of very long waits, although the October 2024 critical incident with the roof at the Princess of Wales hospital affected waiting list recovery. It has good short-term plans, but it needs to develop its clinical services plan to help shape services that can sustainably meet expected growth in demand in the longer term. It also needs to improve how it reports on harm resulting from planned care delays.

I made six recommendations focused on:

- establishing longer-term milestones, linked to clinical service plan development;
- strengthening the management of risks related to the delivery of planned care;
- monitoring the impact of additional funding for planned care recovery;
- securing improvements in efficiency and productivity within planned care pathways ;
- strengthening actions to achieve its treat in turn performance target; and
- managing clinical risks associated with long waits.

Eye Care Services

Building on the wider Planned Care work summarised above, my team looked at whether the Health Board has effective arrangements to improve eye care services. The work reviewed both local and regional arrangements.

I found that the regional eye-care strategy sets a positive direction, but progress with implementation has been slow. Governance arrangements are in place to oversee regional delivery, but decision-making on business cases can be slow and cumbersome, involving multiple groups across the three health boards. It is worth noting that regional working has shifted

away from its original ambition of developing specialist services more broadly, focusing instead on creating short-term service capacity for cataract procedures. While the regional cataract approach aims to reduce long waits, at the time of my work it had not significantly impacted the overall number of patients awaiting treatment.

The Health Board has reduced the longest ophthalmology waits but is not yet meeting planned care recovery targets. Performance against the 'eye care measure' is poor, and long waits increases the risk of avoidable harm. There is a need to strengthen local planning of eye care services, broaden the scope of regional working and secure further productivity and efficiency gains.

I made six recommendations, three for the Regional Ophthalmology Programme Board and three for the Health Board. These focussed on:

- regional partners speeding up decision-making processes for agreeing business cases;
- regional partners developing a resource plan;
- regional partners agreeing realistic but appropriately ambitious timescales for the three phases of the South East Wales Regional Ophthalmology Strategy;
- developing a sustainable eye care plan;
- monitoring and oversight of ophthalmology; and
- progress addressing ophthalmology GIRFT¹ recommendations.

Managing urgent and emergency demand

My team looked at how well the Health Board is managing demand for urgent and emergency care to reduce unnecessary pressure on the system.

¹ Getting It Right First Time

I found that urgent and emergency care service performance continues to be challenging. Whilst plans and new services, including the Navigation Hub, are having a positive impact on managing demand, further action is needed to improve access, patient and staff engagement and clarify resource requirements.

I made nine recommendations focused on:

- resourcing urgent and emergency care plans;
- improving information on services which provide alternatives to emergency departments;
- monitoring data from those alternative services;
- monitoring compliance with national guidance;
- improving data quality;
- ensuring patient and staff feedback informs service delivery plans; and
- oversight and scrutiny of plans and performance in respect of urgent and emergency care.

Performance audit work still underway

At the time of reporting, the following reviews from the 2025 Audit Plan were still underway at the Health Board:

- patient flow out of hospital;
- digital transformation;
- cancer services;
- estates management; and
- follow-up outpatients.

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 three lines of assurance to show how we achieve this. We have set up 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	• Learning and development
• Ethics	• Leadership
• Guidance	• Technical support
• Culture	



Independent assurance

• EQRs	• Peer review
• Themed reviews	• Audit Quality Committee
• Cold reviews	• External monitoring
• Root cause analysis	

Further information

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



Structured Assessment 2025

Cwm Taf Morgannwg University Health Board

December 2025

About us

We have prepared and published this report under section 61(3) (b) of the Public Audit Wales Act 2004.

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Audit snapshot

What we looked at

- 1 We looked at how well Cwm Taf Morgannwg University Health Board (the Health Board) is governed and whether it makes the best use of its resources. We looked at four areas in particular:
 - how well its board works;
 - how it keeps track of risks, performance, service quality, and recommendations;
 - how it produces key plans and strategies; and
 - how it manages its finances.
- 2 We also looked at the Health Board's progress in implementing recommendations from:
 - previous structured assessment reports; and
 - our 2024 report on cost savings.

Why this is important

- 3 NHS bodies continue to face a wide range of challenges associated with the need to modernise and transform services to deal with constrained finances, growing demand, treatment backlogs, workforce shortages, and an ageing estate. It is therefore more important than ever for the boards of NHS bodies to have strong corporate and financial governance arrangements in place. This helps provide assurance to themselves, the public, and key stakeholders that they are taking the right steps to deliver safe, high-quality services and to use public money wisely.

What we have found

- 4 The Board operates well, supported by good governance arrangements. The new committee structure is embedding well. The Board engages with staff, patients, and service users but must improve how it monitors and tracks actions arising from listening and learning stories. While risk management is generally effective, there is a need to strengthen performance management to address persistent challenges in meeting key targets, particularly in urgent and planned care, cancer, and diagnostics. The Health Board needs to focus on maintaining improvements to service quality. It also needs to respond to some longstanding overdue audit recommendations.
- 5 The Health Board has a clear long-term strategy, and a financially balanced Integrated Medium-Term Plan that has been approved by Welsh Government. Work is also underway to develop the Strategic Clinical Services Plan, supported by the appropriate financial modelling. However, the Health Board is slow in progressing this work, impacting the Board's ability to drive forward service transformation at pace. Financial planning is strong, and the Health Board has a good track record of delivering against its financial plan. But gaps in savings plans, along with other financial risks, will still make achievement of financial targets challenging.

What we recommend

- 6 We have made six recommendations to the Health Board which focus on:
 - clearly reporting the impact of actions taken to mitigate organisational risks within its organisational risk register.
 - taking urgent and sustained action to reduce risks identified by the Welsh Risk Pool.
 - ensuring that implementation of audit recommendations is a key part of its new accountability framework.
 - developing and implementing a strategy deployment framework to coordinate all strategic programs and ensure successful delivery of its long-term strategy.
 - standardising the IMTP 'Plans on a Page' to ensure consistency, clarity, and enable easier comparison of priorities and progress.

- strengthening quarterly IMTP reporting by clearly demonstrating the impact of plan delivery across all required domains.

Key facts and figures

Within the Welsh Government's Escalation and Intervention framework, the Health Board is currently at level 4 (targeted intervention) for Urgent and Emergency Care, and level 3 (enhanced monitoring) for Planned Care.

The Health Board has an approved three year Integrated Medium-Term plan (IMTP) for 2025-28.

In 2024-25, the Health Board met its financial targets by breaking even on both revenue and capital spending. However, it did not meet its duty to break even over the last three years because of a £24.2 million deficit reported in 2022-23.

In 2024-25, the Health Board aimed to achieve £26.3 million in savings but achieved £13.1 million.

The Health Board is forecasting a break-even position for 2025–26 but faces £1.3 million in risks. Of its £31.3 million planned savings, £26.5 million (85%) are recurrent.

The Health Board has fully implemented 11 outstanding recommendations from previous structured assessment reviews. 12 remain in progress, 2 are overdue and one has been replaced by a new recommendation made this year.

Our findings

Board effectiveness and openness

The Board conducts its business effectively, with an ongoing commitment to continuous improvement.

Public openness of board business

- 7 The Health Board continues to demonstrate that it is being open and transparent about Board and committee activities:
 - it continues to publish recordings of all public Board meetings;
 - the public can observe any public Board meeting;
 - usually publishes Board and committee papers on its website a week before each meeting¹;
 - live Welsh translation and British Sign Language (BSL) are available for Board meetings on request;
 - private sessions are used only for sensitive or confidential matters, with clear agenda references; and
 - discussions in Board and committee meetings remain open and transparent, especially when discussing challenges.
- 8 The Health Board does not advertise or issue public notices for committee meetings, but it considers any attendance requests with the Chair when they arise.

¹ The Health Board does not publish papers for its Clinical Advisory Groups, Local Partnership Forum and Remuneration and Terms of Service Committee due to their confidential nature.

- 9 The Health Board publishes Board and committee minutes on its website after confirming them at the next meeting. As part of the Health Board's assurance process, they include committee reports in the papers for all routine public Board meetings which clearly articulate any areas requiring escalation.

Supporting effective board conduct

- 10 The Health Board has clear and up-to-date governance arrangements that help the Board and its committees run effectively. It maintains a formal Reservation and Delegation of Powers and a Scheme of Delegation which sets out accountabilities, with dedicated webpages for Standing Orders and Standing Financial Instructions.
- 11 The Audit, Risk and Assurance Committee oversees compliance with Standing Orders, Standing Financial Instructions, and the Scheme of Delegation, and monitors breaches through regular reports.
- 12 The Health Board has good arrangements to promote probity and propriety. It maintains comprehensive policies and procedures. It reviewed the Standards of Good Governance and Probity policy in May 2025 and routinely reports declarations of interest and gifts to the Audit, Risk and Assurance Committee. It is improving policy tracking through the Policy Review which commenced in January 2025, all identified policies on its public facing policy page on the external website are now up to date.

Assurance on Joint Commissioning Committee effectiveness

- 13 The Joint Commissioning Committee (JCC) was set up in April 2024 as a joint committee of the seven health boards in Wales. The JCC plans and commissions a range of specialised services and other healthcare services, including emergency medical services, on behalf of the seven health boards.
- 14 As part of this year's structured assessment, we reviewed whether the Board is receiving the right level of assurance on JCC business, as well as the Health Board's involvement in JCC meetings and activities.

- 15** As the host body for the JCC, the Health Board applies its own governance arrangements to support and oversee the committees that form part of the hosting model. The hosted body Audit, Risk and Assurance Committee is not a standalone entity but forms part of the CTM governance structure. It operates using the Health Board's resources, including the same Committee Chair, Independent Members and governance support, and one JCC lay member is invited to attend. In addition, the JCC utilises the Health Board's Remuneration and Terms of Service Committee and has adopted the Health Board's risk management processes. The Chief Commissioner has quarterly meetings with the Chief Executive of the Health Board. These arrangements enable the Health Board in its role as the host body to seek necessary assurance from the JCC, where required.
- 16** Separately, in its commissioning role, the Chief Executive of the Health Board is a member of the JCC and participates in its decision-making process. The Board receives appropriate assurance and information on the work of the JCC. Board papers include JCC-related items such as approval of the updated Scheme of Delegation, highlight reports with RAG ratings, and updates from the Chief Commissioner. These provide the Board with visibility of JCC activity that is distinct from the additional governance responsibilities it undertakes as the host body.

Board and committee meeting effectiveness

- 17** In January 2025, the Health Board introduced a new committee structure to provide more efficient and effective management of Board and committee business and provide greater strategic and operational oversight of the organisation. It reduced the number of previous Board committees from nine to seven and has created a new Strategic Development and Operational Delivery Committees. The revised arrangements are embedding and maturing, though there were some initial challenges. At times large agendas for the newly created committees have caused some items to be rushed, potentially limiting scrutiny and oversight. Each committee effectively maintains an annual business cycle and forward work plan.

- 18** In October 2025, the Board reviewed the new arrangements, identifying strengths and areas for improvement in agenda setting, scheduling, and business flow. The Corporate Governance Team is now implementing a range of agreed actions to address the issues identified.
- 19** Board and committee meetings are in general operating well. There are clear work plans and committee chairs help set the agenda using the Board Assurance Framework. Routine business is effectively managed through a consent agenda. Meetings are well chaired, with all members able to contribute to key issues, and there is a good balance of challenge and support. Issues are effectively shared and escalated between committees and the Board, with clear actions identified in response.

Quality and timeliness of Board information

- 20** Board and committee papers are generally timely, well-structured, and highlight key risks and decisions. Cover reports follow a standard format, and impact assessments are routinely completed. We previously recommended that the Health Board updates its presentation cover sheets to show key points and risks. It has now addressed this issue, and the Corporate Governance team provides training to staff on report writing upon request and reviews all papers before meetings to ensure quality and compliance. Members value the quality, but some reports could be better summarised to focus on key issues and reduce overall length of papers. While most reports are issued on time, late papers occasionally limit members' ability to review them fully, prior to the meeting².

² The papers for the Extra Ordinary Operational Delivery Committee meeting that took place on 19th May 2025 were published three calendar days in advance of the meeting.

Hearing from staff and service users

- 21** The Health Board engages staff, patients, and service users through listening and learning stories, spotlight presentations, staff surveys, roadshows, and Board walkarounds. With consent, it publishes patient story videos on its website. These stories inform service improvements which were reported to the Board at its meeting in November 2025 showing learning and improvement arising from patient and service user feedback. However, the Health Board must strengthen how it monitors and tracks the impact of improvement actions.

Board cohesion and continuous improvement

- 22** The Health Board has a stable, cohesive Board. Over the last year, it appointed a new Executive Director of Strategy and Transformation, an Executive Director of Nursing, Midwifery and Patient Care, and split Deputy Chief Executive responsibilities between the Chief Operating Officer and Executive Director for People.
- 23** The Health Board effectively inducts and supports its new Board members. During the year it has appointed two Independent Members representing Digital and Local Government. It has also appointed an associate Board Member for Primary Care. Further changes will follow in 2026 when one further Independent Member completes her term.
- 24** The Board and its committees conduct annual self-assessments to review how well they are working. The results from these were generally positive, requiring no major changes. However, some committee's self-assessment response rates were low so there is an opportunity to understand and address the reasons for this.
- 25** The Health Board has a comprehensive Board development programme. This year's sessions covered strategic risk, board assurance, board business, and team building. These sessions strengthen relationships, strategic insight, and networking. Member feedback and Board priorities effectively shape the forward board development programme.

Providing board assurance

The Health Board manages risk well but must show clearer impact from mitigating actions and deliver measurable improvements in performance and quality, especially in high-risk areas.

Managing strategic risks

- 26 The Health Board maintains a comprehensive Board Assurance Framework (BAF) that the Board reviews at every meeting. It captures and monitors key strategic risks aligned to the Health Board's long-term strategy. Each risk clearly identifies a lead director, an assurance committee, a score, a trajectory, and a defined treatment approach.
- 27 The BAF sets out controls, assurance sources, gaps, and mitigating actions. It is updated regularly, escalating or closing risks in response to emerging issues and Board decisions. However, while actions specify intended impacts, the BAF should also track actual impacts to demonstrate effectiveness and support learning.

Managing corporate risks

- 28 The Health Board operates a clear risk management system, updating and reviewing policies and procedures annually. The Corporate Governance Team delivers risk training across the organisation. Committees regularly review the organisational risk register in both public and private meetings, where members routinely examine and discuss risks. The Audit, Risk & Assurance Committee reviews the full register, including new, closed, and emerging risks, and uses a heat map to highlight the highest risks. While the register is detailed and up to date, the Health Board can do more to clearly show and explain how its actions are actually reducing risks.

Managing performance

- 29 The Health Board has reasonable arrangements for managing performance. It is currently developing its accountability framework and will shortly be running a Board development session aimed at improving performance reporting.
- 30 The Integrated Performance Report aligns to national priorities and includes dashboards with trend data, benchmarking, and quality measures. It highlights key risks such as emergency care pressures, delays in elective recovery, workforce shortages, and financial challenges. The Board reviews the report closely asking for extra assurance when needed. Although actions for underperforming areas are in place, the Integrated Performance Report still does not clearly demonstrate whether these actions are achieving their intended impact.
- 31 During the year, the Health Board made progress by improving performance in Child and Adolescent Services, aspects of Planned Care, and Cancer Services. However, major challenges remain. Long waits for planned care and diagnostics continue, and outpatient backlogs still need addressing. Cancer performance at the Health Board remains mixed. While some services are achieving the Single Cancer Pathway target, significant challenges persist in Urology, Breast, and Colorectal cancer services. Urgent and emergency care remains a significant challenge because ambulance handover delays, long waits in emergency departments, and patient flow problems persist. Staff shortages and high demand add to these issues.

Monitoring quality and safety

- 32 The Health Board has built a strong foundation for quality although there is a need for further action in a number of areas. The Quality Strategy and Framework set clear goals for safe, compassionate care, and the Board and the Quality, Safety and Experience (QSE) Committee oversee progress. They use dashboards and reports to track key quality measures, incidents, and improvements, including maternity services and annual quality reports.

- 33** The Health Board has made improvements to help reduce quality risks. These include better complaint handling and new quality improvement projects, but risks remain. However, staff shortages, infection control, and service pressures all present ongoing challenges. End-of-life care services remain a serious concern. Internal audit found major gaps in leadership, staff training, public information, and oversight. A recent Board story also showed that this area needs urgent improvement.
- 34** The Health Board is not always meeting the requirements of the national Welsh Risk Pool service when they identify quality issues that need addressing. Even though the Board has quality policies and frameworks, the Welsh Risk Pool Concerns Assessment report found that they are not consistently applied across the organisation. Delays in submitting Learning from Events Reports have led to financial penalties and the Health Board is slow to demonstrate that it has learnt from mistakes. The Health Board needs to clear the overdue reports, learn from incidents, and make sure all staff understand and follow quality processes.
- 35** The Board is putting the Duties of Quality and Candour into practice and has redesigned the Duty of Quality report as an interactive digital resource. This new report brings together dashboards, patient stories, and feedback from stakeholders. As previously recommended, the Health Board needs to highlight the challenges it is facing in meeting the requirements of the duties and set clear milestones and targets to track improvement.

Tracking and monitoring recommendations

- 36** The Health Board has reasonable arrangements for tracking and acting on audit recommendations, although there are instances where progress is slow. It uses the AMaT³ system to monitor actions from Internal Audit, Audit Wales, and Healthcare Inspectorate Wales. The system provides live updates, clear ownership, and executive sign-off. Regular reminders and escalation help keep progress on track, and overdue actions have reduced, especially for Internal Audit. Reports to Audit Risk and Assurance and Quality, Safety and Experience Committees give structured updates, and further improvements are planned to enhance the system.
- 37** An Internal Audit review of the Audit Recommendations Tracker gave a reasonable assurance rating but did identify that some actions are still late or have very long deadlines, and the process for closing actions is not fully consistent.
- 38** The Health Board is making slow progress in addressing our previous recommendations:
- 11 out of 26 recommendations from past structured assessment reports are now complete. Of the 15 remaining recommendations currently 12 are in progress, two are past their planned completion date, and one has been replaced by a new recommendation made this year.
 - Four out of eight of our 2024 Review of Cost Savings recommendations have been completed. We discuss this more in paragraph **62**.
- 39** The Health Board recognises it needs to strengthen ownership and accountability for actions arising from audit work. To strengthen accountability for improvement, progress on audit recommendations should feature within in the new Accountability Framework.

³ AMaT is an audit management and tracking tool, which utilises dashboards to give intelligence, and enables staff to update progress in real time reducing the burden on governance teams as it automates many of the processes, such as asking for progress updates.

- 40** The Executive Team must take stronger collective ownership and support for audit activity. Throughout the year, the Audit Risk and Assurance Committee received repeated notifications from internal and external auditors about delays in management providing information and responding to some audit reports, particularly about the intended action in response to recommendations. These delays have significantly slowed audit delivery. These issues did not relate to the statutory audit of the financial accounts, where no delays were reported. While recognising senior management face significant service pressures, the Health Board should take all reasonable steps to support timely delivery of audit work and responses to recommendations arising from that work.

Preparing strategies and plans

The Health Board has a clear strategic vision and an approved medium-term plan, although it needs to strengthen some aspects of the way it monitors delivery of its plans.

Producing key strategies and plans

- 41** The Health Board is progressing its long-term strategy, CTM2030: Building Healthier Communities Together, which sets out an ambitious vision to transform health and care. Its four goals, Creating Health, Improving Care, Sustaining Our Future, and Inspiring People, focus on prevention, equity, and sustainability. The strategy aligns with national priorities and supported by key programmes such as the Strategic Clinical Services Plan, Primary and Community Care transformation, and digital programme.

- 42** While the Health Board is demonstrating progress on key strategic projects including Llantrisant Health Park⁴ and Maesteg Community Hospital⁵, progress on developing its Strategic Clinical Services Plan is slow. It is now developing a refreshed plan for 2026–2036 to integrate acute, community, and primary care, supported by digital, workforce, and finance. Engagement has started, but the plan must set out a clear case for change, define milestones, and detail resource requirements. The Health Board is currently creating a strategy deployment framework. The aim of this framework is to coordinate all strategic programmes and deliver service change with greater pace and manage any capacity and sustainability risks.
- 43** The Health Board operates a robust process to develop, approve, and submit a financially balanced Integrated Medium-Term Plan (IMTP). This includes using population health data, needs assessments, and engagement with staff, partners, and the public to inform development. Board members actively contribute to plan development through Board development sessions.
- 44** The 2025–28 IMTP sets out how the Health Board will deliver its strategic goals and aligns with national priorities. The Board approved the IMTP in March 2025, meeting the timeframe for submission to the Welsh Government. The Welsh Government subsequently approved the plan, indicating that for a second year, there continues to be confidence in the Health Board's ability to deliver improvements. We note that the Health Board was the only health board in Wales to submit a balanced IMTP for 2025-28 that was subsequently approved by the Welsh Government.

⁴ The Llantrisant Health Park Programme aims to deliver a cutting-edge diagnostics and treatment centre.

⁵ The Health Board is progressing a case for the development of a health and wellbeing centre for Maesteg.

Board assurance on partnership working

- 45 The Board has good arrangements for receiving assurance on partnership working at local, regional, and partnership levels. Board agendas include a standing item on 'Population / Working with Others', covering topics such as the Well-being of Future Generations Act, regional partnership agreements, and joint committee updates.
- 46 At its July 2025 meeting, the Board approved a Regional Partnership Agreement with the three local authorities within the Cwm Taf Morgannwg footprint. The agreement aims to bring health and social care services together under shared governance and joint accountability. It focuses on prevention, early help, and better outcomes for people across the region. Partners will work jointly to plan services, share resources, and reduce duplication to make care more efficient and easier to access.
- 47 In April 2025, Welsh Government instructed the Chairs of Aneurin Bevan, Cwm Taf Morgannwg and Cardiff and Vale University Health Boards to establish a South-East Wales Regional Joint Committee. In September 2025, the Board approved the establishment of the Committee and approved its terms of reference. The committee's purpose is to drive regional planning and service transformation, improve health outcomes and equity, foster collaboration between organisations, and provide coordinated support to health boards in priority areas. The first meeting took place in November 2025 meaning that it is too early to judge its impact.
- 48 Our recent eye care review across each of the health boards in the south east Wales region shows that whilst some progress is being made, the intended benefits of regional working are yet to be fully achieved and complex governance structures can make decision-making slow and cumbersome. The South-East Wales Regional Joint Committee presents an opportunity to consider how delegated authority and decision-making processes are streamlined.

Monitoring delivery of strategies/plans

- 49** The Health Board has adequate arrangements for overseeing its IMTP. The IMTP 2025–28 aligns with CTM2030 and is delivered through five ‘life-course strategy groups’⁶. Each group produces a “plan on a page” that sets out vision, priorities, actions, outcomes, timelines, and performance indicators. However, the level of detail and structure in these plans varies across groups. For example, the Starting and Growing Well ‘plan on a page’ shows priorities, enablers, success measures, and outcomes. In contrast, the Adulthood / Living Well version only lists priorities and actions.
- 50** Quarterly IMTP updates go to the Operational Delivery Committee and Board. They show last quarter’s progress and delivery against IMTP actions. Cover reports set out key points and challenges and include detailed appendices. While progress against acute services targets is clear and reported through the Integrated Performance Dashboard, further work is required to show impact of plan delivery in other areas, such as primary and community services. Population health outcome measures are still in development.
- 51** While the Health Board has adequate arrangements for overseeing its IMTP, its oversight of wider corporate strategies and plans⁷ needs strengthening. Although these plans set out clear priorities they need clearer milestones, outcomes, and accountability for delivery. Reports on these plans also fail to clearly show delivery progress, risks, actions to reduce risks, and updated timelines.

⁶ The ‘life course’ strategy groups are: starting well, growing well, living well, ageing well, and dying well.

⁷ Integrated Community Services – Primary Care Strategy, Creating Health Delivery Plan, People Plan 2025-28, and Safeguarding Strategy.

Managing finances

The Health Board's financial planning and oversight are robust, but significant risks and savings shortfalls continue to present challenges to the financial position.

Meeting financial objectives and duties

- 52 The Health Board met its financial targets for 2024-25, achieving a break even position for revenue and capital. However, it did not meet its duty to break even over the last three years because of a £24.2 million deficit reported in 2022-23. If the Health Board can achieve break even in 2025-26, it would achieve the three year financial duty for the period 2023-26.
- 53 The Health Board is reporting a £1.4 million deficit in February 2026 and is forecasting a break-even position by the end of the 2025–26 financial year. However, it is managing some financial risks which may impact on its forecast position. This is caused by a £5.6 million gap in meeting savings targets, along with £1.3 million in additional financial risks.

Financial planning arrangements

- 54 The Health Board has strong financial planning approaches that align to its wider priorities. The Board approved its 2025–26 financial plan as part of the IMTP approval process in March. The plan outlines the underlying deficit faced at the beginning of the year, inflationary pressures, and a £31.3 million savings target. As it has done over the last two years, the 2025–28 plan aims to continue to break even over the next three years. This demonstrates good financial planning, prioritisation and control.
- 55 The Health Board understands what drives its costs. Its IMTP sets out risks and opportunities. Main risks include workforce, service delivery and transformation, and capital and estates. Opportunities include saving money through energy and decarbonisation projects, better medicines management, and digital transformation

- 56** The Health Board continues to maintain a strong focus on achieving financial balance. While this approach can limit spending and additional investment in services, it has still identified discretionary service investments within its IMTP, supported by a strengthened quality impact assessment process. The Health Board has committed £2.9 million investments⁸, with an additional £3.4 million⁹ dependent on an improved financial position.
- 57** CTM2030 aims to secure financially sustainable services. The Board is currently developing its Strategic Clinical Services Plan and appropriate financial modelling to support this priority.
- 58** The Health Board has increased the scale of its savings programme for 2025–26, aiming to save 3% of its total expenditure. This equates to £31.3 million, which is £8.1 million more than last year. The plan focuses on Care Groups achieving a savings target of £21.7 million through a range of locally driven initiatives.
- 59** In addition, the Health Board has also introduced a centrally driven savings programme focussing on improving medical and nursing workforce productivity, service changes, and patient-centred contact¹⁰ Each savings area has an Executive Team lead, with the Executive Director for People leading the coordination and assurance processes for the programme. This shared leadership ensures that it is not only finance teams driving savings, and there is a broader focus on value and improvement. Regular meetings, fortnightly progress checks, and monthly reviews by the Executive Management Board keep the programme on track, manage risks, and align financial, workforce, and service goals.

⁸ The Health Board has committed £2.9 million investments into Health Protection, Prince Charles Hospital Intensive Care Unit, Fracture Liaison Service, Consultant Recruitment, Speak Out Guardians, Digital Investment, Velindre Business Cases and Strategies Support.

⁹ The additional £3.4 million investments relate to NICE Diabetes (CLPS), PMVA Training, Children's Weight Management, and Digital Investment.

¹⁰ Patient-centred contact savings are cost reductions achieved by re-designing how patients interact with health services, making contact more efficient, digital and focussed on patient needs.

- 60** Progress against savings plan delivery is slower than anticipated. By Month 7, the Health Board has saved £10.8 million, which is £7.5 million less than the £18.3 million target for that point in the year. As a result, the Health Board is now expecting to save £25.3 million by the end of this year - £6 million below the original £31.3 million target.
- 61** Internal Audit followed up their review of cost savings arrangements in May 2025 gave a reasonable assurance rating. It confirmed the Health Board is making good progress on their previous audit recommendations but also audit found gaps in savings project plans and risk assessment documentation. In 2024, Audit Wales reviewed the Health Board's approach to cost savings. Of the eight recommendations, the Health Board has made some progress with three completed and five in progress. Areas which require further work are set out in **Appendix 2**.

Financial management arrangements

- 62** The Health Board has strong financial management arrangements. The Board and the Audit, Risk and Assurance Committee regularly review reports on changes and breaches of Standing Orders and Financial Instructions. The Committee monitors losses, special payments, post payment verification, scheme of delegation, single tender actions, and high-value purchases. The latest updates in November 2025 do not identify any significant issues.
- 63** We previously recommended that the Health Board update its financial control procedures. Recent reports to the Audit, Risk and Assurance Committee demonstrate that procedures have been updated in response to our recommendation. Counter Fraud plans include both proactive and reactive work. Recent counter fraud updates confirm progress in key risk areas and report no major risks. A recent internal audit of petty cash and special payments gave substantial assurance, finding only minor compliance issues.

- 64** The Health Board submitted its draft unaudited 2024-25 Annual Report and Accounts by the Welsh Government's deadline. The Auditor General issued an unqualified true and fair audit opinion, and a qualified regularity opinion based on the Health Board's inability to achieve financial balance over the last 3 years.

Monitoring financial performance

- 65** Officers give clear financial reports to the Operational Delivery Committee and Board. These reports show key risks to financial targets and explain funding and delivery challenges. This openness helps inform Board decision making, particularly in relation to prioritising investment and understanding the consequences of decisions.
- 66** Board members continue to provide a strong focus on the Health Board's financial performance. Finance officers give clear and detailed answers to Board member questions. Their reports along with active involvement from both officers and Board members, help support good decisions and financial accountability.

Recommendations

The following table details the recommendations arising from our work.

Recommendations

R1	The Health Board should clearly report the impact of actions taken to mitigate organisational risks within its organisational risk register. (see paragraph 28)
R2	The Health Board should take urgent and sustained action to reduce risks linked to the Welsh Risk Pool by: 1.1 Completing outstanding actions identified in the Welsh Risk Pool Concerns Assessment report; 1.2 Rectifying weaknesses highlighted by internal audit in its review of the Welsh Risk Pool; and 1.3 Improving timeliness in submitting Learning from Events Reports (LFERs). (see paragraphs 34)
R3	The Health Board should ensure that accountability for progressing audit recommendations is a key part of its new Accountability Framework. (see paragraph 39)

R4 By April 2026, the Health Board should develop and implement a strategy deployment framework to coordinate all strategic programmes and ensure successful delivery of its long-term strategy. **(see paragraph 42)**

R5 The Health Board should standardise the content of its IMTP 'Plans on a Page' to ensure consistency, clarity, and enable easier comparison of priorities and progress. **(see paragraph 49)**

R6 The Health Board should strengthen quarterly IMTP reporting by clearly demonstrating the impact of plan delivery across all required domains so that progress and challenges are visible. **(see paragraph 50)**

Appendices

1 About our work

Scope of the audit

We looked at the following areas for the period September 2025 to November 2025

- How well the board works.
- How well the board oversees risks, performance, and the quality and safety of services and tracks recommendations.
- How well the body prepares key strategies and plans.
- How well the body manages its finances.

We did not look at the body's operational arrangements.

Audit questions and criteria

Questions

Our audit addressed the following questions:

- Does the Board conduct its business appropriately, effectively, and transparently?
- Is there a sound corporate approach to managing risks, performance, and the quality and safety of services?
- Is there a sound corporate approach to producing strategic plans and overseeing their delivery?
- Is there a sound corporate approach to financial planning, management, and performance?

Criteria

Our audit questions were shaped by:

- Model Standing Orders, Reservation and Delegation of Powers.
- Model Standing Financial Instructions.

- Relevant Welsh Government health circulars and guidance.
- The Good Governance Guide for NHS Wales Boards (Second Edition).

Methods

We reviewed a range of documents, including:

- Board and committee papers and minutes.
- Key governance documents, including Standing Orders and Standing Financial Instructions.
- Key strategies and plans, including the IMTP.
- Key risk management documents, including the Board Assurance Framework.
- Annual Report, including the Annual Governance Statement.
- Relevant policies and procedures.
- Reports prepared by other relevant external bodies.

We interviewed the following key stakeholders:

- Chair of the Board
- Chair of the Strategic Development Committee
- Chair of the Operational Delivery Committee
- Chair of the Audit, Risk and Assurance Committee
- Chair of the Quality, Safety and Experience Committee
- Chief Executive
- Executive Director of Finance
- Chief Operating Officer
- Executive Director of Nursing, Midwifery and Patient Care
- Executive Director of Allied Health Professions and Health Science
- Executive Director of Strategy and Transformation
- Director of Governance / Board Secretary
- Assistant Director of Governance and Risk

We observed Board meetings as well as meetings of the following committees:

- Public Board
- Audit, Risk and Assurance Committee
- Strategic Development Committee
- Operational Delivery Committee
- Quality, Safety and Experience Committee

2 Previous audit recommendations

Outstanding recommendations from previous structured assessment reports

The table below sets out the progress made by the Health Board in implementing outstanding recommendations from previous structured assessment reports.

2022 Recommendations	
R1	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: b) publish the papers for all public Board, committee, and advisory meetings on its website in a timely manner; (Complete, paragraph 7) d) update presentation cover sheets to enable authors to summarise the information sufficiently and capture the relevant risks and issues. (Complete, paragraphs 20)
R4	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. (Complete, paragraph 49)

2022 Recommendations

R5 We found opportunities for the Health Board to enhance its arrangements for monitoring the delivery of corporate plans and strategies, and reporting progress to the Board. The Health Board, therefore, should enhance its arrangements by ensuring:

- a) plans and strategies contain clear summaries of key actions / deliverables, timescales, and measures to support effective monitoring and reporting; **(Overdue, paragraph 51)**
- b) plans and strategies provide greater detail on which Executive Directors are responsible for the delivery of key actions / deliverables to enable appropriate accountability; **(Overdue, paragraph 51)**
- c) reports are aligned to performance reports to enable the Board to assess the extent to which the implementation of key actions / deliverables is having a positive impact on Health Board performance. **(Superseded, 2025 Recommendation 6)**

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:

- c) ensure out-of-date financial control procedures are removed from its website and replaced with the current versions. **(Complete, paragraph 63)**

R9 There is limited capacity within the Health Board to fully deliver its digital transformation agenda. The Health Board, therefore, should seek to set out in its refreshed Digital Strategy how it intends to overcome staffing and funding challenges to fully exploit the benefits offered by digital technologies and solutions. **(Complete, assessed as part of our digital transformation review)**

2023 Recommendations

- R2** The Health Board makes good use of videos in committee meetings to present patient and staff stories. However, they are not subsequently made available on the Health Board's website. The Health Board, therefore, should ensure that any videos shown during committee meetings are made available on its website for completeness with agreement of the contributors. **(Complete, paragraph 21)**
- R3** Draft committee meeting minutes are produced quickly and reviewed by the relevant chair; however, they are not made publicly available until the papers of the subsequent meeting are published. Furthermore, committee meetings are not livestreamed or recorded for public use. The Health Board, therefore, should consider putting appropriate arrangements in place to ensure the public have timelier access to records of committee meetings as part of its wider efforts to enhance transparency of Board business. **(Complete, paragraph 9)**
- R4** Whilst the Board and committees review and confirm the minutes of previous meetings, they are not always uploaded to the Health Board's website in a timely manner. The Health Board, therefore, should ensure that all confirmed minutes are uploaded to the relevant section of its website in a timely manner to ensure the public have full access to the approved records of meetings. **(Complete, paragraph 9)**
- R5** Whilst the Health Board has a dedicated area on its website for policies and procedures, some of them are out of date. The Health Board, therefore, should ensure that all policies and procedures on its website are up-to-date and, if not, put a clear plan in place to revise and approve them. **(Complete, paragraph 12)**
- R6** 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. **(In progress, paragraph 29)**

2024 Recommendations	
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. (In progress, paragraph 12)
R2	The Health Board should introduce arrangements for identifying and monitoring actions arising from its listening and learning stories. (In progress, paragraph 21)
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. (In progress, paragraph 27)
R4	The Health Board should strengthen its Integrated Performance Dashboard by clearly articulating whether actions to improve underperformance are achieving their intended impact. (In progress, paragraph 30)
R5	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; (In progress, paragraph 35) R5.2 including appropriate milestones and targets to help the reader understand when it is aiming to achieve priorities. (In progress, paragraph 35)

2024 Recommendations

R6 The Health Board should:

- R6.1 ensure that it rapidly completes its work to strengthen the audit recommendations tracker; **(Complete, paragraphs 36)**
- R6.2 strengthen ownership and accountability for delivery of audit recommendations. **(In progress, paragraphs 39)**

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. **(In progress)**

R8 The Health Board should develop and report on population outcome measures to demonstrate the impact of its strategy delivery. **(In progress, paragraph 50)**

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. **(In progress, paragraph 51)**

R10 The Health Board should:

- R10.1 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. **(Complete, paragraph 56)**
- 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. **(In progress, paragraph 57)**

Recommendations from our 2024 Review of Cost Savings Arrangements

The table below sets out the progress made by the Health Board in implementing recommendations from our 2024 Review of Cost Savings Arrangements.

Recommendation
R1 The Health Board should assess operational savings delivery potential and risks within each Care Group and Clinical Service Group on an ongoing basis. (Complete)
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. (In progress)
R3 The Health Board should make improvements to how it uses data and intelligence to inform its savings identifications and selections arrangements by: R3.1 Extending its use of data and intelligence across a wider range of services. (In progress) R3.2 Rapidly progressing work on its local data repository to facilitate the systematic capture of benchmarking data. (In progress)

Recommendation

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. **(Complete)**

R5 Plans for service transformation (five 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. **(In progress)**

R6 The Health Board should ensure stronger operational accountability for savings delivery and manage risks to its underlying position more effectively. **(Complete)**

R7 The Health Board should ensure that there are sufficient skills, capacity and capability across its corporate and operational teams to effectively deliver its longer-term service transformation. **(In progress)**

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. **(In progress)**

3 Key terms in this report

Term	Description
Board Assurance Framework	A Board Assurance Framework sets out the risks linked to the organisation’s strategic objectives, and the controls and assurances in place to manage those risks.
Strategic Clinical Services Plan	The Strategic Clinical Services plan is a long-term plan that helps shape how healthcare services are designed and delivered to meet the needs of patients and communities.
Corporate Risk Register	A Corporate Risk Register sets out the organisation’s significant risks (either those with high scores or organisation-wide impact) and the actions in place to manage them.
Counter Fraud	Counter fraud refers to the activity undertaken by the organisation to prevent, detect, and investigate fraud, bribery, and corruption. This work is led by the NHS Counter Fraud Service (CFS) Wales, which operates under the NHS Wales Shared Services Partnership.

Term	Description
Integrated Medium Term Plan	An Integrated Medium-Term Plan is a three-year plan that sets out how the organisation will deliver its services, manage its workforce, and meet its financial duties to break even. The organisation submits its plan to the Welsh Government for approval.
Losses	Losses include things like theft, fraud, overpayments, or damage to property.
Quality Governance	Quality governance is the combination of structures, processes, and behaviours used by an organisation, particularly its board, to lead on and ensure high-quality performance, including safety, effectiveness, and patient experience.
Register of Interests	The Register of Interests helps ensure transparency by recording any personal or business interests of Board members and staff that could influence decisions.
Scheme of Reservation and Delegation	The Scheme of Reservation and Delegation sets out which responsibilities stay with the Board and which are passed to committees and executives, along with reporting arrangements to ensure proper oversight.

Term	Description
Single Tender Action	A Single Tender Action is when an organisation buys goods or services from one supplier without going through a competitive process, usually because there is only one suitable option or urgent need.
Special Payments	Special payments are one-off payments made in unusual situations – like compensation or goodwill gestures – that fall outside of the organisation’s normal business activity.
Standing Financial Instructions	Standing Financial Instructions set out the financial responsibilities, policies, and procedures adopted by the organisation.
Standing Orders	Standing orders set out the rules and procedures by which the organisation operates and make decisions.
Well-being of Future Generations Act (2015)	This Act requires public bodies in Wales to work sustainably and collaboratively to improve well-being across social, economic, environmental, and cultural areas, by setting long-term goals (called well-being objectives), involving citizens, and making decisions that consider the impact on future generations.

About us

The Auditor General for Wales is independent of the Welsh Government and the Senedd. The Auditor General's role is to examine and report on the accounts of the Welsh Government, the NHS in Wales and other related public bodies, together with those of councils and other local government bodies. The Auditor General also reports on these organisations' use of resources and suggests ways they can improve.

The Auditor General carries out his work with the help of staff and other resources from the Wales Audit Office, which is a body set up to support, advise and monitor the Auditor General's work.

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We welcome correspondence and
telephone calls in Welsh and English.

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

4 Management Response Form

Recommendation	Commentary on planned actions	Completion date	Responsible officer
R1 The Health Board should clearly report the impact of actions taken to mitigate organisational risks within its organisational risk register.	We will work with risk owners to be clearer on the quality/quantity of assurances that actions have positively impacted the risk score. However, due to resourcing constraints for the forthcoming year. We suggest that we defer the full implementation of this recommendation until the 2027-28 financial year.	30th June 2027	Director of Governance / Board Secretary
R2 The Health Board should take urgent and sustained action to reduce risks linked to the Welsh Risk Pool by: 2.1 Completing outstanding actions identified in the Welsh Risk Pool Concerns Assessment report;	Recommendation agreed. We will look to make progress in all these areas during 2026-27.	31st December 2026	Executive Director of Nursing

Recommendation	Commentary on planned actions	Completion date	Responsible officer
2.2 Rectifying weaknesses highlighted by internal audit in its review of the Welsh Risk Pool; and 2.3 Improving timeliness in submitting Learning from Events Reports (LFERs).			
R3 The Health Board should ensure that accountability for progressing audit recommendations is a key part of its new Accountability Framework.	Recommendation agreed – we will discharge our performance management responsibilities through the new Accountability Framework. This framework will become part of routine meeting arrangements and provide an integrated escalation route which can include audit recommendations.	30th September 2026	Executive Director of Strategy and Transformation
R4 By April 2026, the Health Board should develop and implement a strategy deployment framework to coordinate all	Recommendation agreed – the development of the framework is in progress with an implementation date of April 2026.	30th April 2026	Executive Director of Strategy and Transformation

Recommendation	Commentary on planned actions	Completion date	Responsible officer
strategic programs and ensure successful delivery of its long-term strategy.			
R5 The Health Board should standardise the content of its IMTP 'Plans on a Page' to ensure consistency, clarity, and enable easier comparison of priorities and progress.	Agreed – we will put this in place for 2027-28	31st March 2027	Executive Director of Strategy and Transformation
R6 The Health Board should strengthen quarterly IMTP reporting by clearly demonstrating the impact of plan delivery across all required domains, so that progress and challenges are visible.	The Health Board is now providing both some metrics and reference to other areas of key delivery, including digital and data plan, people plan etc. We have focused the IMTP report on the Ministerial requirements as the Integrated Performance Report sets out all key measures, we have endeavoured not to replicate this.	30th September 2026	Executive Director of Strategy and Transformation

Recommendation	Commentary on planned actions	Completion date	Responsible officer
	We initially had a focus on several care group updates at each ODC which provided the detail on their progress, so we referred to these updates which occurred at the same meetings. We agree to review our reporting again and intend to do so alongside the changes to the Integrated Performance Report.		



Agenda Item

6.2.3

Audit, Risk & Assurance Committee

**OUTCOME OF THE COMMITTEE REFERRAL FROM AUDIT
RISK & ASSURANCE COMMITTEE
Audit Wales Report – Eye Care Review**

Dyddiad y Cyfarfod / Date of Meeting	19/05/2026
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Kathrine Davies, Corporate Governance Manager
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance/Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance/Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Quality, Saftey & Experience Committee	24/03/2026	Discussed and confirmed sufficient assurance received in terms of process.
Acronyms / Glossary of Terms		
CTMUHB	Cwm Taf Morgannwg University Health Board	
ARAC	Audit, Risk & Assurance Committee	
QSEC	Quality, Safety & Experience Committee	

1. Situation / Background

- 1.1 The purpose of this report is for the Committee to receive the outcome of the Referral to the Quality, Safety and Experience Committee following detailed consideration and discussion at their meeting held on 23rd March 2026.
- 1.2 The ARAC discussed the Audit Wales Report on Eye Care Services at its meeting held on the 3 February 2026.
- 1.3 The Committee raised concerns on reading the report with regard to quality and performance issues which were highlighted as requiring urgent attention and given the nature of the concerns it was recommended that a formal cross Committee referral should be made to the Quality, Safety & Experience Committee in relation to the following:
- Deteriorating eye-care performance
 - Potential patient harm
 - That the management responses did not appear to strongly accept all of the recommendation.
 - There was no clear explanation where recommendations were not accepted as to whether they were reasonable, deliverable and had evidence based-justification.
- 1.4 The Committee have requested that the QSEC reviews and discusses the report and provides assurances back to the ARAC that the issues have been fully examined and the outcomes that have been determined following this.

2. Specific Matters for Consideration

- 2.1 The report produced as a result of the review and presented to the Quality, Safety and Experience Committee as part of the Planned Care Highlight Report is attached at **Appendix 1**.

3. Key Risks / Matters for Escalation

- 3.1 The Quality, Safety & Experience Committee concluded that they were assured from the information and explanations provided that following the review a Management Response form with actions was completed on 4th September 2025. This has been further updated (February 2026) and attached in **Appendix 2**.



- 3.2 It was further agreed and confirmed that a more detailed Ophthalmology update will be brought to a future meeting, given the interest and importance of the Audit Wales Eye Care review.

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 <i>150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)</i>	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality</i> <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	Not Applicable
	If more than one applies please list below:
Dolen i Feysydd Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality</i> <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	Safe
	If more than one applies please list below: Effective Efficient Timely Person Centred
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment



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

5. Recommendation

- 5.1 The Committee are requested to **NOTE** the report and **CONSIDER** if they are satisfied that the review has provided sufficient assurances and that the Committee Referral can now be closed.



Agenda Item

4.5.2

Quality, Safety & Experience Committee

Highlight Report from the Planned Care Quality, Safety, Risk & Experience (QSR&E) Committee meeting

Dyddiad y Cyfarfod / Date of Meeting	24/03/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Sharon O'Brien, Nurse Director, Planned Care
Cyflwynydd yr Adroddiad / Report Presenter	Sharon O'Brien, Nurse Director, Planned Care
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Executive Director of Nursing
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

KPI	Key Performance Indicators
ANPs	Advanced Nurse Practitioners
SSDEC	Surgical Same Day Emergency Care
SAU	Surgical Assessment Unit

1. Introduction

- 1.1 This report had been prepared to provide the Quality, Safety & Experience Committee with details of the key issues considered by the Planned Care Group, Quality, Safety, Risk & Experience meeting on 16th February 2026.
- 1.2 Key highlights from the meeting are reported in section 3.

2.1 Purpose of this Meeting

The purpose of the Planned Care/Surgery Quality, Safety, Risk & Experience Group (QSRE) is to provide assurance to the Care Group and the Health Board's Quality Safety & Experience (QSE) Committee on the provision of safe and high-quality patient care and experience to the population we serve.

2.2 The Planned Care/Surgery QSRE Group will:

- Put the needs of patients, carers and the public at the centre of all its business.
- Provide evidence based and timely advice to the Planned Care Group, based on local need, to assist in discharging its functions and meeting its responsibilities.
- Provide assurance to the Planned Care Group in relation to the arrangements for safeguarding the public and continuously improving the quality and safety of the services we provide.
- Ensure that care is delivered in accordance with the Health & Care Standards for Health Services in Wales.
- Ensure that services are delivered in compliance with regulatory legislation and accreditation bodies.

3.0 Highlight Report

Alert / Escalate	Trauma
	Trauma demand in the Royal Glamorgan Hospital (RGH) • Inpatient trauma demand across RGH. Resulting in a high number of trauma outlier patients on surgical wards. • Reduced community rehabilitation capacity and local authority placements impacting on discharges. • Consistent use of boarding spaces on Trauma Unit in RGH and Prince Charles Hospital (PCH). Mitigation & Assurance • Care Group implementation of 'Trauma Reset Fortnight' 23rd February – 6th March involving different ways of working, processes and pathways with key stakeholders including Occupational Therapy, Physio and Orthotics. • Orthogeriatric in reach service in RGH has commenced. Team consists of an Orthopaedic Registrar, Orthogeriatric Consultant and Advanced Clinical Practitioner (ACP).



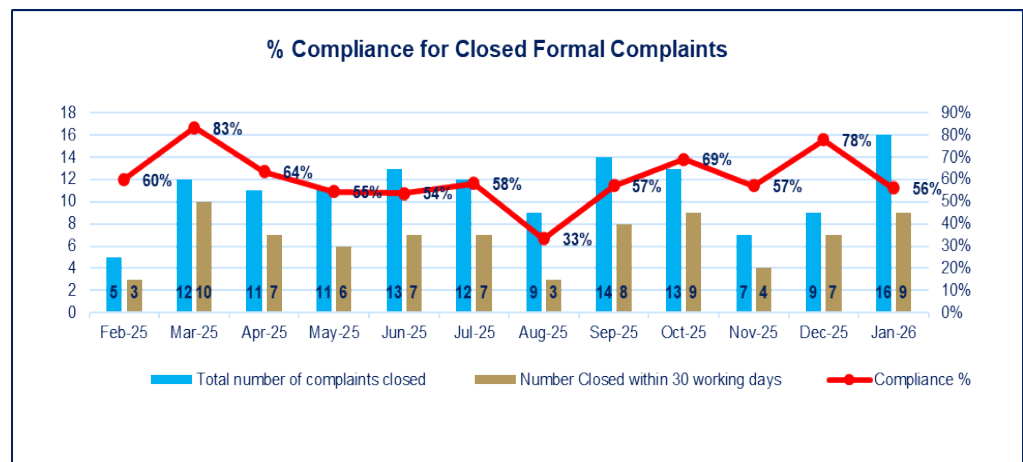
- Clear Guidance produced for Site Managers to inform designated surgical wards in PCH and RGH where staff are also trained to care for certain trauma patients. Also provides guidance on which trauma must go to the Trauma Unit/wards only.
- Weekly review with Governance Leads regarding quality-of-care KPIs to pick up any trends in relation to falls, pressure damage, patient experience.
- Boarding Patient - Risk assessment completion

Theatres

- Estates work on 4 Theatres in RGH near completion.
 - Decant has commenced from Vanguard Mobile Unit back into RGH main theatres.
 - 2 theatres are moving back over the next 2 weeks and the final 2 will be the end of March 2026.
- A new theatre timetable has been shared and finalised for CTMUHB from 1st April onwards. The capacity matches the demand of each service.

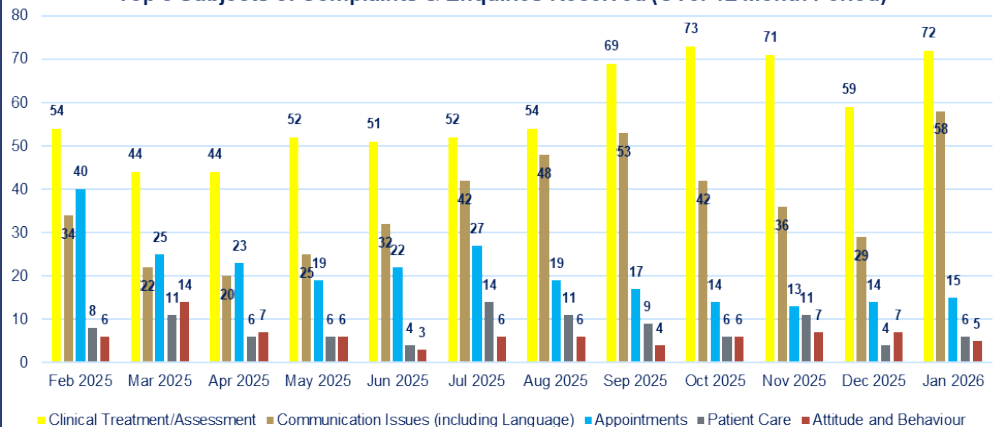
Advise

Concerns





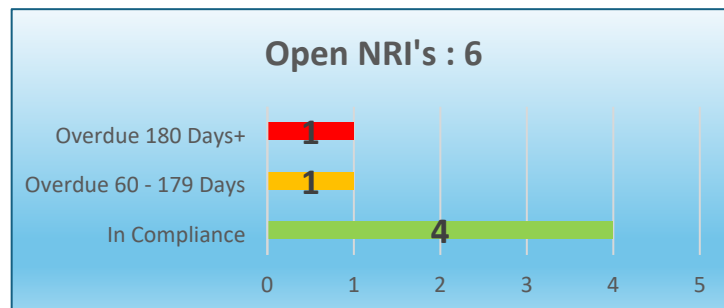
Top 5 Subjects of Complaints & Enquiries Received (Over 12 Month Period)



- Clinic Treatment/Assessment with a large amount relating to waiting lists in Trauma & Orthopaedics (T&O).
- Newly appointed Lead Nurse for Concerns commenced in role December 2025. Key areas of focus initially are these Early Resolutions within T&O.

Incidents

Nationally Reported Incidents (February 2026)



Falls

- No avoidable falls across Planned Care in January 2026.
- Continued focus on Falls Prevention and Management Training Timely investigation reviews

Pressure Damage

- 3 avoidable pressure ulcers in February 2026 (1x T&O, 2 x Surgery)

Key Themes include:

- Purpose T not completed correctly with enough clinical information
- Care plan with insufficient information or not individualised

	• Patient not on optimum surface i.e. correct mattress or air cushion. • Inconsistency of mattress choice • Frequency, consistency and gaps in repositioning regime. Actions – So What? • Key themes have been shared and discussed at Professional Focus Group monthly meetings • Emphasis on timely and detailed investigations • Ward Manager and Senior Nurses working to improve Pressure Ulcer training compliance as a priority • Ward Managers & Senior Nurses focusing on areas of improvement and regular audits • High risk patients to be alerted to Ward Manager and included on ward handovers • Pressure relieving oxygen tubing available in all clinical areas • Focus on device related pressure • Standard Operating Procedure being created
Assure	In-patient Elective Arthroplasty • Arthroplasty 7 day working model commenced in Princess of Wales Hospital (POWH) from the 13th December using Bridgend Clinic for the weekend operating lists. • Aiming to have 0 patients on 104 week waiting times by March 2026. • On 16th February 2026, 1000 patients have received arthroplasty surgery since 13th December 2025, with an average length of stay for hip and knee arthroplasty of 2.5 days. Insourcing Outpatient (OP) Clinics Weekend Activity Between September 2025 to end January 2026 15,738 patients reviewed. Reducing OP waiting lists. RGH – Surgical Assessment Unit (SAU) & Surgical Same Day Emergency Care (SSDEC) Virtual Ward SSDEC/SAU Advanced Nurse Practitioners (ANP's) have developed a Watchlist for a virtual ward/follow ups. GP referrals or follow up patients are sent to the ANPs and they will monitor & review virtually to see if a patient does need to attend SSDEC Unit or telephone advice resulting in: • Improved patient experience. • This is preventing unnecessary referrals attending the hospital, freeing up clinician's time for the SAU patients. • Providing patient's care at home

	Support to GPs to treat and review patient Single Cancer Pathway (SCP) The Health Board has been de-escalated to Level 1 due to improved delivery in its cancer performance. SCP compliance target was 65% in November and 64.1% in December compliance in month. This is the highest in-month performance post COVID with Dermatology achieving 93% and Breast achieving 83% in December. Audit Wales Eye Care Review Following the review a Management Response form with actions was completed on 4th September 2025. This has been further updated (February 2026) and attached in Appendix 1.
Inform	- RGH Ward 8– News2 chart completion champions 2025! - RGH Ward 10 – Fluid Balance chart completion champions 2025  
Appendices	Appendix 1 – Audit Wales Eye Care Review (CTMUHB)

2. **Assessment**

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:



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

Impact Assessment		
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality</i> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: N/A
Cydraddoldeb a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? / Equality and Welsh Language</i>	Yes: ☐	No: ☐
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below:



<i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	Not applicable as CTM board papers are prepared in English
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau <i>(Pobl / Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	Yes (Include further detail below)	

3. Recommendation

- 3.1 The Committee is asked to **NOTE** the highlights outlined in section 3 of this report.

Management response form



Audit Wales use only	
Audited body	Cwm Taf Morgannwg University Health Board
Audit name	Eye Care Review
Issue date	4 September 2025

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)	Audit Wales only
R1	To increase the pace of delivery, regional partners should speed up decision making processes for agreeing business cases.	The Regional Joint Committee (RJC) that will come into existence towards the end of 2025 will streamline regional decision making for all regional programmes	December 2025	Chair of Regional Ophthalmology Programme Board	
R2	Regional partners should develop a resource plan, to better understand operational and clinical commitment needed from	The Regional Programme Plan for 25/26 includes a regional workforce review along with the ongoing demand and capacity reviews for each sub speciality	March 2026	Chair of Regional Ophthalmology Programme Board	

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)	Audit Wales only
	each partner organisation to realistically deliver each phase of the strategy.				
R3	Regional partners should agree realistic but appropriately ambitious timescales for the three phases of the South East Wales Regional Ophthalmology Strategy.	The Regional Ophthalmology Strategy pre-dates the National Clinical Strategy for Ophthalmology. As a result, the Regional Strategy will be reviewed as part of the programme plan in 25/26, with appropriate phasing and timeframes assigned to programme priorities	March 2026	Chair of Regional Ophthalmology Programme Board	
R4	The Health Board should urgently develop an eye care plan, seeking to address current and future challenges. The Health Board should ensure the plan is: - based on current and projected future demand for services; - includes capacity plans based on realistically ambitious levels of productivity;	- Finalised and implemented the Eye Care Plan based on demand and capacity analysis. - Completed demand and capacity reviews for stages 1, 3, and 4 and address gaps by subspecialty. - Reviewed and updated job plans and clinic templates to increase activity and ensure sustainability. - Centralised cataract surgery to POWH (from 1 Sept 2025) and	Completed December 2025 Completed September 2025 Ongoing Completed	Directorate Manager PCR Manager /Directorate Manager Directorate Manager	

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)	Audit Wales only
	- costed, at a minimum, for the medium term (3-5 year); - supported by resource plans i.e. financial, workforce (particularly medical staffing) and infrastructure, reflecting sustainable service models; - supported by clear delivery actions and milestones; and - approved by the Board.	delivering higher volumes through HVLC lists. Achieving 7 eyes on HVLC lists. - Only HB that has achieved 104 weeks for all sub specialities - Implemented Straight to Listing from Sept 2025 to increase outpatient capacity. - Virtual clinics established for medical retina and macular patients to expand outpatient access. - Reduced cataract waiting times to 86 weeks stage 1 cataracts by end of Sept 25 - Continued to undertake bilateral cataract surgeries using the Surgicube at POWH.	September 2025 Completed September 2025 Completed September 2025 Completed October 2025 Completed September 2025 Completed	Directorate Manager Service Manager Directorate Manager Directorate Manager Service Manager	

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)	Audit Wales only
		- Increased virtual clinics for medical retina and macular patients – again increasing outpatient capacity. - Redesigned waiting list cards for better list planning and high-risk case identification. - Implemented Medical Comorbidities SOP. - Implementation of Service Improvement Group with focus on theatre utilisation, PIFU / SOS and DNA rate	September 2025 Completed October 2025 Completed September 2025 Completed September 2025 Completed September 2025	Service Manager Service manager Clinical Director Directorate Manager	
R5	Due to ongoing risks from long ophthalmology waits, an updated ophthalmology 'spotlight' report should be provided to the Quality, Safety and Experience Committee and/or the Operational Delivery Committee to support	Produce a Planned Care Report for the Quality, Safety & Experience Committee, covering waiting times, harm, mitigation, and long-term plans.	October 2025 Ongoing	Directorate Manager / Lead Nurse Directorate Manager	

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)	Audit Wales only
	continued oversight and action. The report should include: - comprehensive overview of current ophthalmology waiting times; - information on avoidable harm suffered by patients as a result of waiting for treatment; - mitigating actions in place; and - outline of longer-term plans for eye care services.	- Continued with regular updates to IQPD meetings with Welsh Government. - Maintain reporting of harm and incidents through the Harm Review Panel, ensuring RCA and Duty of Candour processes are followed. - Full implementation of WGOS pathways updates: WGOS 4 Filtering – Completed for Glaucoma, Wet AMD, Independent prescribing. Medical Retina – Identified lead – developing SOP, training sessions in progress for optometrists. HCQ screening – pathway agreed with full implementation from April 26 when open eyes rolled out WGOS 4 Monitoring – Completed for Glaucoma. DR – local scheme in place - still to transition to WGOS WGOS 5 – Independent prescribing. Waiting administrative support	Ongoing with expectation of completion of historic harm reviews by end March 2026 Ongoing – Some completed as per narrative Local scheme in place since Feb 2025	Directorate Manager Directorate Manager / Clinical Director Service Manager Directorate Manager Directorate Manager / Clinical Director	

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)	Audit Wales only
		- Recruited into band 3 admin post to support WGOS pathway implementation. - Appointment of clinical lead in Optometry and Orthoptist to lead on implementation of WGOS pathways - Launch HCQ pathway and ensure transfer of identified patients to primary care. – HCQ pathway agreed with full implementation scheduled from April 2026 when open eyes rolled out - Implemented Glaucoma pathway and manage referrals to optometry practices.	Planned to implement April 2026 Completed January 2025 – however funding expires March 2026 Completed May 2025 Scheduled April 2026	Directorate Manager Clinical Director Service Director Service Manager Directorate Manager Nurse Director	

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)	Audit Wales only
		- Develop and finalise SOP for Medical Retina pathway and commence filtering once approved. - Continue weekly internal RTT review meetings to monitor high-risk subspecialties and maintain 104-week targets. - Validation of list as high numbers of cataracts patients are inappropriately categorised as R1. Internally agreed vetting prioritisation to mitigate against this risk. – Process changed and no longer are we prioritising patients to R1 following expedite letter - Updated risk register as Risk to patients due to volume, waiting list and service demand is captured on the HB's generic Risk Register - Ensure Planned Care Group provides incident overviews and NRIs to the Q&S Committee.	Completed October 2025 Ongoing – Expected finalisation of SOP April 2026 Ongoing and completed Ongoing Completed		

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)	Audit Wales only
			Ongoing & Completed		
R6	The Health Board should provide routine updates to an appropriate committee on its progress with implementing the ophthalmology GIRFT recommendations.	- Provide regular progress updates on GIRFT implementation at Quality & Safety and Operational Delivery Committees. - Continue to track actions via the Operational Management Group, ensuring alignment with IMTP progress.	Completed October 2025 & ongoing Completed November 2025	Directorate Manager / Service Director Directorate Manager / Service Director	

Point 30

While there is improved focus on efficiency, it is having mixed success. Between April and October 2024, the service has seen a 15% increase in theatre utilisation and reduced surgical cancellations. Ophthalmology outpatient Did Not Attend rates are slowly getting better at 6% in June 2025, this is quite close to the 5% target⁵. However, outpatient efficiency remains a challenge. The limited use of See on Symptom and Patient-Initiated Follow-Ups, at just 3.1% and 0.1% respectively in October 2024, are well below the 20% target.⁶

KPI’s for last 3/12 below

- Increase in % of SOS / PIFU
- Increase in DNA rate
- Reduction in FUNB > 100% - Strategic plan put in place for implementation for all FUNB > 5 years – discharge & all FUNB via agreed CIN pathways to be put on PIFU / SOS

SERVICE	SOS/PIFU (20%)	DNA RATE (5%)	FUNB > 100%
OPHTHALMOLOGY	5.7%↑	10.2% ↑	7,160↓

Jan 2026

- Improvement noted across all KPI’s.
- Achieving target pan CT for in session utilisation and late starts
- Improvement noted in early finishes pan CTM

SERVICE Jan	IN SESSION UTILISATION			LATE STARTS (<10mins)			EARLY FINISHES (<30mins)		
SITE	RGH	PCH	POW	RGH	PCH	POW	RGH	PCH	POW
TARGET	85%			20%			10%		
OPHTHALMOLOGY	↑93.1%		↑80.2%	↓0%		↓15.6%	↓13.3%		↓40.6%

Point 54

We have seen evidence of the Quality, Safety and Experience Committee receiving high level updates on ophthalmology harm, specifically nationally reported incidents (NRI). For example, at the November 2024 committee nine ophthalmology related NIRs were reported, and two at the January 2025 committee. These are mainly reported through the planned care group highlight report. While the Health Board is using lessons learned to improve care, long waiting times still pose a significant risk to some patients.

This is ongoing with sustained reduction in historical NRI's being reviewed as described in report as illustrated in main body of response form. Expected completion of all historical NRI's by end of March 2026.



Agenda Item

6.2.1a

Audit, Risk & Assurance Committee

Committee Annual Cycle of Business 2026

Dyddiad y Cyfarfod / Date of Meeting	19/05/2026
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Kathrine Davies, Corporate Governance Manager
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance/Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary
Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Board Development Session	26/02/2026	Approved

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 2026 to 31 December 2026.
- 1.3 The Cycle of Business was Approved by the Health Board at it's Board Development Session held on 26 February 2026.

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

5. Recommendation

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

6. Next Steps

- 6.1 The Committee will continue to review the Annual Cycle of Business at each of its meetings.

Audit & Risk Assurance Committee – Annual Cycle of Committee Business

(1st January 2026 to the 31st December 2026)

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 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 to meet Annual Report requirements.

Committee Chair: Patsy Roseblade, IM Audit & Finance	Committee Vice Chair: Dilys Jouvenat, IM, Third Sector	Executive Leads for Agenda Planning Sally May, Executive Director of Finance Gareth Watts, Director of Corporate Governance/Board Secretary

[Link to the Board Assurance Framework Dashboard](#)

CTMUHB Committee Business:

Improving Care Strategic Goal aligned to Committee Business - Delivering Safe and Compassionate Care - Developing new models of care - Digital Transformation for patients and staff - Ensuring timely access to care																				
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	Prior Reporting Requirements e.g. EMB/OMB	Onward Reporting into Board	Alignment to Strategic Risks on the BAF	
Board Assurance Framework	Director of Corporate Governance / Board Secretary	All regular meetings		R			R			R			R		X	R	EMB	Yes	N/A	
Organisational Risk Register	Director of Corporate Governance / Board Secretary	All regular meetings		R			R			R			R		X	R	EMB	Received by Board for Information in Admincontrol	Risks aligned from the Organisational Risk Register to the BAF	
Approval of the Annual Review of the Risk Management Framework / Board Assurance Framework	Director of Corporate Governance / Board Secretary	Annually								R					X	R	EMB	Yes	Sets the risk management framework.	
Audit Recommendation Tracker (AW, IA and HIW)	Director of Corporate Governance / Board Secretary	All regular meetings		R			R			R			R		X	R	EMB	No	The audit recommendations are likely to span several the strategic risks	

Improving Care Strategic Goal aligned to Committee Business CONTD.																					
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	Prior Reporting Requirements e.g. EMB/OMB	Onward Reporting into Board	Alignment to Strategic Risks on the BAF		
NWSSP Internal Audit Services – Progress Report	Head of Internal Audit	All regular meetings		R			R			R			R		X	R	No	No	The audit recommendations are likely to span several the strategic risks		
NWSSP Internal Audit Services – Annual Audit Plan	Head of Internal Audit	Annually					R								X	R	No	No	The audit recommendations are likely to span several the strategic risks		
NWSSP Internal Audit Review Reports	Head of Internal Audit	All Regular Meetings		R			R			R			R		X	R	No	No	The audit recommendations are likely to span several the strategic risks		
NWSSP Internal Audit Services – Head of Internal Audit Opinion	Head of Internal Audit	Annually					R								X	R	EMB?	Yes	The audit recommendations are likely to span several the strategic risks		
Audit Wales Progress Update	Audit Wales - Performance Audit Lead	All Regular Meetings		R			R			R			R		X	R	No	No	The audit recommendations are likely to span several the strategic risks		
Audit Wales – Audit Review Reports	Audit Wales - Performance Audit Lead	All Regular Meetings where applicable		R			R			R			R		X	R	No	No	The audit recommendations are likely to span several the strategic risks		
Audit Wales Annual Audit Report	Audit Wales - Performance Audit Lead	Annually					R								X	R	EMB	Yes	The audit recommendations are likely to span several the strategic risks		
Audit Wales Structured Assessment Report	Audit Wales - Performance Audit Lead	Annually		R											X	R	EMB	Yes	The audit recommendations are likely to span several the strategic risks		
Joint Commissioning Committee Audit Recommendations Tracker	Committee Secretary Director of Corporate Governance (JCC)	All Regular Meetings		R			R			R			R		X	R	No	No	N/A		

Improving Care Strategic Goal aligned to Committee Business CONTD. • Delivering Safe and Compassionate Care • Developing new models of care • Digital Transformation for patients and staff • Ensuring timely access to care																				
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	Prior Reporting Requirements e.g. EMB/OMB	Onward Reporting into Board	Alignment to Strategic Risks on the BAF	
Joint Commissioning Committee Corporate Risk Assurance Framework	Committee Secretary Director of Corporate Governance (JCC)	All Regular Meetings		R			R			R			R		X	R	No	No	N/A	
National Imaging Academy Risk Register	Director of the National Imaging Academy	All Regular Meetings		R			R			R			R		X	R	No	No	N/A	
Hosted Organisation External / Internal Audit Reports	Director of Corporate Governance /Director of the National Imaging Academy	All Regular Meetings if a report is received.		R			R			R			R		X	R	No	No	N/A	
Clinical Audit Update – report on any audits not met and why (including a summarised list of all audits completed)	Executive Medical Director	Twice per Annum					R						R				No	No	N/A	

Inspiring People Strategic Goal aligned to Committee Business - Visible and inspiring leadership - Promoting diversity and inclusion - Embedding our values and behaviours - Encouraging local employment																				 INSPIRING PEOPLE
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	Prior Reporting Requirements e.g. EMB/OMB	Onward Reporting into Board	Alignment to Strategic Risks on the BAF	
Speaking Up Safely Updates	Director of Corporate Governance/Board Secretary	Annually					R								X	R	EMB	Yes	Strategic Risk 3	
Declarations of Interest and Gifts, Hospitality & Sponsorship Report	Director of Corporate Governance / Board Secretary	Twice per annum		R			R Annual Report								X	R	EMB	Yes - for the Annual Report Submission	Strategic Risk 3	
Standing Orders – Annual Review	Director of Corporate Governance / Board Secretary	Annually								R					R	X	N/A	Yes	N/A	
Standing Orders – Variation or Breach Report	Director of Corporate Governance / Board Secretary	Twice per annum								R					R	X	EMB	No unless escalation is required	N/A	
Reportable Data Lapses /Data Loss Updates / to the ICO	Director of Digital	Bi-annually					R						R		X	R	EMB	No	Strategic Risk 5	

Inspiring People Strategic Goal aligned to Committee Business CONTD. • Visible and inspiring leadership • Promoting diversity and inclusion • Embedding our values and behaviours • Encouraging local employment																				 INSPIRING PEOPLE
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	Prior Reporting Requirements e.g. EMB/OMB	Onward Reporting into Board	Alignment to Strategic Risks on the BAF	
Annual Accountability Report (Governance Statement)	Director of Corporate Governance / Board Secretary	Annually						✎ An extra-ordinary meeting will be scheduled in May (Draft) and June (Final) as required in the Manual for Accounts							X	✎	EMB	Yes - for the Annual Report Submission	N/A	
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 May (Draft) and June (Final) as required in the Manual for Accounts							X	✎	EMB	Yes - for the Annual Report Submission	N/A	
Local Counter Fraud Report (detail of cases to be received in closed session)	Local Counter Fraud Specialist	All Regular Meetings		✎			✎			✎			✎		X	✎	No	No	N/A	
Counter Fraud Annual Report	Local Counter Fraud Specialist	Annually					✎								X	✎	No	No	N/A	
Counter Fraud Annual Self-Assessment	Local Counter Fraud Specialist	Annually								✎					X	✎	No	No	N/A	
Counter Fraud Draft Work Plan	Local Counter Fraud Specialist	Annually								✎					X	✎	No	No	N/A	
Updates from Counter Fraud Wales Service (to be	Head of Counter Fraud	Quarterly		✎						✎					X	✎	No	No	N/A	

received in closed session)																			
Sustaining our Future Strategic Goal aligned to Committee Business - Becoming a green organisation - Ensuring our services have financial sustainability - Embedding value-based healthcare - Ensuring our estate is fit for the future																			
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	Prior Reporting Requirements e.g. EMB/OMB	Onward Reporting into Board	Alignment to Strategic Risks on the BAF
Financial Control Procedures	Executive Director of Finance	All Regular meetings when required		R			R	R		R			R		R	X	Yes	No	N/A
Annual Financial Accounts	Executive Director of Finance							R An extra-ordinary meeting will be scheduled in May (Draft) and June (Final) as required in the Manual for Accounts							X	R	Yes	Yes - via Annual Report	Strategic Risk 9
Losses and Special Payments Report	Executive Director of Finance	All Regular Meetings		R			R	R		R			R		X	R	No	No	N/A
Procurement & Scheme of Delegation Report	Executive Director of Finance	All Regular Meetings		R			R	R		R			R		X	R	No	No	N/A
Post Payment Verification	Executive Director of Finance	Twice a Year (Mid and End)					R End-Year						R Mid-Year		X	R	No	No	N/A
Audit Wales - Audit of Financial Statements Addendum Report	Audit Wales - Financial Audit Lead	Twice per annum (if required)								R			R		X	R	No	No	Strategic Risk 9
Audit Wales – Audit of the Financial Statement (ISA 260, Letter of Representation and Audit Opinion)	Audit Wales - Financial Audit Lead	Annually						R An extra-ordinary meeting will be scheduled in May (Draft) and June (Final) as required in the Manual							X	R	Yes	Yes - via Annual Report	Strategic Risk 9

								for Accounts											

Governance / Committee Business Governance Activity • To support a strong governance framework to support effective and efficient Board Business. • Creating a culture of integrity, transparency, and accountability																		
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	Prior Reporting Requirements e.g. EMB/OMB	Onward Reporting into Board
Action Log	Director of Corporate Governance / Board Secretary	All Regular Meetings		℞			℞	℞		℞			℞		℞ If all actions are complete	℞ If there are actions in progress / overdue actions	No	No
Minutes of the previous meeting (Public and Closed Session)	Director of Corporate Governance / Board Secretary	All Regular Meetings		℞			℞	℞		℞			℞		℞	X	No	No
Non-Routine Committee Business (Forward Plan)	Director of Corporate Governance / Board Secretary	All Regular Meetings		℞			℞	℞		℞			℞		℞	X	No	No
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	No	No
Committee Annual Report	Director of Corporate Governance / Board Secretary	Annually								℞					X	℞	No	Yes
Outcome of Annual Committee Self-Assessment	Director of Corporate Governance / Board Secretary	Annually								℞					X	℞	No	No
Terms of Reference Review	Director of Corporate Governance / Board Secretary	Annually								℞					X	℞	No	Yes

CTMUHB Board Assurance Framework - Dashboard

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

Audit Risk & Assurance Committee – Non-Routine Committee Business Forward Plan

(1st January 2026 to the 31st December 2026)

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
13 April 2026	Email	Executive Director of Finance	Counter Fraud Steering Group Highlight Report	Add to Consent Agenda	Executive Director of Finance	Executive Director of Finance	May 2026	This item is on the consent agenda for the May 2026 meeting
24 October 2025	Email	Audit Wales	Audit Wales – Structured Assessment	Audit Wales Report	Audit Wales Performance Audit Lead (Health)	Audit Wales Performance Audit Lead (Health)	Deferred from February 2026	This item is on the agenda for the May 2026 meeting.
24 October 2025	Email	Audit Wales	Audit Wales Report – Eye Care	Audit Wales Report	Audit Wales Performance Audit Lead (Health)	Audit Wales Performance Audit Lead (Health)	Deferred from November 2025	This item is on the Agenda for the February 2026 meeting.
22 January 2026	Internal Audit Progress Report	Internal Audit	IA Review – PoW Roof Replacement	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026
22 January 2026	Internal Audit Progress Report	Internal Audit	IA Review – Savings	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026
22 January 2026	Internal Audit Progress Report	Internal Audit	IA Review – Individually Commissioned Packages of Care	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026
22 January 2026	Internal Audit Progress Report	Internal Audit	Internal Audit Review – Risk Management	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026
22 January 2026	Internal Audit Progress Report	Internal Audit	Internal Audit Review – Medical Sickness Records (Advisory)	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026
22 January 2026	Internal Audit Progress Report	Internal Audit	Internal Audit Review – Re-audit – Gastro Intestinal Demand Management	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026
22 January 2026	Internal Audit Progress Report	Internal Audit	Internal Audit Review – Falls Management	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026

22 January 2026	Internal Audit Progress Report	Internal Audit	Internal Audit Review – Re-Audit – Additional Medical pay	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026
22 January 2026	Internal Audit Progress Report	Internal Audit	Internal Audit Review – Cyber Security	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026
22 January 2026	Internal Audit Progress Report	Internal Audit	Internal Audit Review – digital – Bridgend Disaggregation	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026
22 January 2026	Internal Audit Progress Report	Internal Audit	Internal Audit Review – Speaking up Safely	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026
22 January 2026	Internal Audit Progress Report	Internal Audit	Internal Audit Review – Financial Systems	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026
22 January 2026	Internal Audit Progress Report	Internal Audit	Internal Audit Review – Outpatient Booking Process	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026
22 January 2026	Internal Audit Progress Report	Internal Audit	Internal Audit Review – Medical Annual Leave and Rostering	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026
22 January 2026	Internal Audit Progress Report	Internal Audit	Internal Audit Review – Welsh Risk Pool	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026
22 January 2026	Internal Audit Progress Report	Internal Audit	Internal Audit Review – Ward Audits	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026
22 January 2026	Internal Audit Progress Report	Internal Audit	Internal Audit Review – Medical Job Planning re-audit	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026
22 January 2026	Internal Audit Progress Report	Internal Audit	Internal Audit Review – Interventions not normally used re-audit	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026
22 January 2026	Internal Audit Progress Report	Internal Audit	Internal Audit Review – Estates Assurance – follow up	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026

3 February 2026	Audit, Risk & Assurance Committee meeting	Committee	JAG Accreditation Update	To receive a further update in six months time	Chief Operating Officer	Chief Operating Officer	November 2026	To consider readiness for the November 2026 meeting

COMPLETED ITEMS:

January 2026	Audit, Risk & Assurance Committee	Internal Audit	IA Review – Discharge Planning	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	February 20226	Received at the February 2026 meeting - closed
August 2025	Audit, Risk & Assurance Committee	Internal Audit	IA Review – Stroke Services	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	Deferred from November 2025	Received at the February 2026 meeting - closed
August 2025	Audit, Risk & Assurance Committee	Internal Audit	IA Review – Estates Assurance Asbestos Management	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	Deferred from November 2025	Received at the February 2026 meeting – closed
August 2025	Audit, Risk & Assurance Committee	Internal Audit	IA Review – Operational response critical incident	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	Deferred from November 2025	Received at the February 2026 meeting – closed
August 2025	Audit, Risk & Assurance Committee	Internal Audit	IA Review – Clinical Coding	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	Deferred from November 2025	Received at the February 2026 meeting - closed
18 January 2026	Email	Audit Wales	Audit Wales Report - Urgent and Emergency Care Arrangements for Managing Demand	Audit Wales Report	Audit Wales Performance Audit Lead (Health)	Audit Wales Performance Audit Lead (Health)	February 2026	Received at the February 2026 meeting - closed
November 2025	Audit Risk & Assurance Committee	Internal Audit	IA Review – PCH Redevelopment Programme and Audit Plan	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	November 2025	This item was received at the November 2025 meeting – Closed
November 2025	Internal Audit Progress Report	Internal Audit	IA Review – Follow up - Decarbonisation	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	August 2026	This item was received at the August 2026 meeting - Closed
October 2025	Audit, Risk & Assurance Committee	Internal Audit	IA Review – Follow Up Vaccination Implementation	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	November 2025	This item was received at the November 2025 meeting – Closed
November 2025	Audit Risk & Assurance Committee	Internal Audit	IA Review – PCH Financial and Technical – Final	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	November 2025	This item was received at the November 2025 meeting – Closed

10 October 2025	Email	Audit Wales	Audit Wales Report – Tackling Planned Care - Management Response	Audit Wales Report	Audit Wales Performance Audit Lead (Health)	Audit Wales Performance Audit Lead (Health)	November 2025	Received at the November 2025 meeting - Closed
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	November 2025	Received at the November 2025 meeting - Closed
28 October 2025	Notification from Welsh Government	Assistant Director of Governance & Risk	Amendments to CTMUHB Standing Orders (Schedule 4.1 – Standing Orders for the NHS Wales Joint Commissioning Committee)	Revised JCC Standing Orders	Director of Corporate Governance/Board Secretary	Director of Corporate Governance/Board Secretary	November 2025	Received at the November 2025 meeting - Closed
16 October 2025	Email	Audit Wales	Audit Wales Briefing National Fraud Initiatives 2024-25 CTMUHB Update	Audit Wales Briefing Report	Audit Wales Performance Audit Lead (Health)	Audit Wales Performance Audit Lead (Health)	November 2025	Received at the November 2025 meeting - Closed
July 2025	Welsh Government	Welsh Government	Interim Amendments to the Model Standing Financial Instructions Chapter 11 for Local Health Boards	Model Standing Orders, Reservation and Delegation of Powers for LHBs Schedule 2.1: Standing Financial Instructions Revised Chapter 11 May 2025	Gareth Watts, Director of Governance/Board Secretary	Gareth Watts, Director of Governance/Board Secretary	14 August 2025	Received at the August 2025 meeting. Closed.
July 2025	Audit Wales	Audit Wales	Audit Wales Review – Tackling the Planned Care Challenges	Audit Wales Review Report	Audit Wales	Gareth Watts, Director of Governance/Board Secretary	14 August 2025	Received at the August 2025 meeting. Closed
December 2024	Audit & Risk Committee	Internal Audit	IA Review – end of Life Care Management – Final	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	14 August 2025	Received at the August 2025 meeting. Closed
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	14 August 2025	Received at the August 2025 meeting. Closed
December 2024	Audit & Risk Committee	Internal Audit	IA Review – Audit Recommendations Tracker Review	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	14 August 2025	Received at the August 2025 meeting. Closed

December 2024	Audit & Risk Committee	Internal Audit	IA Review – Decarbonisation Follow Up	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	14 August 2025	Received at the August 2025 meeting. Closed
December 2024	Audit & Risk Committee	Internal Audit	IA Review – Financial Systems	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	14 August 2025	Received at the August 2025 meeting. Closed
December 2024	Audit & Risk Committee	Internal Audit	IA Review – Access to Diagnostics Criteria	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	14 August 2025	Received at the August 2025 meeting. Closed
May 2025	Audit, Risk & Assurance Committee	Committee	Penalties for Late submitted Evidence Update	Action arising out of discussion on Losses & Special Payments Report	Deputy Director	Richard Hughes, Deputy Director of Nursing & Midwifery	14 August 2025	Received at the August 2025 meeting. Closed