

Agenda

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

1.1. Welcome and Introductions

Information Kath Palmer, Chair

1.2. Apologies for Absence

Information Kath Palmer, Chair

1.3. Declarations of Interest

Information Kath Palmer, Chair

10:05 - 10:10 2. CONSENT AGENDA BUSINESS
5 min

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.

10:10 - 10:30 3. PRELIMINARY BOARD MATTERS/GOVERNANCE
20 min

3.1. Action Log

Discussion Kath Palmer, Committee Chair

📄 3.1 Action Log ARAC 4 August 2026.pdf (26 pages)

3.2. Matters Arising not contained within the Action Log

Discussion Kath Palmer, Committee Chair

3.3. Draft Committee Annual Report 2025-26

Decision Gareth Watts, Director of Corporate Governance/Board Secretary

📄 3.3a Draft Annual Report 25-26 ARAC 4 August 2026.pdf (4 pages)

📄 3.3b Draft Annual Report 25-26 ARAC 4 Aug 26 LS CLEAN.pdf (15 pages)

3.3.1. Annual Review of the Committee Terms of Reference

Decision Gareth Watts, Director of Corporate Governance/Board Secretary

📄 3.3.1a Review of Terms of Reference ARAC 4 Aug 2026.pdf (4 pages)

📄 3.3.1b GC01 Standing Orders - Schedule 3.1 - ARAC ToR - Approved by HB 26.03.2026.pdf (17 pages)

3.4. Annual Review of the Risk Management Strategy & Framework

Discussion Gareth Watts, Director of Corporate Governance

📄 3.4 Annual Review of the Risk Management Strategy ARAC 4 August 26.pdf (5 pages)

10:30 - 11:00
30 min

4. STRATEGIC PILLAR: INSPIRING PEOPLE

4.1. Losses and Special Payments Report

Discussion Sally May, Executive Director of Finance

 4.1 Losses & Special Payments ARAC 4 Aug 26.pdf (12 pages)

4.2. Procurement & Scheme of Delegation Report

Discussion Sally May, Executive Director of Finance

 4.2 Procurement and SoD Report Q1 2026_27.pdf (11 pages)

4.3. Local Counter Fraud Report

Discussion Neil Jones, Local Counter Fraud Specialist

 4.3a LCF Presentation ARAC 4 August 2026.pdf (4 pages)

 4.3b LCF Report ARAC 4 August 2026.pdf (4 pages)

 4.3c LCF Update ARAC 4 Aug 26.pdf (4 pages)

11:00 - 11:40
40 min

5. STRATEGIC PILLAR: IMPROVING CARE

5.1. Organisational Risk Register

Discussion Gareth Watts, Director of Corporate Governance/Board Secretary

 5.1 Org Risk Register ARAC 4 Aug 2026.pdf (10 pages)

 5.1a Org Risk Register Summary ARAC 4 Aug 26.pdf (6 pages)

 5.1b Org Risk Register ARAC 4 Aug 2026.pdf (12 pages)

5.2. Audit Recommendations Tracker

Discussion Gareth Watts, Director of Corporate Governance/Board Secretary

 5.2a Audit Tracker - ARAC 4 August 2026.pdf (9 pages)

5.3. NWSSP Internal Audit Progress Report

Discussion Paul Dalton, Head of Internal Audit

 5.3 IA Progress Report ARAC 4 Aug 2026 v2.pdf (11 pages)

5.3.1.

5.4. NWSSP Internal Audit Review Reports

Discussion

5.4.1. IA Review - Medical Job Planning - Re-audit

Discussion Emma Samways, Deputy Head of Internal Audit

 5.4.1 Medical Job Planning (re-audit) ARAC 4 Aug 26.pdf (14 pages)

5.4.2. IA Review - Medical Sickness Records - Advisory Report

Emma Samways, Deputy Head of Internal Audit

 5.4.2 Med Sickness Absence ARAc 4 Aug 2026.pdf (14 pages)

5.5. Audit Wales Progress Report

Discussion *Nathan Couch, Performance Lead, Audit Wales*

 5.5 Audit Wales Update ARAC 4 August 2026.pdf (11 pages)

5.6. Audit Wales - Audit of Accounts Report Addendum

Discussion *Mark Jones, Audit Wales*

 5.6 Audit of Accounts Addendum ARAC 4 Aug 26.pdf (14 pages)

11:40 - 11:50

10 min

6. CONSENT AGENDA

6.1. Items for Approval

6.1.1. Unconfirmed Minutes of the Meeting held on 19 May 2026

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

 6.1.1 Unconfirmed Minutes 19.05.26 ARAC 4 Aug 26.pdf (17 pages)

6.1.2. Unconfirmed In Committee Minutes of the Meeting held on 19 May 2026

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

 6.1.2 Unconfirmed IC Minutes 19.5.26 ARAC 4 Aug 2026.pdf (8 pages)

6.1.3. Unconfirmed Minutes of the EO Meeting held on 24 June 2026

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

 6.1.3 Unconfirmed EO Minutes 29.06.26 ARAC 4 August 2026.pdf (5 pages)

6.2. Items for Noting

6.2.1. Board Assurance Framework

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

 6.2.1a BAF Cover Report ARAC 4 Aug 26.pdf (7 pages)

 6.2.1b BAF_BOARD_FINAL UHB 30 July 2026.pdf (73 pages)

6.2.2. Committee Annual Cycle of Business 2026

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

 6.2.2a ACB Cover ARAC 4 August 2026.pdf (3 pages)

 6.2.2b Annual Cycle of Business ARAC 2026 V5.pdf (8 pages)

6.2.3. Committee Forward Work Plan (non routine business)

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

 6.2.3 Forward Work Plan ARAC 4 August 2026.pdf (4 pages)

11:50 - 11:55

5 min

7. CLOSE OUT BUSINESS

7.1. Any Other Urgent Business

Discussion *Kath Palmer, Committee Chair*

7.2. Committee Highlight Report to Board

Discussion *Kath Palmer, Committee Chair*

7.3. How did we do in this meeting?

Discussion Kath Palmer, 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?

11:55 - 11:55 8. PRIVATE/CLOSED SESSION BUSINESS

0 min

Information Kath Palmer, Committee Chair

- Organisational Risk Register - Business Sensitive Risks
- Financial Control Procedures - Medical Variable Pay - Summary of Authorised Breaches
- Local Counter Fraud Report (Individual Cases)

11:55 - 12:00 9. DATE AND TIME OF NEXT MEETING - 3 NOVEMBER 2026 AT 9:00 AM

5 min

Information Kath Palmer, Committee Chair

Audit Risk & Assurance Committee - Action Log (as at 23.07.26)									
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 - May 2026	4,3	4	Post Payment Verification End of Year Report 1st April 2025 * 31st March 2026	To review Practice 13 recovery figures and confirm position outside the meeting.	Post Payment Verification Manager	Executive Director of Finance	jul-26	Propose to close	The standard PPV routine claim errors were 22 out of 349 which gave the percentage error rate of 6.30%. There were 4 claim errors for Care Homes, 5x Denosumab, 1x DOAC/DOAR, 6x Pertussis, 6x Gonadorelins which resulted in the recovery amount of £936.67 The majority of the large recovery amounts were from the Duplicate claims, with the highest claim errors being for Substance Misuse. There were 120 claim errors with a recovery amount of £11,563.20. The practice claimed monthly for them, but they are a quarterly claim. The second highest was Warfarin where there were 70 claim errors with a recovery amount of £1,712.50. The other duplicate claims were 1x Alcohol Patient, 11x Contraceptives, 2x Denosumab, 79x Flu and 18x DOAC/DOAR. All these claims had either already been claimed by the practice, or they cannot claim for example Warfarin A & B for the same patient in the same month. The Health Board support a recommended revisit to further review Care Homes, Denosumab, Pertussis and Gonadorelins Service claims and stated that the practice is happy to pay the recovery costs, over an agreed 3-month period. We have also provided relevant advice to prevent these errors in the future.nda to update
Audit Risk & Assurance Committee - May 2026	4,5	5	Counter Fraud Annual Report 2025 / 2026	G Watts to discuss who holds the Counter Fraud lead role within the Corporate Governance Team with the Corporate Governance Senior Management Team outside the meeting.	Director of Corporate Governance / Board Secretary	Director of Corporate Governance/ Board Secretary	jul-26	Propose to close	The Director of Corprate Governance within holds the lead role for Counter Fraud within the CG team.
Audit Risk & Assurance Committee - May 2026	4,6	5	Counter Fraud Functional Standard Return 2025 / 2026	G Watts, to confirm whether JCC Declarations of Interest should be included within the Counter Fraud Functional Standards Return and clarify the reporting approach.	Director of Corporate Governance / Board Secretary	Director of Corporate Governance/ Board Secretary	jul-26	Propose to close	For completeness JCC DoI should be included and the Director of Corprate Governance will laise with the JCC Committee Secretary on this.
Audit Risk & Assurance Committee - May 2026	4,8	7	Speaking Up Safely Update	To consider Board-level reporting of Speaking Up Safely themes following consideration by ODC, including whether both formal and informal discussion routes are required. This matter to also be included in the highlight report to Board	Director of Corporate Governance / Board Secretary	Director of Corporate Governance/ Board Secretary	jul-26	Propose to close	Speaking Up Safely update on the Agenda for the July 2026 meeting of the ODC and on the agenda for the July Board Meeting.
Audit Risk & Assurance Committee - May 2026	4,9	8	Declaration of Interests & Gifts, Hospitality and Sponsorship Register	G Watts to liaise with JCC and review the approach to JCC Declarations of Interest, including whether they should be incorporated within the CTM Declarations of Interest, Gifts, Hospitality and Sponsorship Register or managed separately, ensuring appropriate oversight and that reporting is not duplicated	Director of Corporate Governance / Board Secretary	Director of Corporate Governance/ Board Secretary	jul-26	Propose to close	Worked with JCC - seprate and distinct processes will remian in place but awareness of the processes is in place. This wil be covreed off in the regaular catch ups between the Director of Corporate Governance at CTM and the JCC Committee Secretary
Audit Risk & Assurance Committee - May 2026	5,2	9	Organisational Risk Register	S May to discuss risk 6498 further with G Hughes regarding dynamic mattress systems in order to come up with a plan	Director of Finance	Director of Finance	jul-26	opose to close	July 2026: Action plan for this risk summarised within ORR report is as follows: • Continue phased replacement programme to increase the number of compliant mattress systems. • Progress review and renewal of supplier contract to ensure sustainable provision. • Maintain close monitoring of incidents and pressure care outcomes. • Ensure continued prioritisation of high-risk patients through clinical assessment and care planning. • Escalate through governance routes to secure a clear plan and actions to address the risk.
Audit Risk & Assurance Committee - May 2026	5,2	9	Organisational Risk Register	Review and amend the wording of Datix 1793 (Lack of isolation facilities available negative pressure rooms) to ensure the rationale for the reduced risk rating is clearly articulated and reflects mitigation rather than change in ownership.	Director of Corporate Governance / Board Secretary	Director of Corporate Governance/ Board Secretary	aug-26	Propose to close	This risk was deescalated in February 2026 with the agreement of the Care Group, as the capital project team was about to start the building project.
Audit Risk & Assurance Committee - May 2026	5,2	9	Organisational Risk Register	Review the risk scoring for Datix 6475 (Health Visitor strike) and provide assurance that the rating appropriately reflects the likelihood and impact	Director of Corporate Governance / Board Secretary	Director of Corporate Governance/ Board Secretary	aug-26	Open	July 2026: Confirmed with risk owner and handler that the rating (16) continues to appropriately reflect the likelihood and impact. Industrial action continues to impact Health Visiting capacity, with daily operational oversight and prioritisation in place to maintain support for high-risk families. Given this is very much still a live dispute propose that we keep this open and under review
Audit Risk & Assurance Committee - May 2026	5,2	9	Organisational Risk Register	Provide an updated position on the Specialist School Nursing risk, including assurance regarding service impact and mitigation actions.	Director of Corporate Governance / Board Secretary	Director of Corporate Governance/ Board Secretary	aug-26	Propose to close	July 2026: All funded posts are now filled; however, the absence of an agreed sustainable service model and SLA with Local Authorities means the risk to equitable and compliant Special School Nursing provision remains unchanged. Further discussions are taking place with the Executive Director of Nursing to agree next steps, following which the risk score will be reviewed. The associated controls, gaps in controls and actions have been clarified within the ORR (please refer to main report) and progress continues to be monitored through established governance arrangements.

Audit Risk & Assurance Committee - May 2026	5,2	9	Organisational Risk Register	Review alternative approaches to presenting the Organisational Risk Register to improve readability and accessibility for Members.	Director of Corporate Governance / Board Secretary	Director of Corporate Governance/ Board Secretary	aug-26	Propose to close	July 2026: The ORR has been reformatted to improve readability and accessibility for Members, including removal of the need for horizontal scrolling. All risks have also been reviewed and rewritten in plain language with risk owners and handlers, and are now presented in a consistent format setting out current controls, gaps in controls and planned actions. Further opportunities to improve readability, accessibility and the quality of risk information will continue to be explored.
Audit Risk & Assurance Committee - May 2026	5,3	10	Audit Recommendations Tracker Update Report	Escalate to Executive colleagues where audit updates are not being provided to ensure accountability.	Director of Corporate Governance / Board Secretary	Director of Corporate Governance/ Board Secretary	aug-26	Propose to close	
Audit Risk & Assurance Committee - May 2026	5,3	10	Audit Recommendations Tracker Update Report	Explore alternative methods of presenting audit progress (e.g. SPC charts) to improve clarity and trend visibility.	Director of Corporate Governance / Board Secretary	Director of Corporate Governance/ Board Secretary	aug-26	Open	Work is ongoing and continuous to improve reporting outputs and trend visibility for the Committee.
Audit Risk & Assurance Committee - May 2026	5,3	10	Audit Recommendations Tracker Update Report	G Watts and N Couch to review and progress historic audit recommendations, ensuring that longstanding actions are either completed or appropriately closed following reassessment.	Director of Corporate Governance / Board Secretary	Director of Corporate Governance/ Board Secretary	aug-26	Open	Work is ongoing with continuous escalation as maybe required and regular meetings with Audit Wales - further work on this was undertaken on 27 July.
Audit Risk & Assurance Committee - May 2026	5,4	12	NWSSP Internal Audit Progress report	Present the Long-Term Strategy Internal Audit report to Strategic Delivery Committee	Director of Corporate Governance / Board Secretary	Director of Corporate Governance/ Board Secretary	aug-26	Propose to close	Added to the Agenda for the August meeting of the SDC
Audit Risk & Assurance Committee - May 2026	5.5.1	13	IA Review – Savings Centrally Led Programmes	G Watts to discuss with K Palmer and the Chair whether any elements of the centrally led savings programme should be escalated to Board level including consideration of increased scrutiny and potential deep dives into underperforming areas.	Director of Corporate Governance / Board Secretary	Director of Corporate Governance/ Board Secretary	aug-26	Open	Discussion to take place in Sptember as we approach the end of quarter two.
Audit Risk & Assurance Committee - May 2026	5.5.1	13	IA Review – Savings Centrally Led Programmes	The IA Review- savings Centrally Led Programmes report to be presented to Operational Delivery Committee	Director of Corporate Governance / Board Secretary	Director of Corporate Governance / Board Secretary	jul-26	Propose to close	Added to the Consent Agenda for Noting at the July 2026 meeting of the ODC
Audit Risk & Assurance Committee - May 2026	5.5.1	13	IA Review – Savings Centrally Led Programmes	Review the positioning of finance reporting within the ODC agenda to ensure sufficient time is allocated for detailed discussion of savings performance	Corporate Governance Manager	Director of Corporate Governance/ Board Secretary	jul-26	Propose to close	
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	Propose to close	The February 2026 minutes state: "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." July 2026: Emerging risks have been clearly identified in the ORR coversheet and summary version, including the originating Care Group/Directorate, providing additional context and visibility. Please advise whether the Committee is satisfied that this addresses the action or whether further refinement is needed
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	aug-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 clairty 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 late summer/autumn.

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. Meeting between DCG and ARAC Chair to be arranged.
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	aug-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 - 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	Propose to close	Renewal agreement is now live and covered within budget
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

Open
Closed
Paused

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
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
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
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
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
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

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
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
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
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

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

Added to Forward Work Plan for November 2026 meeting.
Complete - The date 20 January 2026 is correct but the Committee to which it is referring is the ~~Quality Safety~~
Complete - business continyity both current and preparedness for the future is covered off at ~~ODC~~
Complete - the plan is to stand down the unspportedsystem s and use alternative systems - it is agreed that unsupported systems should not be developed and only corprately approved systems will be used in undertaking HB processes any new approved systems will require appropriate sign off.
Referral was received at Quality, Safety & Experience Committee and the response is on the Agenda for the May 2026 ~~meeting~~
Recommendation was reviewed and updated.

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
An update was provided at the February 2026 meeting
Complete - but will keep under review the heat up has been updated following ARAC feedback to provide more context in movement of risks etc
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.

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.

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.

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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 <u>last updates.</u>
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

Audit, Risk & Assurance Committee – Annual Report 2025-26

Eitem yr Agenda / Agenda Item	3.3
Dyddiad y Cyfarfod / Date of Meeting:	04/08/2026
Statws Cyhoeddi / Publication Status:	Open/Public.
	Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	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
Diben yr Adroddiad / Report Purpose:	Endorse for Board Approval
Argymhelliad (<i>Wedi'i gysylltu â'r adran "Beth Nesaf" uchod</i>). Recommendation (Linked to the "What Next" section above).	As above



1. Situation /Background

- 1.1 The purpose of this report is to highlight the activities and performance of the Audit, Risk & Assurance Committee (ARAC) during 2025-2026.
- 1.2 The Chair of the ARAC is required to present an annual report outlining Committee business throughout the financial year to provide the Board with assurances on the monitoring and scrutiny undertaken in relation to those issues set out under the Terms of Reference (TOR) for this Committee.
- 1.3 The Committee's draft Annual Report for 2025-2026 is presented at **Appendix 1** for endorsing.
- 1.4 The Terms of Reference for the ARAC Committee were last approved by the Board in March 2026 and are available on the Health Boards website via the following link: [Standing Orders - Cwm Taf Morgannwg University Health Board \(nhs.wales\)](https://www.nhs.uk/health-boards/cwm-taf-morgannwg-university-health-board/standing-orders).
- 1.5 An annual self-assessment questionnaire is also required to be undertaken and this will be completed by members outside of the meeting, the results of which will be reviewed at the August 2026 meeting.

2. Specific Matters for Consideration

- 2.1 The Committee is asked to approve the Audit, Risk & Assurance Committee Annual Report for 2025-2026.

3. Key Risks / Matters for Escalation

- 3.1 The publication of the annual report demonstrates compliance with the Standing Orders, which stipulates that each Committee is required to submit an annual report to the Board through the Chair at the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub-groups it has established.

4. Assessment

5. Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd	Not Applicable
6. (Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)	If more than one applies please list below: Not Applicable
7. Link to Strategic Risk(s) on the Board Assurance Framework	
8. (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Not Applicable



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	Not Applicable	
	If more than one applies please list below:	
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	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, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)</i>	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact:	If no, please select a reason below. Not Applicable
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): POSITIVE/NEUTRAL/NEGATIVE Summary of impact:	Named Executive/Board member sign off for no EWLIA completion:
Canlyniad Asesiad Effaith Ansawdd <i>(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)</i>	Not applicable	
Quality Impact Assessment Outcome <i>(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)</i>		
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

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	
ODC	Operational Delivery Committee
CTMUHB	Cwm Taf Morgannwg University Health Board

9. Recommendation

- 9.1 The Audit, Risk & Assurance Committee are asked **ENDORSE FOR BOARD APPROVAL** the Draft Annual Report 2025-26

10. Next Steps

- 10.1 Following this meeting, the report will be presented to the Health Board for Approval on the 24 September 2026.

ANNUAL REPORT 2025-2026

AUDIT, RISK & ASSURANCE COMMITTEE

AUDIT, RISK & ASSURANCE (ARAC) COMMITTEE

DRAFT ANNUAL REPORT 2025-2026

FOREWORD

I am pleased to be able to commend to you this annual report, which has been prepared for the attention of the Board and reviews the work of the Committee for the financial year 2025-2026.

I would like to recognise the significant commitment of all the officers of the Committee who have supported and contributed to the work carried out and for their continued dedication in meeting important targets and deadlines. I also wish to record my appreciation for the support and contribution given by the Internal Audit team at the NHS Wales Shared Services Partnership (NWSSP), by Audit Wales and Local Counter Fraud Services.

Going forward, the Committee intends to continue to pursue a full programme of work covering a wide range of topics and subject areas as part of its long-term aim to help further strengthen the governance arrangements of the Health Board.

Patsy Roseblade

Chair of the Audit, Risk & Assurance Committee

Cwm Taf Morgannwg University Health Board (CTMUHB)

INTRODUCTION

The Committee's business cycle runs from the closure of the Annual Accounts in one financial year to the next. This reflects its key role in the development and monitoring of the Governance and Assurance framework for Cwm Taf Morgannwg University Health Board (CTMUHB), which culminates in the production of the Accountability Report including the Governance Statement.

The Terms of Reference for the Committee were formally approved by the Board in March 2026 following changes made to quoracy. The Terms of Reference will be reviewed by the Committee in August 2026 as part of its annual review.

Members will be aware that all papers relating to the Committee (unless closed or 'in-committee') are available on the Health Board [website](#).

This report sets out the role and functions of the Audit, Risk & Assurance Committee and summarises the key areas of business undertaken during the year. In addition, the report sets out some of the key issues, which the Committee will be focussing on over the next few years.

ROLE, MEMBERSHIP, ATTENDEES AND COMMITTEE ATTENDANCES

ROLE

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

The Organisation's system of internal control has been designed to identify the potential risks that could prevent Cwm Taf Morgannwg UHB achieving its aims and objectives. It evaluates the likelihood of the risks being realised, considers the impact should they occur, and seeks to manage them efficiently, effectively and economically. Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, the assurance framework may be strengthened and developed further.

The Committee's Terms of Reference are reviewed annually and are included within the Standing Orders for the Cwm Taf Morgannwg UHB.

MEMBERSHIP

The membership of the Audit, Risk & Assurance Committee during 2025-2026 comprised five Independent Members, enabling the Committee to provide

appropriate scrutiny and assurance to the Board independently of the management decision-making processes.

A summary of the Independent membership during 2025-2026 is outlined in table 1 below:

Table 1 – Composition & Membership of the Audit, Risk & Assurance Committee 1 April 2025 – 31 March 2026

Name	Period
Members	
Patsy Roseblade Committee Chair/Independent Member	April 2025 – March 2026
Kath Palmer UHB Vice Chair/Independent Member	April 2025 – March 2026
Dilys Jouvenat – Independent Member	April 2025 – March 2026
Helen Lentle – Independent Member	April 2025 – March 2026
Kathy Mason – Independent Member	July 2025 – March 2026

ATTENDEES

As Executive leads for the Committee the Executive Director of Finance and the Director of Corporate Governance/Board Secretary attend every meeting as do members and are often accompanied by members of the respective teams. The Committee’s work is also informed by reports provided by Audit Wales, Internal Audit, Local Counter Fraud Services and CTMUHB personnel. Although they are not members of the Committee, auditors and other key personnel are expected to attend each meeting of the Audit, Risk & Assurance Committee. Invitations to attend the Committee meeting are also extended, where appropriate and on an ‘ad hoc’ basis, to specific staff when reports which relate to their specific area of responsibility are being discussed by the Audit, Risk & Assurance Committee.

ATTENDANCE AT AUDIT, RISK & ASSURANCE COMMITTEE 2025-2026

During the year, the Committee met on seven occasions. *One Extra Ordinary meeting was held during this period which was devoted to the Approval of the Annual Accounts and Annual Report. All meetings were quorate and were well attended as shown in Table 2 below:

Table 2 - Meetings and Member Attendance 2025-2026

Public Meeting Attendance:

Name:	22.05.25	25.06.25*	14.08.25	13.11.25	03.02.26
Patsy Roseblade - Independent Member (Chair)	✓	X	✓	✓	✓
Kath Palmer - UHB Vice Chair/Independent Member	X	✓	✓	X	✓
Kathy Mason – Independent Member		✓	✓	✓	✓

Helen Lentle – Independent Member	X	✓	✓	✓	X
Dilys Jouvenat – Independent Member	✓	✓	✓	X	✓

* Extra Ordinary Meeting (to sign off Annual Report and Accounts 2024-2025)

In Committee (IC) Meeting Attendance:

Name:	22.05.25	14.08.25	13.11.25	03.02.26
Patsy Roseblade - Independent Member (Chair)	✓	X	✓	✓
Kath Palmer - UHB Vice Chair/Independent Member	X	✓	X	✓
Kathy Mason – Independent Member		✓	✓	✓
Helen Lentle – Independent Member	✓	✓	✓	X
Dilys Jouvenat – Independent Member	✓	✓	X	✓

Hosted Bodies Meeting Attendance:

Name:	22.05.25	14.08.25	13.11.25	03.02.26
Patsy Roseblade - Independent Member (Chair)	✓	✓	✓	✓
Kath Palmer - UHB Vice Chair/Independent Member	X	✓	X	✓
Kathy Mason – Independent Member		✓	✓	X
Helen Lentle – Independent Member	X	✓	✓	X
Dilys Jouvenat – Independent Member	✓	✓	X	✓

AUDIT RISK & ASSURANCE COMMITTEE BUSINESS

The Audit, Risk & Assurance Committee provides an essential element of the Health Board's overall assurance framework. It has operated within its Terms of Reference in accordance with the guidance contained within the NHS Wales Audit Committee Handbook.

A Consent agenda approach was adopted across all Board and Committee meetings during 2020 and has continued to be used since. This enabled a number of reports to be received by Members for approval/noting, with an opportunity provided to Members to raise questions against these items in advance of the meeting.

The Committee has embedded the Health Board's Strategic Goals into its work programme, ensuring alignment with the "**CTM2030: Our Health, Our Future strategy**" and the Health Board's "**Values and Behaviour**"



The Audit, Risk & Assurance Committee agenda broadly followed a standard format, comprising of specific sections, which are outlined below:

Main Areas of Audit, Risk & Assurance Committee Activity – Part 1

The agenda for each meeting followed a standard format, broken down into the following 6 main parts:

1. Preliminary Matters

This included the apologies for absence, welcome and introductions and declarations of interest.

2. Consent Agenda for Approval/Noting

The following written reports were received by the Audit, Risk & Assurance Committee and considered accordingly:

- Unconfirmed Minutes;
- Action Log;
- Committee Annual Cycle of Business;
- Forward Work Programme;
- Clinical Audit Annual Plan and Clinical Audit Annual Report 2025-2026;
- Audit Wales – Annual Audit Enquiries Letter Response;
- Audit, Risk & Assurance Committee Annual Audit Plan 2025-26;
- Audit, Risk & Assurance Committee Terms of Reference;
- Audit, Risk & Assurance Committee Effectiveness Self-Assessment;
- Annual Report Timetable 2025-2026
- Standards of Good Governance and Probity Policy
- Audit Wales Review - Tackling the Planned Care Challenges Report and Management Response

- Outcome of Committee Referral to Quality, Safety & Experience Committee - Concern in relation to increased medical negligence costs

It is important to note any member of the committee can request that an item planned for the consent agenda can be moved to the main agenda for discussion.

3. Main Agenda

4. Sustaining Our Future

The following reports were received for discussion:

- Local Counter Fraud Report;
- Counter Fraud Annual Report;
- Counter Fraud Functional Standard Return 2024-25
- National Fraud Initiative Progress and Outcomes;
- Audit Wales Briefing - National Fraud Initiative 2024-25 Update for CTMUHB
- Counter Fraud Annual Self Review;
- Counter Fraud Draft Work Plan;
- Procurement and Scheme of Delegation Report;
- Post Payment Verification Mid-Year Update;
- Post Payment Verification Annual Report and End of Year Update;
- Penalties for Late Submitted Evidence Update;
- Draft Annual Report and Draft Annual Accounts 2024-2025;
- Losses and Special Payments Report;
- Financial Control Procedure – Medical Variable Pay – Summary of Authorised Breaches;
- Amendment to the Standards of Behaviour Framework Policy – Declarations of Interest Form;
- Declarations of Interest & Gifts and Hospitality Report;
- Audit Wales Audit of the Financial Statements (ISA 260) (Including the Letter of Representation and Audit Opinion);
- Breaches to the Standing Orders;
- CTMUHB ISO14001 Certification Progress Report;

5. Improving Care

The following reports were received for discussion:

- Audit Recommendations Tracker;
- Approval of the Annual Review of the Risk Management Framework/Board Assurance Framework;
- National Clinical Audit Plan;
- Organisational Risk Register;
- Annual Review Risk Management Framework;
- Organisational Risk Register;
- Interim Amendments to the Model Standing Financial Instructions Chapter 11 for Local Health Boards;
- Amendments to CTMUHB Standing Orders (Schedule 4.1 – Standing Orders for the NHS Wales Joint Commissioning Committee);

- Data Lapses/Data Loss Updates Report;
- Response to the updated HM Treasury Audit & Risk Assurance Committee Handbook.

Also received under this section were reports from:

- **Internal Audit**

NHS Wales Shared Services Partnership are the appointed Internal Auditors to the Health Board and provide an update on progress against the internal audit annual plan of business at each meeting together with finalised reports for each area that was subject to audit.

Each report contained an assessment on the level of assurance provided. Follow-up action was agreed for recommendations raised, which informed future audit plans.

- **External Audit**

The Auditor General for Wales (AGW) is the statutory external auditor for the Health Board. The AGW has a wide range of audit and related functions, including auditing the accounts of the Health Board, and reporting on the economy, efficiency and effectiveness with which the Health Board has used their resources. The AGW undertakes his work using staff and other resources provided by Audit Wales. The Engagement Lead and or the Financial Audit Manager from Audit Wales provide an Audit Position Statement at each meeting, summarising progress against its planned financial audit work. Additionally, the Performance Audit Manager will attend to update the Committee on performance audit work in relation to local audit work, national studies and the Structured Assessment

4.2. MAIN AREAS OF AUDIT, RISK & ASSURANCE COMMITTEE ACTIVITY – PART 2 HOSTED BODIES

During 2025/2026 The organisations hosted by the Health Board are the NHS Wales Joint Commissioning Committee (JCC) and the National Imaging Academy for Wales (NIAW).

On the 1st April 2024, the NHS Wales Joint Commissioning Committee (JCC) was established in response to the findings of an independent review commissioned by Welsh Government into the national commissioning arrangements undertaken by the Emergency Ambulance Services Committee (EASC), the Welsh Health Specialised Services Committee (WHSSC) and the National Collaborative Commissioning Unit (NCCU). From April 01 2024, the JCC replaced EASC and WHSSC and NCCU and has assumed responsibility for the services previously commissioned by these Committees.

Regular, standing agenda reporting to the CTMUHB Audit, Risk & Assurance Committee for Hosted Organisations include;

- Internal and External Audit Plans

- Internal and External Audit Reports with completed management action plans
- JCC Update Report
- Progress reports against audit recommendations (Audit Tracker)
- JCC Assurance Framework Report and Risk Register
- NIAW Risk Register

To support the requirements for the JCC and the NIAW, the Health Board's Audit, Risk & Assurance Committee is separated into two parts, specifically Part 1 for Health Board business and Part 2 for the Hosted bodies. The relevant officers attend for the relevant components of the meeting.

The Director of Corporate Governance/Board Secretary for CTMUHB and the CTMUHB Executive Director of Finance also attends both parts of the meetings.

The JCC and NIAW have shared the same External and Internal Audit teams and Local Counter Fraud Services (LCFS) with CTMUHB. All these factors enable CTMUHB to take necessary assurances from the hosted bodies, particularly in relation to the Accounts and the Annual Governance Statement and vice-versa for areas carried out by CTMUHB as part of its hosting responsibilities.

4. WORK/ACTION LOG

In order to monitor progress and any necessary follow up action, in line with recognised 'house style' templates a work log is maintained to capture all agreed actions from the CTMUHB Audit, Risk & Assurance Committee and Hosted Organisations. This provides an essential element of assurance both to the Committee and from the Committee to the Board.

5. INTERNAL AUDIT - OVERALL SUMMARY

In overall terms for the year 2025/2026, the Head of Internal Audit opinion provided **Reasonable Assurance** to the Board that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively in the relevant assurance domains. The full opinion report was presented to the Audit, Risk & Assurance Committee in June 2026 and is available on the link [here](#).

A breakdown of the Internal Audit reviews presented to the Audit, Risk & Assurance Committee in 2025-2026 is linked in Appendix 1.

6. EXTERNAL AUDIT

6.1 Audit Wales Audit Wales provide a progress report at each meeting, covering both probity and performance audits. The audit strategy, audit letters and statements of responsibilities were received and the ISA 260¹ Report was

¹ Auditors are required by International Standard on Auditing (ISA) 260 - Communication with those Charged with Governance - to communicate audit matters of governance interest to those charged with governance. It is important that

recommended for approval by the Board as part of the Accounts approval process.

A breakdown of the Audit Wales reviews presented to the Audit, Risk & Assurance Risk Committee in 2025-2026 is linked in Appendix 1.

6.2 Approval of the Annual Accounts 2024-2025

A meeting of the Audit, Risk & Assurance Committee was convened on 25 June 2025 to scrutinise the 2024-2025 Annual Accounts prior to approval by the Health Board including the letter of representation to Auditors and the Annual Governance Statement. The 2024-2025 Annual Accounts were scrutinised and approved by the Board on 26 June 2025. The meeting also scrutinised the Accounts and Statements for 2024-2025 from the Health Board's hosted organisations as appropriate. Formal presentation of the Annual Report and Accounts took place at the Annual General Meeting held on 31 July 2025.

PRIVATE MEETING WITH AUDITORS

In line with recognised good practice a private meeting between Audit, Risk & Assurance Committee members, Internal Audit, External Audit and the Local Counter Fraud Specialist can be held as and when required. This provides an opportunity for free and frank discussion. The Audit, Risk & Assurance Committee Chair also meets privately with Internal Audit and External Audit on occasions. This process will continue for 2026-2027.

LINKS WITH OTHER COMMITTEES

8.1 Other Sub Committees

The Audit, Risk & Assurance Committee has close links with the Quality, Safety & Experience Committee and other Committees of the Board. Through either specific meetings or the regular Independent Member meetings, there is an opportunity for Committee Chairs to support the work of each of the Committees they chair, share learning and avoid duplication.

During 2025-2026, a Committee Referral process continued to be adopted for all Committees where the following three questions were posed by the Committee Chair for each referral request:

- What are you referring?
- Why are you referring it?
- What is the outcome that you are anticipating for this referral?

those charged with governance have an understanding of all significant issues that have arisen from the audit process. In the UK and Ireland this must be done in a written format. The communication is done through the issuance of an Audit Completion Report known as the ISA 260 Report. This outlines the findings of the auditors and any other issues the auditor may wish to raise with management.

During this period one Committee Referral was made to the Quality, Safety & Experience Committee - Concern in relation to increased medical negligence costs.

The Chair of the Audit, Risk & Assurance Committee provides a report to the Board after each meeting via the Committee Highlight Report.

LOCAL COUNTER FRAUD SERVICES

The work of the Local Counter Fraud Service (LCFS) is undertaken to minimise the occurrence of fraud, corruption, and other economic crime within Cwm Taf Morgannwg University Health Board (CTMUHB) and to maintain such activity at the lowest possible level. This work is delivered in accordance with the Welsh Government Directions to NHS Bodies on Counter Fraud Measures and the Government Functional Standard for Counter Fraud, ensuring compliance with the NHS Counter Fraud Requirements expected of all Health Boards.

Regular reports are presented to the Committee to provide assurance and monitor progress against the approved Counter Fraud Work Plan.

The Health Board commissions its Counter Fraud Service from Swansea Bay University Health Board through a Service Level Agreement. The Health Board maintains an accredited Counter Fraud resource equivalent to 2.6 FTE, which is consistent with the level of provision within comparable sized Health Boards across NHS Wales.

During 2025/26, the Counter Fraud Team received 42 new referrals for investigation and carried forward 14 investigations from the previous reporting period. A total of 42 investigations were concluded during the year, resulting in the 2 applications of civil sanction and 3 applications for disciplinary sanction.

Counter fraud investigative activity led to the recovery of £10,973.00 in Health Board funds and identified fraud losses totalling £10,973.00.

An annual review of compliance with the Government Functional Standard: Counter Fraud NHS Requirements was undertaken during the year. As part of this process, the Health Board completed a self-assessment against 12 key requirement areas using a Red, Amber, and Green (RAG) rating methodology.

Following review, the CTMUHB achieved an overall Green rating, with all 12 requirement areas assessed as Green. This maintains the Health Board's full Green compliance status across all areas of the Government Counter Fraud Functional Standard, demonstrating sustained compliance and a strong organisational counter fraud governance framework. The achievement provides assurance that effective arrangements are in place and that the Health Board continues to meet the standards expected in protecting public funds.

As part of its counter fraud responsibilities, the Counter Fraud Team delivers an annual programme of fraud awareness and prevention activity across the Health Board. Dedicated resources are allocated to this work, which is incorporated within the annual Counter Fraud Work Plan, and formally approved by the Executive Director of Finance.

To support the development of a strong Anti-Fraud Culture, the Counter Fraud Team produces a quarterly newsletter and Blog, which is made available to all staff via the Health Board's intranet. The newsletter provides updates on emerging fraud risks, fraud prevention advice, and examples of counter fraud activity. In addition, details of successful prosecution and sanction outcomes are publicised, where appropriate, to maximise the deterrent effect and reinforce the Health Board's commitment to protecting the public purse.

The Counter Fraud Team also delivers general awareness presentations designed for all staff, together with targeted and bespoke sessions for departments and staff groups whose roles present a higher potential exposure to fraud risk. This risk based approach helps ensure that fraud prevention messages are tailored to specific operational environments and emerging threats, thereby strengthening the Health Board's overall counter fraud resilience.

The Health Board's approach to fraud risk management is now fully integrated within the Health Board's wider Risk Management Framework, ensuring that fraud risks are identified, assessed, monitored, and mitigated in a structured manner. This approach also facilitates greater collaboration between Counter Fraud and Internal Audit risk management, strengthening the Health Board's overall governance and assurance arrangements.

Building on the progress made to date, the Cwm Taf Morgannwg University Health Board can further develop the use of fraud risk management data as a strategic key performance indicator. This will provide additional assurance regarding the effectiveness of the counter fraud arrangements and support the ongoing growth of a strong anti-fraud culture throughout the organisation.

ASSURANCE TO THE BOARD

The Audit, Risk & Assurance Committee provides an essential element of the overall governance framework for the organisation and has operated within its Terms of Reference and in accordance with the guidance contained in the NHS Wales Audit Committee Handbook.

Internal Control & Risk Management - In addition to the audit reports received by the Committee during the reporting period, a wide range of internally generated 'governance' reports/papers were produced for consideration by the Audit, Risk & Assurance Committee.

Governance Statement - For the period 2025-2026 the Health Board produced its Governance Statement, which explains the processes and procedures in place to enable the Health Board to carry out its functions effectively. The Statement was produced following a review of CTMUHB's governance arrangements undertaken by the Board with the support of the Board Secretary/Director of Corporate Governance. The Statement brings together all disclosures relating to governance, risk and control for the organisation. The Governance Statement is captured in the CTMUHB's Annual Report which is available via this [link](#)

Tracking of Audit Recommendations

The Committee has increased the focus on tracking the implementation of agreed audit recommendations and the clarity of reporting of this, which achieved improvement during the year and laid the foundations for the further improvements now being made in 2025/2026, in particular the transition to an automated system using AmAT.

Audit Committee Effectiveness Survey - A Committee Effectiveness Survey was undertaken in 2025-2026 to obtain feedback from Committee members on potential areas for development.

The statements used in the survey were devised in accordance with the guidance outlined within the NHS Audit Committee Handbook.

CONCLUSION AND FORWARD LOOK

The Audit, Risk & Assurance Committee in discharging its scrutiny and assurance role on behalf of the Board considers that on the basis of the risk based work completed by the Committee during 2025-2026, that there are effective measures in place **and that there are no outstanding issues that the Audit, Risk & Assurance Risk Committee wishes to bring to the attention of the Board.**

The Directors have been held to account and have responded positively in dealing with any concerns raised by the Auditors and the Audit, Risk & Assurance Committee.

This Annual Report will be supplemented by the annual self-assessment process, which will be undertaken via Microsoft Office Forms, which reviews the individual and collective function of the Committee against the NHS Audit Committee Handbook best practice guidance and helps to inform the work of the Committee going forward.

The Committee is committed to continuing to develop its function and effectiveness and intends seeking further assurance in 2025-2026 in respect of:

- Reviewing audit outcomes and ensure actions are taken as a result of learning.
- The continued transition to an automated system for tracking audit recommendations and inspections, with the ambition to introduce trends and themes into reporting.
- Discharging effectively the Board approved Committee Terms of Reference, including the changes made in response to the Effective Management of Board Business Review.
- Increased reporting in relation to Declarations of Interest for the organisation.
- Ensuring all parties discharge their responsibilities appropriately as outlined within the Audit Charter.
- Continue to strengthen processes and resources in place to prevent and respond to fraud activity.

Appendix 1 – Audit Reviews Undertaken in 2025-2026

The Internal Audit reviews undertaken in 2025-2026 are captured in the 'Head of Internal Audit Opinion & Annual Report 2025-2026' as received at the Extra-Ordinary Audit, Risk & Assurance Committee which met on the 29 June 2026, available [here](#).

An update on the Audit Wales reviews undertaken in 2025-2026 are captured in the 'Audit Wales Annual Audit Summary 2025' received at the Public Board Meeting on the 26 March 2026, available [here](#).



Audit, Risk & Assurance Committee

Terms of Reference – Audit, Risk & Assurance Committee

Eitem yr Agenda / Agenda Item	3.3.1
Dyddiad y Cyfarfod / Date of Meeting:	4 August 2026
Statws Cyhoeddi / Publication Status:	Open/Public.
	Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	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
Diben yr Adroddiad / Report Purpose:	For Review
Argymhelliad (<i>Wedi'i gysylltu â'r adran "Beth Nesaf" uchod</i>). Recommendation (Linked to the "What Next" section above).	The Committee are asked to review the Terms of Reference.



1. Situation /Background

- 1.1 The Cwm Taf Morgannwg University Health Board Standing Orders form the basis upon which the Health Board's governance and accountability framework is developed and, together with the adoption of the Health Boards Standards of Good Governance & Probity Policy is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.
- 1.2 All Health Board members and officers must be aware of the Standing Orders and, where appropriate, should be familiar with their detailed content.
- 1.3 The Audit, Risk & Assurance Committee Terms of Reference form schedule 3.1 of the Standing Orders and the purpose of the paper is for the Committee to note.

2. Specific Matters for Consideration

- 2.1 The Terms of Reference are attached as Appendix 3.3.1a and were Approved by the Health Board at its meeting held on 26 March 2026 and are being presented to the Committee to review.

3. Key Risks / Matters for Escalation

- 3.1 The Standing Orders will be further strengthened in year as and when required.

4. Assessment

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>	Not applicable
	If more than one applies please list below:
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)	
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant /	Not applicable



Link to Wellbeing of Future Generations Act – Wellbeing Goals	If more than one applies please list below:	
Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Not applicable	
	If more than one applies please list below:	
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	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, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)</i>	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact:	If no, please select a reason below. Not required Named Executive/Board member sign off for no EWLIA completion:
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): POSITIVE/NEUTRAL/NEGATIVE Summary of impact:	
Canlyniad Asesiad Effaith Ansawdd <i>(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)</i>	Not applicable	
Quality Impact Assessment Outcome <i>(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)</i>		
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>	There is no direct impact on resources as a result of the activity outlined in this report	
Operational Delivery Committee – Review of Terms of Reference	Page 3 of 4	Operational Delivery Committee 28/07/2026

Resource Impact (People / Financial)	

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Health Board	26/03/2026	Approved

Acronyms / Glossary of Terms	

5.

Recommendation

The Committee are asked to review the Terms of Reference.



GIG
CYMRU
NHS
WALES

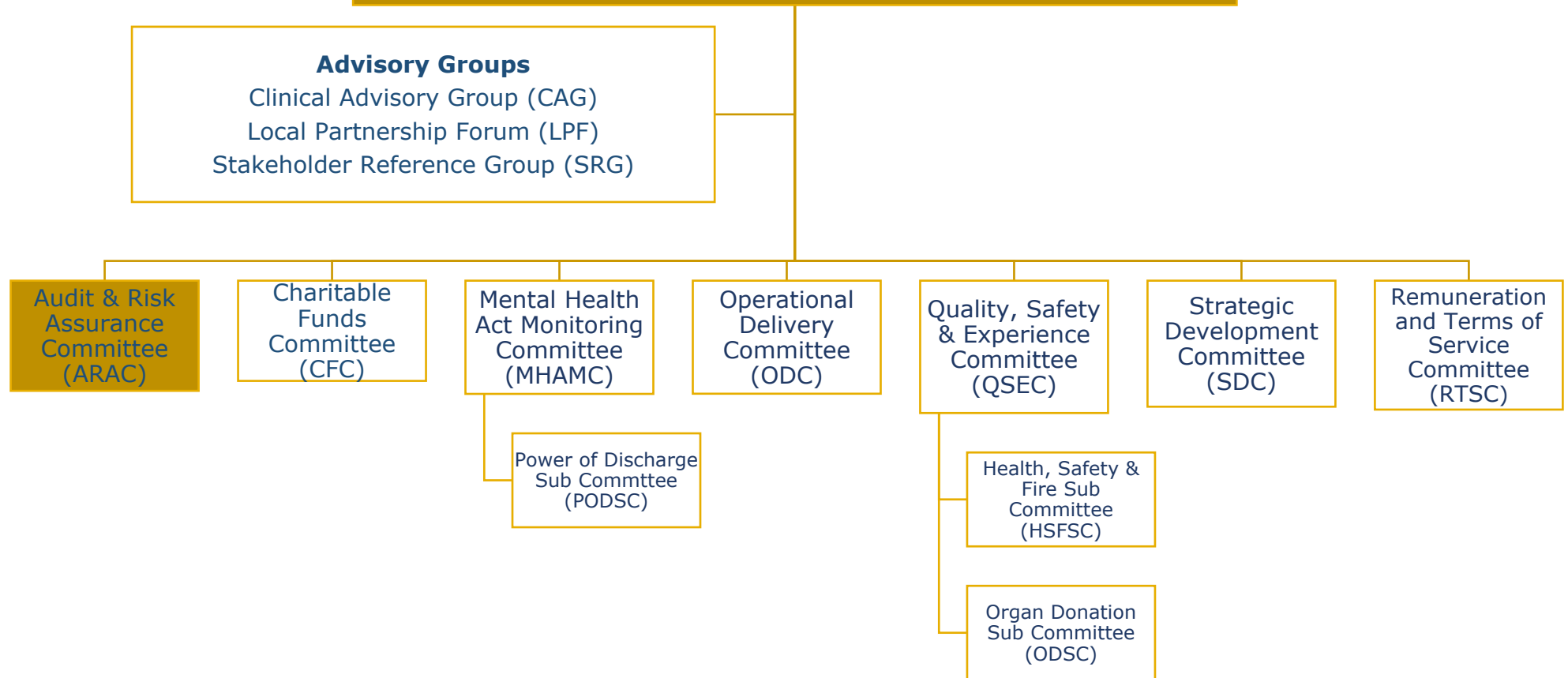
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

AUDIT & RISK ASSURANCE COMMITTEE (ARAC)

Terms of Reference & Operating Arrangements
(Schedule 3.1 of the Standing Orders)

Last Approved: Health Board Meeting 26th March 2026
CTM_Corporate_Governance@wales.nhs.uk

Cwm Taf Morgannwg University Health Board



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Version Control

Version	Issued To	Date	Outcome	Next Review Date
Version 1	Health Board Meeting	26.9.2024	Approved	No later than September 2025
Version 2	Health Board Meeting	26.03.2026	Approved	No later than March 2027

Board Committee Arrangements: This schedule forms part of, and shall have effect as if incorporated in the Health Boards Standing Orders

1. Introduction & Constitution

- 1.1 The Cwm Taf Morgannwg University Health Board (CTMUHB) Standing Orders provide that "The Board may and, where directed by the Welsh Government must, appoint Committees of the Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees".
- 1.2 In accordance with Standing Orders (and the CTMUHB scheme of delegation), the Board shall nominate annually a committee to be known as the **Audit & Risk Assurance Committee (ARAC)**. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set in this document.
- 1.3 The Committee will also consider items within the remit of the ARAC in respect of the roles and responsibilities of Committees/Programmes hosted by the CTMUHB on behalf of NHS Wales as appropriate. These are the Joint Commissioning Committee (JCC) and the National Imaging Academy for Wales (NIAW). The meeting will be split into two parts with Cwm Taf Morgannwg CTMUHB business and JCC and NIAW discussed and recorded separately. Please refer to Appendix 1 which articulates the specific remit and responsibilities for the hosted ARAC Committee.

2. Purpose

- 2.1 The Audit and Risk Assurance Committee should support the Board and Accounting Officer by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of financial statements. The scope of the Audit and Risk Assurance Committee's work should be defined in its Terms of Reference and should encompass all the assurance needs of the Board and Accounting Officer. Within this the Audit and Risk Assurance Committee should have particular engagement with the work of Internal Audit, the work of the External Auditor and Financial Reporting issues.
- 2.2 The ARAC will advise and assure the Board and the Accountable Officer on whether effective arrangements are in place, through the design and operation of CTMUHB's system of assurance, to support them in their decision taking and in discharging their accountabilities for securing the achievement of the Health Boards objectives, in accordance with the standards of good governance determined for the NHS in Wales.

- 2.3 The Committee independently monitors, reviews and reports to the Board on the processes of governance, and where appropriate, facilitates and supports, through its independence, the attainment of effective processes.
- 2.4 Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.
- 2.5 The Committee's **principal duties** encompass the following:
- the strategic processes for risk, control and governance and the Governance Statement;
 - the accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, and management's letter of representation to the external auditors;
 - the planned activity and results of both internal and external audit;
 - adequacy of management response to issues identified by audit activity, including external audit's management letter;
 - assurances relating to the management of risk and corporate governance requirements for the organisation;
 - (where appropriate) proposals for tendering for either Internal or External Audit services or for purchase of non-audit services from contractors who provide audit services
 - anti-fraud policies, raising concerns (Speaking up Safely) processes, and arrangements for special investigations;
 - receiving assurance from the Senior Information Risk Owner and Data Protection Officer that the data and cyber security and information risk is being effectively managed and that there are appropriate and sustainable frameworks in place. It is important to understand the organisation's tolerance for risk and evaluate the risk decisions made by Health Board officers.
 - periodically review its own effectiveness and report the results of that review to the Board.

3. Scope and Duties

Governance, Risk Management and Internal Control

- 3.1 The Committee shall review the adequacy of CTMUHB's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives.
- 3.2 In particular, the Committee will review the adequacy of:

- all risk and control related disclosure statements (in particular the Accountability Report and the Performance Report), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board;
 - the underlying assurance processes that indicate the degree of the achievement of strategic and planning objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
 - the policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements; and
 - the policies and procedures for all work related to fraud and corruption as set out in Welsh Government Directions and as required by the Counter Fraud and Security Management Service.
- 3.3 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, Clinical Audit, External Audit and other assurance functions, however, will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.
- 3.4 This will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.
- 3.5 The Committee will seek assurance that effective systems are in place to manage risk, that the organisation has an effective framework of internal controls to address principal risks (those likely to directly impact on achieving strategic objectives), and that the effectiveness of that framework is regularly reviewed.
- 3.6 Monitor the assurance environment and challenge the build-up of assurance on the management of key risks across the year, and ensure that the Internal Audit plan is based on providing assurance that controls are in place and can be relied upon (particularly where there is a significant shift between the inherent and residual risk profile), and review the internal audit plan in year as the risk profile changes.
- 3.7 Seek assurance on delivery against Planning Objectives aligned to the Committee, considering and scrutinising the frameworks, charts/charters and action plans that are developed, supporting and endorsing these as appropriate.
- 3.8 Consider and recommend to the Board approval of any changes to the Risk Management Framework and oversee development of the Board Assurance Framework.

- 3.9 Provide assurance with regard to the systems and processes in place for clinical audit, and consider recommendations from appropriate clinical forums on suggested areas of activity for review by internal audit.
- 3.10 The Committee will be responsible for reviewing CTMUHB's Standing Orders and Standing Financial Instructions and Scheme of Delegation annually, (including associated framework documents as appropriate), monitoring compliance, and reporting any proposed changes to the Board for consideration and approval.
- 3.11 Review the adequacy of the circumstances associated with each occasion where Standing Orders or Standing Financial Instructions are waived/breached.
- 3.12 To receive annually a full report of all offers of gifts, hospitality, sponsorship and honoraria recorded by CTMUHB and report to the Board the adequacy of these arrangements.
- 3.13 To review and report to the Board annually the arrangements for declaring, registering, and handling interests.
- 3.14 Approve the writing-off of losses or the making of special payments within delegated limits.
- 3.15 Review the adequacy of arrangements related to counter fraud activity.
- 3.16 Receive an assurance on Post Payment Verification Audits through bi-annual reporting to the Committee.
- 3.17 Receive a report on all Single Tender Actions and extensions of contracts.
- 3.18 Retrospectively assure any purchase / expenditure above the delegated financial limit of the Chief Executive.

Internal Audit and Capital / Private Finance Initiative

- 3.19 The Committee shall: consider the proposals for accessing internal audit services via a shared services arrangement (where appropriate), the audit fee and any questions of resignation and dismissal;
- 3.20 The Committee shall ensure that there is an effective internal audit and capital/PFI function established by management that meets mandatory Internal Audit Standards for NHS Wales and provides appropriate independent assurance to the Committee, Chief Executive and Board.
- 3.21 This will be achieved by:

- review and approval of the Internal Audit Strategy, Charter, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation;
- review of the adequacy of executive and management responses to issues identified by audit, inspection and other assurance activity, in accordance with the Charter;
- regular consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources;
- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation; and
- annual review of the effectiveness of internal audit.

External Audit

- 3.22 The Committee from time to time, will consider and make any necessary representations to the Auditor General for Wales on his appointment of an engagement partner.
- 3.23 Receive a report from the Auditor General for Wales / Wales Audit Office on the results of his audit of the annual accounts before recommending adoption of those accounts to the Accountable Officer and the Health Board.
- 3.24 The Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work.
- 3.25 The Committee shall consider the work carried out by key sources of external assurance, in particular but not limited to the Health Board external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity. This will be achieved by:
- discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors and inspection bodies in the local health economy;
 - discussion with the External Auditors of their local evaluation of audit risks and assessment of the Local Health Boards/NHS Trusts and associated impact on the audit fee;
 - review all External Audit reports, including agreement of the Annual Audit Report and Structured Assessment before submission to the Board, and any work carried outside the annual audit plan, together with the appropriateness of management responses; and
 - review progress against the recommendations of the annual Structured Assessment.

Other Assurance Functions

- 3.26 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications on the governance of the organisation.
- 3.27 The Committee's programme of work will be designed to provide assurance that the work carried out by the whole range of external review bodies be brought to the attention of the Board. This will ensure that the Health Board is aware of the need to comply with related standards and recommendations of these review bodies and the risks of failing to comply. These will include, but will not be limited to, any reviews by Inspectors and other bodies (e.g. Healthcare Inspectorate Wales, Welsh Risk Pool, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).
- 3.28 The ARAC and the Quality, Safety and Experience Committee both have a role in seeking and providing assurance on Clinical Audit in the organisation. The Audit and Risk Assurance Committee will seek assurance on the overall plan, its fitness for purpose and its delivery. The Quality, Safety and Experience Committee will seek more detail on the clinical outcomes and improvements made as a result of clinical audit. The internal audit function will also have a role in providing assurance on the Annual Clinical Audit Plan.
- 3.29 The ARAC will also seek assurances where a significant activity is shared with another organisation and collaborative partnerships, in particular the NHS Wales Shared Services Partnership, Joint Committees and other regional committees. The ARAC will expect to receive assurances from internal audit performed at these organisations that risks in the services provided to them are adequately managed and mitigated with appropriate controls.

Management

- 3.30 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.
- 3.31 The Committee may also request specific reports from individual functions within the organisation (e.g. clinical audit), as they may be appropriate to the overall arrangements.
- 3.32 The Committee may also request or commission special investigations to be undertaken by Internal Audit, directors or managers to provide specific assurance on any areas of concern that come to its attention.

Financial Reporting

- 3.33 The Committee shall review the Annual Accounts and Financial Statements before submission to the Board, focusing particularly on:
- the ISA 260 report to those charged with governance;
 - changes in, and compliance with, accounting policies and practices;
 - unadjusted mis-statements in the financial statements;
 - major judgemental areas;
 - significant adjustments resulting from the audit;
 - other financial considerations include review of the Schedule of Losses and Compensation.
- 3.34 The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

4. Membership

Members

- 4.1 The Membership of ARAC is as follows:

Chair	Independent Member The Chair of the ARAC should also be a member of the Quality, Safety & Experience Committee.
Vice Chair	Independent Member
Members	2 further Independent Members

Support to Committee Members

- 4.2 The Director of Corporate Governance / Board Secretary, on behalf of the Committee Chair, shall:
- Arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
 - Co-ordinate the provision of a programme of organisational development for committee members as part of the overall Health Board's Organisational Development programme developed by the Executive Director for People.
- 4.3 The Chair of CTMUHB should not be a member of the Audit and Risk Assurance Committee and will not normally attend but may be invited by the Committee Chair to attend all or part of a meeting to assist with its discussions on any particular matter.
- 4.4 The membership of ARAC will be reviewed annually.

4.5 In Attendance

Executive Director of Finance (Joint Executive Lead)
Director of Corporate Governance / Board Secretary (Joint Executive Lead)
Representative of the Auditor General
Head of Internal Audit
Local Counter Fraud Specialist
Head of Corporate Finance

- 4.6 The Chief Executive, as the Accountable Officer, should be invited to attend, as a minimum when the Committee considers the draft internal audit plan, to present the draft Accountability Report and the annual accounts, and on request by the Committee.
- 4.7 As and when required the Senior Information Risk Owner and Data Protection Officer will be asked to attend the Committee to provide assurance on mitigating actions taken in terms of Data Breaches / cyber incidents and also on the sustainability of relevant frameworks to support the digital and data infrastructure.

By Invitation:

- 4.8 Other Directors / Health Board Officers may be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that Director.
- 4.9 The Committee may also co-opt additional independent external members from outside the organisation to provide specialist skills, knowledge and experience.

5 Quorum & Attendance

- 5.1 A quorum shall consist of no less than three of the membership and must include as a minimum the Chair or Vice Chair of the Committee, together with a third of the "In Attendance" members.
- 5.2 The membership of the Committee shall be determined by the Board, based on the recommendation of CTMUHB Chair, taking into account the balance of skills and expertise necessary to deliver the Committee's remit, and subject to any specific requirements or directions made by the Welsh Government.
- 5.3 Any senior officer of CTMUHB or partner organisation may where appropriate, be invited to attend, for either all or part of a meeting, to assist with discussions on a particular matter.
- 5.4 The Committee may also co-opt additional independent external 'experts' from outside the organisation to provide specialist skills.

- 5.5 Should any 'in attendance' officer member be unavailable to attend, they may nominate a deputy to attend in their place, subject to the agreement of the Chair.

6 Meeting Secretariat

- 6.1 The Committee Secretariat shall be determined by the Director of Corporate Governance/Board Secretary.

7 Frequency of Meetings

- 7.1 The Committee will meet **at least four times per annum** and shall agree an annual schedule of meetings.
- 7.2 Any additional meetings will be arranged as determined by the Chair of the Committee in discussion with the Lead Executive(s).
- 7.3 The Chair of the Committee, in discussion with the Committee Secretary, shall determine the time and the place of and procedures of such Committee meetings.
- 7.4 The External Auditor and Head of Internal Audit may request a meeting if they consider one is necessary.

8 Withdrawal of Individuals in Attendance

- 8.1 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

9 Circulation of Papers

- 9.1 All papers will be distributed at least 7 calendar days in advance of the meeting.

10 Access

- 10.1 The Head of Internal Audit and the representative of the Auditor General shall have unrestricted and confidential access to the Chair of ARAC at any time, and vice versa.
- 10.2 The Committee members will meet separately with Internal Auditors, External Auditors, the Local Counter Fraud Specialist and the Accountable Officer without the presence of other officers on at least one occasion each year.

- 10.3 The Chair of ARAC shall have reasonable access to Executive Directors and other relevant senior staff.

11 Accountability, Responsibility & Authority

- 11.1 The ARAC is an independent Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.
- 11.2 Although the Board has delegated authority to the Committee for the exercise of certain functions, as set out in these Terms of Reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.
- 11.3 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.
- 11.4 The ARAC has a key role in assisting the Board to fulfil its oversight responsibilities in areas such as the Health Board's financial reporting, internal control systems, risk management systems and the internal and external audit functions.
- 11.5 The Committee shall embed CTMUHB's vision, corporate standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.
- 11.6 The Committee is authorised by the Board to:
- Investigate or have investigated any activity within its Terms of Reference and in performing these duties shall have the right, at all reasonable times, to inspect any books, records or documents of the CTMUHB. It may seek relevant information from any:
 - Employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
 - Any other Committee, sub Committee or group set up by the Board to assist it in the delivery of its functions.
 - obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject to the Board's budgetary and other requirements;
 - By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Board at any meeting of the Committee.
 - Approve policies relevant to the business of the Committee as delegated by the Board.

Sub Committees

- 11.7 The Committee may, subject to the approval of the Health Board, establish sub Committees or task and finish groups to carry out on its behalf specific aspects of Committee business.
- 11.8 At this stage, no sub Committees/task and finish groups have been established.

12 Reporting

- 12.1 The Committee, through its Chair and members, shall work closely with the Board's other Committees, including joint/sub committees and groups, to provide advice and assurance to the Board through the:
- joint planning and co-ordination of Board and Committee business;
 - sharing of information.
- 12.2 In doing so, the Committee shall contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.
- 12.3 The Committee may establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee business. The Committee will receive an update following each sub-committee or task and finish group meeting detailing the business undertaken on its behalf.
- 12.4 The Committee will consider the assurance provided through the work of the Board's other Committees and Sub-Committees to meet its responsibilities for advising the Board on the adequacy of CTMUHB's overall assurance framework.
- 12.5 The Committee Chair, supported by the Committee Secretary, shall:
- Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update report as well as the presentation of an annual report within six weeks of the end of the financial year and timed to support the preparation of the Accountability Report. This should specifically comment on the adequacy of the assurance framework, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Committee's self-assessment and evaluation.
 - Bring to the Board's specific attention any significant matter under consideration by the Committee.
 - Ensure appropriate escalation arrangements are in place to alert CTMUHB Chair, Chief Executive or Chairs of other relevant Committee, of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

- 12.6 The Director of Corporate Governance/Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committees performance and operation, including that of any sub-committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.
- 12.7 The CTMUHB ARAC will undertake an annual assessment of effectiveness, with reference to this assurance framework. The self-assessment will inform continuous improvement of the arrangements and will be included in the Committee's annual report to the CTMUHB Board

13 Applicability of Standing Orders to Committee Business

- 13.1 The requirements for the conduct of business as set out in the CTMUHB's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:
- Quorum

14 Chairs Action on Urgent Matters

- 14.1 There may, occasionally, be circumstances where decisions which would have been made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Committee, after first consulting with at least two other members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.
- 14.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

15 In Committee (Private Meeting)

- 15.1 The Committee can operate with an In Committee function to receive updates on the management of sensitive and/or confidential information.

16 Review

- 16.1 These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.

Appendix 1 – Hosted Audit and Risk Assurance Committee

1 Purpose

- 1.1 As per the approved Assurance Map of the Joint Commissioning Committee (JCC), issues relating to the functions of the JCC delegated from the seven LHBs will be fed into a separate Hosted Bodies Audit Risk Assurance Committee, operating within its own work cycle as required. The assurance for this will be to the seven LHBs.
- 1.2 Additionally, the Hosted Bodies Audit Risk Assurance Committee will also consider issues relating to the National Imaging Academy Wales (NIAW).
- 1.3 The assurance for the governance and issues relating to the hosting of the JCC and NIAW will be to the Cwm Taf Morgannwg Board.

2 Reporting Requirements in relation to Hosted Organisations

- 2.1 CTMUHB will convene an ARAC at a frequency determined by the CTMUHB Board, but not less than four times a year, to consider matters relating to the organisations hosted by CTMUHB.
- 2.2 The following provides an outline of the requirements (not exhaustive) to satisfy the CTMUHB Board in relation to seeking assurance on the governance arrangements in hosted bodies. This list can be reviewed at any time, as determined by the CTMUHB's ARAC.
 - Internal and External Audit Plans (It is for CTMUHB ARAC to ensure there is an audit plan in place, but not to determine what is agreed to be within the plan, this is for the host body to agree with Joint Committee Members or SRO. This does not preclude any audit areas that CTMUHB may wish to instruct Internal Audit to review in relation to gaining assurance from hosted body activities in regarding the hosting relationship).
 - Internal and External Audit Reports with completed management action plans
 - Progress reports against audit recommendations (Audit Tracker) NB - to be highlighted to Joint Committee and/or Lead Sponsor if progress is deemed unsatisfactory
 - Assurance Framework Report and Risk Register
 - Compliance and activity governed by CTMUHB Standards of Behaviour Policy (i.e. Declarations of Interest, Gifts & Hospitality)
 - Single Tender Actions
 - Breach or waivers to Standing Orders and/or Standing Financial Instructions

- 2.3 Other routine information will be monitored by the Joint Commissioning Committee/SRO Performance meetings and where necessary, may be appropriate/necessary to report to and be scrutinised by any relevant CTMUHB Committee.
- 2.4 Taking advice from CTMUHB's Director of Corporate Governance, hosted bodies will also be expected to report on novel or contentious issues relating to any activity governed by CTMUHB Policy.

3 Membership and Attendance

- 3.1 The Membership of the Hosted Bodies ARAC and support offered to the members will be in line with the details outlined in paragraphs 4.1 to 4.4 inclusive in the main ARAC Terms of Reference.
- 3.2 The Director of Finance and Committee Secretary for the Joint Commissioning Committee will normally attend the Hosted Bodies meetings of the Hosted Bodies Audit, Risk & Assurance Committee. The Chief Commissioner shall be invited to attend at least annually to discuss the process for assurance that supports the Annual Governance Statement and at the meeting to discuss the Accounts in particular in respect of their role as an Accountable Officer for the purposes of regularity and propriety. Additionally a nominated Lay Member of the JCC will also attend the Hosted Bodies ARAC.
- 3.3 The National Imaging Academy Director will normally attend the Hosted Bodies meetings of the ARAC on at least a six monthly basis.
- 3.4 The CTMUHB Executive Director of Finance and Head of Corporate Finance will also attend the Hosted Bodies meetings of the ARAC, as will the Director of Corporate Governance/Board Secretary.

4 Other Meeting Arrangements

- 4.1 Meeting arrangements including secretariat support and quoracy for the Hosted Bodies ARAC will mirror those set out in the terms of reference of the main CTMUHB ARAC.



Audit, Risk & Assurance Committee

Annual Review: Risk Management Framework

Eitem yr Agenda / Agenda Item	3.4
Dyddiad y Cyfarfod / Date of Meeting:	4 August 2026
Statws Cyhoeddi / Publication Status:	Open/Public.
	Not applicable
Adroddiad wedi'i baratoi gan / Report Prepared by:	Louise Stait, Interim Assistant Director Governance and Risk
Cyflwynydd yr Adroddiad / Report Presenter:	Gareth Watts, Director of Corporate Governance / Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance/Board Secretary
Diben yr Adroddiad / Report Purpose:	Endorse for Board Approval
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	The Audit, Risk & Assurance Committee is asked to ENDORSE this report for presentation to Board
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>	All Strategic Pillars
	<i>If more than one applies please list below:</i> The Risk Management Framework underpins delivery of all strategic pillars
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynnyddol <i>(Cyfeiriad blaenoriaeth berthnasol)</i> Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan <i>(Reference relevant priority)</i>	The Risk Management Framework supports delivery of the Integrated Medium Term Plan and Annual Delivery Plan by identifying, monitoring and reporting the principal risks that may affect delivery of the Health Board's objectives, priorities and statutory duties.

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*)

As good governance on an annual basis the Health Board reviews its risk management framework which is comprises the following documents:

1. Risk Management Strategy, including:
 - o Risk Appetite Statement
 - o Risk Domain & Scoring Matrix
 - o Board Assurance Framework
2. Risk Management Policy
3. Risk Assessment Procedure

A comprehensive review of the framework was undertaken during 2025, including a dedicated Board Development Session.

During 2026, a further desktop review has been undertaken by the Governance and Risk Team to determine whether any material amendments are required. No changes requiring amendment to the framework documents have been identified.

The current documents can be viewed as follows:

Document	Location
Risk Management Strategy	Website: Risk Management Strategy
Risk Management Policy	Website: Risk Management Policy
Risk Assessment Procedure	Intranet: Risk Assessment Procedure.docx
Risk Appetite Statement	Appendix to Risk Management Strategy
Risk Domain & Scoring Matrix	Appendix to Risk Management Strategy
Board Assurance Framework	Routine Board reporting

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 /*

This review confirms that the Health Board can continue to place reliance on its existing Risk Management Framework as the basis for organisational risk oversight and assurance.

This position is supported by recent internal audit work, which concluded that the Health Board's risk management framework, policies and guidance remain appropriate and available to staff. Some current actions arising from both internal and external audit relate primarily to the implementation and operation of risk management arrangements and are being progressed through separate action plans.

No issues have been identified by our auditors that require amendment of the framework itself.



<i>Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)</i>	Since the last review, some changes have been made to the format and presentation of the Organisational Risk Register and Board Assurance Framework. The review confirms that these changes do not alter the underlying framework and therefore do not require amendment of the framework documents.
Beth Nesaf (<i>crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud</i>) What Next (<i>summary of intended action and benefits supporting the choices and recommendation(s) being made</i>)	Subject to Audit, Risk & Assurance Committee endorsement, this report will be presented to the Board for final approval. The Governance Team will continue to monitor the effectiveness of the framework through routine operation, reporting and assurance activity, and a further annual review will be undertaken during 2027.
Argymhelliad (<i>Wedi'i gysylltu â'r adran "Beth Nesaf" uchod</i>). Recommendation (Linked to the "What Next" section above).	The Committee is asked to • Endorse the continuing use of the following documents to the Audit, Risk and Assurance Committee: ○ Risk Management Strategy. ○ Risk Appetite Statement. ○ Risk Domain and Scoring Matrix and associated escalation arrangements. ○ Risk Management Policy. ○ Risk Assessment Procedure. • Confirm that the Board Assurance Framework remains fit for purpose and continues to appropriately support oversight of the Health Board's principal strategic risks.

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)	All Strategic Risks on the BAF <i>If more than one applies please list below:</i> The Risk Management Framework supports oversight of all principal risks within the Board Assurance Framework.
	All applicable



Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	<i>If more than one applies please list below:</i> The Risk Management Framework supports consideration of the Health Board's strategic risks across all relevant Wellbeing Goals.
Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	All applicable <i>If more than one applies please list below:</i> The Risk Management Framework enables oversight of risks that may affect all Enablers of Quality.
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	Not applicable The report itself does not propose a new service change or operational decision with a direct environmental impact.
Asesiad Effaith Impact Assessment	
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg <i>(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)</i> 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 Equality: NEUTRAL Summary of impact: A separate Equality Impact Assessment has not been undertaken for this covering report, as it provides an assurance update on the Risk Management Framework rather than proposing a new policy, service change or decision. Outcome for Welsh Language: NEUTRAL Summary of impact: A separate Welsh Language Impact Assessment has not been undertaken for this covering report, as it provides an assurance update on the Risk Management Framework. If no, please select a reason below: Not required — assurance report only / no new policy, service change or decision proposed. Named Executive/Board member sign off for no EWLIA completion: Executive Sponsor: Director of Corporate Governance / Board Secretary
Canlyniad Asesiad Effaith Ansawdd	Outcome for Equality: Neutral Summary of impact: A separate Quality Impact Assessment has not been undertaken for



(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)

this covering report, as it provides an assurance update on the risk management process rather than proposing a new service change or operational decision.

Cyfreithiol / Legal

There are no specific legal implications related to the activity outlined in this report

Enw da / Reputational

Yes (include further detail below)

Having a robust risk management framework is critical to maintaining the Health Board's reputation.

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

This report does not request additional resource.

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

Committee / Group / Individuals

Date

Outcome

Governance & Risk Team

June 2026

Desktop review of framework documents completed

Internal and External Audit Reports

2025/26

Considered as part of annual review

ELG

13 July 2026

Endorsement sought prior to ARAC and Board approval

Acronyms / Glossary of Terms

Audit, Risk & Assurance Committee

Losses & Special Payments 1st April 2026 to 30th June 2026

Eitem yr Agenda / Agenda Item	4.1
Dyddiad y Cyfarfod / Date of Meeting:	04/08/2026
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>	Not applicable
Strategic Context: <i>This report aligns to the following Strategic Pillars</i>	If more than one applies please list below:
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynnyddol <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 Committee on the losses and special payments made by the University Health Board (UHB) for the 3-month period from 1 April 2026 to 30 June 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 £3,229k, 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 £1,321k, giving a net cash in position for the period of £1,908k. The significant payments of claims, especially on medical negligence has increased the amount owed by Welsh Risk Pool and therefore the debtor balance we are anticipating. At 30th June the amount paid but not yet received from Welsh Risk Pool is £31.1m.

This is £1.4m higher than it was at the end of the 2025/26 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 Committee on the losses and special payments made by the University Health Board (UHB) for the 3-month period from 1 April 2026 to 30 June 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.

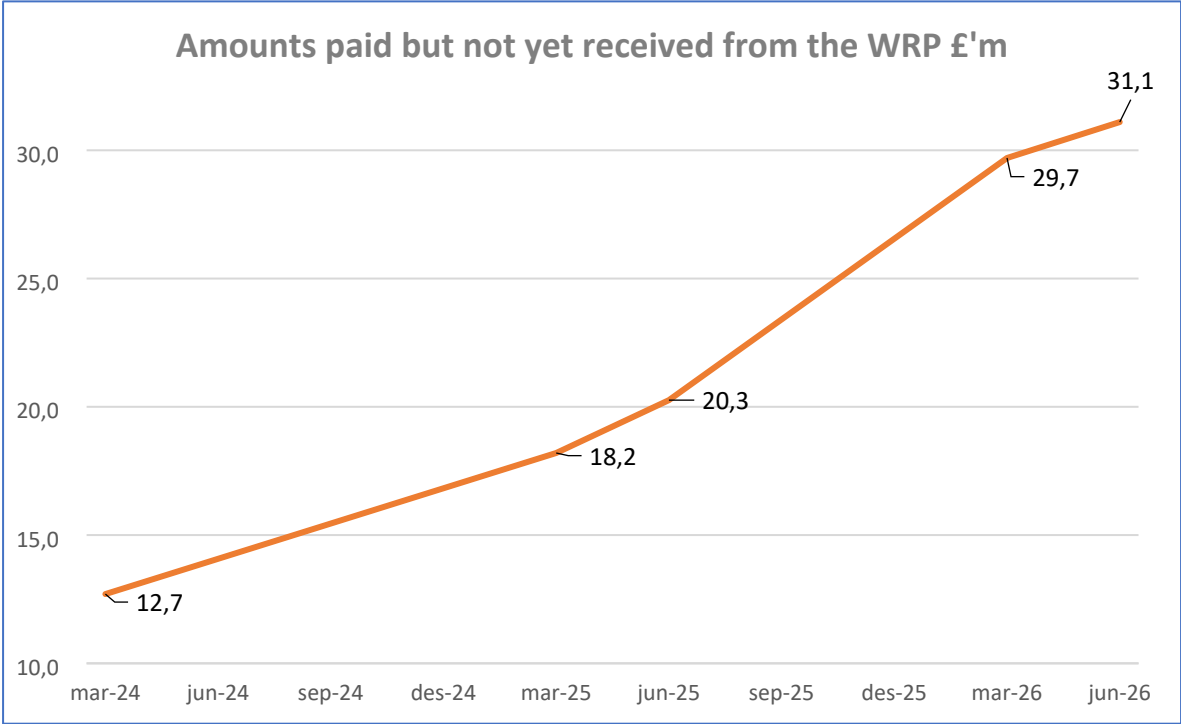
2. Strategic Insights

- 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.

Losses and Special Payments recorded during period

- 2.3 The losses and special payments recorded during this period totalled £3,229k, 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 £1,321k, giving a net cash in position for the period of £1,908k. The significant payments of claims, especially on medical negligence has increased the amount owed by Welsh Risk Pool and therefore the debtor balance we are anticipating. At 30th June the amount paid but not yet received from Welsh Risk Pool is £31.1m. The chart below shows the increasing trend in the number of claims paid but not yet received from the WRP since 31st March 2024.



2.6 This is £1.4m higher than it was at the end of the 2025/26 financial year. The amount paid but not reimbursed has increased from £12.7m in March 2024 and has been increasing steadily since. If the reimbursements are received in a timely manner it may have a detrimental effect on cash flow by the end of the 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.

	01.04.26 - 30.06.26 £000	Previous Periods	Total 26-27 £000
Medical Negligence Claims	1,184	0	1,184
Medical Negligence Costs	1,041	0	1,041

Medical Negligence Defence Fees	359	0	359
Medical Negligence Totals	2,584	0	2,584
Redress Medical Negligence Claims	(15)	0	(15)
Redress Medical Negligence Costs	10	0	10
Redress Medical Negligence Defence Fees	4	0	4
Redress Medical Negligence Totals	(1)	0	(1)
GP Indemnity Claims	25	0	25
GP Indemnity Costs	62	0	62
GP Indemnity Defence Fees	14	0	14
GP Indemnity Totals	101	0	101
Personal Injury Claims	403	0	403
Personal Injury Costs	96	0	96
Personal Injury Defence Fees	26	0	26
Personal Injury Totals	525	0	525
Permanent Injury Benefit	0	0	0
Permanent Injury Benefit Totals	0	0	0
Other:	0	0	0
Ex-Gratia	19	0	19
Debt Write Off	1	0	1
WRP Penalty Charge	0	0	0
Ombudsman	0	0	0
Employment Matter/Other	0	0	0
Other Totals	20	0	20
TOTAL	3,229	0	3,229
Recovered from Welsh Risk Pool	(1,321)	0	(1,321)
Net Cash Write-Off/(Recovery)	1,908	0	1,908

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 £1,321k of claims (13 claims), this was paid in June. 3 further claims reviewed by the committee were deferred, and another 15 claims were deferred until further information was received.

Provision as at 30 June 2026

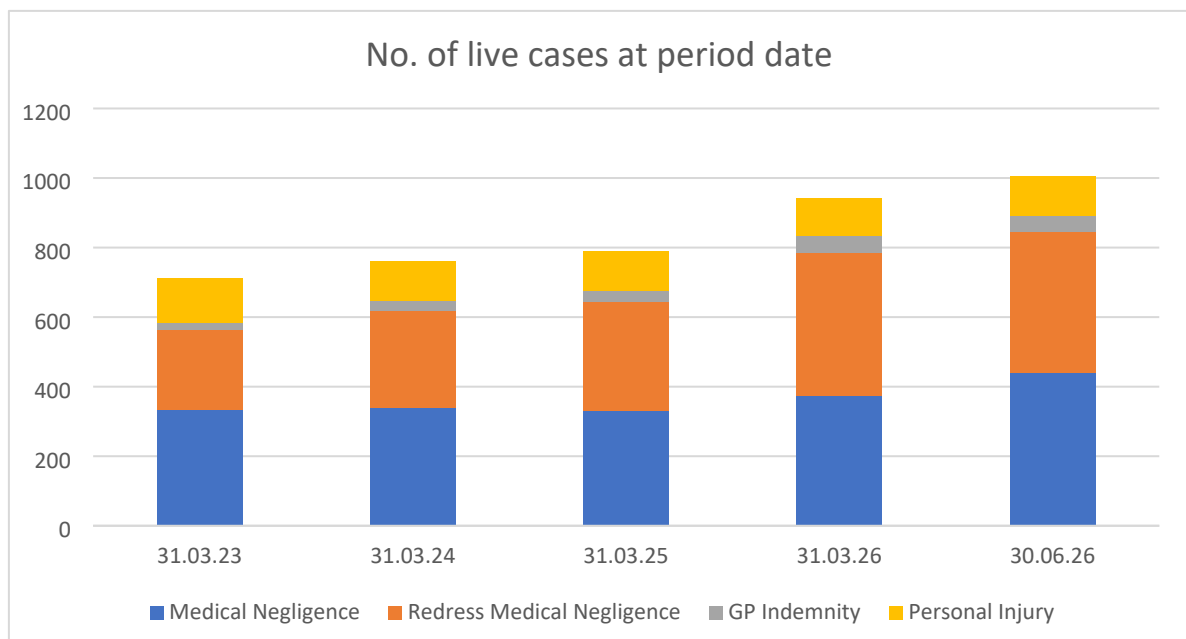
- 2.9 A provision reflecting the estimated value of the claim will be made on the balance sheet as a claim is deemed probable. There will also be an estimate for the value recoverable from Welsh Risk Pool, leading to a net provision value on the balance sheet.
- 2.10 The table below shows the provision 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 increased by £20,935k since 31 March 2026, this is mainly due to an increase in value of medical negligence claims.
- 2.12 The net provision at the end of 30th June 2026 was £23,651k which is £670k higher 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.



	30.06.26	31.03.26	31.03.25	31.03.24	31.03.23
	£000	£000	£000	£000	£000
	Cumulative	Cumulative	Cumulative	Cumulative	Cumulative
Medical Negligence claims/costs	154,013	133,219	136,729	94,478	72,198
Redress Medical Negligence claims/costs	1,153	1,082	490	372	385
GP Indemnity (Note 1)	2,481	2,240	1,670	612	0
Personal Injury claims/costs	2,221	2,393	1,734	917	701
TOTAL CLAIMS/COSTS PROVISION	159,868	138,933	140,623	96,379	73,284
Recoverable from Welsh Risk Pool	(187,586)	(165,890)	(156,234)	(106,450)	(83,623)
NET CLAIMS / COSTS PROVISION	(27,718)	(26,957)	(15,611)	(10,071)	(10,339)
Permanent Injury Benefit	4,067	3,976	3,707	3,755	4,077
NET PROVISION inc Perm Injury Ben.	(23,651)	(22,981)	(11,904)	(6,316)	(6,262)

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 2026/27 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 30th June 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
	30.06.26
	£000
Medical Negligence claims/costs	23,378
Redress Medical Negligence claims/costs	70
GP Indemnity	343
Personal Injury claims/costs	352
Recoverable from Welsh Risk Pool	(23,017)
Net claim expenditure (Note 1)	1,126
Permanent Injury Benefit	91
Other	20
Total Net expenditure	1,237

Note 1: The annual budget for net claim expenditure for 2026-27 is £2,084k with a year-to date budget of £521k, actual expenditure for the year is £1,126k, therefore showing an overspend of £605k. It is important to note that these costs can fluctuate during the year.

WRP Risk Sharing Agreement

- 2.16 The Audit & Risk Committee will be aware that any overspend incurred by the Welsh Risk Pool will need to be shared amongst NHS organisations and is therefore an additional financial risk to those organisations.
- 2.17 At the time of reporting, we are projecting the value to be on budget for 2026/27.



3. Risks and Opportunities

Net provision increase

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

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. Assessment

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)	Choose an item.
	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, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)</i>	Outcome for Equality (delete as appropriate): NEUTRAL Summary of impact:	If no, please select a reason below. Choose an item. Named Executive/Board member sign off for no EWLIA completion:
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 <i>(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)</i>	The majority of losses and special payments are as a result of things going wrong and where quality, safety or patient experience may therefore have been compromised. Details of medical negligence and personal injury claims are provided quarterly to the Concerns (Claims) Scrutiny Panel who subsequently reports to the Quality, Safety & Risk Committee	
Quality Impact Assessment Outcome <i>(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)</i>		
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 <i>(Pobl /Ariannol) / Resource Impact</i> <i>(People / Financial)</i>	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.	

6. Conclusion

6.1 The Audit, Risk and Assurance Committee is requested to:

- **NOTE** the losses and special payments made for the period 1 April 2026 to 30 June 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 £31.1m at the end of June.

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



Audit, Risk & Assurance Committee

Procurement & Scheme of Delegation Update

Eitem yr Agenda / Agenda Item	4.2
Dyddiad y Cyfarfod / Date of Meeting:	04/08/2026
Statws Cyhoeddi / Publication Status:	Open/Public.
	Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Adele Lewis – Senior Finance Manager
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
Argymhelliad (<i>Wedi'i gysylltu â'r adran "Beth Nesaf" uchod</i>).	NOTE the position on procurement matters for the period 01.04.2026 to 30.06.2026;
Recommendation (Linked to the "What Next" section above).	NOTE the update regarding Purchase to Pay and achievement of PSPP target up to Month 3 of 2026/27



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 01.04.26 to 30.06.26

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 2026-27.

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 during the period 01 April 2026 to 30 June 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 April 2026 to 30 June 2026

Table A – Single Tender Actions

None for Q1 2026/27

Table B - Single Tender Actions - Retrospective CTM

None for Q1 2026/27

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 Q1 2026/27

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

None for Q1 2026/27

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 Q1 2026/27

f) Retrospective orders and non-receipting areas

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

Supplier	Area	Retro Orders	Comment
MEDSTROM LTD	555003_Clinical Engineering (EBME) Dept PCH	31	Recliner Chair rental
ST DAVID RECRUITMENT SERVICES LTD	559157_H and N RGH Directorate Office	17	Administration Agency – Non-Framework supplier
MEDTRONIC LTD	533862_RGH THEATRE	11	
NHS SUPPLY CHAIN	534122_POW ENDOSCOPY UNIT	4	
OMNICELL LTD	534135_POW MEDICINE DIRECTORATE ADMIN SUPP	2	

LEICA MICROSYSTEMS (UK) LTD	533379_POW OPHTH DAY SURG	2	
SUPPLY POINT SYSTEMS LTD	533238_POW ENG DEPT	2	
EASTWOOD PARK LTD	533934_RGH PHARMACY	2	
ROTAMAP LTD	555763 Tair Afon Bth Cntr PCH	1	
IDEAL HEALTH CONSULTANTS LTD	555043 PCH A and E	1	
HAYS SPECIALIST RECRUITMENT LTD	544066_LLW GEN OFF	1	
PITNEY BOWES LTD	533930_RGH CSSD	1	
QUADIENT UK LTD	544072_LLW ENGIN DEP	1	
MITIE TECHNICAL FACILITIES MANAGEMENT LTD	534124_POW ADMINISTRATION	1	
Grand Total		77	

In terms of the top 3 suppliers where retrospective orders have been processed the next steps to reduce the number of retrospective orders are as follows:

- Medstrom Ltd - These provide hospital beds and the issue of retrospective orders is being picked up as part of a wider beds project being led by clinical engineering within CTM.
- St David Recruitment – These are not on any framework to allow quick route to market and equally at point of PO these are already retrospective. This is being picked up as part of wider engagement session with CTM, but should see a reduction as admin posts from agency are reduced.
- Medtronic Ltd – procurement team are hopeful these will reduce in future months, as were they were isolated and dealt with at department level, with engagement direct with the department taking place to ensure they understand the correct procedures going forward.

Top 3 Receiving Areas	Total
A418-POW Theatres	77
K702-POW Medical Staff - Ophthalmology	37
D602-POW Radiology	32

g) Consultancy Contracts

None for Q1 2026/27



h) File Notes (retrospective)

Below is a table detailing File Notes that have been completed between 01 April 2026 to 30 June 2026

File Note reference no.	Department	Value of PO (ex VAT)	Supplier	Status
CTM-FN-031	Capital Works	£ 12,041.00	Hoare Lea LLP	Completed
CTM-FN-032	Cancelled			
CTM-FN-033	Capital Works	£ 25,064.00	James & Nicholas	Completed
CTM-FN-034	Theatres	£ 52,531.20	Rotamaps	Completed
CTM-FN-035	Patient Care & Safety Group	£ 24,000.00	Venn Group Agency	Completed
CTM-FN-036	ENT/Infection Control	£ 8,800.00	IM Med Ltd	Completed
CTM-FN-037	Occ Health	£ 21,546.00	OXFORD IMMUNOTEC LTD	Completed
CTM-FN-038	PCH Therapy	£ 13,500.00	Corporate Research Forum Ltd	Completed
CTM-FN-039	Sterile Services	£ 71,771.36	GETINGE LTD	Completed
CTM-FN-040	Facilities	£ 195,000.00	Pitney Bowes Ltd,	Completed
CTM-FN-041	Facilities	£ 305,000.00	QUADIENT UK LTD	Completed
CTM-FN-042	Facilities	£ 50,000.00	Manpower UK Ltd	Completed
CTM-FN-043	Facilities	£ 300,000.00	Days Rental	In progress Service signature required
CTM-FN-044	Theatres	£ 30,000.00	Medtronic	Completed
CTM-FN-045	Endoscopy POW	£ 14,000.00	HAYS SPECIALIST RECRUITMENT LTD	Completed
CTM-FN-046	Endoscopy POW	£ 9,525.00	NHSSC/IM Med Ltd	Completed
CTM-FN-047	A & E	£ 14,995.00	SUPPLY POINT SYSTEMS LTD (Mediwell)	Completed
CTM-FN-048	Capital Finance	£ 10,050.00	Tetra Tech	Completed
CTM-FN-049	Cancelled			
CTM-FN-050	T&O	£ 433,175.20	St Josephs	Completed
CTM-FN-051	Cancelled			
CTM-FN-052	Theatres	£ 16,240.00	Leica Microsystems	Completed
CTM-FN-053	A & E	£ 7,997.03	Omnicell	Completed
CTM-FN-054	Cancelled			
CTM-FN-055	Cancelled			
CTM-FN-056	Facilities	£ 27,500.00	Prodem Fire & Safety Ltd	Completed

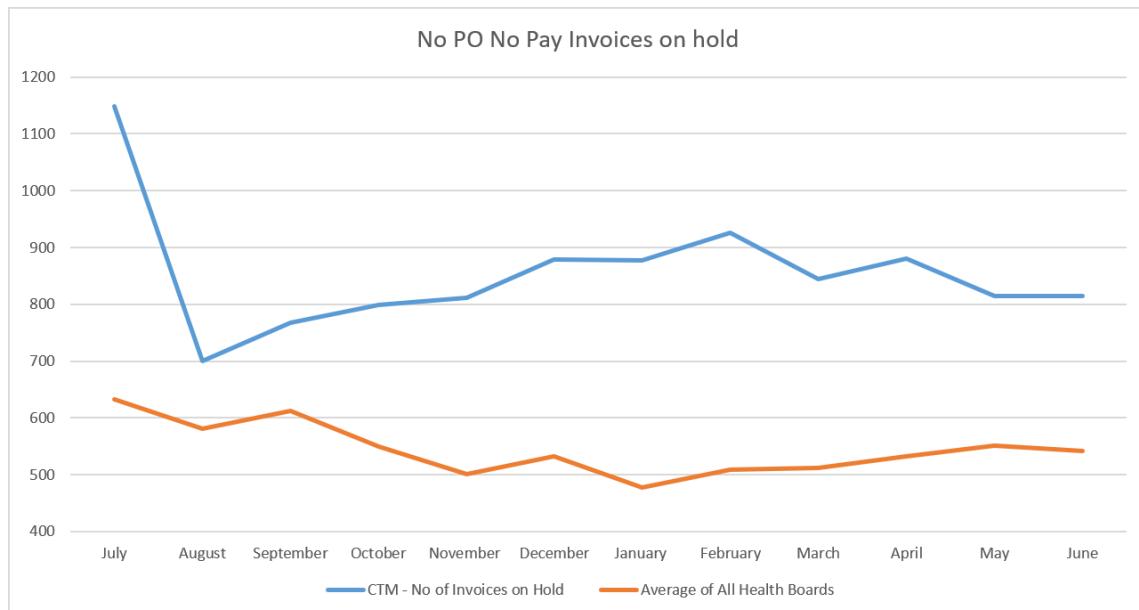


CTM-FN-057	Community Health	£ 9,634.28	Abergarw Care home	Completed
CTM-FN-058	Obs and Gynae/Digital & Data	£ 45,680.00	Badgernet Floor Walking	Completed
CTM-FN-059	Planned Care	£ 42,840.00	ID Medical	Completed
CTM-FN-060	CAMHS	£ 6,120.00	EZEC MEDICAL TRANSPORT SERVICES TA EMED GROUP LTD	Completed
CTM-FN-061	Capital Works	£ 5,400.00	WL Squared	Completed

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, Culligan (UK) Ltd TA Angel Springs and Oxford Immunotec Ltd account for 20% of all No PO No Pay holds, totalling 168 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 30th June 2026.

The Health Board has met its 95% target of paying non-NHS invoices within 30 days to Month 3 2025-26 achieving 95.5% (value 90.2%). 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-26	19,560	25,339,379	20,450	27,603,358	95.65%	91.80%
May-26	17,852	19,477,597	18,662	21,385,536	95.66%	91.08%
Jun-26	17,840	20,380,938	18,772	23,326,325	95.04%	87.37%
Jul-26						
Aug-26						
Sep-26						
Oct-26						
Nov-26						
Dec-26						
Jan-27						
Feb-27						
Mar-27						
YTD	55,252	65,197,914	57,884	72,315,219	95.45%	90.16%

The NHS invoice position continues to be challenging and shows a position of 83.1% (number) and 97.9% (value) of invoices were paid within 30 days to Month 3 2026-27. 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. Specific Matters for Consideration

- 3.1 Organisational values and behaviours have been reflected within the policy.



4. Key Risks / Matters for Escalation

- 4.1 No matters for escalation

5. Assessment

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd (Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg) 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)	Choose an item.
	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, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)</i> 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 Equality (delete as appropriate): N/A Summary of impact: Outcome for Welsh Language (delete as appropriate): N/A Summary of impact:	If no, please select a reason below. Does not impact people Named Executive/Board member sign off for no EWLIA completion:
Canlyniad Asesiad Effaith Ansawdd <i>(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)</i> Quality Impact Assessment Outcome <i>(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)</i>	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) / Resource Impact</i> <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report	

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	
FCPs	Financial Control Procedures
SoD	Scheme of Delegation
PSPP	

5 Recommendation

- 5.1
NOTE the position on procurement matters for the period 01.04.2026 to 30.06.2026;
- NOTE the update regarding Purchase to Pay and achievement of PSPP target up to Month 3 of 2026/27

6. Next Steps



Meeting Name:	Audit, Risk & Assurance Committee
Report Title:	Local Counter Fraud Update Report
Agenda Item:	4.3
Date of Meeting:	04/08/2026
Publication Status:	Open/Public
Report Prepared by:	R Neil Jones, Head of Counter Fraud Services (Interim)
Report Presenter:	R Neil Jones Head of Counter Fraud Services (Interim)
Report Executive Sponsor	Sally May, Executive Director of Finance
Report Purpose:	For Noting
Action / Decision Required:	Note
Strategic Context: This report aligns to the following Strategic Pillars	Counter Fraud Functional Standard CTMUHB Counter Fraud Work Plan 2026-27
Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan (Reference relevant priority)	This report updates the Committee on progress against the CTMUHB Counter Fraud Work Plan 2026-27.

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:

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

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)

What Next (summary of intended action and benefits supporting the choices and recommendation(s)being made)

The report provides detail on tasks and actions undertaken within the four Strategic Counter Fraud work areas – Strategic Governance, Inform & Involve, Prevent & Deter & Hold to Account.

RESOURCE UTILISATION - AREA OF WORK		
	Planned Days	Used (30/06/26)
Strategic Governance	48	9
Ensuring that anti-crime measures are embedded at all levels across the organisation		
Inform and Involve	100	15
Identifying the risks and consequences of crime against the NHS, and raising awareness of these risks amongst staff, stakeholders, and the public.		
Prevent and Deter	143	10
Discouraging those who may want to commit crimes against the NHS and ensure that such opportunities are minimised.		
Hold to Account	290	85
Detecting and investigating crime, prosecuting those who have committed crimes and seeking redress as a result.		
TOTAL	581	119

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



Recommendation (Linked to the “What Next” section above).	Noting
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)	Strategy Risk 9 If more than one applies please list below:
Link to Wellbeing of Future Generations Act – Wellbeing Goals	 If more than one applies please list below:
Environmental Sustainability Impact (5Rs)	 If more than one applies please list below:
Link to Enablers of Quality	 If more than one applies please list below:
Impact Assessment	
Equality & Welsh Language Impact Assessment Outcome (Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)	The QIA is not a requirement for this report as it does not support the planning, approval, or implementation of any service changes.
Quality Impact Assessment Outcome (Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)	As above
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
Resource Impact (People / Financial)	There is no direct impact on resources as a result of the activity outlined in this report

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

1. STRATEGIC GOVERNANCE

The Counter Fraud Functional Standard Report 2025–2026 has been formally approved by both the Audit Committee Chair (ACC) and the Director of Finance (DoF). The completed report was subsequently submitted to the NHS Counter Fraud Authority (NHSCFA) and has been accepted without issue.

2. INFORM AND INVOLVE

The Counter Fraud Team has continued to engage proactively with Health Board managers and key partners to deliver face-to-face fraud awareness training, helping to strengthen understanding of fraud risks and prevention measures across the organisation.

In addition, the Team has made effective use of the Employee Engagement Platform, Viva Engage, to further promote a positive counter fraud culture within the Health Board. This has included the launch of the NHS Wales Fighting Fraud Strategy 2026–2030.

The Team is also exploring opportunities to further develop the use of Artificial Intelligence (AI) as an innovative platform to enhance staff engagement and awareness. This includes assessing how AI can support the delivery of counter fraud messaging, provide accessible learning opportunities, and increase understanding of the impact that fraud has on both the Health Board and the wider NHS. Through these initiatives, the Team aims to strengthen fraud resilience and further encourage a culture in which fraud prevention is everyone's responsibility.

3. PREVENT AND DETER

During a recent presentation delivered by the NHS Counter Fraud Authority (NHSCFA), guidance was provided regarding the utilisation of a Fraud Prevention Figure (FPF) formula. The NHSCFA methodology, which is currently adopted and reported upon by a number of Health Boards across Wales and England, offers a straightforward and consistent approach to performance reporting, by converting an identified fraud loss into a quantified estimate of future losses avoided through counter fraud intervention. The underlying principle is that, where an ongoing fraud has been detected and stopped, it is reasonable to assume that the offending would have continued if it not been identified. Consequently, the formula seeks to show the value of counter fraud activity by calculating a reported prevention figure, in addition to the actual loss identified.

The formula and accompanying example is set out below:

For a Detected Fraud:

Total detected fraud ÷ duration of offending (months) = monthly fraud value

Monthly fraud value × 12 = fraud prevention figure

Example of Fraud prevented calculation:

A nurse has submitted false claims for expenses over a 14 month period. The total value of the false expenses was £15,000.

$£15,000 \div \text{by } 14 \text{ months} = £1,071$ is the monthly value of the fraud.

$£1,071 \times \text{by } 12 \text{ months} = £12,852$ is the preventive figure that can be recorded

Fraud prevention is notoriously difficult to quantify because it involves measuring events that never happen. This formula provides a tangible measure of benefit.

4. HOLD TO ACCOUNT

The status of the LCFS investigative caseload is summarised in Appendix 1 of this report. A summary of key investigation KPI data is provided at the beginning of the appendix.

Case information is categorised according to the current stage of the investigation process. Cases that remain open and are subject to active investigation by the LCFS are detailed within the Open Cases table.

The Pending Cases table includes those investigations where active LCFS enquiries have been concluded, but the case must remain open pending the completion of actions by third parties. These may include, but are not limited to, disciplinary proceedings, professional body investigations, and financial recovery processes.

A Closed Cases table is also provided, detailing the outcomes of investigations that have been fully concluded.



Audit, Risk & Assurance Committee

Local Counter Fraud Update Report

Eitem yr Agenda / Agenda Item	4.3
Dyddiad y Cyfarfod / Date of Meeting:	04/08/2026
Statws Cyhoeddi / Publication Status:	Open/Public.
	Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	R Neil Jones, Head of Counter Fraud Services (Interim)
Cyflwynydd yr Adroddiad / Report Presenter:	R Neil Jones, Head of Counter Fraud Services (Interim)
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance
Diben yr Adroddiad / Report Purpose:	For Noting
Argymhelliad (<i>Wedi'i gysylltu â'r adran "Beth Nesaf" uchod</i>). Recommendation (Linked to the "What Next" section above).	<i>Note</i>



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 within the four Strategic Counter Fraud work areas – Strategic Governance, Inform & Involve, Prevent & Deter & Hold to Account.

- 2.2 Engagement on this Policy and Procedure has taken place with:

Name Title	Date Consulted/Completed
Equality Impact Assessment	Not Undertaken
Informal Consultation with interested parties	21/07/2026
Formal Consultation	Not Undertaken
Committee – For approval	04/08/2026

- 2.3 The policy has been reviewed and is consistent with the approach across NHS Wales / legislation.

- 2.4 Director of Finance has been engaged in the consultation

- 2.5 Organisational values and behaviours have been reflected within the policy.



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

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 <i>(Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)</i>	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	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:

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> 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 Equality (delete as appropriate): Not Applicable	If no, please select a reason below. Does not impact people Named Executive/Board member sign off for no EWLIA completion:
	Summary of impact: No impact	
	Outcome for Welsh Language (delete as appropriate): NEUTRAL	
	Summary of impact: No impact	



Canlyniad Asesiad Effaith Ansawdd <i>(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)</i> Quality Impact Assessment Outcome <i>(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)</i>	The QIA is not a requirement for this report as it does not support the planning, approval, or implementation of any service changes.
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

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

5. Recommendation

The Committee are asked review the report for noting.

6. Next Steps

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



Cwm Taf Morgannwg University Health Board

Audit & Risk Committee – 4th August 2026

Counter Fraud Progress Report

R Neil Jones
Head of Local Counter Fraud Services (Interim)

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 as of 30/06/26
Strategic Governance		
Ensuring that anti-crime measures are embedded at all levels across the organisation	48	9
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	15
Prevent and Deter		
Discouraging those who may want to commit crimes against the NHS and ensure that such opportunities are minimised.	143	10
Hold to Account		
Detecting and investigating crime, prosecuting those who have committed crimes and seeking redress as a result.	290	85
TOTAL	581	119

4. STRATEGIC GOVERNANCE

The Counter Fraud Functional Standard Report 2025–2026 has been formally approved by both the Audit Committee Chair (ACC) and the Director of Finance (DoF). The completed report was subsequently submitted to the NHS Counter Fraud Authority (NHSCFA) and has been accepted without issue.

5. INFORM AND INVOLVE

The Counter Fraud Team has continued to engage proactively with Health Board managers and key partners to deliver face-to-face fraud awareness training, helping

to strengthen understanding of fraud risks and prevention measures across the organisation.

In addition, the Team has made effective use of the Employee Engagement Platform, Viva Engage, to further promote a positive counter fraud culture within the Health Board. This has included the publication of monthly newsletters, awareness campaigns, and informative blogs designed to keep staff informed of emerging fraud risks and lessons learned from Court cases.

The Team is also exploring opportunities to further develop the use of Artificial Intelligence (AI) as an innovative platform to enhance staff engagement and awareness. This includes assessing how AI can support the delivery of counter fraud messaging, provide accessible learning opportunities, and increase understanding of the impact that fraud has on both the Health Board and the wider NHS. Through these initiatives, the Team aims to strengthen fraud resilience and further encourage a culture in which fraud prevention is everyone's responsibility.

6. PREVENT AND DETER

During a recent presentation delivered by the NHS Counter Fraud Authority (NHSCFA), advice and guidance was provided regarding the utilisation of a Fraud Prevention Figure (FPF) formula. The NHSCFA methodology, which is currently adopted and reported upon by a number of Health Boards across Wales and England, offers a straightforward and consistent approach to performance reporting by converting an identified fraud loss into a quantified estimate of future losses avoided through counter fraud intervention. The underlying principle is that, where an ongoing fraud has been detected and stopped, it is reasonable to assume that the offending would have continued for a further period had it not been identified. Consequently, the formula seeks to demonstrate the value of counter fraud activity by calculating a reported prevention figure, in addition to the actual loss identified.

The formula and accompanying example is set out below:

For a Detected Fraud:

Total detected fraud ÷ duration of offending (months) = **monthly fraud value**

Monthly fraud value × 12 = **fraud prevention figure**

Example of Fraud prevented calculation:

A nurse has submitted false claims for expenses over a **14 month** period. The total value of the false expenses was **£15,000**.

- **£15,000 ÷ by 14 months = £1,071** is the monthly value of the fraud.
- **£1,071 × by 12 months = £12,852** is the preventive figure that can be recorded

Fraud prevention is notoriously difficult to quantify because it involves measuring events that never happen. This formula provides a tangible measure of benefit.

7. HOLD TO ACCOUNT

The status of the LCFS investigative caseload is summarised in Appendix 2 of this report. A summary of key investigation KPI data is provided at the beginning of the appendix.

Case information is categorised according to the current stage of the investigation process. Cases that remain open and are subject to active investigation by the LCFS are detailed within the Open Cases table.

The Pending Cases table includes those investigations where active LCFS enquiries have been concluded, but the case must remain open pending the completion of actions by third parties. These may include, but are not limited to, disciplinary proceedings, professional body investigations, and financial recovery processes.

A Closed Cases table is also provided, detailing the outcomes of investigations that have been fully concluded.

CTMUHB Audit, Risk and Assurance Committee (ARAC)

Organisational Risk Register – July 2026

Eitem yr Agenda / Agenda Item	5.1
Dyddiad y Cyfarfod / Date of Meeting:	4 August 2026
Statws Cyhoeddi / Publication Status:	Open/Public.
Adroddiad wedi'i baratoi gan / Report Prepared by:	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
Diben yr Adroddiad / Report Purpose:	For Review
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	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.
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>	Choose an item.
	Applies across all areas
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>	Supports delivery in general



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

Dechreuwch drwy **grynhof'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 presents the July 2026 position of the Organisational Risk Register (ORR).

The ORR has been substantially refreshed and rewritten in collaboration with risk handlers, with a focus on:

- improving readability and clarity through plain language descriptions
- presenting risks in a consistent format (current controls, gaps, and actions)

The main report (Excel document) has also been redesigned to fit onto a single A4 page, responding to feedback from Independent Members for a more accessible, navigable view.

Please note however that the two deescalated risks (Tab 2 of the Excel document) have not been reformatted, and appear in the previous format.

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*)

From the July iteration:

- The majority of risks remain unchanged in score and trajectory, with several continuing at high levels (including 20)
- A small number of new risks and recent escalations are included in the ORR
- There is limited movement overall in risk ratings, reflecting an ongoing stable but challenged risk position across the organisation
- As part of the refinement of the Organisational Risk Register, some specific operational risks have been de-escalated to local risk registers where they are more appropriately managed.
- To ensure continued organisational oversight, these are being replaced by broader strategic risks that provide a consolidated view of the key themes, controls and assurance arrangements across multiple related local risks.

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*)

- The next iteration of the ORR will be presented to the Executive Leadership Group (ELG) on 14 September 2026 and shared with the Board for its 24 September meeting.
- Work has been undertaken to review and refine the actions associated with each risk. The September iteration of the ORR will include clearer, time-bound

What Next (*summary of intended action and benefits supporting the choices and recommendation(s) being made*)

- actions and progress updates, supporting more effective monitoring of risk mitigation and delivery.
- The Executive Leadership Group met on 13 July 2026 and carried out its routine review and moderation of the ORR, ahead of presentation to the Board and committees. As part of this discussion, the ELG noted a high number of risks with a current score of 20, and committed to review and moderate the risk scores for a future iteration of this report.

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

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

No decision required – this document is shared for background information and does not appear on the Board agenda

The following risks are currently marked as business sensitive / confidential, and shared via a separate report to the In Committee meeting of the Audit and Risk Assurance Committee:

- ID4664: Ransomware Attack resulting in loss of critical services and possible extortion
- ID4671: Lack of a resilient and performant Digital Network Infrastructure and Assets
- ID6451: Orthoplastic Pathway

1. Background / Context

- 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.

Risk Review

- 1.2 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.
- 1.3 The Operational Management Board / Chief Operating Officer approves escalation of Care Group risks to the Organisational Risk Register.
- 1.4 The Executive Lead approves escalation of central/core function risks to the Organisational Risk Register.
- 1.5 All risks on the Organisational Risk Register have been substantially revised for quality, consistency and readability. Whilst amendments are normally highlighted in red text to aid visibility of changes, this has not been applied on this occasion due to the extent of the revisions, which would have significantly reduced the readability of the document.

- 1.6 In parallel, Executive review by the Chief Operating Officer has supported a comprehensive refresh of the Organisational Risk Register. This has included constructive challenge to risk scoring and escalation decisions, clarification of risk ownership and accountability, strengthening of controls and action plans, identification of opportunities to consolidate overlapping risks, and ensuring that risks are presented at an appropriate strategic level.
- 1.7 The review has also prompted further work with Care Groups to validate risk assessments, update mitigating actions and confirm the ongoing appropriateness of organisational escalation. This work remains ongoing and will continue to inform future iterations of the Organisational Risk Register.

Risk Training

- 1.8 Risk training, although not a core training requirement under the statutory and mandatory framework, is available via the Electronic Staff Record (ESR).
- 1.9 The sessions are run by the Interim Assistant Director of Governance & Risk, currently joined by the Business Manager for Chief Operating Office. The session are held virtually via Teams on a monthly basis for a duration of one hour.
- 1.10 Bespoke team sessions on Risk are also available by arrangement.

2. Strategic Insights

- 2.1 The July 2026 review suggests that the Health Board's overall risk profile remains broadly stable, with many of the principal organisational risks continuing to reflect longstanding challenges relating to workforce, capacity, service demand, infrastructure and regulatory compliance.
- 2.2 The review has also supported a move towards a more strategic level of organisational oversight in some places. A number of operational risks are being de-escalated to local registers where they can be managed most effectively, whilst new overarching risks are being developed to provide greater visibility of key organisation-wide themes and cumulative risk exposure.

3. Risks and Opportunities

3 NEW RISKS AND NEW ESCALATIONS

DTPS Care Group

- Datix Risk ID 3567 - *Patient safety and service delivery risk due to insufficient Cellular Pathology space*. This risk is proposed for escalation due to increasing

Cellular Pathology space pressures, particularly following SBUHB disaggregation and cessation notice for POW work, which will increase workload beyond the capacity of the current environment

Cross-Cutting Risks (affecting multiple care groups)

- The following new overarching / cross-cutting risk will draw together and provide oversight for multiple risks relating to Hydroxychloroquine retinal screening which have been identified across care groups. It will replace the current ORR risk ID5797: *Lack of Capacity for Hydroxychloroquine Screening in Ophthalmology*
→ **Risk ID TBC: Hydroxychloroquine (HCQ) Retinal Screening Capacity and Pathway Delivery**
- The following new overarching / cross-cutting risk will draw together and provide oversight for multiple risks relating to safety and security which have been identified across care groups. It will replace the current ORR risks 4958 and 4933 (fire safety) and potentially also 4417 (access control and site security)
→ **Risk ID TBC: Inconsistent Security Management Across Health Board Sites**

Digital Directorate

- The following new overarching risk will draw together and provide strategic oversight for the current ORR risks 6604, 6605 and 6426, which will now be deescalated from the ORR although remain open (please see below); and for other related risks on Datix.
→ **RISK ID TBC: Failure to comply with data protection legislation**

3 CHANGES TO RISKS

Risk Score Increased

No ORR risks have increased in score since May 2026

Risk Score Decreased

Unscheduled Care Group

- Risk ID3826 - *Emergency Department overcrowding impacting patient safety and quality of care*. A review has been undertaken using the Community Emergency Department Overcrowding Scale (CEDOCS) and an outcome has been for the risk current score to reduce from 20 to 15.

Risk De-escalated from the ORR

Urgent Care Care Group

- The following risk is being replaced by a new overarching risk (see above):
 - 5797: Lack of Capacity for Hydroxychloroquine Screening in Ophthalmology

Digital

- The following risks are being deescalated from the Organisational Risk Register, although they will remain open. Following review, it has been agreed that these risks relate to specific operational issues that are more appropriately managed through local risk registers.
 - 6604: Misdirected clinical correspondence to GP practices
 - 6605: Legal compliance with access to records requests
 - 6426: Access to E-Whiteboards (Business sensitive risk)
- Organisational oversight will instead be provided through a new overarching information governance and data compliance risk (please see above)

People Directorate

- The following risks are being deescalated from the Organisational Risk Register although they will remain open. Following review, it has been agreed that these risks relate to specific operational issues that are more appropriately managed through local risk registers.
 - 4958: Fire Safety #1 (Business sensitive risk)
 - 4933: Fire Safety #2 (Business sensitive risk)
- Organisational oversight will instead be provided through a new overarching site security and safety risk (please see above)

3.3 CLOSED RISKS REMOVED FROM THE ORGANISATIONAL RISK REGISTER

- No risks have been closed

3.4 HEAT MAP

The heat map provides a visual representation of the current Organisational Risk Register, showing the relative position of each risk based on its residual likelihood and consequence score, together with indicators of risk movement and escalation status since the previous report.

KEY:

↑ = score increased since previous report (May 2026)

↓ = score decreased since previous report

↔ = score unchanged since previous report

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

XX = risk closed

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

Consequence	5			3337 ↔ 6451 ↔	4664 ↔ 5276 ↔	
	4			5820 ↔	6318 ↔ 6498 ↔ 6429 ↔ 4417 ↔ 4632 ↔ 4671 ↔ 4885 ↔ 5045 ↔ 5579 ↔ 5761 ↔	5877 ↔ 6235 ↔ 6280 ↔ 6397 ↔ 6424 ↔ 5374 ↔ 6475 ↔ 6629 N TBC Data Protection (N) TBC Security (N)
						4491 ↔ 5554 ↔ 6596 ↔ 6597 ↔ 5821 ↔ 6052 ↔ 6179 ↔ 3826 ↔ 6294 ↔ 5753 ↔ 3567 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 July 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
- **Mental Health and Learning Disabilities Care Group:** Clinical Medical Cover within CTM Adult Mental Health Services (Datix Risk ID 4973) was deescalated in May 2026 but is now being revisited as a potential re-emerging risk, as ongoing fragility in clinical medical cover within adult mental health services persists despite existing mitigations and requires renewed organisational oversight.
- **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.

4. Compliance and Governance

4.1 The Organisational Risk Register remains a key component of the Health Board's assurance framework.

- 4.2 It supports the identification, oversight and mitigation of significant organisational risks; strengthens executive accountability and committee assurance arrangements; and promotes transparency through structured reporting and publication where appropriate.

5. Benchmarks

- 5.1 Whilst there is no formal benchmarking mechanism for the Organisational Risk Register, the Health Board's approach is informed by internal and external audit recommendations, together with learning and good practice shared through NHS Wales governance and risk management networks. This provides an element of continuous comparative review and supports ongoing development of the organisation's risk management arrangements.

6. Conclusion

- 6.1 The July 2026 ORR reflects the outcomes of a comprehensive review of all risks with risk handlers and owners.
- 6.2 The July 2026 ORR is presented for information. Feedback from Board members on the content and presentation of the register is welcomed.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd (Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg) 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)	Choose an item. The risks contained within the Organisational Risk Register collectively underpin all strategic risks within the Board Assurance Framework and support the delivery of the Health Board's strategic objectives.
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	A Resilient Wales The Organisational Risk Register supports long-term organisational resilience by identifying risks which may impact the sustainability of services, workforce, infrastructure and system working, and by supporting mitigation and continuous improvement.
Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Learning, Improvement & Research

	The ORR strengthens organisational learning and continuous improvement by: • identifying areas of risk and vulnerability • supporting structured action planning • enabling oversight of risk management arrangements across the organisation

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	Choose an item.
	The ORR itself has no direct environmental impact. However, it includes risks related to environmental sustainability (e.g. estates, infrastructure and wider environmental responsibilities), supporting organisational oversight and mitigation of environmental risks.

Asesiad Effaith Impact Assessment	
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg <i>(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)</i>	Outcome for Equality: NEUTRAL The ORR is a governance and oversight document and does not directly impact on individuals or groups. Individual risks within the ORR may have equality implications, which are considered separately where relevant.
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: NEUTRAL The ORR itself does not directly impact Welsh language provision. Any impacts relating to specific services or risks are considered within the relevant service or policy context.
Canlyniad Asesiad Effaith Ansawdd <i>(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)</i>	EWLIA not required for the ORR as a whole. Individual risks may be subject to impact assessment where appropriate.
Quality Impact Assessment Outcome <i>(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)</i>	Quality Impact Assessment Outcome not required for the ORR as a whole. The ORR does not introduce service change but provides oversight of risks which may affect quality. Individual risks may be subject to Quality Impact Assessment where relevant.
Cyfreithiol / Legal	Yes (Include further detail below) Legal implications are inherent within a number of risks included in the ORR (e.g. statutory compliance, regulatory requirements and duty of



	care). These are captured and managed at individual risk level.
Enw da / Reputational	Yes (include further detail below) Failure to manage identified risks may result in: • adverse patient outcomes • regulatory or audit findings • loss of stakeholder confidence The ORR supports mitigation of reputational risk through structured identification, monitoring and escalation of organisational risks.
Effaith Adnoddau (Pobl / Ariannol) / Resource Impact (People / Financial)	Yes (include further detail below) The risks within the ORR reflect pressures and dependencies relating to: • workforce capacity and capability • financial sustainability • infrastructure and service delivery resources The ORR supports visibility and management of these resource impacts at organisational level.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Comprehensive review of risks at care group and directorate team meetings	June and July 2026	Changes captured in this report.
Executive Leadership Group (ELG)	13 July 2026	Review and moderation. Commitment to moderate risk scores for next iteration.

Acronyms / Glossary of Terms	

Organisational Risk Register (ORR) – Summary Version – July 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 May 26	Rating July 26	Trend	Notes
Planned Care Group						
6294	COO (Chief Operating Officer)	Insufficient consultant workforce in endoscopy and gastroenterology	20	20	↔	July 2026: Temporary emergency service change enacted on 7 May 2026 for a minimum of 6 months; acute gastro admissions ceased at POWH and are now admitted at the RGH site. This was due to the fragility of the consultant workforce at the POWH site. There will be a review in 3 months and any impact to this risk noted.
6451	COO	Orthoplastic Pathway (Business sensitive risk)	15	15	↔	<i>Due to business sensitivities the details of this risk are captured in the report to the closed session of this committee</i>
4152	COO	Backlog for Imaging in all modalities	12	12	↔	POSSIBLE (RE)EMERGING RISK: For awareness – awaiting further update from care group following performance review
Unscheduled Care Group						
3826	COO	Emergency Department overcrowding impacting patient safety and quality of care	20	15	↓	July 2026: A comprehensive programme of work is underway across the Health Board to address Emergency Department (ED) overcrowding and reduce excessive waits. A review has been undertaken using 'The Community Emergency Department Overcrowding Scale (CEDOCS)' and an outcome has been for the risk to reduce to a 15.
5045	COO	Insufficient neurology capacity impacting timely access to services	16	16	↔	July 2026: The Health Board has implemented a comprehensive neurology recovery programme, including consultant-led waiting list validation, backlog reduction activity, and escalation of commissioning concerns where external capacity is impacting delivery. Early validation work has identified opportunities to reduce demand on specialist neurology services through alternative pathways, whilst plans are being developed to strengthen local provision and improve long-term sustainability of neurology services for the CTM population
4632	ED T&HS	Inability to deliver timely, high-quality stroke care across CTM	16	16	↔	July 2026: The temporary stroke service model at RGH has been extended to March 2027 and improvement actions are underway; however, performance has

Datix ID	Strategic Risk Owner	Risk Title	Rating May 26	Rating July 26	Trend	Notes
						declined and further work is required to improve early pathway standards and develop a sustainable future model.
Children and Families Care Group						
5753	END	Inadequate Special School Nurse Provision	20	20	↔	July 2026: All funded posts are now filled; however, the absence of an agreed sustainable service model and SLA with Local Authorities means the risk to equitable and compliant Special School Nursing provision remains unchanged. Further discussions are taking place to work through next steps with Executive Director of Nursing in July 2026, where a further review of the risk score will be completed.
6475	COO and END	Patient safety and service delivery risks arising from industrial action impacting Health Visiting services	16	16	↔	July 2026: Industrial action continues to impact Health Visiting capacity, with daily operational oversight and prioritisation in place to maintain support for high-risk families.
Diagnostics, Therapies, Pharmacy & Specialties Care Group						
5554	DTPS	Inability to meet containment level 3 (CL3) standards creating risks to patient safety and statutory compliance	20	20	↔	July 2026: The risk remains high due to non-compliance of the CL3 laboratory, with interim safety measures in place and refurbishment re-tendering underway with WG major capital scheme. Meeting held 4 June CAV and ABUHB to discuss regional options which are not feasible at this time. A review of the risk score will be completed ahead of the next update to determine if a reduction is feasible with mitigating controls reviewed.
5579	ED PH	Insufficient provision of children's weight management services	16	16	↔	July 2026: Rollout of Level 1 services is underway; however, the absence of a Level 3 service and a fully developed pathway means the risk to providing comprehensive children's weight management services remains unchanged.
6429	ED H&TS	Risk to patient safety from an unfit Physiotherapy MSK self-referral system	16	16	↔	July 2026: The risk remains high, with further incidents reported and the current self-referral form still in use, while a revised digital solution is in development but not yet live. Microsoft Forms mechanism in development to assist reduce the risk further, a review on implementation will be completed to assess this impact on the score.
6498	COO	Risk to patient safety from insufficient availability of compliant dynamic mattress systems	16	16	↔	July 2026: A replacement programme and contract review are underway, but insufficient availability of compliant dynamic mattresses continues to present a risk to safe patient care.
3567 NEW	DTPS	Patient safety and service delivery risk due to insufficient Cellular Pathology space	20	20	↔	July 2026: The risk is proposed for escalation due to increasing Cellular Pathology space pressures, particularly following SBUHB disaggregation and cessation notice for POW work, which will increase workload beyond the capacity of the current environment. Existing controls help manage day-to-day risk but do not resolve the underlying estate constraint, with ongoing risks to patient safety, staff safety, diagnostic turnaround times, accreditation, service repatriation and future pathology developments. Internal plan in development to identify an interim solution in collaboration with estates
Mental Health and Learning Disabilities Care Group						
6318	COO	Tier 3 SHED (Severe and High-Impact Eating Disorders) Team Service capacity and resilience	16	16	↔	July 2026: Improved joint governance and communication arrangements are now in place with CAVUHB; however, underlying workforce and capacity challenges remain unresolved and the risk to service sustainability continues.

Datix ID	Strategic Risk Owner	Risk Title	Rating May 26	Rating July 26	Trend	Notes
3337	COO & Director of Digital	Lack of a Single Electronic Patient Record in Mental Health Services inc CAMHS	15	15	↔	July 2026: Procurement is progressing with contract award and implementation planning expected imminently, but the absence of a single electronic patient record continues to present a risk to safe and effective information sharing.
4691	COO	Provision of safe and appropriate estate for Mental Health inpatient services	15	15	↔	July 2026: No change in risk position, with estate limitations continuing to impact inpatient environments while feasibility and capital planning work progresses.
4973	COO	Clinical Medical Cover within CTM Adult Mental Health Services.	12	12	↔	July 2026: This risk was deescalated in May 2026 but is now being revisited as a potential re-emerging risk, as ongoing fragility in clinical medical cover within adult mental health services persists despite existing mitigations and requires renewed organisational oversight.
Primary and Community Care Group						
5877	COO	Impact of new GP Out of Hours (OOH) contract on service capacity and rota fill	16	16	↔	July 2026: The risk remains under review while NHS Employers and BMA negotiations continue, with regular rota oversight, ongoing recruitment efforts and local Adastra procurement being progressed to support service continuity.
6397	COO	Shortage of GPs impacting urgent primary care (OOH and Navigation Hub) service delivery	16	16	↔	July 2026: No material change, with the risk remaining under close care group monitoring as recruitment challenges and rota gaps persist.
Cross-Cutting Risks (affecting multiple care groups)						
4491	COO	Failure to meet demand across the patient pathway resulting in system-wide pressure on care delivery	20	20	↔	July 2026: A whole-system programme of improvement is in place across urgent, emergency and planned care pathways; however, capacity and flow pressures persist and the risk to timely access and safe care remains unchanged.
4417	COO	Inadequate access control and site security across Health Board premises	16	16	↔	July 2026: Phase 1 security improvements are progressing, with further work planned across sites; however, inconsistent access control and incomplete rollout mean risks to site security and patient safety remain.
TBC NEW	COO	Hydroxychloroquine (HCQ) Retinal Screening Capacity and Pathway Delivery	---	15	↔	July 2026: Multiple risks relating to Hydroxychloroquine retinal screening have been identified across care groups, reflecting backlog, capacity constraints and early implementation of a new community-based pathway. A pan-CTM approach has been agreed; however, delivery remains at an early stage.
6052	COO	Inadequate patient hydration and nutrition due to failure of beverage trolley infrastructure	20	20	↔	July 2026: Replacement programme is underway with initial trolley deliveries expected mid July; however, the ageing fleet and constrained capacity continue to present risks to safe and compliant patient nutrition and hydration services, and the risk score remains unchanged.
6181	COO	RGH car parking pressures	12	12	---	July 2026: This emerging risk remains under close monitoring, with ongoing pressures on parking capacity at RGH. The removal of the Vanguard endoscopy unit has provided some additional capacity; however, as the Vanguard theatre units remain in situ demand continues to exceed available provision. A paper has been submitted which identifies potential longer-term solutions to manage site pressures effectively for Exec consideration including the option of introducing a new permit system (currently pending approval)
TBC	TBC	Inconsistent Security Management Across Health Board Sites	---	16	---	July 2026: An overarching Health Board-level risk relating to security is being assessed for inclusion on the ORR to reflect the cumulative impact of security incidents, variable provision and system-wide vulnerabilities across sites.

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 May 26	Rating July 26	Trend	Status update
ED of Strategy & Transformation					
6280	<i>See below under Executive Medical Director - Regional Hepato-Pancreato-Biliary Service (Jointly owned risk)</i>				
5821	Provision of secondary care immunology services by external provider (this is a service that is not provided by CTM UHB)	20	20	↔	July 2026: Arrangements for secondary care immunology remain reliant on external provision, with no sustainable solution yet confirmed. Options for future provision continue to be explored, recognising ongoing funding constraints.
5374	Fulfilling our environmental and social duties	16	16	↔	July 2026: Risk reviewed; additional controls but no substantial change overall
Executive Director of Finance					
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	20	↔	July 2026: Risk reviewed; no change to mitigations or score
6597	Failure to achieve the planned break-even position in 2026/27.	20	20	↔	July 2026: Risk reviewed; no change to mitigations or score
6235	Insufficient funding to address backlog maintenance across the estate.	16	16	↔	July 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	↔	July 2026: Level 1 childhood obesity services remain in place following confirmed funding; however, overall preventative capacity remains insufficient, including limited Adult Weight Management Service capacity and a continued gap in Level 3 provision, meaning the risk to population-level obesity rates remains unchanged.
5579	<i>See above under DTPS Care Group - Rising childhood obesity rates</i>				
5820	Potential inability to deliver all elements of the Health Protection Strategic priorities as a result of reduced allocation of funding	12	12	↔	July 2026: Risk score unchanged pending confirmation of future allocations.
Director of Digital					
4664	Cyber attack resulting in loss of critical services, data and potential extortion (<i>Business sensitive risk</i>)	20	20	↔	<i>Due to business sensitivities the details of this risk are captured in the report to the closed session of this committee</i>
5276	Delay to LIMS 2.0 implementation impacting pathology service continuity (Jointly owned with Executive Director of Therapies and Health Sciences)	20	20	↔	July 2026: LIMS 2.0 implementation remains high risk, with low confidence in delivery within required timescales and ongoing concerns regarding safe deployment sequencing, legacy system reliance, Blood Transfusion risk and additional financial exposure.

Datix ID	Risk Title	Rating May 26	Rating July 26	Trend	Status update
4671	Ageing digital infrastructure impacting service resilience (Business sensitive risk)	16	16	↔	Due to business sensitivities the details of this risk are captured in the report to the closed session of this committee
6604	Misdirected clinical correspondence to GP practices	16	16	↔	July 2026: Following review, it has been agreed that Risks 6604, 6605 and 6426 would be more appropriately managed through local risk registers. A new overarching Data Protection compliance risk is proposed below to provide strategic oversight. These risks will therefore be de-escalated from the ORR and replaced by the new risk
6605	Legal compliance with access to records requests	16	16	↔	
6426	Access to E-Whiteboards (Business sensitive risk)	16	16	↔	
TBC NEW	Failure to comply with data protection legislation	---	16	---	July 2026: NEW overarching risk to replace Risks 6604, 6605 and 6426 and provide strategic oversight of Data Protection compliance.
6424	Mental Health Subject Access Requests (SARs) (IG/15)	16	16	↔	July 2026: Risk reviewed; no change to scoring or controls
4672	Inability to achieve timely, accurate clinical coding and structured data standards	15	15	↔	July 2026: Work continues to align Digital and Data activities to IMTP priorities through the Tektology partnership, while ongoing digitisation, structured data capture and coding improvement programmes support continued progress in data quality and information management.
5040	Digital system integration dependencies	15	15	↔	July 2026: Integration challenges with national digital systems continue to impact delivery of local programmes, including ePMA and maternity systems, although successful deployment of key data feeds has enabled further progress with ePMA implementation.
3337	See above under MH Care Group - Lack of a Single Electronic Patient Record in Mental Health Services including CAMHS				
Executive Nurse Director					
5753	See above under Children & Family Care Group - Inadequate Special School Nurse Provision				
6231	Failure to effectively manage patient concerns	16	16	↔	July 2026: Continued improvement in performance and implementation of OCP (Organisational Change Programme) and Listening to People requirements, however recruitment to strengthen capacity is ongoing and changes are not yet fully embedded, so the risk level is unchanged.
6232	Sustainability of the Legal Services Function	15	15	↔	July 2026: The revised establishment in the revised and concluded OCP continues to be progressed. This will enable the Legal Services team to be strengthened in capacity and leadership, full workforce establishment and embedded service improvements are in progress however, the recruitment process has not yet been fully achieved resulting in the risk remaining at its current risk rating.
Executive Director of Therapies and Health Sciences.					
4632	See above under <i>Unscheduled Care Group</i> - Provision of an effective and comprehensive stroke service across CTM				
5276	See above under <i>Director of Digital (jointly owned risk)</i> - Delay to LIMS 2.0 implementation impacting pathology service continuity				
Director of Corporate Governance / Board Secretary					
4885	Failure to deliver and sustain effective Policy Management System and Process	16	16	↔	July 2026: Controls for non-clinical policies have improved following implementation of the SharePoint policy system; however, processes remain reliant on manual input and consistency is variable, with clinical policy migration at an earlier stage.
Executive Medical Director					

Datix ID	Risk Title	Rating May 26	Rating July 26	Trend	Status update
5761	Cross Health Board Data Sharing	16	16	↔	July 2026: The risk remains unchanged, with ongoing reliance on national partners (DHCW) to resolve system and data sharing issues, and no confirmed delivery timescales.
6280	Suspension of the Regional Hepato-Pancreato-Biliary service model	16	16	↔	July 2026: Interim case-by-case arrangements remain in place following suspension of the regional service model, with resolution dependent on regional commissioning decisions and associated funding.
6629	GMC/HEIW Conditions on PCH Emergency Department	---	16	---	July 2026: Risk opened in May 2026 following GMC and HEIW concerns relating to the Emergency Department at Prince Charles Hospital, with an action plan in place and delivery now being monitored through governance arrangements.
Executive Director for People					
4958	Fire Safety #1 <i>(Business sensitive risk)</i>	15	---	↔	July 2026: These two risks have been reviewed and are proposed for deescalation from the ORR. This reflects assurance that these risks are well-managed within existing operational and compliance frameworks and do not require escalation at organisational level. This review has informed the development of a broader, overarching risk relating to security and site safety (see below), ensuring that the ORR focuses on areas where there is a need for strategic oversight and system-wide mitigation.
4933	Fire Safety #2 <i>(Business sensitive risk)</i>	15	---	↔	
Emerging risk (July 2026): An overarching Health Board–level risk relating to security has been identified and is being formalised on the ORR to reflect the cumulative impact of security incidents, variable provision and system-wide vulnerabilities across sites. Please see above under Cross-Cutting Risks					
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	F	G	H	I	K
	Datix ID and details	Risk Title / Risk Description	Current controls in place	Gaps in controls	Action Plan	Rating (current) and details
1						
3	Planned Care Group					
4	6294 Risk Owner: COO Risk Handler: Directorate Manager for General Surgery and Gastrointestinal Services Risk Domain: Workforce / Organisational Development / Staffing / Competence	Insufficient consultant workforce in endoscopy and gastroenterology IF the Health Board is unable to recruit and retain sufficient consultant workforce in endoscopy and gastroenterology THEN services may be unable to sustain safe and timely provision RESULTING IN delays in diagnosis and treatment, increased waiting times, service disruption and risks to patient safety	• Consultant recruitment campaign underway, with posts currently out to advert • Interim service continuation plans in development • Ongoing Care Group and executive oversight following escalation	• Critically low consultant workforce, particularly following departure of locum staff • Limited or no agency interest to provide interim cover • Service provision remains fragile, particularly at Princess of Wales Hospital • Mitigations are limited and largely dependent on successful recruitment • No sustainable short-term solution in place to stabilise the service	• Progress recruitment to substantive consultant posts • Develop and implement plans to sustain service provision during recruitment period • Review and strengthen mitigations as requested by COO • Continue escalation and oversight through governance structures	20 ↔ C4 X L5 Target Score: 9 Opened: 07/08/2025 Last Updated: 01/07/2026
5	6451 Risk Owner: COO Risk Handler: Clinical Service Group Manager, Surgery & ACCT, POW Risk Domain: Safety & Well-being - Patients / Staff / Public	Orthopaedic pathway <i>Due to business sensitivities the details of this risk are captured in the report to the closed session of this committee</i>				15 ↔ C5 x L3 Target Score: 4 Opened: 15/12/2025 Last Updated: 01/07/2026
7	Unscheduled Care Group					
8	3826 Risk Owner: COO Risk Handler: Deputy Clinical Service Group Manager - Acute Medicine and ED Risk Domain: Safety & Well-being - Patients / Staff / Public	Emergency Department overcrowding impacting patient safety and quality of care IF the Health Board is unable to maintain patient flow across urgent, emergency, inpatient and community services THEN Emergency Departments will remain overcrowded RESULTING IN delays in treatment, increased risk of harm, poor patient experience and failure to meet national performance standards	• Urgent and Emergency Care improvement plans in place, aligned to national guidance (e.g. GIRFT, MAG, ED quality standards) • ED flow and performance action plans in place (including 12-hour wait reduction and ambulance handover improvements) • Six Goals / TRUE / UNITE programmes driving system-wide flow and demand management • Acute medicine transformation in place (e.g. AMU/SDEC models, early senior review, 72-hour model) • Discharge and flow improvements in place (including increased discharge rates and admission avoidance) • Workforce investment and recruitment underway to strengthen acute medical cover • Single Point of Access (SPOA) and integrated working with community services • Routine monitoring through dashboards, escalation processes and operational meetings	• Sustained system pressure continues to drive ED overcrowding • Flow remains constrained by inpatient capacity and discharge delays • Performance deterioration in 12-hour waits despite improvement actions • Whole-system dependency limits pace of improvement (e.g. community and partner capacity) • Improvements are not yet delivering consistent reduction in overcrowding • Workforce and demand pressures continue to challenge sustainability	• Progress ED 12-hour improvement plan and Safe Transfer of Patient policy • Deliver Urgent and Emergency Care action plan aligned to national recommendations • Continue development of long-wait reduction plans and ED performance improvement actions • Further embed acute medicine transformation and SDEC models • Continue recruitment to strengthen 7/7 acute medical workforce • Maintain system-wide focus on patient flow, discharge and admission avoidance • Engage with national UEC programmes and improvement forums	15 ↓ C4 X L5 Target Score: 12 Opened: 24/09/2019 Last Updated: 01/07/2026 July 2026: A review has been undertaken using 'The Community Emergency Department Overcrowding Scale (CEDOCS)' and an outcome has been for the risk to reduce to a 15.
9	4632 Risk Owner: ED Therapies and Health Sciences Risk Handler: Senior Quality & Safety Manager - Unscheduled Care Risk Domain: Safety & Well-being - Patients / Staff / Public	Inability to deliver timely, high-quality stroke care across CTM IF stroke prevention, urgent assessment, acute treatment and rehabilitation pathways are not consistently delivered across CTM THEN patients may experience delays in access to specialist assessment, treatment and rehabilitation RESULTING IN poorer outcomes, increased disability, longer lengths of stay, poorer patient/carer experience and failure to meet stroke quality standards	• Executive-led stroke governance and oversight arrangements in place • Temporary stroke service model at RGH agreed to continue to 31 March 2027 • Stroke improvement programme in place, with focus on key quality measures • Daily multidisciplinary huddles reviewing stroke presentations, breaches and actions • SOPs, escalation arrangements and medical clerking pathways in place • CNS presence in ED and routine daily/weekly performance reporting • Regional and national stroke programme engagement continuing	• Stroke performance has declined and key quality measures are not consistently met • Temporary service model remains in place pending development of a sustainable future model • Delays remain in the early pathway, particularly time to CT and access to the Stroke Unit • Workforce fragility remains across aspects of the pathway • Flow, capacity and estate constraints continue to impact timely stroke care • Psychology support and full pathway rehabilitation provision remain areas of concern	• Deliver the launched stroke improvement plan, with immediate focus on the first 30 days • Develop trajectories for all stroke quality improvement measures, prioritising the first four hours of the pathway • Progress 3-month pilot for 7-day stroke service delivery from July 2026 • Use multidisciplinary stroke teams to support development of the future service model • Continue recruitment and workforce actions to support improvement work • Roll out improvement approach across PCH and POWH, informed by baseline data	16 ↔ C4 X L4 Target Score: 12 Opened: 11/05/21 Last Updated: 01/07/2026

	A	F	G	H	I	K
	Datix ID and details	Risk Title / Risk Description	Current controls in place	Gaps in controls	Action Plan	Rating (current) and details
1						
10	5045 Risk Owner: COO Risk Handler: Directorate Manager Specialty Unscheduled Care Risk Domain: Safety & Well-being - Patients / Staff / Public	Insufficient neurology capacity impacting timely access to services IF the Health Board does not have sufficient neurology workforce and diagnostic capacity THEN patients may experience delays in access to neurology assessment and treatment RESULTING IN delays in diagnosis and care, deterioration in patient condition, longer waiting times and increased risk of harm	- Recruitment to Consultant Neurologist posts underway, with one substantive appointment confirmed (May 2026 start) - Locum consultant in place supporting inpatient care and outpatient clinics - Plans in place to establish a neurology liaison model within CTM - Ongoing engagement with Cardiff and Vale regarding commissioned service capacity - Transfer of neurology waiting list reporting for PCH and RGH to CTM completed	- Neurology workforce remains below required establishment, with a second consultant post still vacant - Ongoing reliance on locum provision to maintain service delivery - Significant outpatient backlog and long waits remain - Limited access to neurophysiology diagnostics impacting pathway timeliness - Uncertainty regarding long-term sustainable service model and commissioned capacity - Delivery of a proportion of neurology activity remains dependent on CV UHB meeting its commissioned obligations.	- Complete recruitment to remaining Consultant Neurologist post - Continue development and implementation of CTM neurology liaison service - Work with Cardiff and Vale to confirm delivery of commissioned activity - Monitor and reduce outpatient backlog and long waits - Review risk score following full implementation of additional consultant capacity	16 ↔ C4 X L4 Target Score: 8 Opened: 09/03/2022 Last Updated: 01/07/2026
12	Children and Families Care Group					
13	5753 Risk Owner: Executive Director of Nursing Risk Handler: Senior Nurse Community Children's Nursing Services Risk Domain: 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 Board is unable to provide sufficient Special School Nursing capacity and a clear service model aligned with Local Authority responsibilities THEN the service will be unable to meet requirements across special schools RESULTING IN inequitable provision, risks to children and young people, and failure to meet national standards and partnership expectations	- All funded Special School Nursing posts are currently filled - Ongoing engagement with Local Authorities and education partners - Executive and Care Group oversight in place with escalation through governance routes - Welsh Government guidance now issued clarifying Health Board and Local Authority responsibilities - Active review of the service model and workforce arrangements underway	- No agreed, sustainable service model across Health Board and Local Authorities - SLA with Local Authorities not yet finalised - Service resilience remains fragile despite posts being filled - Lack of long-term clarity on roles, responsibilities and funding arrangements - Risk of inequitable provision across special schools	- Redraft and agree SLA with Local Authorities - Update service model in line with Welsh Government expectations - Continue engagement with stakeholders to agree responsibilities and funding - Develop updated paper for internal decision-making and next steps - Maintain escalation through governance routes pending resolution	20 ↔ C4 X L5 Target Score: 8 Opened: 16/04/2024 Last Updated: 01/07/2026
14	6475 Risk Owner: COO and Executive Director of Nursing Risk Handler: Head of Nursing CYP Risk Domain: Service / Business Interruption	Patient safety and service delivery risks arising from industrial action impacting Health Visiting services IF industrial action reduces the capacity of Health Visiting services to deliver the full programme of care, THEN the Health Board may be unable to provide the expected level of universal and targeted support to children and families, RESULTING IN reduced contact with vulnerable families, risks to early identification of need and safeguarding, and potential gaps in delivery of statutory and national programme requirements.	- High-risk families are prioritised for service delivery and support. - Daily "strike action cell" in place, led by senior leaders, to review staffing levels and reallocate available capacity. - Additional review meetings (cells) arranged as required to respond to changes in service demand and staffing. - Formal communications issued to Local Authorities and supported through corporate communications arrangements. - Use of FAQs and guidance to support staff understanding of roles and responsibilities during industrial action. - Agreed mitigation plan and ongoing dynamic risk assessment in place through senior oversight.	- Reduced workforce capacity due to ongoing industrial action limits service delivery. - Inability to deliver the full Health Visiting service offer across all families. - Reliance on prioritisation means lower-risk families may not receive routine contacts. - Sustained disruption to preventative and early intervention work. - Continued need for dynamic reallocation of staff to maintain safe service delivery.	- Continue prioritisation of high-risk families to maintain safeguarding and essential service delivery. - Maintain daily operational oversight through "strike action cell" and adjust deployment of staff as required. - Continue engagement and communication with Local Authorities and stakeholders. - Maintain dynamic risk assessment and escalation through governance arrangements. - Keep the risk under review as industrial action continues and service capacity changes.	16 ↔ C4XL4 Target Score: 12 Opened: 21/01/2026 Last Updated: 01/07/2026
15	Diagnostics, Therapies, Pharmacy & Specialties Care Group					
16	5554 Risk Owner: Risk Handler: Clinical and Laboratory Haematology Service Manager Risk Domain: Statutory Duty, Regulation, Mandatory Requirements	Inability to meet containment level 3 (CL3) standards creating risks to patient safety and statutory compliance IF the CL3 laboratory does not meet required sealability and containment standards, THEN the Health Board may be unable to safely process high risk specimens in line with COSHH and HSE requirements, RESULTING IN risks to patient safety, disruption to critical diagnostic services, and potential regulatory enforcement action.	- Interim mitigation measures implemented to enable continued handling of high risk specimens while maximising safety. - Advice sought and aligned with Public Health Wales and HSE-supported approaches. - Escalation through organisational governance, including review at senior leadership level. - Refurbishment programme initiated to address laboratory compliance issues. - Engagement with estates and procurement teams to progress required works.	- CL3 laboratory remains non compliant with sealability requirements. - Fumigation is not currently possible in the existing environment. - Interim mitigations reduce but do not eliminate compliance and safety risks. - Refurbishment project delayed due to procurement issues and need to re tender. - Full compliance with HSE/COSHH standards not yet achieved.	- Progress re tendering and delivery of the CL3 laboratory refurbishment project. - Continue to implement and monitor interim mitigation measures to support safe operation. - Maintain engagement with HSE/Public Health Wales guidance to ensure mitigations remain appropriate. - Escalate funding and delivery requirements through governance routes to support timely resolution. - Review risk score in light of mitigations and progress, as requested by COO.	20 ↔ C4XL5 Target Score: 4 Opened: 19/09/2023 Last Updated: 01/07/26

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	Datix ID and details	Risk Title / Risk Description	Current controls in place	Gaps in controls	Action Plan	Rating (current) and details
1						
17	6498 Risk Owner: COO Risk Handler: Care Group Service Director - DTPS & Children and Family Risk Domain: Safety & Well-being - Patients / Staff / Public	Risk to patient safety from insufficient availability of compliant dynamic mattress systems IF there are insufficient compliant dynamic mattress systems available across the Health Board, THEN the delivery of appropriate pressure area care may be compromised, RESULTING IN avoidable patient harm, including increased incidence of pressure damage, extended lengths of stay, and reduced assurance of safe and effective care.	- Phased replacement programme in place to increase availability of dynamic mattress systems. - Ongoing monitoring of incidents and reporting related to pressure care. - Clinical teams alerted to shortages to support enhanced observation and clinical decision-making. - Individual patient risk assessments undertaken to prioritise high-risk patients. - Patient care plans in place to manage pressure care needs. - Contract with current provider under review ahead of expiry. - Escalation and governance processes in place to monitor and manage the risk.	- Current supply of compliant dynamic mattresses remains insufficient to meet demand. - Replacement programme not yet complete and insufficient to fully mitigate the risk. - Continued reliance on prioritisation and workarounds to manage shortages. - Risk of ongoing incidents and harm while full compliance is not achieved. - Contract renewal and long-term supply arrangements not yet secured.	- Continue phased replacement programme to increase the number of compliant mattress systems. - Progress review and renewal of supplier contract to ensure sustainable provision. - Maintain close monitoring of incidents and pressure care outcomes. - Ensure continued prioritisation of high-risk patients through clinical assessment and care planning. - Escalate through governance routes to secure a clear plan and actions to address the risk.	16 ↔ C4 X L4 Target Score: tbc Opened: 11/02/2026 Last Reviewed: 01/07/2026
18	6429 Risk Owner: ED Therapies and Health Sciences. Risk Handler: Physiotherapy Manager for Rehabilitation Risk Domain: Safety & Well-being - Patients / Staff / Public	Risk to patient safety from an unfit Physiotherapy MSK self referral system IF the Physiotherapy MSK self referral system does not safely triage patients or identify those requiring urgent medical assessment, THEN patients may remain within the physiotherapy pathway when they should seek urgent or alternative care, RESULTING IN delays in appropriate clinical intervention and potential patient harm.	- Existing self referral form remains in use to provide access to physiotherapy services. - Attempts made to improve the form, including development of enhanced triage and safety netting functionality. - Engagement with digital colleagues to develop a replacement MS Forms solution with improved functionality. - Approval in principle obtained to proceed with updated digital form. - Welsh language and DPIA requirements being progressed to support implementation. - Ongoing monitoring of incidents related to the self referral process via Datix reporting.	- Current self referral form is not fit for purpose and does not reliably support safe triage. - Increased demand has exceeded triage capacity, leading to delays in assessment. - Patients requiring urgent medical care may not be appropriately identified at point of referral. - Safer digital solution not yet implemented due to system and approval dependencies. - Continued reliance on an unsafe or suboptimal process while alternative solution is in development	- Progress implementation of the revised MS Forms self referral system. - Secure final approvals required for digital solution and publish on Physiotherapy internet page. - Review performance and safety of the new system once live, including impact on incidents and triage timeliness. - Continue monitoring Datix incidents and adjust controls as required. - Keep the risk under review until a safe and sustainable referral system is established.	16 ↔ C4 X L4 Target Score: 1 Opened: 24/11/2025 Last Reviewed: 01/07/2026
19	5579 Risk Owner: Executive Director of Public Health Risk Handler: Interim Head of Dietetics Risk Domain: Quality / Complaints / Assurance / Patient Outcomes	Insufficient provision of children's weight management services IF the Health Board is unable to provide appropriate children's weight management services across all levels of need THEN children and young people will not receive timely access to appropriate support RESULTING IN in worsening health outcomes, reduced opportunity for early intervention and increased demand on secondary and specialist services	- Level 1 service (PIPN) in place in parts of CTM, with Health Board-wide rollout funded and underway - First-line advice and guidance available to referrers, families and carers - Stakeholder engagement in place to develop future service model - Business case under development for phased model across Levels 1-3 - Internal governance oversight and monitoring in place	- No established Level 3 service, with significant unmet need - Limited Level 2 provision and unclear full pathway - Service delivery remains dependent on future investment - True scale of demand and incidents likely under-reported - Current model does not provide a comprehensive, sustainable pathway	- Complete rollout of Level 1 PIPYN service across the Health Board - Develop and progress business case for Level 3 service provision - Map and formalise full pathway from prevention through to specialist services - Continue stakeholder engagement to agree sustainable service model - Identify and secure funding to support phased implementation	16 ↔ C4 X L4 Target Score: 8 Opened: 13/10/2023 Last Updated: 01/07/2026
20	3567 Risk Owner: Risk Handler: Risk Domain: Quality / Complaints / Assurance / Patient Outcomes	Patient safety and service delivery risk due to insufficient Cellular Pathology space IF there is insufficient laboratory and office space for Cellular Pathology to safely manage current and increasing workload, including service disaggregation and future Health Board requirements, THEN the service may be unable to operate safely, efficiently and in line with required quality, infection prevention, health and safety, and accreditation standards, RESULTING IN risk of diagnostic delay or error, poorer cancer performance, staff safety and wellbeing concerns, increased outsourcing costs, and inability to support service repatriation, digital pathology and regional service developments.	- SOPs in place to standardise practice and reduce variation caused by environmental constraints. - Local workflows adapted to maximise use of limited space. - Reception and dissection areas managed to reduce use as a thoroughfare, including signage and demarcation. - Block and slide filing removed from laboratory areas where possible. - Checking processes in place within dissection to reduce risk of error. - IPC, health and safety, fire safety and UKAS findings reviewed to inform ongoing mitigation. - Office moves have created additional reporting space. - Fire build form submitted to scope potential laboratory expansion. - Regional and local estate options being explored, including short-term improvements and medium-term solutions.	- Existing laboratory and office space remains insufficient for current and anticipated workload. - Current mitigations do not resolve the underlying estate constraint. - Increased workload from service disaggregation and repatriation cannot be safely accommodated within the current footprint. - Limited space restricts ability to increase internal capacity, support additional staffing, introduce equipment, or reduce outsourcing. - Environmental constraints continue to present daily operational, patient safety, staff safety and accreditation risks. - Long-term regional or local estate solution has not yet been agreed or implemented.	- Complete costing of Phase 1 "make safe" arrangements for Statement of Need submission. - Progress scoping of laboratory expansion following submission of the fire build form. - Continue to develop local short-term estate options to improve safety and capacity. - Progress regional estate options through financial assessment. - Review the risk score and escalation following director review, including whether this should remain separate from Risk 5554. - Continue monitoring IPC, health and safety, fire safety, UKAS and operational impacts while estate options are progressed.	20 ↔ C4 X L5 Target Score: 6 Opened: 28/05/2019 Last Updated: 01/07/2026
22	Mental Health and Learning Disabilities Care Group					

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	Datix ID and details	Risk Title / Risk Description	Current controls in place	Gaps in controls	Action Plan	Rating (current) and details
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23	6318 Risk Owner: Chief Operating Officer Risk Handler: Directorate Manager - CAMHS and Specialist Services (Mental Health and Learning Disabilities) Risk Domain: Safety & Well-being - Patients / Staff / Public	Tier 3 SHED (Severe and High Impact Eating Disorders) Team Service Capacity and Resilience IF the Health Board and partner organisations are unable to provide sufficient workforce capacity and sustainable arrangements for the Tier 3 SHED service THEN the service may not be able to deliver safe, effective and consistent care RESULTING IN risks to patient safety and outcomes, reduced service effectiveness and increased operational and organisational pressure	- Regular joint working with Cardiff and Vale UHB, including established monthly oversight meetings - Improved governance, communication and escalation arrangements between organisations - Temporary service mitigations in place (e.g. nurse practitioner support, drop-in clinics, physical health monitoring) - Staff training and service development actions underway - Ongoing monitoring through Care Group and executive governance structures	- Workforce capacity challenges remain unresolved - Service sustainability remains dependent on partner organisation capacity - Temporary mitigations do not provide a long-term solution - Continued pressures on service delivery and effectiveness - Underlying structural issues not yet addressed	- Continue joint working with CAVUHB to develop sustainable service arrangements - Maintain regular oversight and monitoring through established governance routes - Progress workforce and service model improvements - Continue implementation of agreed actions arising from joint reviews and reports	16  C4 X L4 Target Score: 6 Opened: 29/08/2025 01/07/2026
24	3337 Risk Owner: COO and Director of Digital Risk Handler: Service Director, Mental Health and Learning Disability Risk Domain: 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 electronic patient record system, THEN clinical staff may not have access to complete and consistent patient information, RESULTING IN risks to patient safety, including potential for clinical decisions to be made on incomplete information and avoidable harm.	- Dedicated programme in place to procure and implement a single electronic patient record system. - Procurement process underway, with supplier engagement and contract negotiation planned/ongoing. - Programme governance arrangements in place, including Programme Board oversight. - Key programme roles (e.g. project and programme management) recruited to support delivery. - Workshops undertaken to review current systems, processes and information requirements. - Interim measures in place to support information sharing across existing systems (e.g. defined access and recording arrangements).	- No single integrated electronic patient record currently in place across Mental Health services. - Dependence on multiple systems and interim arrangements to access patient information. - Programme remains in procurement/delivery phase, with full implementation not yet confirmed. - Continued reliance on manual or workaround processes to access and share information. - Benefits of a fully integrated digital record not yet realised.	- Progress procurement, contract award and mobilisation of the new electronic patient record system. - Undertake detailed implementation planning with the selected supplier. - Continue programme governance and oversight to support delivery to planned milestones. - Maintain and refine interim arrangements to support safe information sharing until implementation. - Keep the risk under review as the programme progresses through procurement and into delivery.	15  C5 X L3 Target Score: 6 Opened: 07/11/2018 Last Updated: 01/07/2026
25	4691 Risk Owner: COO Risk Handler: Service Director, Mental Health and Learning Disability Risk Domain: Safety & Well-being - Patients / Staff / Public	Provision of safe and appropriate estate for Mental Health inpatient services IF Mental Health inpatient environments do not meet required design, safety and quality standards, THEN care delivery may be constrained and the ability to provide safe, therapeutic and effective inpatient care may be compromised, RESULTING IN increased risks to patient and staff safety, reduced quality of care, and negative impact on patient experience and clinical outcomes.	- Inpatient Improvement Programme in place, including a workstream focused on safe and therapeutic environments. - Review and remodelling of adult inpatient services underway, with oversight through MHLG governance structures. - Feasibility work progressing to assess Mental Health inpatient estate requirements. - Engagement with Capital Team to support development of estate solutions. - Routine environmental and safety assessments undertaken, including ligature risk identification and mitigation. - Additional staffing measures implemented where environmental risks require enhanced observation or supervision. - Ongoing programme of service and workforce redesign supporting improvements in inpatient care delivery.	- Current inpatient estate does not fully meet required standards across all areas. - Long-term estate solution not yet agreed or implemented. - Reliance on interim mitigation (e.g. staffing adjustments) to manage environmental risks. - Feasibility and capital planning work not yet translated into a deliverable programme of change. - Environmental constraints continue to impact service delivery and patient experience.	- Progress feasibility work and develop options for improving Mental Health inpatient estate. - Work with Capital Team to develop and secure approval for estate solutions. - Continue inpatient service review and remodelling to align with future estate requirements. - Maintain environmental risk assessments and implement interim mitigations where required. - Keep the risk under review as estate planning and service redesign work progresses.	15  C3 X L5 Target Rating: 6 Opened: 15/06/2021 Last Updated: 01/07/2026
27	Primary and Community Care Group					
28	5877 Risk Owner: COO Risk Handler: Development Manager - Out of Hours Risk Domain: Service / Business Interruption	Impact of new GP Out of Hours (OOH) contract on service capacity and rota fill IF changes associated with the new GP Out of Hours (OOH) contract and Working Time Regulations reduce GP availability for OOH shifts, THEN rota gaps will increase, particularly for weekday evening cover, RESULTING IN reduced OOH service capacity and potential increased pressure on ambulance services, Emergency Departments, and timely patient access to urgent care.	- Regular oversight of the GP OOH rota. - Liaison with the GP pool to fill additional shifts where possible. - Alternative recruitment routes have been explored, including locum platforms. - Additional GP recruitment remains a key mitigation. - Procurement team engaged to progress local procurement of the Adastra clinical system, following advice that Health Boards should procure locally.	- NHS Employers and BMA negotiations remain unresolved, creating uncertainty about the final contract position and local impact. - Current recruitment routes are not sufficiently agile or flexible for how GPs book OOH shifts, often at short notice. - Additional GP recruitment remains critical to sustaining the service. - Weekday evening cover is expected to be particularly affected where GPs are unable to work late OOH shifts and then work in practice the following morning. - The Adastra contract ends in December 2026, with limited alternative providers available and local procurement still to be completed.	- Continue to monitor the outcome of NHS Employers and BMA negotiations and assess the local implications for GP OOH rota cover. - Maintain regular oversight of the GP rota and continue liaison with the GP pool to fill shifts where possible. - Continue to explore alternative recruitment and engagement routes for GPs. - Progress local procurement for Adastra to support continuity of the GP OOH and Navigation Hub clinical system. - Keep the risk under review as the contract position, rota impact and procurement position become clearer.	16  C4 X L4 Target Score: 8 Opened: 07/08/2024 Last Updated: 01/07/2026

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	Datix ID and details	Risk Title / Risk Description	Current controls in place	Gaps in controls	Action Plan	Rating (current) and details
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29	6397 Risk Owner: COO Risk Handler: Development Manager - Out of Hours Risk Domain: Service / Business Interruption	Shortage of GPs impacting urgent primary care (OOH and Navigation Hub) service delivery IF there is an ongoing shortage of GPs to deliver urgent primary care services, THEN rota gaps will persist, particularly for home visiting and out of hours shifts, RESULTING IN unfilled shifts and increased conveyance of patients (including palliative and end of life) to Emergency Departments.	- All GPs on holding lists have been contacted to maximise available workforce. - Recruitment adverts placed via bank routes to encourage GP applications. - Shift cover maintained through senior GP leadership where required (e.g. over peak periods such as winter). - Risk remains under close monitoring by the care group, with ongoing review of position and mitigation.	- Bank recruitment processes are not aligned to how GPs prefer to work (lack flexibility and do not support short-notice shift fill). - Persistent shortage of GPs available for urgent primary care roles. - Ongoing challenges in filling specific shift types, particularly home visiting. - Reliance on senior clinical staff to cover gaps is not sustainable. - No substantive change in control effectiveness since previous reviews.	- Continue to promote recruitment through existing bank and holding list routes. - Maintain active monitoring of shift fill rates and escalation through care group governance. - Develop revised mitigation proposals for Executive consideration (as identified by the care group review process). - Keep the risk under review and update mitigation as workforce position changes.	16 ↔ C4 X L4 Target Score: 12 Opened: 31/10/2025 Last Updated: 01/07/2026
31	Deputy COO Risks					
32	4491 Risk Owner: COO Risk Handler: Deputy COO Care Group: Business Manager for Chief Operating Office Domain: Safety & Well-being - Patients / Staff / Public	Failure to meet demand across the patient pathway resulting in system-wide pressure on care delivery IF the Health Board is unable to meet demand across the full patient pathway (urgent, emergency, inpatient and planned care) THEN timely access to care and patient flow will be compromised RESULTING IN increased risk of harm, delays in treatment, poor patient experience and sustained operational and performance pressures	- Whole-system improvement approach in place across urgent, emergency and planned care - Six Goals programme and UEC action plans in place (including ED flow and ambulance handover improvements) - Planned Care Recovery and PIT programmes supporting demand and capacity management - Integrated discharge arrangements in place (e.g. D2RA, Hospital at Home, community services) - Admission avoidance and integrated front door models in operation - Targeted pathway interventions in high-pressure areas (e.g. ophthalmology) - Routine performance monitoring and escalation through governance structures	- Capacity constraints remain across the system, particularly impacting flow and emergency demand - Dependency on whole-system delivery (including partners and community capacity) limits pace of improvement - Persistent discharge delays continue to impact bed availability and flow - Workforce and estate constraints continue to limit sustainable capacity - Performance remains fragile in high-pressure areas despite improvement actions - Actions are extensive but not yet delivering consistent system-wide impact	- Continue delivery of urgent and emergency care improvement plans, including ambulance handover and ED flow targets - Progress Six Goals programme actions across admission avoidance, flow and discharge - Further develop integrated discharge models and community alternatives to admission - Continue elective recovery and demand management initiatives across specialties - Target high-pressure pathways (e.g. ophthalmology) for stabilisation and improvement - Maintain enhanced performance oversight and escalation arrangements - Review and refine risk through Care Group-level review (as requested by COO)	20 ↔ C4 x L5 Target Score: 12 Opened: 11/01/21 Last Reviewed: 01/07/26
33	4417 Risk Owner: COO Risk Handler: Assistant Director of Operations MH and LD Risk Domain: Safety & Well-being - Patients / Staff / Public	Inadequate access control and site security across Health Board premises IF access control systems and site security arrangements across Health Board premises are not consistently implemented and maintained THEN there is an increased risk of unauthorised access, absconding and inability to safely manage patients and visitors RESULTING IN risks to patient and staff safety, breaches of security protocols and potential harm and reputational impact	- Access control assessments completed across acute sites, with wider programme of work established - Phase 1 security improvement works underway at Princess of Wales Hospital - Capital funding approved for initial works at POW and PCH - Programme of works overseen through Operational Capital Group - Incident monitoring and review in place to inform risk assessment - Standard operating procedures and action plans in place for high-risk areas	- Inconsistent access control systems across sites, with known vulnerabilities (particularly historically at POW) - Programme of works not yet completed across all sites (phase 2 pending) - Reliance on capital funding and prioritisation processes to progress improvements - Ongoing incidents indicating that risks are not fully mitigated - Full impact and effectiveness of improvements not yet evaluated	- Complete Phase 1 works at Princess of Wales Hospital - Scope and deliver Phase 2 programme across remaining sites - Develop further capital bids to support wider rollout - Maintain an analysis of incidents to inform risk scoring and prioritisation - Keep under review and consider alignment with overall Health Board risk relating to security	16 ↔ C4 X L4 Target Score: 8 Opened: 30/09/2020 Last Updated: 01/07/2026
35	Facilities Directorate Risks					
36	6052 Risk Owner: COO Risk Handler: Assistant Director OSS (Facilities) Risk Domain: Statutory Duty, Regulation, Mandatory Requirements	Inadequate patient hydration and nutrition due to failure of beverage trolley infrastructure IF the Health Board is unable to maintain or replace ageing beverage trolleys THEN patient meal and beverage services may be disrupted RESULTING IN risks to patient hydration and nutrition, alongside non-compliance with safety, IPC and quality standards	- Reactive repair arrangements in place to maintain existing trolley fleet - Partial replacement programme underway, with funding secured for a limited number of new trolleys - Procurement of additional trolleys in progress, with delivery expected end June 2026 - Use of decommissioned trolleys for spare parts to extend life of remaining fleet - Investment bid submitted through IMTP to support wider replacement programme - Estates condition assessments commissioned to understand current fleet risks - Operational prioritisation in place where trolley availability is constrained	- Ageing fleet (10+ years) no longer compliant with maintenance contracts - Insufficient funding to replace the fleet at the required scale - Current capacity below service standard (not one trolley per ward) - Ongoing risk to food safety, infection prevention and staff safety due to equipment condition - Interim repair approach is not sustainable and does not address underlying risk - Procurement delays mean benefits of replacement not yet realised	- Complete delivery and deployment of procured trolleys (June 2026) - Progress phased replacement programme through revenue and IMTP funding routes - Develop and implement a sustainable long-term replacement plan - Review risk score following operationalisation of newly delivered trolleys - Continue condition assessments to support prioritisation of further replacements - Explore additional funding options to accelerate fleet renewal	20 ↔ C4 X L5 Target Rating: 8 Opened: 15/01/2025 Last Updated: 01/07/2026
39	ED of Strategy & Transformation					

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	Datix ID and details	Risk Title / Risk Description	Current controls in place	Gaps in controls	Action Plan	Rating (current) and details
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40	5821 Risk Handler: Assistant Director of Transformation Risk Domain: Service / Business Interruption	Lack of sustainable commissioned provision for secondary care immunology services IF a sustainable commissioning solution for secondary care immunology services is not secured, THEN CTM residents may lack timely access to appropriate specialist assessment and treatment, RESULTING IN delays in diagnosis and management, increased clinical risk, and poor patient experience.	- Organisational working group in place and meeting regularly to oversee the risk and identify solutions - Review underway of Welsh Government immunology recommendations (2025) to inform future service model - Ongoing engagement with Welsh Government and regional partners on longer-term options - Referral management arrangements in place, including oversight of patients requiring onward management (where possible)	- No confirmed, sustainable commissioned provider for secondary care immunology services - Limited capacity from external providers, with previous arrangements not currently deliverable - Lack of consistent pathway for both urgent and routine referrals - Ongoing uncertainty pending outcome of national (Welsh Government) service model decisions	- Executive discussion to confirm preferred commissioning approach and next steps (June 2026) - Explore potential commissioning options with North Bristol Trust (scoping meeting July 2026) - Use Welsh Government review findings to inform development of a sustainable service model - Continue regional and national discussions to secure a longer-term solution	20  C4 X L5 Target Rating: 4 Opened: 11/07/2024 Last Updated: 01/07/2026
41	5374 Risk Handler: Executive Director of Strategy & Transformation (temporary until Deputy Director role is filled) Risk Domain: Environmental / Estate / Infrastructure	Fulfilling environmental and social duties IF the Health Board's decision-making does not consistently reflect its values or consider long-term environmental and social impact, THEN it may fail to meet its socio-economic duty, Wellbeing of Future Generations objectives and value-based healthcare principles, RESULTING IN negative environmental and social outcomes and a loss of stakeholder trust and confidence.	- Integrated Medium Term Planning aligned to Welsh wellbeing goals and ways of working 'CTM 2030' programme supporting community, employment and local procurement objectives - Climate Action Plan and Environmental Sustainability governance arrangements in place - Environmental Sustainability Group and wider governance structures supporting delivery and oversight - Environmental impact considerations incorporated into Board and Committee cover papers - Established range of environmental initiatives (e.g. emissions reduction, procurement, waste management, infrastructure improvements) - Progress underway to raise the profile of sustainability beyond 'sustainability' projects	- Inconsistent consideration of environmental, social and adaptation impacts across all decision-making processes - Limited assurance that impacts are systematically assessed and evidenced, particularly for non-sustainability originated projects - Climate adaptation risks and responses not yet fully embedded into organisational planning and service change decisions - Social value considerations less explicitly and consistently applied than environmental requirements	- Develop and implement a Health Board-wide climate adaptation approach, including an organisational plan to inform service change decisions (Action ID 7483) - Strengthen understanding and assessment of environmental impacts across all projects and programmes, including those not explicitly defined as sustainability initiatives (Action ID 7283) - Embed environmental, social and adaptation considerations consistently into decision-making processes and supporting documentation - Implement actions in the Climate Action Plan, including actions to address identified adaptation risks (Action ID 7483 evidence)	16  C4 X L4 Target Rating: 8 Opened: 21/02/2023 Last Updated: 01/07/2026
43	Executive Director of Finance					
44	6597 Risk Handler: Executive Assistant, Corporate/Finance Risk Domain: 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		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 27/28 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. - Develop the Value & Efficiency Programme with a focus on 'Enabling schemes' to support savings identification and delivery. - Reinforce the requirements to remain within delegated budgets and to control expenditure and commitments. - Maximise opportunities and non recurrent benefits.	20  C4 X L5 Target Rating: 8 Opened: 01/04/2026 Last Updated: 01/07/2026

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	Datix ID and details	Risk Title / Risk Description	Current controls in place	Gaps in controls	Action Plan	Rating (current) and details
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45	6596 Risk Handler: Executive Assistant, Corporate/Finance Risk Domain: 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. • WG 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		The main actions are to : • Manage establishments and recruitment within the context of the underlying deficit included in the Financial Plan for 2026/27 • Manage cost pressures and demands within the scope of the resources identified in the Financial Plan for 2026/27. • Critically review and challenge prior commitments to ensure they remain relevant, robust and deliver value. • Develop a more streamlined 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. • Maintain an investment free plan throughout 2026/27.	20  C4 X L5 Target Rating: 8 Opened: 01/04/2026 Last Updated: 01/07/2026
46	6235 Risk Handler: Head of Governance Estates Risk Domain: Environmental / Estate / Infrastructure	Insufficient funding to address backlog maintenance across the estate. IF the Health Board is unable to secure sufficient funding to address backlog maintenance across the estate, THEN it may be unable to maintain estate infrastructure to a safe and compliant standard, RESULTING IN increased risk of infrastructure failure, inability to replace ageing assets, non-compliance with statutory requirements, deterioration of the care environment, service disruption, and continued growth in backlog maintenance.	• Risk-based prioritisation of estates activity • Planned and reactive maintenance programme managed through the Planet Facilities Management System • Digitisation of estates operations (mobile working) to support real-time management and maintain performance • Applications to Welsh Government funding streams (Targeted Estates Funding (TEF), All Wales Capital Programme) • Use of discretionary capital funding and maximisation of available revenue funding for statutory compliance and high-risk issues • Oversight via Executive Capital Management Group and Capital Scheme Delivery Programme • Routine monitoring and reporting to Estates and Capital Governance Board and Estates Operational Management Team • Annual Estates and Energy Performance Report to Committee • Risk escalation through the Capital and Estates Risk Escalation Group • Internal and external audit programmes	• Available capital and revenue funding is insufficient to address the scale of backlog maintenance across the estate • Current funding streams (including TEF and discretionary capital) only address a small proportion of high-risk backlog items • Continued reliance on external funding opportunities limits the Health Board's ability to deliver a sustained, planned reduction in backlog • Inability to fully replace ageing infrastructure and equipment at end of life • Even where additional funding is secured, there are inherent delivery constraints (e.g. planning, procurement and physical works) which mean backlog maintenance can only be addressed over an extended timeframe	• Continue to pursue all available Welsh Government funding opportunities, including TEF and capital allocations • Target available funding towards highest-risk backlog maintenance and statutory compliance issues • Progress approved capital schemes (e.g. major refurbishment programmes) to reduce backlog at priority sites • Continue to use maintenance and interim interventions to extend the life of critical assets where replacement is not yet possible	16  C4 X L4 Target Rating: Opened: 04/07/2025 Last Updated: 01/07/2026
48	Executive Director of Public Health 					
49	6179 Risk Handler: Assistant Director Public Health Risk Domain: Quality / Complaints / Assurance / Patient Outcomes	High prevalence of overweight and obesity leading to increased demand and complexity of care IF preventative actions are insufficient to reduce overweight and obesity, THEN prevalence will remain high, RESULTING IN increased demand, complexity and clinical risk, poorer outcomes, and ongoing financial and operational pressures, including challenges in safely managing patients with extreme body mass index (BMI).	• Whole-system healthy weight programme to influence population behaviours and environments • Weight management services in place, including Level 1 services for children supported through confirmed funding (e.g. Pipyn) • Healthy settings work (e.g. schools) to promote healthier environments • National policy framework in place, including Healthy Weight: Healthy Wales and forthcoming regulations	• Significant gap in Level 3 weight management provision, particularly for children and young people • Overall scale of services insufficient to deliver population-level impact • Limited capacity across the full weight management pathway	• Further development of services in line with the All-Wales Weight Management Pathway, including Level 3 provision • Implementation of refreshed national healthy weight action plan • Continued system-wide work to strengthen prevention and delivery at scale	20  C4 X L5 Target Rating: 9 Opened: 06/05/2025 Last Updated: 01/07/2026

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	Datix ID and details	Risk Title / Risk Description	Current controls in place	Gaps in controls	Action Plan	Rating (current) and details
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50	5820 Risk Handler: Assistant Director Public Health Risk Domain: Safety & Well-being - Patients / Staff / Public	Insufficient Health Protection resource to deliver vaccination, immunisation and wider health protection priorities IF as a result of reduced Welsh government funding, Health Protection resources are insufficient, THEN the Health Board may be unable to deliver vaccination and immunisation programmes and fully respond to infectious disease and environmental hazards, RESULTING IN avoidable harm to patients and the public, health inequalities, and reputational risk.	- Health Protection governance arrangements established, including a Health Protection Board - Workforce structure approved, with recruitment underway to strengthen capacity - Collaborative planning with partners to develop a Health Protection strategy and optimise available resources - Ongoing engagement with Welsh Government regarding funding allocation	- Funding allocation remains insufficient to deliver the Health Protection strategic plan - Resource gap impacting ability to deliver vaccination/immunisation and wider health protection functions - Lack of parity in Health Protection funding across Wales	- Complete recruitment to agreed workforce structure and reassess remaining gaps - Continue work with partners to develop a deliverable Health Protection plan aligned to available resources - Ongoing discussions with Welsh Government to address funding gap and future allocations	12 ↔ C4 X L3 Target Rating: 8 Opened: 10/07/2024 Last Updated: 01/07/2026
51						
52	Director of Digital					
53	4664 (Confidential risk) Risk Handler: Head of Server Management Risk Domain: Statutory Duty, Regulation, Mandatory Requirements	CYBER: Ransomware/Exfiltration Resulting in Loss of Critical Services/Data and Possible Extortion <i>Due to business sensitivities the details of this risk are captured in the report to the closed session of this committee</i>				20 ↔ C5 X L4 Target Rating: 12 Opened: 03/05/2021 Last Reviewed: 01/07/2026
54	5276 Joint Risk Owners: Director of Digital AND ED Therapies and Health Science. Risk Handler: Pathology Quality Manager Risk Domain: Service / Business Interruption	Delay to LIMS 2.0 implementation impacting pathology service continuity IF the LIMS 2.0 programme is not delivered within required timescales THEN pathology services may need to rely on unsupported or interim legacy systems RESULTING IN risks to service continuity, patient safety, regulatory compliance, financial sustainability and delivery of Blood Transfusion and laboratory services.	- Programme governance in place through LIMS Programme Board, Chief Executive Group and local Health Board oversight. - Regular executive updates and escalation routes in place for emerging operational, clinical and financial risks. - CTM working with DHCW, supplier and partner organisations on revised deployment sequencing. - Business continuity options being explored, including continued use or extension of legacy systems. - Expert review / stocktake completed and used to inform programme next steps. - Dedicated Pathology IT resource in place, although capacity remains limited. - Linked risks being developed for key themes including Blood Transfusion, staffing, finance and legacy data.	- Low confidence in delivery of the full programme within required timescales. - Revised deployment sequencing may be clinically or operationally difficult to deliver safely. - Blood Transfusion remains a significant concern due to system dependency and regulatory requirements. - Legacy system reliance creates operational, compliance and traceability risks. - Financial exposure remains unresolved, including additional programme delay costs and legacy support costs. - Programme delivery remains dependent on DHCW, supplier performance and all-Wales decisions outside CTM's direct control.	- Continue formal engagement with DHCW and partners to confirm safe and deliverable implementation plans. - Seek formal assurances on revised deployment sequencing, particularly for Blood Transfusion and Blood Sciences. - Complete assessment of the implications of bringing Tranche 4 ahead of Tranche 3. - Maintain executive escalation of clinical, operational and financial risks. - Progress business continuity planning for legacy system support beyond current timelines. - Develop and link supporting Datix risks for staff resource, finance, legacy data / compliance and Blood Transfusion.	20 ↔ C5 X L4 Target Rating: 5 Opened: 03/05/2021 Last Updated: 01/07/2026
55	4671 Confidential Risk Risk Handler: Head of Datacentres and Cloud, Digital & Data Risk Domain: Service / Business Interruption	Ageing digital infrastructure impacting service resilience <i>Due to business sensitivities the details of this risk are captured in the report to the closed session of this committee</i>				16 ↔ C4 X L4 Target Rating: 9 Opened: 03/05/2021 Last Updated: 01/07/2026

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	Datix ID and details	Risk Title / Risk Description	Current controls in place	Gaps in controls	Action Plan	Rating (current) and details
1						
56	6424 Risk Owner: TBC (currently Director of Digital) Risk Handler: Head of IG Risk Domain: 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 to uphold data subjects' rights	• Mental Health Subject Access Request processes are established and in operation. • Executive leads and senior managers have been made aware of the backlog and staffing pressures affecting the service.	• Insufficient staffing and resources to process requests efficiently. • Backlogs have developed due to workforce capacity constraints. • Limited capacity to undertake the required review and redaction of records within statutory timescales.	• Escalate backlog and staffing pressures through appropriate management arrangements. • Support consideration of additional recruitment to increase capacity for request processing, redaction and review. • Monitor compliance with statutory timescales.	16  C4 X L4 Target Score: 16 Opened: 20/11/2025 Last Updated: 01/07/2026
59	NEW - Datix ID tbc	Failure to comply with data protection legislation IF the Health Board does not comply with statutory requirements THEN the Information Commissioner's Office (ICO) holds broad statutory powers to enforce compliance with Subject Access Requests (SARs) under the UK GDPR and the Data Protection Act 2018. For failure to respond within the statutory timeframes or for improper handling. RESULTING IN regulatory action, data breaches, complaints, reputational damage, loss of public confidence, and potential impacts on patient care, service delivery and organisational performance.	<i>The controls and actions for this risk are being developed as this is a new risk.</i> <i>For context, the ICO can issue the following:</i> • Warnings & Reprimands: Formal written warnings or public reprimands for non-compliance, which can damage an organisation's reputation. • Information & Assessment Notices: Legally binding orders to compel organisations to provide specific information or allow the ICO to enter premises and audit procedures. • Enforcement Notices: Direct, legally binding orders that mandate an organisation to take specific steps (like clearing a backlog of requests) or cease processing certain data until compliance is met. • Monetary Penalty Notices: Fines of up to £17.5 million or 4% of global annual turnover, whichever is higher, though these are typically reserved for severe or systemic breaches.			TBC
60	4672 Risk Handler: Head of Information Risk Domain: Business objectives or Projects	Inability to achieve timely, accurate clinical coding and structured data standards IF clinical information is not recorded, coded and structured consistently and accurately, THEN the data used to support clinical, operational and strategic decision-making may be incomplete or unreliable, RESULTING IN reduced service effectiveness, poorer decision-making, failure to meet national standards, and delays in delivering digital transformation and organisational objectives	• Coding performance, productivity and backlog are monitored through key performance indicators. • Clinical coding quality is subject to national audit and supported by an ongoing coding improvement programme • Automated coding tools are in place to support coding accuracy and efficiency. • Day-forward scanning is maintained within a 48-hour turnaround target to support timely access to records. • Digital developments are underway to improve structured data capture, including e-forms, integrated care records and digitisation programmes. • Strategic digital and data planning is underway through the Tektology partnership and alignment to IMTP priorities.	• Workforce capacity and specialist skills remain insufficient to fully support coding and data quality requirements. • Data quality, completeness and consistency remain variable across some services. • Reliance on paper records and scanning processes continues in parts of the organisation. • Use of structured and standardised clinical data remains limited in some systems and processes. • Access to and sharing of clinical data across organisational boundaries remains constrained.	• Continue delivery of the clinical coding improvement programme. • Progress digitisation and structured data capture through e-forms, integrated records and future EPR developments. • Develop workforce capacity and capability to support coding quality and data management. • Reduce reliance on paper records through ongoing digitisation and scanning programmes. • Continue improvement of data sharing, interoperability and access to clinical data • Maintain active management of coding performance, backlog and data quality.	15  C3 X L5 Target Rating: 9 Opened: 05/06/2021 Last Updated: 01/07/2026
61	5040 Risk Handler: Assistant Director for Digital Delivery Risk Domain: Business objectives or Projects	Digital system integration dependencies IF the Health Board is unable to integrate new digital systems into its existing architecture in a timely manner, THEN services may need to rely on disconnected systems or manual workarounds, RESULTING IN delays to patient care, reduced efficiency, delays to digital programmes, and increased information governance risks.	• National digital programmes led by DHCW and supported by Welsh Government funding. • Strategic oversight through national CEO and Digital Director groups. • Service agreements in place between DHCW and NHS Wales organisations. • Approved Digital and Data IMTP and strategic partner (Tektology) supporting development of the digital roadmap. • Progress being made in priority programmes, including ePMA integration and deployment activity.	• No single governance structure to prioritise and oversee digital developments across NHS Wales. • National priorities do not always align with local Health Board requirements. • Significant delays before digital developments can commence. • Current architecture and integration arrangements limit connectivity between systems. • Internal capacity to deliver and support digital change remains constrained.	• Work with Welsh Government and DHCW to influence future digital strategy, architecture and funding. • Continue development of the Health Board's digital roadmap and future electronic patient record approach. • Support development of more open and interoperable digital architecture. • Continue delivery of integration-dependent programmes, including ePMA. • Ensure local requirements are represented through national governance arrangements.	15  C3 X L5 Target Rating: 9 Opened: 07/02/2022 Last Updated: 01/07/2026
63	Executive Nurse Director					

	A	F	G	H	I	K
	Datix ID and details	Risk Title / Risk Description	Current controls in place	Gaps in controls	Action Plan	Rating (current) and details
1						
64	6232 Risk Handler: Deputy Executive Director of Nursing Risk Domain: Safety & Well-being - Patients / Staff / Public	Sustainability of the Legal Services function IF: the Health Board does not sufficiently resource and support the Legal Services function THEN: it may not have the capacity, resilience or capability to meet its statutory and operational responsibilities RESULTING IN: increased staff turnover, reduced wellbeing and morale, and an increased risk of failing to meet legal obligations, with consequent reputational impact.	- Organisational Change Process (OCP) completed, and implemented on 5 May 2026 - Additional posts within the Legal Services Team approved, with recruitment underway to strengthen capacity and resilience, with the aim of achieving full recruitment to the revised establishment by 31 July 2026 - Recruitment of a new Lead for Legal Services - Plan to transition from recovery to a 'business as usual' model, from the Legal Services Recovery Plan, including implementation of the revised structure following delivery of the OCP, with full recruitment to the new establishment targeted for completion by July 2026. - Benchmarking undertaken with other organisations to inform structure and demand requirements - Additional workforce in place (via recruitment and redeployment) to support service recovery - Ongoing review of demand, including inquests and response requirements	- There remains a gap in the full establishment of staff within the Legal Services Team, which is due to challenges with recruitment to the revised staffing structure, in line with the implementation of OCP. While full recruitment is targeted for 31 July 2026, this remains in progress and will extend beyond this timeframe. - Improvements from the OCP and recovery programme not yet fully embedded - Continued reliance on interim arrangements to maintain service delivery - Ongoing risk to staff wellbeing, retention and stability of the team	- Complete recruitment to the approved Legal Services Team structure and embed new staffing model - Continue implementation of OCP changes and associated service improvements - Deliver actions within the Legal Services Recovery Plan to strengthen capacity, processes and resilience - Continue to monitor demand and align workforce capacity accordingly	15  C3 X L5 Target Rating: 6 Risk opened: 03/07/2025 Last updated: 01/07/2026
65	6231 Risk Handler: Deputy Executive Director of Nursing Risk Domain: Statutory Duty, Regulation, Mandatory Requirements	Failure to effectively manage concerns IF the Health Board does not comply with, or effectively manage, concerns under the former Putting Things Right arrangements and the transition to the new Listening to People framework THEN it may not manage concerns in a timely, consistent and person-centred way RESULTING IN delays in learning and improving patient safety and experience, missed opportunities for early resolution, increased likelihood of cases progressing to litigation with associated costs, and reputational impact, as well as reduced confidence that concerns are handled openly and effectively.	- Putting Things Right (PTR) procedures in place - Engagement with Legal & Risk Services - Experienced Concerns Handlers in post - Legal Services Recovery Plan in place to improve capacity, processes and systems - Operational Control Plan (implemented May 2026), including additional approved posts (recruitment underway) - Implementation of Listening to People (LTP) requirements from April 2026 - Head of Concerns, Clinical Audit and Compliance role established - PALS staff have been integrated within the Concerns Team to support the early resolution process under LTP - Routine performance monitoring of response and acknowledgement standards with executive oversight	- Capacity constraints within the Redress and Claims Team pending completion of recruitment - Performance against key standards (particularly acknowledgement times) not yet consistently achieved - Variability in early resolution and timeliness of responses - Improvements arising from Organisational Change Policy (OCP) and LTP changes not yet fully embedded	- Complete recruitment to the approved staffing model and embed revised team structure - Continue implementation and embedding of OCP and LTP changes - Strengthen performance against response and acknowledgement standards through ongoing monitoring and oversight - Deliver actions within the Legal Services Recovery Plan to improve capacity, systems and processes	15  C3 X L5 Target Rating: 8 Opened: 03/07/2025 Last Updated: 01/07/2026
70	Director of Corporate Governance / Board Secretary					
71	4885 Risk Handler: Head of Quality Assurance and Compliance Risk Domain: Quality / Complaints / Assurance / Patient Outcomes	Failure to implement and sustain an effective policy management system and governance process IF the Health Board is unable to maintain a clear and effective system and governance framework for managing policies (including review cycles, approval routes, version control and accessibility), THEN staff may not have access to current and appropriately approved guidance, RESULTING IN inconsistent practice, unclear accountability risk of non-compliance with legislation and standards, and potential exposure to legal or regulatory challenge.	- Policy on Policies and supporting guidance in place - Centralised SharePoint policy library (non-clinical) with controlled access - Master policy register and supporting archive arrangements maintained - Ongoing Directorate engagement to improve baseline position and compliance - Templates, guidance and governance support available - Oversight via Executive Management Board - Training and user support in place - Initial work underway to develop a clearer policy categorisation and approval framework	- Reliance on manual processes and workarounds - No clearly defined or consistently applied framework for policy approval routes, leading to reliance on judgement and precedent - Ambiguity in delegation between Board, committees and executive groups - Variable user understanding and engagement - Baseline policy position not yet fully confirmed; some policies overdue review - Clinical policies not yet fully aligned within the system - Capacity constraints continue to impact pace and sustainability	- Finalise baseline policy position by 30 September 2026. - Develop and implement a clear policy categorisation and approval framework (via the Scheme of Delegation) Timeframe tbc - interdependent with the work of the Strategy Team to map governance pathways - Provide targeted Directorate support to improve policy review compliance from September 2026 baseline position within date (tbc) to target position (tbc in September) by 31st December 2026.	16  C4 X L4 Target Rating: 8 Opened: 26/10/2021 01/07/2026
72	Executive Medical Director					

	A	F	G	H	I	K
	Datix ID and details	Risk Title / Risk Description	Current controls in place	Gaps in controls	Action Plan	Rating (current) and details
1						
73	5761 Risk Handler: Medical Directorate Manager, YMH Risk Domain: 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	- The Health Board has escalated this as a significant patient safety issue since 2024 and continues to press Digital Health and Care Wales (DHCW) for resolution. - The specific system issues and requirements have been clearly articulated. - The matter is regularly raised through national forums, including the All-Wales Medical Directors' meetings, to maintain visibility and support collective escalation.	- Resolution is dependent on DHCW and wider national agreement on provider status and data sharing arrangements. - The Health Board does not have direct control over system changes or delivery timescales, and no confirmed implementation date has been provided.	Ongoing escalation and monitoring through national forums, with continued engagement with DHCW to seek progress updates, clarity on delivery timelines, and exploration of potential alternative solutions.	16 ↔ C4 X L4 Target Rating: 8 Opened: 26/04/2024 Last Updated: 01/07/2026
74	6280 Risk Handler: Directorate Manager for General Surgery and Gastrointestinal Services Risk Domain: 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 suboptimal care for this group of acutely unwell patients	- The risk has been formally recognised and escalated within the Health Board, with executive ownership assigned to the Executive Director of Strategy, Transformation and Planning and the Executive Medical Director. - Individual patient cases are reviewed on a case-by-case basis with neighbouring Health Boards to enable access to specialist input where possible. - The issue is subject to internal discussion through Planned Care forums and has been identified for escalation through regional commissioning	- There is currently no commissioned regional service model in place for Severe Acute Pancreatitis. - The interim case-by-case arrangements are not a formalised pathway and may introduce delays to time-critical care. - Resolution is dependent on regional commissioning decisions and ongoing funding through the Joint Commissioning Committee, which is outside the direct control of the Health Board.	- Ongoing engagement with regional partners and the Joint Commissioning Committee to seek agreement on a sustainable commissioned service model and associated funding. - Continued internal escalation through Planned Care and executive oversight to support regional resolution.	16 ↔ C4 X L4 Target Rating: 9 Opened: 06/08/2025 Last Updated: 01/07/2026
75	6629 Risk Handler: Medical directorate manager, YMH Risk Domain: Safety & Well-being - Patients / Staff / Public	GMC/HEIW Conditions on PCH Emergency Department IF the recommendations from the General Medical Council (GMC) and Health Education and Improvement Wales (HEIW) following the targeted review of Prince Charles Hospital Emergency Department are not implemented, THEN there is a risk that clinical supervision, workforce capacity and training environments will not be sufficiently robust, RESULTING IN potential impacts on the safety, quality and timeliness of care for	- Following the Health Education and Improvement Wales (HEIW) targeted visit to Prince Charles Hospital (PCH) Emergency Department in March 2026, a comprehensive action plan has been developed by the ED Clinical Lead, ED Leadership Team and the Unscheduled Care Group. - This addresses key areas including clinical supervision, training opportunities, rota sustainability, recruitment, leadership engagement and patient flow. - Progress is being monitored through established governance arrangements, with ongoing engagement with HEIW.	- The effectiveness of the action plan is dependent on sustained delivery of improvements across workforce, supervision and patient flow. - Until these improvements are embedded and evidenced, there remains a risk of continued scrutiny from HEIW and the General Medical Council (GMC), and potential impact on trainee experience and retention.	Implementation and ongoing monitoring of the HEIW action plan, with regular review through governance structures and continued engagement with HEIW to demonstrate progress and address any further concerns.	16 ↔ C4 X L4 Target Rating: 9 Opened: 06/08/2025 Last Updated: 01/07/2026

	A	B	C	D	E	F	G	H	I	K	L	M	N	O	P
	Datix 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	Rationale for deescalation
1															
	6604 NEW	Director of Digital	Digital Directorate	Information Governance Officer	Statutory Duty, Regulation, Mandatory Requirements	IG 18 Misdirected clinical correspondence - NHS to GP	If..... 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 NWSSP, 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 UHB: • 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/MPIX demographic updates • reduction of reliance on warehouse refresh cycles • event-driven demographic synchronisation • investigation and resolution of Myrddin PAS correspondence routing issue • reconciliation of historic demographic records"		16	C4 x L4	6	N/A (new risk)	01/05/2026	July 2026: The following risks are being deescalated from the Organisational Risk Register, although they will remain open. Following review, it has been agreed that these risks relate to specific operational issues that are more appropriately managed through local
2															
	6605	Director of Digital	Digital Directorate	Information Governance Officer	Statutory Duty, Regulation, Mandatory Requirements	IG20 Legal compliance with access to records requests	If..... 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 patients rights.	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.		16	C4 x L4	16	N/A (new risk)	01/05/2026	risk registers - 6604: Misdirected clinical correspondence to GP practices - 6605: Legal compliance with access to records requests - 6426: Access to E-Whiteboards (Business sensitive risk)Organisational oversight will instead be provided through a new overarching information governance and data compliance risk (please see main tab)
3															

Audit, Risk & Assurance Committee

Audit Recommendations Tracker Update Report

Eitem yr Agenda / Agenda Item	5.2
Dyddiad y Cyfarfod / Date of Meeting:	04/08/2026
Statws Cyhoeddi / Publication Status:	Open/Public.
	Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Kelly Eddington, Quality Assurance & Compliance Officer on behalf of 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
Diben yr Adroddiad / Report Purpose:	For Noting
Argymhelliad (<i>Wedi'i gysylltu â'r adran "Beth Nesaf" uchod</i>). Recommendation (Linked to the "What Next" section above).	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.



Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Overdue Audit activity report



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 highlight the total 'overdue' actions based on the originally assigned due date. The position as at the last ARAC in April 2026 is included as a comparator for the August 2026 ARAC position. The actions are split by the priority of High, Medium and Low as assigned at the finalisation of the Audit Review.

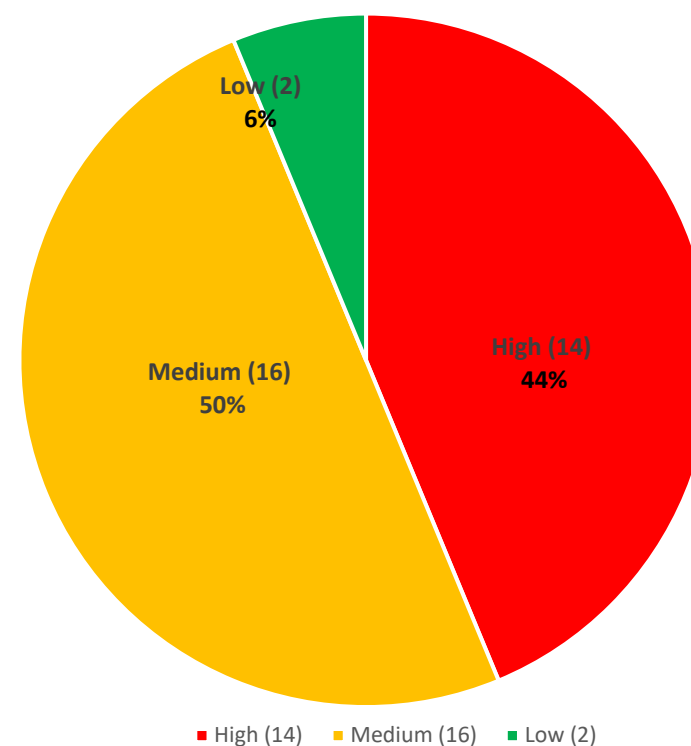
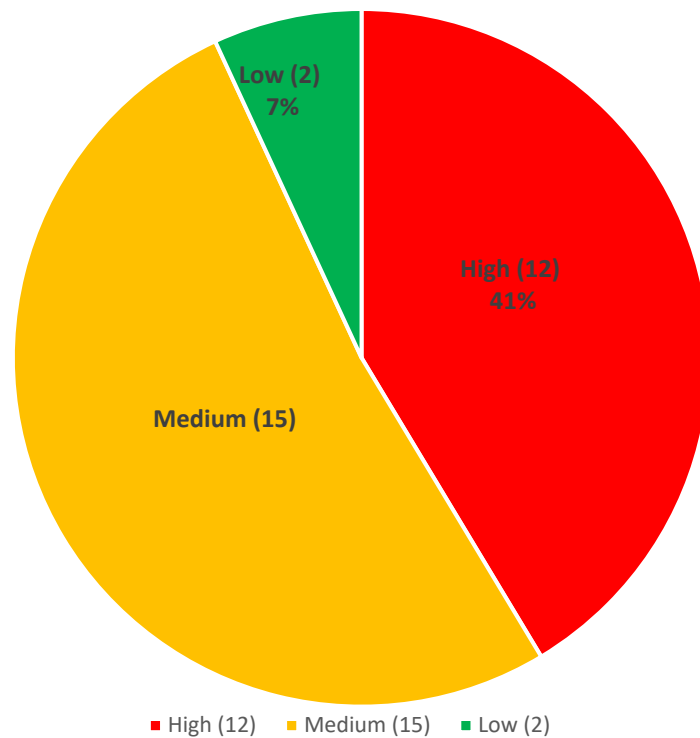
The following Internal Audit Reviews have the longest overdue audit actions against the original due date for Limited Assurance rated reports:

April 2026

July 2026

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

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



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

6 open actions overdue between 864-1046 days from the original due date.

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

2 open actions overdue by 772 days from the original due date.

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

5 open actions overdue between 559-743 days from the original due date.

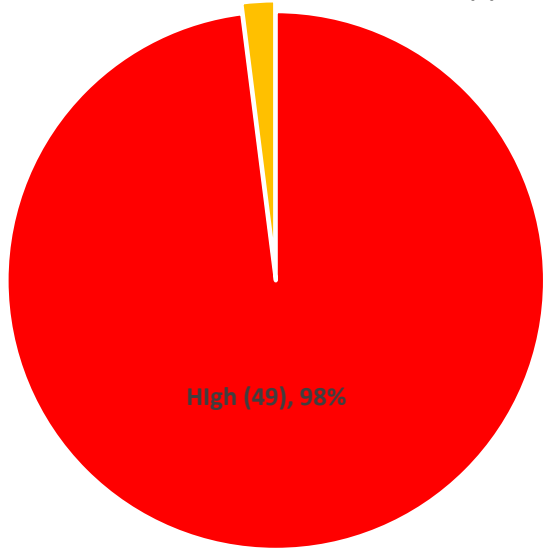
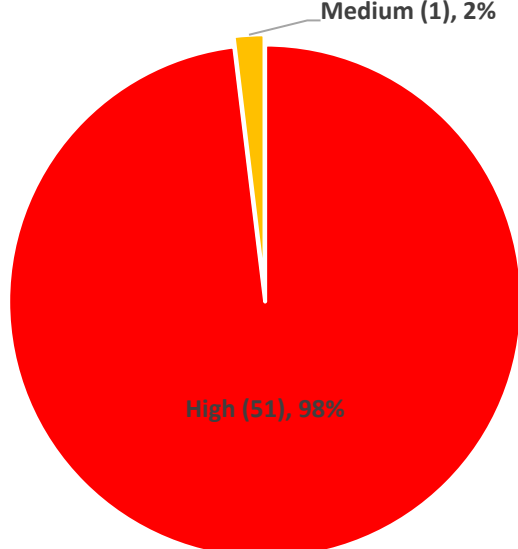
Narrative Commentary – There has been a sustained effort across most Directorates to ensure that updates are provided during this reporting period, with actions also being updated and marked as Fully Complete, awaiting approval. However, it is acknowledged that increasing operational pressures and competing demands have impacted progress during this period. Targeted focus will therefore be maintained to ensure updates remain on track.

Whilst these audits remain on the dashboard as areas of suggested focus, there have been updates provided during this reporting period.

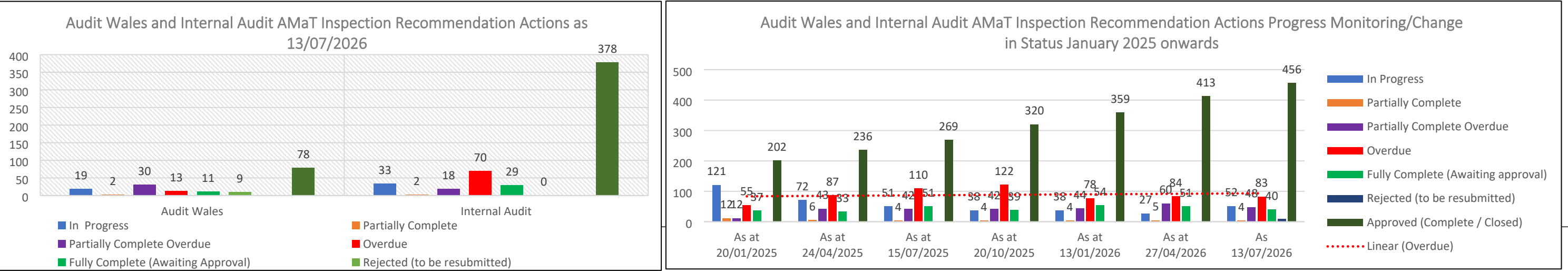
Overdue Limited Assurance Actions – Breakdown by Executive Portfolio

Overdue actions that fall within the portfolio of the Chief Operating Officer	23 (increase of 4)
Overdue actions that fall within the portfolio of the Strategy and Transformation	3 (no change)
Overdue actions that fall within the portfolio of the Executive Medical Director	2 (no change)
Overdue actions that fall within the portfolio of the Director of Digital	1 (no change)

Overdue actions that fall within the portfolio of the Executive Director of People	3 (new to overdue reporting this period)

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 April 2026 is included as a comparator for the August 2026 ARAC position. The actions are 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:
April 2026	July 2026	
Overall overdue Audit Wales open Inspection Recommendation Actions by Action priority as at 27/04/2026 Medium (1), 2%  High (49), 98% ■ High (49) ■ Medium (1) ■ Low (0)	Overall overdue Audit Wales open Inspection Recommendation Actions by Action priority as at 13/07/2026 Medium (1), 2%  High (51), 98% ■ High (51) ■ Medium (1) ■ Low (0)	Audit Wales/2021/144 - Audit Wales Quality Governance Follow Up Review 1 open action overdue by 1746 days from the original due date. Audit Wales/2022/12 - Transformational Leadership Programme Board – Baseline Governance Review 1 open action overdue by 1200 days from the original due date. Audit Wales/2023/18 Structured Assessment 2022 – CTMUHB 2022_February 2023 1 open action overdue by 1109 days from the original due date. Audit Wales/2021/144 - No updates have been provided for several reporting periods; therefore, this will continue to be carried forward for further Directorate discussion. Audit Wales/2022/12- Discussions remain ongoing with Audit Wales in relation to closure. Audit Wales/2023/18- Discussions remain ongoing with Audit Wales in relation to closure.
Narrative Commentary – During this reporting period, discussions have taken place with Directorate and Audit colleagues to re-evaluate a number of outstanding actions. Work is ongoing to update, evidence and close historic audit recommendation actions.		

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 areas of focus within the "Overdue Audit Recommendations Tracker" with an increased focus on those actions with a Limited Assurance rating. The 'Overdue Audit Recommendations Action' is included at *Appendix 1*. If members wish to view the full tracker, this is made available to all members for scrutiny in the supplementary folder available in Admincontrol.
- 2.2 As AMaT is a live system, the data presented within this report was captured and analysed as at 13th July 2026.
- 2.3 The Dashboard at the beginning of this report has been designed to evidence any progress and to highlight areas that require an increased focus. This written report adds narrative to the graph data to add context to the data which is being presented. All reports are presented by the **original due date**. Revised due dates are noted within the narrative of the Audit Recommendations Tracker.
- 2.4 *Graph 1* shows a direct comparison on the Health Board's position between reporting periods in relation to overdue, Limited Assurance Internal Audit Reports. The graphs evidence a slight increase in overdue actions during this reporting period. However, it should be noted that Directorates continue to make sustained efforts to provide updates and close overdue actions, with an increased focus on addressing highest priority areas.
- 2.5 *Graph 3* in both performance dashboards focuses on audits requiring further attention due to the number of days actions have exceeded their original due date. The areas of focus highlighted within both dashboards identify audits where actions have remained overdue for the longest periods of time based on their original implementation date. There remains an increased focus to complete and close historic overdue actions. This highlighted focus is the first step in triangulating the data and raising awareness of actions that may present a higher level of risk to the organisation.

- 2.6 As demonstrated in the table **Overdue Limited Assurance Actions – Breakdown by Executive Portfolio**, there has been a marginal increase in the number of overdue Limited Assurance Actions.
- 2.7 The Quality Assurance and Compliance Team continues to implement focused and individualised Audit Performance Meetings with Business Managers and wider colleagues. Engagement and focus on updating audit recommendation actions and progressing those actions to closure, have been sustained during this reporting period.
- 2.8 **40** audit recommendations actions are proposed for closure this reporting period. **51** closures were recorded at the last reporting period, April 2026. The current format and targeted approach of the Audit Performance Meetings is proving effective. The team will continue to promote this level of engagement through the prescribed meetings to sustain momentum and encourage independent review and updating of AMaT in between meetings.
- 2.9 Progress on this work will continue to be reported to this Committee following appropriate Executive approval at Executive Leadership Group prior to closure on the system. Across both Audit Wales and Internal Audit, **40** actions are proposed for **closure** with **5 audits fully completed**.
- 2.10 The current position on the status of audit recommendation actions which are overdue can be viewed in **Appendix 1**, with the most recent updates highlighted in red.

3. Tracker Updates

3.1 Internal Audit (NWSSP)

Since the last meeting, the following changes and updates are noted:

- **10 New** Internal Audit reviews have been added to the Audit Recommendations Tracker incorporating **33** new actions.
- **5** Internal Audit Reviews have been completed, with **29** audit recommendation actions 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 incorporating **19** new actions.
- **0** External Audit reviews have been completed with **11** audit recommendations actions proposed for **CLOSURE**.



- 3.3 **Health Inspectorate Wales (HIW)** – Reports for HIW are presented at the Quality, Safety and Experience Committee. For the reporting period ending 3rd June 2026, and as at 11th May 2026, **1** new Improvement Plan had been received incorporating **32** new actions. **33** actions were marked for closure.

4. Key Risks / Matters for Escalation

- 4.1 The Quality, Assurance and Compliance Team will continue to work closely with Directorates 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. Directorates will be encouraged to provide updates to the original audit recommendation rather than updating from the previous tracker update.
- 4.2 The Audit Recommendations Tracker will continue to be updated with a targeted focus on actions that have received Limited Assurance and remain overdue against their original due date. This report, together with the tracker will continue to evolve to support a transparent and assurance focused account of the Health Board's position.

5. Assessment

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd (Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg) 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)	Choose an item.
	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	Leadership
	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> 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 Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Not required for this report Summary of impact: Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Not required for this report Summary of impact:	If no, please select a reason below. Does not impact people Named Executive/Board member sign off for no EWLIA completion:
Canlyniad Asesiad Effaith Ansawdd <i>(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)</i> Quality Impact Assessment Outcome <i>(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)</i>	Not applicable for this report	
Cyfreithiol / Legal	Yes (Include further detail below) There may be an adverse effect on the organisation if CTMUHB does not fully implement learning and improvements identified as part of Audit arrangements.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report	
Effaith Adnoddau <i>(Pobl / Ariannol) / Resource Impact</i> <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report	



Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Executive Leadership Group	20 th July 2026	Management sign off

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

Cwm Taf Morgannwg University Health Board

Audit, Risk & Assurance Committee Internal Audit Progress Report

August 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 28 July 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 for the Health Board, along with details regarding the delivery of the plan and any required updates.

2 Report summary

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

Table 1: Summary of position 2026/27 (Core and Capital projects)

Status	Number	%	Note
Final	2	6%	-
Draft	-	-	-
Work in progress	6	18%	-
Planning /Planned	9	27%	-
Not started	16	49%	-
Defer	-	-	-
Total	33	100	-

- 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
PCH – Section 3 final account (2025/26)	-	2	2	Substantial
Individually commissioned packages of care (2025/26)	1	7	8	Reasonable
Risk management (2025/26)	-	4	4	Reasonable
Outpatient booking process	-	5	5	Reasonable

Assignments	High	Medium	Total	Assurance rating
(2025/26)				
PCH – Assessment of community benefits	2	1	3	Reasonable
Welsh Risk Pool	1	5	6	Reasonable
Medical job planning (re-audit) (2025/26)	4	3	7	Limited
Medical sickness records (2025/26)	-	-	-	Advisory

3 Summary of finalised substantial and reasonable 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.

Individually commissioned packages of care (IPCC) (2025/26)

IPCC can be funded through a number of sources including Continuing Health Care (CHC), Funded Nursing Care (FNC) and Section 117.

Within the Health Board, packages of care are delivered for both adults and children and include mental health and learning disability patients. Our review focussed on adult cases. A team within the Mental Health & Learning Disabilities care group manage the applications and assessments for those with a mental health need. All other applications and assessments are managed by the Primary & Community care group team.

We issued a reasonable assurance opinion. While governance, record management and oversight arrangements were generally effective, several improvements are required, including updating policies, strengthening financial controls, improving review processes, and addressing invoice management and access controls.

We identified one high priority action that relates to panel governance and decision-making arrangements. We saw instances where the Mental Health & Learning Disabilities commissioning panels were not quorate, and key members were absent. We also note that the adult CHC panel lacked formal terms of reference and defined quorum requirements.

Risk management (2025/26)

We issued a reasonable assurance opinion. The Health Board has an established risk management framework, policies and training arrangements. We identified four medium priority actions relating to improving monitoring training uptake, standardising care group and corporate risk registers, ensuring escalation of

significant risks, and strengthening risk reporting by corporate directorates to support effective oversight and governance.

Outpatient booking process (2025/26)

This review has considered the Health Board's processes in the context of the Welsh Government's April 2025 Referral to Treatment (RTT) guidelines, which set out principles for timely, equitable, and transparent management of patient pathways. The guidelines emphasise that patients should wait the shortest possible time for treatment and follow-up and that health boards must maintain robust booking and communication processes. We issued a reasonable assurance opinion and identified five medium priority actions. Controls and governance were generally effective, with booking practices largely compliant with guidance. Improvements are needed to update procedures, strengthen patient administration system data quality, formally close patient pathways, capture lessons learned from insourcing, and standardise booking responsibilities.

Welsh Risk Pool

Compensation claims can take several years from receipt of the claim to settlement and can involve many payments and repayments, increasing the chance of mistakes occurring. Welsh Risk Pool Services (WRPS) require claims for reimbursement and repayment to be made within specific timescales.

In 2025/26 there were a total of 106 reimbursable closed clinical negligence, personal injury and redress cases. We tested a sample of cases from across the three claim types to provide assurance that the claims were submitted to WRPS within the specified timeframes, and to verify the accuracy of the data.

We issued a reasonable assurance opinion. We agreed five medium priority actions and one high priority action, which related to the need to introduce a learning from events quality checklist to help ensure that complete and timely information is provided for learning from event submissions.

Prince Charles Hospital refurbishment (PCH) – Section 3 final account (2025/26)

The purpose of this audit was to provide independent assurance over the final account for section 3 of the PCH redevelopment programme contracted under the NEC 3 Engineering and Construction Contract (ECC) option C contract. The review sought to assess whether costs had been accurately reported and classified, that the pain/gain share mechanism had been correctly applied, and to verify compliance with contractual terms and governance framework. We issued a substantial assurance opinion, with two medium priority findings.

PCH – Assessment of community benefits

This review considered the social value delivered through the PCH refurbishment programme and assessed the arrangements in place to monitor, evidence and report community benefit outcomes.

The refurbishment programme has created a significant skills and employment legacy, supporting vocational placements, practical learning opportunities,

employability activities and engagement with local learners. We issued a reasonable assurance opinion, with two high priority findings: one relating to standardisation of forms to evidence community benefits; and one relating to introducing a records management system to evidence reporting against delivery targets, and one medium priority finding.

4 Other activity

Meetings

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

Appendix A – Programme of work**Table 3: Core programme of work 2025/26**

Plan Ref.	Review	Rating	Review period	AC	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
1	Individually commissioned packages of care	Reasonable	Q1	~~Nov~~ August	Final	Y	N	Draft issued 27.03.26 Final issued 01.06.26
7	Risk management	Reasonable	Q3	~~Feb~~ August	Final	Y	N	Draft issued 18.03.26, revised draft 08.05.26 Final issued 18.06.26
2	Outpatient booking process	Reasonable	Q3	~~May~~ August	Final	Y	Y	Draft issued 07.05.26 Final issued 28.05.26
23	Medical job planning - re-audit	Limited	Q4	~~May~~ August	Final	Y	Y	Draft issued 03.06.26 Final issued 19.06.26
5	Medical sickness records (Advisory)	N/A	Q2	~~Nov~~ May	Final	Y	N	Revised draft issued 11.06.26 Final issued 27.07.26
32	WLI - re-audit	Reasonable	Q3	~~May~~ August	Draft	Y	-	Draft issued 05.06.26
3 (PCH)	Deep dive into the final account	Substantial	Q4	~~May~~	Final	Y	N	Draft issued 08.06.26

Plan Ref.	Review	Rating	Review period	AC	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
				August				Final issued 27.07.26
4 (PCH)	Annual assessment	Substantial	Q4	May August	Draft	Y	-	Draft issued 08.06.26

Table 4: Programme of work 2026/27

Plan Ref.	Review	Rating	Review period	AC	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
27	Welsh risk pool – 2025/26 data	Reasonable	Q1	August	Final	Y	Y	Draft issued 10.07.26 Final issued 27.07.26
2 (PCH)	PCH - Assessment of community benefits	Reasonable	Q1	August	Final	Y	Y	Draft report issued 13.07.26 Final issued 27.07.26
25	Ward audits	-	Q1	August	WIP	-	-	Fieldwork complete, fieldwork being reviewed.
26	Interventions not normally used (INNU) re-audit	-	Q1	August	WIP	-	-	Delays in receiving data required to undertake audit.
1	Neurodevelopment services - Children	-	Q1	November	WIP	-	-	Brief agreed 06.07.26. Fieldwork commenced 13.07.26
25	Neurodevelopment services - Adults	-	Q1	November	WIP	-	-	Brief agreed 06.07.26. Fieldwork commenced 13.07.26 Will report adults and children separately as systems are different.
11	Software development	-	Q1	November	WIP	-	-	Brief agreed 21.05.26. Fieldwork commenced 06.07.26

18	Gastro-Intestinal demand management re-audit	-	Q1	November	WIP	-	-	Fieldwork commenced 21.07.26
16	Nurse staff rostering	-	Q1	November	Planned	-	-	Brief agreed 01.07.26. Fieldwork to commence 30.07.26 (Auditor on leave)
19	Patient pathways re-audit	-	Q1	November	Planned	-	-	Brief issued 24.06.26. Agreed 20.07.26
21	End of life care management re-audit	-	Q2	November	Planned	-	-	Brief agreed 07.07.26
20	Follow up – Digital benefits realisation	-	Q2	February	Planned	-	-	Final brief issued 08.07.26
12	Electronic Prescribing Medicines Administration	-	Q2	February	Planning	-	-	Final brief issued 09.07.26
2	Urgent and Acute medicine - application of standard model	-	Q2	November	Planning	-	-	Planned meeting 23.06.26 cancelled by CTM. Rescheduled for 27.07.26
3	Trauma pathway	-	Q2	November	Planning	-	-	Planned meeting 23.06.26 cancelled by CTM. Rescheduled for 27.07.26
8	Finance – Budgetary control and governance	-	Q2	November	Planning	-	-	-

9	Staff overpayments	-	Q2	February	Planning	-	-	-
14	Harm free governance	-	Q2	February	-	-	-	Planning to be started.

Medical Job Planning (re-audit)

Final Internal Audit Report

2025/26

Cwm Taf Morgannwg University Health Board



Limited Assurance

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Review Reference

CTM-2526-23

Fieldwork

February 2026 – May 2026

Executive Sign Off

June 2026

Audit Committee

August 2026

Executive Lead

Dom Hurford, Medical Director

Audit team

Paul Dalton, Head of Internal Audit

Emma Samways, Deputy Head of Internal Audit



Executive Summary

Purpose

A re-audit of our medical job planning review was completed in line with the 2025/26 Internal Audit Plan for Cwm Taf Morgannwg University Health Board (the 'Health Board'). Our original medical job planning report was issued in February 2025. We issued a 'limited' assurance opinion and identified three high priority matters arising.

A job plan is a professional and contractual obligation for consultants and employers, and sets out the duties, responsibilities, accountabilities and outcomes of the consultant, and the support and resources provided by the employer for the coming year. The Health Board uses the Allocate system to capture job plans, where a record of the work that a consultant will undertake for the Health Board is split by Direct Clinical Care (DCC), Supporting Professional Activities (SPA) and other activities. Welsh Government has set health boards the target that over 90% of consultants should have an agreed, up-to-date job plan in place. To aid achievement of this target by the end of 2025/26, the Health Board set its care groups quarterly job planning completion targets, with the quarter 2 target set at 50% and quarter 3 at 75%. Data on care group completion rates is reported monthly at the medical workforce productivity board. Whilst three of the five care groups met the quarter 2 target, only one achieved the quarter 3 target, with rates varying between 28% and 80% completion. Quarter 4 data was not presented to the productivity board.

Our review revisited the scope of our original audit to provide assurance on the systems and controls in place for medical job planning within the Health Board. None of the four high priority findings raised in our previous report have yet been addressed.

Overview

We have concluded limited assurance on this area. The key findings requiring management attention are:

- Job planning guidance contains no information in relation to new starters or SPA requirements.
- Most of the job plans that we reviewed contained some personal outcomes but no service outcomes.
- The WG compliance target has not been achieved. There are low levels of timely job plan completion, and some newer consultants and SAS doctors are missing from the Allocate system.
- Some SAS doctors and consultants have never had a signed job plan.
- The presumed sign off process is not being fully used, with many job plans held at an 'in discussion' stage for lengthy periods of time.
- Some job plan sessions within the e-allocate system do not align with the session payments made.
- Job planning compliance reporting is limited and inconsistent.

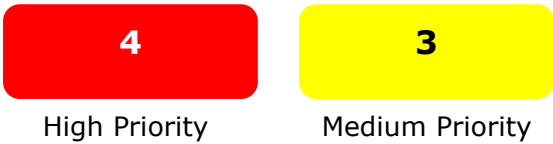
Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

- Superseded historic guidance documents should be removed from the intranet.
- The E-job planning user guide should be reviewed to ensure it remains current in light of updates to other guidance, such as the Health Board's recommendation for consultants to be offered two SPA sessions per standard ten session week.
- Where a consultant's SPA time is less than 10% of their total job plan, this should be reviewed to ensure it is appropriate.

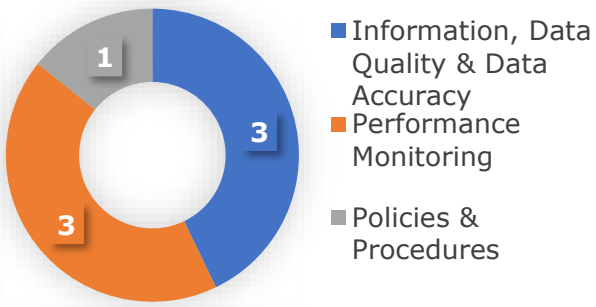
Scope & Assurance Summary

Objectives	The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.	Related Findings	Assurance
1	There are relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance	1	Reasonable
2	Job plans accurately reflect both the individual and organisation activity requirements and have links to the Health Board's objectives.	2	Limited
3	Job plans are completed in a timely manner to allow departments to manage their demand and forward plan	3,4,5	Limited
4	Completed job plans reconcile to system records and session payments are correct	6	Reasonable
5	The completion rates of job plans are monitored and regularly reported to an appropriate forum, with further escalation if there is low compliance	7	Reasonable

Management Actions



Themes



Risk Types

Quality or Safety Issues
Legal & Regulatory Non-Compliance

Findings & Agreed Action Plan

Objective 1: There are relevant and up to date procedures in place that are available to staff and align to the All Wales guidance.

Reasonable

Overview / Summary of Observations

There is detailed job planning guidance in place that is available to staff on the Health Board’s intranet. This includes:

- All-Wales NHS job planning guidance published by Welsh Government (WG) in 2014.
- CTM ‘Job Planning Guidance for Consultants and SAS Doctors’ approved in September 2024 and contains references to the all-Wales guidance.
- ‘Core Supporting Professional Activities (SPA) Guidance for CTMUHB consultants’ dated January 2023.
- A job planning checklist dated November 2024
- E-job planning user guide dated 2022.

The e-job planning user guide, was created by the workforce team in 2022, and is a detailed reference guide to the administrative aspects of job planning and the use of the Allocate e-job planning system. The guide has not been reviewed following the update of other job planning guidance documents.

In July 2024 the Health Board approved additional guidance for consultants and department managers in relation to core Supporting Professional Activities. The paper was written following agreement between the Local Negotiating Committee (LNC) and the Health Board to provide clarity and consistency on SPA sessions, including guidance on the expected number of SPA sessions per week. From our review of the various documents available, we found no reference to the details contained in this paper. We also note that the job planning guide does not specify a timescale for the completion of a job plan for new starters.

An older version of the CTM job planning guidance from 2017, is still available to staff on the intranet.

There is no requirement for managers or consultants / SAS doctors to undertaken job planning training, although training materials have been developed and informal training sessions are run on request. However, our fieldwork and the Health Board’s compliance rate may indicate that there is limited awareness of the importance of completing timely job plans.

Key Findings		Risk & Impact	Agreed Management Action
1	Guidance documents and staff awareness Guidance documents are available including the ‘Job Planning Guidance for Consultants and SAS Doctors’. We note that this document makes no reference to the timeframe for completing a job plan for new staff, nor is there any reference to the DCC/SPA split. We acknowledge that the 8:2 DCC/SPA is a guide and not a requirement, however, the approval of this ratio by	Insufficient staff awareness result in incomplete, inaccurate, or delayed job plans.	Agreed Actions: • Revise guidance to include the 8:2 DCC/SPA guide. • Remove outdated intranet document. • Standardise CTM JD advert. • Issue communications for CDs and Managers. • Issue training sessions for CDs and Managers.

the LNC and Health Board in July 2024 sets out the desire to have more plans in line with this split. There is no requirement for formal managers or consultants / SAS doctors to undertake training on the job planning process, but training sessions are run if requested. Our fieldwork and the Health Board’s overall compliance rate may indicate that awareness in relation to the importance of undertaking timely job plan reviews that include relevant objectives and are signed off in a timely manner, is not fully understood.		• Issue briefing guidance for medical team.
		Expected Evidence of Implementation: • Approved revised guidance. • Intranet update, communication pack, attendance records from awareness sessions.
	Medium Priority	Officer: AMD Medical Workforce Target Implementation Date: 30 July 2026
Theme: Policies & Procedures	Control Design	

Objective 2: Job plans accurately reflect both the individual and organisation activity requirements and have links to the Health Board’s objectives.		Limited															
Overview / Summary of Observations																	
The Health Board's job planning guidance requires consultants and SAS doctors to record personal outcomes, service outcomes, and Health Board outcomes for the year ahead. Our testing of a sample of signed job plans confirmed that while all had standard Health Board outcomes, not all contained information on personal outcomes, and none had information on service outcomes. Whilst the Health Board outcomes recorded were largely identical across job plans, they described activity areas rather than measurable objectives. All of the job plans in our sample contained timetabled activity covering the required number of sessions, including Direct Clinical Care (DCC), Supporting Professional Activities (SPA), and other agreed duties. SPA guidance approved by the Health Board recommends that consultants are offered two SPA sessions per standard ten session week: an 8:2 DCC / SPA ratio. Testing of a sample of 40 job plans identified three that were not signed off. Of the remaining 37 we identified:																	
<table border="1"> <thead> <tr> <th>Proportion of DCC time in job plan</th><th>Number of job plans</th><th>Percentage</th></tr> </thead> <tbody> <tr> <td>More than 80% DCC time</td><td>14*</td><td>38%</td></tr> <tr> <td>Between 70% and 80% DCC time</td><td>15</td><td>41%</td></tr> <tr> <td>Less than 70% DCC time</td><td>8</td><td>21%</td></tr> <tr> <td colspan="3">*6/14 the SPA time was less than 10%</td></tr> </tbody> </table>			Proportion of DCC time in job plan	Number of job plans	Percentage	More than 80% DCC time	14*	38%	Between 70% and 80% DCC time	15	41%	Less than 70% DCC time	8	21%	*6/14 the SPA time was less than 10%		
Proportion of DCC time in job plan	Number of job plans	Percentage															
More than 80% DCC time	14*	38%															
Between 70% and 80% DCC time	15	41%															
Less than 70% DCC time	8	21%															
*6/14 the SPA time was less than 10%																	
Our testing identified that less than 40% of the job plans sampled met the recommended 8:2 ratio. We acknowledge that the 8:2 ratio is a guide, and managers can use their discretion to adjust the allocation if the individual has additional responsibilities. This was seen to be the case in the majority of cases we sampled where the number of weekly DCC sessions was less than 80%. As such, no finding has been raised in relation to this matter. Conversely, we note six job plans that had less than 10% of their time allocated to SPA activity.																	
Key Findings	Risk & Impact	Agreed Management Action															
2 Lack of personal & service outcomes (re-raised) The e-job planning system records enables personal outcomes to be linked to service outcomes. Our review of a sample of 40 job plans identified: - One that was not populated. - None had service outcomes recorded. 30 did not record personal outcomes. Whilst all plans included Health Board outcomes, that were mostly identical across the plans, these were descriptive in nature, rather than measurable. The outcomes did not meet SMART criteria or alignment to wider organisational objectives.	SPA time is not used in a way that achieves Health Board and Service outcomes. Personal outcomes cannot be monitored and do not contribute to wider Health Board / Service outcomes.	Agreed Actions: - Introduce a standard outcomes framework and exemplar wording; require review of all new and renewed job plans for personal and service outcomes. - Issue communications for CDs and Managers. - Issue training sessions for CDs and Managers. - Issue briefing guidance for medical team. - Explore mandatory objective fields within Allocate. - Undertake dip-sample quality assurance. Expected Evidence of Implementation:															

			• Template / guidance for SMART objectives, sample audit results, Allocate configuration review, evidence of linked personal and service outcomes on completed plans.
	Theme: Performance Monitoring	High Priority Control Operation	Officer: AMD Medical Workforce and support from Medical Workforce Team, Allocate System Lead Revised Target Implementation Date: 31 October 2026

Overview / Summary of Observations

The Health Board’s job planning guidance states that job planning is an annual process and that the completion of a job plan is a contractual requirement for consultants and SAS doctors. Our analysis of 740 job plans on the e-Allocate system identified that, while some job plans have been reviewed annually, the WG target of 90% of job plans to be reviewed has not been achieved.

Neither national nor local guidance specifies a defined timescale for the completion of an initial job plan for newly appointed staff. Our testing identified that new starters are not always set up on the Allocate system in a timely manner.

Health Board guidance requires job plans to be signed off as soon as they are mutually agreed and sets out a ‘presumed sign-off/ lock down’ process. This process involves a series of reminder emails issued over a 10-week period where a consultant has verbally agreed a job plan but not completed sign-off in the system, after which the job plan is deemed approved. The lock down process is undertaken manually by the Medical and Dental e-systems manager, however our testing has identified that this process is not always undertaken.

During our fieldwork we saw instances of consultants and SAS doctors who appear to have never had a signed off job plan, some of whom have been in post for several years. We also note a number of consultants and SAS doctors who appear to have never logged into the e-Allocate system, further limiting assurance over timely review and approval of job plans.

Key Findings		Risk & Impact	Agreed Management Action
3	Creation and annual review of job plans (re-raised) To meet the 90% WG target, the Health Board set quarterly stepped targets and aimed to achieve 75% compliance by Q3 of 2025/26. We reviewed a report from the Allocate system for February 2026. It listed 740 Consultants / SAS Doctors and the status of their job plans. Our analysis identified: • 531 (72%) of job plans were started in the last year, however not all were signed off. • 484 (65%) of job plans were signed off / locked down, however not all were from the last year. However, WG requirement means job plans should be up to date (from the last year) and agreed (signed off). As such, only 320 (43%) meet these criteria. We obtained a report for the period November and December 2025 that showed 16 new consultants and SAS doctors commenced employment during these months. We identified that by mid-May 2026, 7/16, had not been added to the Allocate system and therefore had no job plan.	Lack of up-to-date job plans means the Health Board cannot properly identify the capacity it has.	Agreed Actions: • Implement a formal onboarding process to add all new starters to Allocate promptly. • Define expected completion timelines for first job plan. • Issue executive communication reinforcing contractual requirements. • provide directorate-level compliance data monthly and maintain active monitoring through MWPP. Expected Evidence of Implementation: • Documented onboarding SOP. • Allocate setup log for new starters. • Monthly compliance reports. • Executive communications, improved in-date signed-off job plan rates.

		High Priority	Officer: AMD Medical Workforce Team, and support from HR Recruitment, Care Groups
	Theme: Information, Data Quality & Data Accuracy	Control Operation	Revised Target Implementation Date: 31 October 2026
4	Never had job plans (re-raised) Our analysis identified 144/740 (19.5%) cases where no job plan 'last sign off date' has been recorded in Allocate. This means those individuals have never had a fully signed off job plan as agreed by both the consultant / SAS doctor and their manager. We note that 22/144 of these plans have been 'locked down', using the assumed sign off process. However, the majority are 'in discussion', with some having been at that stage since 2018.	Non-adherence to organisational policies and contractual requirements for annual job planning and sign-off. Inappropriate payments to staff made.	Agreed Actions: • Issue named exception lists to each care group. • Require recovery plans for all overdue cases. • Validate and record accurate sign-off dates in Allocate. • Escalate unresolved cases through directorate and executive performance routes.
		High Priority	Officer: AMD medical workforce with support from Medical Workforce Team
	Theme: Information, Data Quality & Data Accuracy	Control Operation	Revised Target Implementation Date: 31 October 2026
5	Presumed sign-off procedure (re-raised) The assumed sign off can take place approximately ten weeks after management sign off, if the consultant / SAS doctor has failed, following a series of reminders, to log into the Allocate system and sign off their plan. We reviewed the number of job plans that are classed as 'in-discussion' or awaiting sign off, to determine if the presumed sign off process is being correctly applied. At the time of our fieldwork, there were 256/740 (36%) job plans that had not been signed off or locked down. Our analysis identified that of the 256: • 152 were still 'in discussion', however, 69 had been in this stage since between 2016 and 2024, so presumed sign off cannot take place. • A further 38 were 'awaiting manager sign off', so the assumed sign off cannot take place.	Resources are not used effectively and efficiently to ensure the delivery of high-quality patient care.	Agreed Actions: • Review current presumed sign-off workflow. • Clarify trigger points and responsibilities. • Consider reducing elapsed time from 4 weeks and implement routine reporting on plans stalled "in discussion", awaiting manager sign-off, or awaiting consultant sign-off.

53 were awaiting sign off by the consultant, though only approximately 19 were 'older' and should have had the assumed sign off process applied. As part of our analysis, we also identified: 55/740 job plan owners (7.43%) have never logged into the Allocate system, an improvement from 64/685 (9.34%) in November 2024, despite an increase in consultants and SAS doctors. - All 17 community dentists (SAS doctors) had job plans under discussion, with no plans signed, and 12 of these individuals had never logged into the system. - Where job plans had been fully signed off, 33 job plans showed delays of between 66 and 574 days between manager and consultant sign-off. If the presumed consent sign off had been applied, many of these plans would have been signed off more timely.	High Priority	
Theme: Information, Data Quality & Data Accuracy		Expected Evidence of Implementation: Revised process note, evidence of automated or manual tracking, exception reports showing reduction in aged cases and delayed sign-offs. Officer: Medical Workforce Team / Allocate System Lead with support from: Care Groups, MWPP Delivery Group Revised Target Implementation Date: 30 November 2026

Overview / Summary of Observations

When a job plan is signed off in the Allocate system by the consultant / SAS doctor and their manager, an automated e-mail notification is sent to a senior HR manager within the medical workforce team. Where there is a change to the number of sessions, the manager notifies the medical recruitment team who adjust the sessions payable in ESR and the effective date of the change. The consultant / SAS doctor is copied into the notification.

For a sample of consultants / SAS doctors, we looked at the total number of job planning sessions recorded in the Allocate system on their job plan and payroll data showing the number of sessions paid per week. The reconciliation testing identified some inconsistencies between job plans and payments and missing job plans.

Key Findings		Risk & Impact	Agreed Management Action
6	Inaccurate alignment between job plans and paid sessions We reviewed a sample of 40 consultant / SAS doctor job plans and compared the total number of agreed sessions to payroll data. We acknowledge that some rounding tolerances are accepted when comparing agreed sessions to paid sessions and this has been considered in our testing. We identified: 3/40 had no signed off job plan in place. All are 'in discussion', with start dates more than one year ago. Two of which, are paid above the standard 10 sessions per week, but without an agreed job plan in place, it is unclear how this has been approved. 1/37 there is an agreed job plan in place, but the individual is paid for an additional 0.5 sessions per week above the agreed job plan. Periodic reconciliations between agreed sessions within ESR and paid sessions recorded in payroll data are not undertaken.	Overpayment or underpayment of consultants and SAS doctors.	Agreed Actions: - Complete a targeted review of discrepancies identified by audit - Assign responsibility for periodic reconciliation between Allocate, ESR and payroll - Investigate and correct over- or under-payments - Maintain management sign-off of exception reports.
			Expected Evidence of Implementation: Reconciliation logs, corrected payroll records where needed, exception reports and management review sign-off.
		Medium Priority	Officer: Medical Workforce / Payroll / ESR Leads with support from Care Group Managers
	Theme: Performance Monitoring	Control Operation	Target Implementation Date: 31 March 2027

Overview / Summary of Observations

The Medical Workforce Productivity Programme (MWPP) Board and Delivery Group, both meet monthly. Data by care group on a range of measures, including job plan compliance rates, should be presented at each meeting. Our review of the information presented at the MWPP Board between July 2025 and February 2026 identified that more recently some meetings did not take place, and where they did happen it appears that old data was presented.

The Health Board had job planning compliance targets of 50% compliance by end of quarter two 2025/26, 75% by the end of quarter three, and 90% by the end of quarter four. We identified that 3/5 care groups achieved the 50% target for quarter two, but only one care group met the target for quarter three. No quarter four data has been presented. While a RAG rating is applied to the compliance data presented at the MWPP Board this is not accompanied by an explanation of the ratings. We also saw inconsistencies in the data.

We have been unable to determine any other Health Board forums where job planning compliance data is presented. As such, we are unclear on what the Health Board’s overall compliance rate is. We understand that in the future, this data will be presented to the MWPP Board.

Key Findings		Risk & Impact	Agreed Management Action
7	Job planning compliance monitoring and reporting We identified limitations in the arrangements for monitoring and reporting job planning compliance data. We understand that limitations with the reporting functionality of the Allocate system impact the ease of reporting. Care group compliance ratings are reported to the MWPB Board, though towards the latter end of 2025/26, data from December 2025 was still being presented. RAG ratings are included against each care group’s compliance rate. We were unable to confirm if the RAG rating is based on achievement of the quarterly target or based on month-on-month improvement/decline. We identified that the ratings were not applied in a consistent or standardised manner. For example, October’s data shows Diagnostics care group as green with a compliance rate of 64%, yet Children & Families is amber with a higher compliance rate of 69%. The terms of reference for the MWPP Delivery Group set out a target from quarter one of 2025/26 to enhance reporting	Inadequate and inconsistent reporting. Limited board and management oversight of job planning compliance.	Agreed Actions: • Define and standardise RAG thresholds. • Ensure current data is presented at every MWPP meeting. • Introduce speciality-level reporting. • Identify an organisation-wide forum for formal oversight. • Review reporting functionality within Allocate and any supplementary reporting tools. Expected Evidence of Implementation:

including the introduction of reporting by speciality within care groups. At the time of our review, this action remained open. Furthermore, we have been unable to identify where, at an organisational wide level, job planning compliance rates are reported or monitored.		Approved RAG definitions, refreshed reporting templates, speciality-level reports, evidence of organisation-wide reporting and monitoring.
	Medium Priority	Officer: MWPP Board / Medical Workforce Team with support from Business Intelligence, Allocate System Lead
Theme: Performance Monitoring	Control Operation	Target Implementation Date: 30 Nov 2026

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

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

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Medical Sickness Records

Final Advisory Report

2025/26

Cwm Taff Morgannwg University Health Board



Advisory

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Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

CTM-2526-05

November 2025 - April 2026

July 2026

August 2026

Hywel Daniel, Executive Director for People

Paul Dalton, Head of Internal Audit

Emma Samways, Deputy Head of Internal Audit



Executive Summary

Purpose

Our advisory review of medical workforce sickness recording was undertaken as part of the 2025/26 Internal Audit Plan for Cwm Taf Morgannwg University Health Board. Sickness absence continues to present a significant operational and financial challenge, affecting service delivery, staff wellbeing and organisational performance. Consistent monitoring and accurate recording are essential to achieving Welsh Government expectations and ensuring effective application of the All Wales Managing Attendance at Work (MAAW) policy.

The Health Board has set a target to reduce its rolling 12-month sickness rate by 1% (July 2025 baseline 6.98%) to achieve a rate of 5.98% by October 2026. As of April 2026, the 12-month rolling sickness rate stood at 7.50%, while medical workforce in month sickness was reported at 3.06%. Given the disparity, and evidence of inconsistent recording practices, it is unclear whether medical workforce absence is being fully and accurately captured.

The Health Board's People Plan 2025–2030, approved in May 2025, identifies an inclusive and healthy environment as a key priority and has committed to supporting people through sickness, helping them to successfully stay well and return to work. Absence monitoring, including frequency, reasons and hotspot identification are utilised as key workforce metrics to support delivery of the plan. To strengthen this, the People Directorate has developed enhanced action plans aimed at improving understanding of sickness data, refining processes for capturing and monitoring absence, and supporting targeted improvement activity.

This advisory review supports the work of the People Directorate by examining the arrangements for recording sickness absence for medical and dental staff, including staff awareness of relevant processes.

Once the People Directorate's improvement initiatives have embedded, as part of our 2026/27 work, we plan to undertake a separate assurance audit. At that stage, we will consider the effectiveness of revised arrangements for capturing and managing medical and dental sickness absence in line with the MAAW policy.

Overview

We reviewed the effectiveness of sickness management arrangements for medical and dental staff, focusing on policy awareness, accuracy of sickness recording and the quality of monitoring and reporting. Our review highlighted variation in practice, fragmented system usage, and inconsistent policy application, all of which impact the completeness and reliability of sickness data. Our testing across six departments showed strong corporate-level reporting but inconsistent operational practice, variable adherence to policy and differing levels of understanding of roles and responsibilities. Furthermore, we noted that system fragmentation is affecting data quality, with departments relying on different platforms and processes and gaps in training contributing to inconsistent recording. Engagement with the review varied, and limited availability of information in some areas indicates cultural and behavioural barriers that influence how sickness is communicated and managed. These observations highlight opportunities to strengthen consistency, accuracy and managerial confidence in the management of medical sickness absence.

This is an advisory review to improve and add value to governance, risk management and control processes within the area under review. As such, we have not given an assurance opinion. In this report, where appropriate, we have made observations related to the objectives following the conclusion of our fieldwork, which management may choose to act upon. We plan to undertake an assurance review, in this area, as part of our 2026/27 programme of work. The following observations have been identified for management attention:

- Review and consolidate procedural documentation. Supporting documents for the Managing Attendance at Work Policy should be updated, consolidated and checked to ensure hyperlinks direct users to current versions.
- Strengthen training for managers. All staff responsible for managing medical sickness should complete policy and procedural training, with content tailored to the specific challenges of medical and dental staff.

- Undertake a system analysis. A full review of rota-management systems should determine functionality, benefits and limitations. The Health Board should then determine if systems are to be retained or retired, and develop ESR integrations where systems remain in use.
- Standardise absence communication. A consistent approach to notifying absence should be implemented, with medical staff trained to meet policy requirements.
- Improve timeliness of sickness recording. Staff responsible for system entry should be trained to ensure sickness is recorded 'as soon as practicable' in line with policy.
- Investigate Health Roster–ESR interface failures. Root causes should be identified and controls implemented to ensure data integrity between systems.
- Issue central sickness reports routinely. Reports should be distributed to all department managers with clear guidance on dissemination and use to support consistent management action.

Full details of matters arising are detailed within the Findings & Actions section of the report.

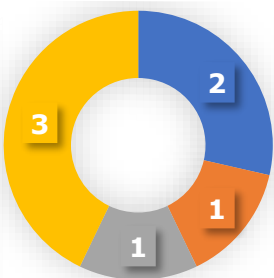
Scope & Assurance Summary

Objectives		Related Actions
1	Appropriate policies and procedures for managing sickness absence are in place, with training and guidance available for those managers who have a responsibility for managing sickness absence.	1, 2
2	Sickness absence is appropriately recorded on ESR or other systems that feed into ESR.	3, 4, 5, 6
3	Monitoring and reporting of sickness absence is undertaken at appropriate levels within the health board.	7

Management Actions



Themes



- Information, Data Quality & Data Accuracy
- Policies & Procedures
- Reporting
- Training & Development

Risk Types

Quality or Safety Issues

Findings & Actions

Objective 1: Appropriate policies and procedures for managing sickness absence are in place, with training and guidance available for those managers who have a responsibility for managing sickness absence.

Our review considered the adequacy, accessibility and practical application of sickness management policies and procedures relating specifically to medical staff, along with the consistency and robustness of associated recording processes. The All Wales Managing Attendance at Work (MAAW) policy is used and provides the primary framework for sickness management. This policy is current and in-date under the national review model.

The MAAW policy is available for staff through SharePoint and all of the staff that we spoke were able to access the policy. However, we note that several hyperlinks to supporting documents and guidance embedded in the policy are inactive and that any standalone supporting guides and procedures are dispersed and require consolidation. (**Observation 1**)

Training on the MAAW policy and supporting procedures is available for managers and was updated in early 2026. We met with seven staff and managers with day-to-day responsibility for recording and managing medical sickness during our fieldwork and all demonstrated an understanding of the policy, although only one had completed formal training. We note that the theoretical understanding of managers did not always appear to translate effectively to practical application, with several managers vocalising a lack of confidence when applying the standards and guidance from the policy specifically in relation to medical staff. (**Observation 2**)

Overall, our fieldwork identified that the practical application of the policy framework for medical staff appears inconsistent, supporting documentation requires rationalisation, and training uptake has been limited. Strengthening operational processes, improving document accessibility, and increasing targeted training would enhance the reliability of medical sickness management across the Health Board.

Observation 1: Procedural Documentation

The Health Board have included several hyperlinks within the MAAW policy to useful supporting procedures and guides, however, several of these link to inactive pages, for example the 'Well-being' SharePoint pages and 'Information for new and expectant mothers'. The People Directorate pages on SharePoint contain a considerable number of helpful resources for users in respect of managing attendance but, these documents are not easy to locate and some documents available on SharePoint are updated versions in comparison to the document linked in the MAAW policy, for example the 'Return to Work' form.

Action 1:

The Health Board should consider reviewing and consolidating all documents relating to the provision of support for managing attendance and update the hyperlinks in the MAAW policy to ensure these are valid and operational before relaunching the policy. All documents should be held in a single point within SharePoint.

Management response – Action 1

1. Seven links have been identified that require update. These will be updated following migration from legacy system to new SharePoint site during August 2026.
2. Documents supporting management of sickness contained within the "Managing Attendance at Work Toolkit" will be consolidated, and any web hyperlink navigating users to the consolidated document structure will be reviewed and amended where required to ensure these are operational.

Responsible Officer(s): Head of People Policy and Compliance / Head of Employee Engagement and Involvement

Target Completion Date: 31 August 2026

Observation 2: Managing Attendance at Work Training

Training rates for managing medics' sickness amongst the staff we met were low, with only one of the seven managers we interviewed during the review able to confirm they had completed formal training. Whilst this did not affect their theoretical knowledge of the policy several managers voiced a lack of confidence with practical application of the policy with respect to managing sickness for medics.

Our key observation was the inconsistency between documented procedure and actual practice in relation to its application for medical staff. Our onsite work identified significant variation across departments in how sickness is reported, recorded and managed. For example, multiple notification routes, unclear responsibilities for ESR updates, and gaps in out of hours communication; all challenges which are complex in nature for medical staff due to complicated matrix management arrangements and shift work patterns. These inconsistencies increase the risk of incomplete or inaccurate medical sickness records.

Action 2:

The Health Board should consider clearly defining roles and responsibilities for management of medical sickness including the appropriate staff roles for receiving and managing absence notification communications. Training should be developed for staff with responsibility for managing medic's sickness including department and service managers and administrative staff with involvement in the process. Training could include:

- Adding and updating system records of sickness absence.
- Prioritisation of sickness management in busy operational environments.

Management response – Action 2

1. A working group of key stakeholders will be established to lead development of bespoke training for managing absence of Medical and Dental staff.
2. Work will be undertaken to identify the number and scope of staff requiring input to the updated training.
3. Updated training will be piloted across a sample of staff representatives from a selection of Care Groups including operational, management and medical staff.
4. An impact assessment will be conducted to validate effectiveness of training and determine further amendments that may be required.

Responsible Officer(s): Head of People for Unscheduled Care and Facilities, Health and Wellbeing Action Plan Lead

Target Completion Date: 30 November 2026

Objective 2: Sickness absence is appropriately recorded on ESR or other systems that feed into ESR.

We reviewed how sickness absences for medical staff are communicated, recorded and transferred into ESR, focusing on the application of the MAAW policy, system usage and local processes. We found that sickness management is often de-prioritised over the management of day-to-day operational issues and that fragmented system architecture and inconsistent communication practices raise significant challenges for staff managing sickness.

Across the six departments we visited, we identified significant variation in the systems used to record sickness. Health Roster, Health Rota, CLW and ESR are all in use, sometimes with more than one system in use within the same service/department. Where ESR or Health Roster were the primary systems, sickness is more consistently recorded, visible and reportable. Conversely, where rota-management systems were primarily used (Health Rota/CLW), our testing identified that sickness often appears to be under-recorded (**Observation 3**). Through the course of our system usage discussions with directorate managers, we identified that one directorate management team were unable to confirm the system used, and only through discussion with administrative staff in that directorate were we able to confirm the system used.

When medical or dental staff are sick, the communication of absence was inconsistent and often informal across most of the departments we sampled. Medics frequently notify shift lead consultants, rota coordinators or service managers, but not necessarily all individuals who need to be informed or specifically, the individual responsible for entering sickness into the systems. The use of multiple communication channels – telephone, SMS, WhatsApp, Email, Teams and in-app communications where available, further increase the risk of missed absence notifications. (**Observation 4**)

Recording sickness in good time also appears to vary. While absences are usually recorded promptly in the system primarily used for rota management, if that system is not Health Roster, the transfer of the record to Health Roster and subsequently ESR can often be delayed with some services relying on month-end batch uploads to populate records. This practice contributes to unrecorded or unreconciled sickness, particularly in ED and Anaesthetics (**Observation 5**).

An analysis of 693 Health Roster sickness records by the People Directorate identified 91 records that had never interfaced with ESR. This was as result of use of temporary employee numbers. Our analysis of this data identified a further 45 records that had not interfaced with ESR, and our detailed onsite testing of 44 records found a further five that had not interfaced. These issues demonstrate a weakness in the completeness and reliability of sickness data. (**Observation 6**)

Observation 3: Systems Integration

Several systems are in use across different departments for capturing sickness. Our sample testing showed that Health Roster, Health Rota, CLW and ESR are used in different settings, often with multiple systems used within the same department. However, sickness is only visible to the People Directorate, and therefore reportable by the Health Board, if recorded in ESR or in Health Roster, (which interfaces sickness records to ESR monthly). All staff we met were aware that sickness required recording in one of these systems however, for services using CLW and Health Rota, staff are required to duplicate input and create sickness records in more than one system as there is no interface from these systems to ESR.

Action 3

The Health Board should consider undertaking a detailed systems review exercise to understand the functionality, advantages and disadvantages for both CLW and Health Rota, plus any other standalone systems in use. The objective of this review should be to conclude if systems will be retained or retired and, if a decision is made to retain, then to what extent recorded data (e.g. sickness data) can be interfaced to ESR.

Management response – Action 3

1. A detailed review of rostering systems currently in use within the Health Board will be initiated. The review will aim to set strategic direction for use of rostering systems for Medical and Dental staffing and will cover:
 - a) Functionality of the systems and specific service needs
 - b) Cost effectiveness
 - c) National programmes e.g. Resident Doctors All Wales mandate to use Health Roster
 - d) Interoperability
 - e) Efficiencies and productivity
 - f) Staff management processes for absences

Responsible Officer(s): Head of People Analytics / Medical and Dental e-Systems Manager

Target Completion Date: 31 December 2026

Observation 4: Absence Notification Process

Our sample testing across six services found it was common for medics to need to notify multiple people if they were absent. This was particularly prevalent across emergency and theatre services (Acute, ED, Anaesthetics and T&O) where medics are required to inform shift lead consultants and/or service managers so that appropriate cover could be arranged but also, rota coordinators or administration teams who have responsibility for recording absence. We noted that in these services where these matrix management structures were employed, communication processes were highly informal, and as a result, it was common for absences not to be communicated to everyone requiring the notification. In these environments, it appeared that medics prioritised informing shift lead consultants who would then be required to pass on the notification and the person responsible for recording the absence was often least likely to receive direct notification.

We also identified that several communication channels, such as telephone, WhatsApp and in-app notifications were used by medics to inform of a sickness absence. These channels were used inconsistently by individuals and many of the channels used did not align to the MAAW policy (telephone).

This lack of consistency resulted in significant challenges for those with responsibility for recording absence and increased the risk that notifications will be missed entirely resulting in unrecorded absence, as the focus tends to be around arranging shift cover.

Action 4

The Health Board should consider supporting development of processes that will work effectively in matrix management scenarios to ensure notification of absences are received by rota managers and coordinators. This may include a review of existing communication methods and re-educating consultants and medical staff regarding their obligation to report and inform using telephone as default, when unable to attend work due to sickness.

Management response – Action 4

1. An assessment of system functionality and technological options will be conducted to determine efficiencies that support matrix management structures, particularly in context of communicating notifications of absence.
2. The training and procedural work as outlined under Observation 2 will identify clear expectations in relation to reporting and recording sickness absence.

Responsible Officer(s): Head of People Analytics / Medical and Dental e-Systems Manager

Target Completion Date: 31 December 2026

Observation 5: Timeliness of Absence Recording

Absences were not always recorded in line with MAAW policy guidance, which requires recording 'as soon as practicable'. Instead, we found that absences were usually recorded in rota management systems (Health Rota, CLW) in compliance with the guidance but were often recorded in ESR and Health Roster much later. In some cases, service managers and rota coordinators have developed localised processes where sickness absence reports are run from rota management systems at the end of the month and these records are used to add sickness records to Health Roster/ESR in batches. This was particularly prevalent in ED and Anaesthetics, services that use Health Rota and CLW respectively. Our sample testing identified that these services had the highest level of unrecorded sickness absence in ESR.

In addition, this batch loading process further creates an issue in terms of timeliness of reporting. For example, if a staff member is sick toward the beginning of a calendar month but, the sickness record is not created in Health Roster until the beginning of the subsequent month, there would potentially be a 10-week delay in that record being visible and reportable from ESR which may result in the delay of any required intervention or management action.

Action 5

The Health Board should consider training service managers and rota coordinators on absence recording and this training should highlight the importance of recording absences as soon as practicable in ESR/Health Roster, including the risk of not doing so.

Management response – Action 5

1. Communications will be issued to all operational teams reinforcing the requirement for timely system recording of reported sickness absences.

Responsible Officer(s): Head of People for Unscheduled Care and Facilities, Health and Wellbeing Action Plan Lead

Target Completion Date: 31 August 2026

Observation 6: Systems Integration Failure

The People Directorate identified at the outset of this advisory audit that temporary employee numbers were used for new medics in Health Roster. While the temporary employee number is in use, if a period of sickness is recorded for that staff member, the interface between Health Roster and ESR fails due to an inability for the system to match to an employee number in ESR. This resulted in 91 of 693 sickness records in Health Roster not transferring to ESR between April to September 2025.

Our analysis of the same dataset identified an additional 45 sickness records in Health Roster that had not interfaced to ESR and that had not been identified during the People Directorate analysis which can be attributed to the same cause.

Furthermore, our detailed sample testing of 44 sickness records identified another five records in Health Roster that had not been migrated to ESR during the same period. The root cause for these five records cannot be identified.

Action 6

The Health Board should consider investigating the integration between Health Roster and ESR to:

- Validate Internal Audit's finding of the 45 additional records that had not migrated between the two systems to confirm this was also result of the issue noted with use of temporary employee numbers. Ensure all sickness records in Health Roster have now been properly captured in ESR.
- Determine root cause for why the five records identified during audit sample testing had not successfully migrated from Health Roster to ESR.

On establishing root causes for integration failures, the Health Board should then further consider implementing a monthly check to ensure that sickness data in ESR reconciles with data recorded in Health Roster.

Management response – Action 6

1. All Health Roster assignment numbers will be reviewed and any identified as invalid will be updated to ensure validity
2. All employee records in ESR identified to have missing sickness data resulting from an issue with validity of Health Roster assignment number will be updated to ensure sickness data is accurately recorded
3. The Standard Operating Procedure (SOP) and training around implementation of the procedure will be updated to ensure the practice of utilising temporary assignment numbers for non-Single Lead Employer (SLE) doctors is discontinued
4. A monthly Interface Validation Error Report will be produced and circulated, and a supporting process will be implemented to correct any records rejected by the interface
5. A Standard Operating Procedure (SOP) will be developed, implemented and staff trained in its use to support correction and resending of records rejected by the interface to ESR. This interface will be approved by Payroll and will include mandated timelines for record correction.
6. Data validations will be implemented to validate data prior to submission to and processing by payroll. These validations will highlight and correct any discrepancies in assignment numbers between Health Roster and ESR
7. Sickness records specifically highlighted by the audit as being recorded on Health Roster but not transferring to ESR will be investigated to determine route cause and corrected once that has been established.

Responsible Officer(s): Head of People Analytics

Target Completion Date: 31 August 2026

Objective 3: Monitoring and reporting of sickness absence is undertaken at appropriate levels within the Health Board.

We considered how sickness absence for medical staff is monitored, reported and used to support effective management across the Health Board. We found that, while reporting structures exist at multiple levels within the organisation, the practical use of information by service managers is inconsistent and often limited to awareness rather than active management.

Service managers predominantly rely on system-generated reports from ESR or the core rostering system in use, as opposed to the consolidated Sickness Dashboard developed by the People Directorate. This indicates a gap between the availability of data and its operational application. **(Observation 7)**

At a corporate level, we note that reporting has strengthened significantly since Q3 2025/26. Monthly People Directorate packs now provide comprehensive metrics, including trends, long and short-term sickness splits, compliance indicators and case management activity. Committee and Board reporting is well-established, with sickness metrics presented routinely and feedback used to refine report format.

However, there is an opportunity to improve the flow of information from corporate reporting to operational team, which remains weak and is compounded by a lack of manager knowledge regarding how to create and use core system reporting. Service managers are not consistently receiving, recognising or using centralised or localised reports, limiting the Health Board's ability to ensure consistent sickness management practices.

Observation 7: Operational Sickness Reporting

We had a limited response from directorate managers to our request for information on sickness reporting (1/6). While the manager that responded confirmed that they received centralised dashboard reporting, and that this was used for monitoring, the low response rate on this subject inhibits our ability to fully conclude.

Four of six service management teams we spoke with as part of sample testing confirmed they do not receive dashboard reports or feedback/updates from their directorate managers therefore, the only sickness reports available to them were those available from ESR or the core rostering systems used. Among these four, one was unable to produce reports on request as they were unaware of how and where to create the reports and one manager was unaware of what system was in use and therefore, could not produce reports. Of the two service management teams that confirmed they received dashboard reports, both stated these were used purely for information and were not employed to inform the active management of sickness within their departments.

Action 7

The Health Board should ensure that:

- Service managers and staff with responsibility for managing sickness are aware of available sickness reports within ESR and how to produce and use these reports for their respective areas;
- Service and directorate management are clear on what actions to take in response to issues identified by reports
- Directorate managers are sharing highlights and pertinent information from dashboard reports produced by the People directorate, particularly where areas of focus may be required to improve recording, address issues or support ongoing cases.

Management response – Action 7

1. Signposting of ESR Manager training (calendar and self-serve booking process) to be undertaken for all operational teams with Directorate Managers promoting locally to increase uptake.
2. Reinforcing of expectations for People Metrics to form part of the local Directorate meeting agendas including the use of dashboards and various performance data.

Officer: Head of People, Unscheduled Care and Facilities, Health & Wellbeing Action Plan lead

Target date: 31 August 2026

Appendix A

Assurance Opinion

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

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

Date issued: August 2026



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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 presented 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:** completed.
- **Audit certification:** they were certified by the Auditor General on 30 June 2026 and submitted to the Welsh Government that day (meeting the Welsh Government's deadline).
- The Audit of Accounts Addendum Report is being presented at today's Audit and Risk Assurance Committee.

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

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:** November 2026

Review of Follow-Up Outpatients (2025 Local Work)

- **Executive Lead:** Chief Operating Officer
- **Focus of the work:** This work examined whether the Health Board is taking appropriate action to strengthen its management of follow-up outpatient appointments. In doing so, we have assessed whether it has fully addressed the audit recommendations from our follow-up outpatient reviews in 2015 and 2017.
- **Status:** Draft report issued for clearance
- **Expected committee date:** November 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 examined 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:** Draft report issued for clearance
- **Expected committee date:** November 2026

Review of Cancer Services

- **Executive Lead:** Chief Operating Officer
- **Focus of the work:** This work follows on from the review of national leadership arrangements for cancer services. This work evaluated 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:** Draft report issued for clearance
- **Expected committee date:** November 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.
- **Status:** Planning
- **Expected committee date:** February 2027

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

**Review of Agency Usage and 2023 Workforce Planning Review
Follow-up (2026 Local Work)**

- **Executive Leads:** Director of People, Director of Nursing, Midwifery and Patient Care, and Medical Director
- **Focus of the work:** This work will examine whether the Health Board has effective arrangements in place to manage and reduce its use of agency staff, including its implementation of recommendations arising from our 2023 workforce planning review.
- **Status:** Planning
- **Expected Committee Date:** TBC

Other relevant publications

Since the last committee update, the Auditor General has published the following outputs relevant to the NHS.

<u>NHS urgent and emergency care – a system under constant pressure</u>	June 2026
<u>NHS planned care – fit for the future?</u>	June 2026

Since the last committee update, Audit Wales has published the following corporate documents.

<u>Annual Report and Accounts 2025-26 Audit Wales</u>	June 2026
<u>The Code of Audit Practice of the Auditor General for Wales Audit Wales</u>	July 2026

There are no relevant Audit Wales consultations currently underway.

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Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

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Audit of Accounts Report Addendum – Cwm Taf Morgannwg University Health Board

Audit year: 2025-26

Issued: July 2026

Document reference: 5419A2026



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Introduction

This report is an addendum to our Audit of Accounts Report that we presented to you in June 2026. The report sets out the recommendations arising from our audit of the 2025-26 accounts and an update on the progress you have made against past recommendations that remain open.

We should like to take this opportunity to once again thank all your staff who helped us throughout the audit.

Recommendations from this year's audit

Exhibits 1 to 4 set out our recommendations arising from this year's audit.

Exhibit 1: Lack of the relevant Welsh Government approvals for two interim executive director appointments

Finding

As reported to Members in June, the Auditor General qualified his regularity opinion due to the remunerated paybands for two interim executive directors exceeding the relevant paybands set out by Welsh Ministers.

While the Health Board's Remuneration and Terms of Services Committee had approved both cases, they required consideration and approval by Welsh Ministers, who retrospectively determined not to approve them.

This outcome resulted in irregular 2025-26 costs of £11,929, being material to the audit.

Recommendation

During each recruitment and appointment process the Health Board should ensure that the appropriate approvals are sought and obtained, before making any binding commitment to an individual.

Accepted in full by management:

Yes

Management response:

A Standard Operating Procedure is being developed for Executive recruitment which will ensure appropriate approvals are sought and obtained as part of the recruitment process.

Implementation date:

Immediately

Exhibit 2: Appropriate audit evidence for remuneration report disclosures

Finding

Each year we formally set out the key information we require to facilitate our audit work, which we processed prior to the start of the 2025-26 audit. However, during the audit we established that information relating to employment contracts and relevant Welsh Government approvals were not available at the outset of the audit, which resulted in delays and our audit of the remuneration report being significantly extended.

Recommendation

The Health Board should provide us with all requested remuneration report records at the start of the audit; or sooner if possible to enable early audit testing.

Accepted in full by management:

Yes

Management response:

As Executive Directors / Independent Members are appointed an audit working paper will be brought together which will include employment contracts, relevant Welsh Government approvals, and any other relevant documentation. This will be available during the audit process for review.

Implementation date:

Immediate

Exhibit 3: Related party year-end confirmation process

Finding

Each year the Health Board issues a confirmation email to members and senior officers, seeking an update on their related party declarations. This year the confirmation request was issued in February 2026, with most replies predating the financial year end of 31 March 2026 (three replies were provided after 31 March 2026). Early replies received before 31 March increase the risk that changes up to 31 March are overlooked and omitted.

Recommendation

When issuing the year-end confirmation email regarding related party declarations, the Health Board should stipulate that members and senior officers reply on or soon after 31 March each year.

For example, for the 2026-27 declarations update, replying on or soon after 31 March 2027.

Accepted in full by management:

No

Management response:

While it would be ideal to have confirmation from members and senior officers on 31 March 2026, the practicalities of doing so for the number of respondents and turning around in that timescale is impractical. Capturing the information in February 2026 allows for review, chasing and follow up of any queries and still meet the timescales of completing the relevant accounts notes for related parties.

Members and senior officers are required to inform Corporate Governance of any changes to their Declarations of Interest (DOIs) as they occur. Therefore, in the unlikely event that a declaration changes between February and the end of March, the updated information should be provided to Corporate Governance as soon as the change occurs.

Implementation date:

N/A

Exhibit 4: capitalisation of salary costs

Finding

We found instances where the supporting evidence for capitalised staff costs was weak or inaccurate. For example, a staff member whose costs were capitalised at a certain percentage, had insufficient appropriate documentation to support the calculation of the percentage.

There were also instances where the salary used in the recharge calculation was based on 2024-25 figures rather than the appropriate 2025-26 figures.

Recommendation

The Health Board should ensure that capitalised salary costs are fully supported by detailed calculations and recorded judgements for the amounts involved. Ideally, this should be supported by timesheets or other forms of sufficient appropriate documentation.

Accepted in full by management:

Yes

Management response:

The Capital Finance Team will ensure that a documented rationale is maintained to support the capitalisation of staff costs.

Implementation date:

March 2027

Recommendations from past audits

Exhibit 5 summarises our audit recommendations that remain open. The number of open recommendations is much lower than reported last year.

Exhibit 5: past recommendations that remain open

Audit year	Recommendation	Progress
2024-25	Nil Net Book Value Assets The Health Board should: • undertake a documented assessment of the existence and use of its assets with a £nil net book value; • introduce a documented annual rolling programme of physical verification and assessment of assets with a £nil net book value, including replaced assets; and • introduce a periodic review of categories of asset lives, to gain assurance that they remain appropriate	The Health Board has introduced additional checks and controls and continues to review the position with nil net book value assets. We will continue to assess this area as part of our 2026-27 audit planning; and if necessary we will highlight the audit risk in our 2027 audit plan.

Network User Access

The Health Board should review its current data admin accounts and remove any access from staff who do not need it.

This action should include the removal of any duplicate accounts.

Also, the Health Board should regularly review (i.e. monthly) its privileged access accounts so that access is maintained only for the appropriate personnel.

The Health Board has not fully implemented the recommendation, as intended. The Health Board has now removed the duplicate accounts that existed in 2023-24 but still needs to ensure that privileged access accounts are regularly reviewed.

2022-23

Wellsky System

The Health Board should regularly check the Wellsky 'Active Users' report to ensure that all live users are set up with the correct access rights, and that any leavers' access has been removed by Digital Health and Care Wales (i.e. where requested by the Health Board).

Also, the Health Board should document its review of the Wellsky 'Inactive Users' report to determine whether any inactive user accounts need to be closed or suspended.

Officers provided only verbal assurance that this recommendation has been implemented but were unable to provide documented evidence. We will review the position as part of next year's audit.

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Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

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Agenda Item
Draft Minutes of the Audit Risk and Assurance Committee

Date and Time of Meeting	Tuesday 19 May 2026, 12:30pm–3:30pm
Venue	Virtual via Microsoft Teams

Members Present	Patsy Roseblade	Committee Chair/Independent Member
	Dilys Jouvenat	Committee Vice Chair/Independent Member
	Carolyn Donoghue	Independent Member
	Kath Palmer	Health Board Vice Chair
In Attendance	Gareth Watts	Director of Governance
	Sally May	Executive Director of Finance
	Paul Dalton	Head of Internal Audit NWSSP
	Emma Samways	Deputy Head of Internal Audit
	Emma Walters	Head of Corporate Governance & Board Business
	Owen James	Head of Corporate Finance
	Dom Hurford	Executive Medical Director
	Mark Jones	Audit Wales
	Nathan Couch	Audit Wales
	Darren Griffiths	Audit Wales (In part)
	Amanda Legge	Post Payment Verification Manager (In part)
	Neil Jones	Local Counter Fraud Specialist
	Claire Jones	Head of Quality Assurance & Compliance
	Kelly Eddington	Quality Assurance & Compliance Officer
Meeting Observers		

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 virtual format of the proceedings was noted. Members also noted that the meeting would be recorded to support the Committee Secretariat in ensuring

	the accuracy of scrutiny 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 that they were content to proceed. The Committee Chair advised that, at the end of the meeting, she would invite Members' views on how the meeting had gone.
1.2	Apologies for Absence
	Apologies were received from: • Kathy Mason – Independent Member • Rhys Goode – 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 6) that the Committee Members wished to bring forward to the main agenda for discussion. No items were raised.
3.	MATTERS ARISING
3.1	Action Log
	G Watts presented the Action Log, and the items proposed for closure were agreed.
Resolution:	The Committee DISCUSSED and NOTED the Action Log
Action:	None identified.
3.2	Matters Arising Not Captured on the Action Log
	No matters were raised.
4.	STRATEGIC PEOPLE – INSPIRING PEOPLE
4.1	Losses & Special Payments report
	S May and O James presented the report which highlighted the continued high value of claims awaiting reimbursement from the Welsh Risk Pool, currently estimated at approximately £29 million. It was noted that this represents an increase compared to previous years and was identified as a potential financial risk if reimbursements were not received in a timely manner. It was noted that ongoing liaison is taking place with the Patient Care & Safety Team to expedite the submission of claims. P Roseblade sought assurance in relation to cash flow impacts at year-end arising from this position. O James confirmed that the Health Board had effectively managed its cash position at year-end, by securing additional working capital (£9 million) from Welsh Government, which ensured that the closing cash balances remained within the target range.

	K Palmer queried whether additional resource was required for learning from events in order to mitigate the challenges and issues being faced. S May emphasised the importance of prioritising Learning from Events reports as a key mechanism for identifying and sharing learning across the organisation and added that this remains a risk area and requires a balanced approach to ensure it is appropriately prioritised alongside clinical service demands. D Hurford supported this view, advising that the issue is primarily one of prioritisation within clinical workloads and emphasising the need to strengthen engagement across medical, Allied Health Professionals (AHP) and nursing staff to ensure that Learning from Events is embedded as a core element of clinical practice. P Roseblade noted that the number of live cases at March 2026 was significantly higher than at March 2025, particularly in relation to redress. In response, D Hurford advised that the underlying themes remain consistent, including prescribing errors, delays in transfers between teams and communication issues. He highlighted that the increase is unlikely to reflect a decline in the standard of care provided but rather represents a growing willingness among the population to challenge care and raise concerns where they feel the standard has not met expectations. C Donoghue queried whether there is sufficient evidence to support the reasons outlined by D Hurford. D. Hurford confirmed that the position was that the rise in claims reflected increased reporting and scrutiny rather than deterioration in care quality. However, he acknowledged that the organisation still need to improve how it responds to and learns from these issues. In response, S May emphasised the importance of focusing on how the organisation reduces harm arising from incidents, noting that while human error cannot be eliminated, the priority is to minimise its impact through strengthened processes and system learning. She also highlighted ongoing work through Shared Services and the Welsh Risk Pool, including a targeted review of the process, aimed at improving understanding of the issues and informing future improvements.
Resolution:	The Committee - NOTED the losses and special payments made for the period 1 January to 31st March 2026 report - NOTED the key risks for escalation on the increasing net provision value - NOTED that the amount of claims that have been paid out, and that reimbursement is awaited from Welsh Risk Pool for £29.7m at the end of March.
Action:	None identified
4.2	Procurement & Scheme of Delegation Update
	S May presented the report and highlighted key areas of focus within the report, including ongoing issues relating to retrospective orders and non-receipting, and



a small number of areas with significant activity, notably in relation to oxygen and gases, recruitment expenditure, and engineering and theatres.

It was noted that the report included a number of retrospective approvals, reflecting both a degree of process non-compliance and a backlog of activity. Particular attention was drawn to a high-value retrospective procurement relating to Abergarw Care Home, which had originally been commissioned as part of the emergency response to the Princess of Wales (POW) Hospital roof but had continued beyond that period. It was confirmed that this arrangement has now ceased and procurement processes have returned to normal pathways.

K Palmer queried the issue of invoices on hold and asked what approaches other Health Boards have implemented that CTM could learn from. In response, O James advised that CTM is broadly comparable with similar organisations; however, there are variations in practice and opportunities to further strengthen processes, training and organisational engagement. He advised that finance staff have been encouraged to have proactive engagement with budget holders to improve awareness and timely resolution of invoices on hold. He also noted that targeted training has been delivered in conjunction with the enablement team and confirmed that the Health Board is undertaking a pilot to automate the escalation of invoices on hold, which will progress through the approval hierarchy to support timely resolution.

It was acknowledged that receipting remains an issue, but this is recognised as an All-Wales challenge. S May further noted that Shared Services regularly escalate invoices on hold back to the Health Board, highlighting the need for improved organisational compliance and understanding of receipting processes.

P Roseblade queried the position regarding Cardiff & Vale NHS retrospective receipting within Mental Health services, noting that these arrangements do not appear to sit within a Service Level Agreement (SLA). S May highlighted that this contributes to a higher number of invoices on hold, as the services provided cannot be deferred whilst awaiting formal procurement arrangements.

O James noted that NHS Wales invoices sit outside the "No PO, No Pay" process; however, CTM requires purchase orders to be raised for all invoices as part of its strengthened governance approach. Members acknowledged that there are a significant number of transactions across NHS organisations that sit outside SLAs, which contributes to the complexity of managing invoices on hold.

P Roseblade queried the position regarding Abergarw Care Home and noted that facilities services frequently appear on the list relating to retrospective purchase orders, often involving high-value expenditure. In response, S May advised that this remains an area requiring further focus, particularly in relation to planning and the management of temporary staffing and procurement processes.



	P Roseblade also congratulated the team on their performance against Public Services Payment Policy (PSPP) targets, recognising the significance of this achievement.
Resolution	The Committee • NOTED the position on procurement matters for the period 01/01/26 to 31/03/26 • NOTED the update regarding Purchase to Pay and achievement of PSPP target up to Month 12 of 2025 / 2026
Action:	None identified
4.3	Post Payment Verification End of Year Report 1st April 2025 * 31st March 2026
	A Legge presented the report, highlighting that routine assurance visits had been completed across most disciplines, with Pharmacy activity ongoing. She advised that work is progressing to strengthen assurance processes, including the development of improved data management and reporting tools. It was also highlighted that there is a key issue relating to duplicate claims arising from incorrect submission by practices. A high number of duplicates were identified in Practice 13, where quarterly claims had been incorrectly submitted on a monthly basis. It was noted that this issue has been raised with system providers and that additional validation has now been built into the system to prevent recurrence. P Roseblade queried Practice 13, noting that the number of recoveries for both the routine and revisit appeared identical, which seemed unusual. A Legge agreed to review this matter outside of the meeting and report back. P Roseblade also referred to paragraph 2 of the cover paper, noting that she had not previously been aware of the issue relating to duplicate claims (including vaccinations). She sought assurance as to whether the changes implemented had fully resolved the issue and whether costs are consistently recoverable. In response, A Legge noted that controls have been strengthened to identify duplicate claims and reduce the risk of recurrence. However, whilst the majority of duplicate payments can now be prevented or identified, there remain some limitations due to clinical and system factors. Ongoing work is being undertaken to improve validation processes and minimise the risk further.
Resolution:	The Committee NOTED the report
Action:	A Legge to review the Practice 13 recovery figures and confirm the position outside the meeting.
4.4	Local Counter Fraud Update
	R N Jones presented the report, advising that it reflects a successful year for Counter Fraud, with good levels of proactive activity undertaken to manage fraud risk and hold individuals to account. He noted that there has been an increase in referrals and investigations, which was viewed positively as evidence of staff confidence and willingness to report concerns. He also highlighted that some investigations remain resource intensive, a position which has been reported previously and continues to be monitored.

	P Roseblade queried whether there is a process in place to sift referrals and whether any are found to be false or vexatious, asking if there is any evidence of misuse through inappropriate reporting. In response, R N Jones confirmed that there is no evidence to suggest abuse of the reporting system, and no significant issues have been identified relating to inappropriate referrals.
Resolution:	The Committee DISCUSSED and NOTED the report
Action:	None identified
4.5	Counter Fraud Annual Report 2025 / 2026
	R N Jones presented the Annual Report which demonstrated that the Health Board is performing satisfactorily in managing fraud risks, with effective processes in place. Members noted that there has been increased reporting activity which reflects a strong organisational culture of transparency and speaking up and noted the report highlighted ongoing work to strengthen both preventative and punitive approaches to fraud management.
	P Roseblade queried who holds the Counter Fraud lead role within the Corporate Governance team. G Watts confirmed that this would be discussed further with the Corporate Governance Senior Management Team outside of the meeting.
Resolution:	The Committee DISCUSSED and NOTED the report
Action:	G Watts to confirm, with the Corporate Governance Senior Management Team, who holds the Counter Fraud lead role within the Corporate Governance Team.
Action:	G Watts to review whether JCC Declarations of Interest are routinely reported to the Audit Risk and Assurance Committee.
4.6	Counter Fraud Functional Standard Return 2025 / 2026
	R N Jones presented the report which highlighted the Counter Fraud Functional Standards Return for 2025–26, noting that this requires Chair sign-off and provides an opportunity for Members to contribute to the assurance process. It was noted that the Health Board has achieved green ratings across all standards, reflecting the resilience and commitment of the organisation in supporting counter fraud activity.
	P Roseblade queried whether the number of JCC Declarations of Interest are included within the Counter Fraud return or whether they submit their own return. In response, R N Jones advised that, to his knowledge, they are not currently included. However, he confirmed that he would liaise with G Watts to confirm the position.
	C Donoghue queried the apparent discrepancy within the Counter Fraud standards return, specifically in relation to the number of investigations recorded, and sought clarification on how the figures reconcile. R N Jones clarified that the discrepancy relates to two additional investigations that had initially been recorded within CTM but were subsequently transferred to Counter Fraud Services Wales due to their complexity and severity. As a result, these cases are reflected within the overall figures but are not recorded in the same way within the standards return, which accounts for the apparent difference.



	P Roseblade referred to Appendix 7 (Sanctions and Redress) and queried whether a recent case of a criminal nature, which had proceeded through Cardiff Crown Court, had been captured within the report. In response, R N Jones confirmed that the case had been recorded in the previous reporting period and would be referenced within the closed session. The Committee noted that all identified redress has been successfully recovered, which was acknowledged as a positive outcome. Members confirmed they were content for P Roseblade and S May to sign off the report.
Resolution:	The Committee DISCUSSED and NOTED the report
Action:	G Watts to confirm whether JCC Declarations of Interest should be included within the Counter Fraud Functional Standards Return and clarify the reporting approach.
4.7	Counter Fraud Work Plan 2026/27
	R N Jones presented the Counter Fraud Workplan, advising that it seeks to consolidate work from previous years in order to maintain the current standards rating, whilst also strengthening preventative counter fraud activity across the Health Board. He outlined that the focus will be on building and enhancing existing arrangements, taking account of identified risks, and further embedding counter fraud practices within the organisational culture. Members noted that this includes a particular emphasis on identifying previously unknown or emerging fraud risks through the utilisation of the new national fraud prevention platform and increased engagement with partner Health Boards. It was noted that this approach is intended to support a more proactive, intelligence-led model of fraud prevention and deliver long-term benefits to the organisation.
Resolution:	The Committee DISCUSSED and NOTED the report
Action:	None Identified
4.8	Speaking Up Safely Update
	G Watts presented the report, advising that it provides the Committee with assurance against the requirements set out within the relevant handbook, including the key questions that have been raised. He outlined areas where the Committee can take assurance, whilst also highlighting the current limitations associated with some of those assurances. D Jouvenat congratulated G Watts and his team on the work undertaken, noting the significant progress made. She also confirmed her involvement in the appointment process for the Speaking Up Safely Guardians. K Palmer queried whether it would be beneficial for the Board to receive an update on themes arising from Speaking Up Safely. In response, G Watts confirmed that this would be possible and represents good practice. He advised that the report would be presented to the Operational Delivery Committee (ODC)



	in the first instance and that he would advocate for annual reporting to Board going forward. P Roseblade suggested that a summary of this work should also be included within the Committee's Highlight Report to the Board to raise awareness. P Roseblade further queried succession arrangements for the Speaking Up Safely Champion role following the departure of D Jouvenat. G Watts confirmed that this would be considered as part of wider Independent Member responsibilities.
Resolution:	The Committee • NOTED the assurance provided against the SUS Questions, and • CONFIRMED that it is content with triangulated approach to assurance over Speaking Up Safely provided this year and to receive further reports annually going forward.
Action:	To consider Board-level reporting of Speaking Up Safely themes following consideration by ODC, including whether both formal and informal discussion routes are required. This should also be reflected in the Committee's Highlight Report to the Board.
4.9	Declaration of Interests & Gifts, Hospitality and Sponsorship Register G Watts presented the annual report on Declarations of Interest, Gifts and Hospitality. It was noted that there is an established process in place whereby declarations are submitted by individuals, reviewed through line management, and recorded within a central system. This supports transparency and accountability across the organisation. K Palmer queried whether there is oversight of staff declarations and if someone reviews the detail provided to which G Watts confirmed that declarations are submitted via a system, reviewed through line management approval, and then checked centrally, providing an established assurance process. K Palmer queried whether JCC staff Declarations of Interest are included within the register and whether there are any legacy issues. In response, G Watts advised that JCC staff are CTM employees and should therefore follow CTM processes. However, he agreed to undertake a cross-check to ensure consistency and provide assurance that appropriate oversight is in place and that no necessary checks are being missed. This will include confirming whether JCC are undertaking their own Declarations of Interest checks or whether these are being captured through CTM processes and ensuring that reporting is aligned and that figures are not duplicated. P Roseblade asked whether Declarations of Interest are triangulated with National Fraud Initiative (NFI) (e.g. staff working elsewhere). M Jones and S May confirmed that while there is no routine triangulation, data sources are used



	together where concerns arise (e.g. fraud investigations), and NFI supports wider data matching.
Resolution:	The Committee NOTED the entries on the registers
Action:	G Watts to liaise with JCC and review the approach to JCC Declarations of Interest, including whether they should be incorporated within the CTM Declarations of Interest, Gifts, Hospitality and Sponsorship Register or managed separately, ensuring appropriate oversight and that reporting is not duplicated.
5. STRATEGIC PILLAR – IMPROVING CARE	
5.1	Board Assurance Framework
	G Watts presented the Board Assurance Framework (BAF) report, confirmed that there were no substantive changes to the overall strategic risks at this time. He recognised that the BAF provides a high-level overview of strategic risks, supported by more detailed risk information.
Resolution:	The Committee • ENDORSED for Board Approval the amendments made to the existing risks and confirm that the updates provide adequate assurance and reflect recent discussions.
Action:	None Identified
5.2	Organisational Risk Register
	G Watts presented the report noting that this reflects a significant update since the previous review, highlighting the dynamic nature of the Health Board's risk profile. It was noted that a substantial amount of work has been undertaken to ensure the register is up to date, including engagement with Care Groups and corporate teams. Members also noted the reintroduction of risk training across the organisation to strengthen risk management capability. The Committee was advised of key risks with increased scores, including: • Workforce pressures impacting service delivery (e.g. consultant workforce challenges), • Laboratory compliance risks, and • Capacity and patient safety risks associated with Physiotherapy Musculo-Skeletal (MSK) services. P Roseblade welcomed improvements to the presentation of the risk register, including the addition of a summary and enhanced visibility of risk movements. C Donoghue raised concern regarding a specific risk (dynamic mattress systems), noting the absence of a clear action plan and querying whether this risk would be appropriately escalated through the Quality, Safety & Experience Committee given its alignment with the preventing harm area of focus and the importance of ensuring appropriate oversight from a quality and safety perspective. S May advised that the issue is not solely financial but relates to a failure to plan and manage replacement cycles effectively and confirmed that the service has been asked to develop a clear replacement plan and that this requires further action. S May agreed to discuss this further outside the meeting with G Hughes.



	C Donoghue and P Roseblade noted that it is difficult to review the level of detail within the document and queried whether an alternative format could be considered to improve clarity and usability. P Roseblade referred to Datix 1793, noting that the reduced risk rating appeared to be linked to a change in risk owner rather than evidence of mitigation or resolution. She requested that the wording be reviewed to ensure it accurately reflects the position. P Roseblade also referred to Datix 6475 (Health Visitor strike), acknowledging the rationale for inclusion but querying whether the current risk rating of 16 is sufficiently high, given that the issue is ongoing and has persisted over a prolonged period. She requested assurance that the risk is appropriately scored within the Risk Register. K Palmer welcomed the improvements to the heat map but queried the position of the Specialist School Nursing risk, which remains rated at 20. She noted that this has been an area of concern for some time and is also referenced within the Quality, Safety & Experience Committee highlight report. K Palmer requested an update and assurance that service provision is not adversely impacting school children.
Resolution:	The Committee • REVIEWED the risks escalated to the Organisational Risk Register • CONSIDERED whether the Committee can seek assurance from the report that all that can be done is being done to mitigate the risks
Action:	S May to discuss risk 6498 further with G Hughes and develop a plan in relation to dynamic mattress systems.
Action:	Review and amend the wording of Datix 1793 to ensure the rationale for the reduced risk rating is clearly articulated and reflects mitigation rather than change in ownership.
Action:	Review the risk scoring for Datix 6475 (Health Visitor strike) and provide assurance that the rating appropriately reflects the likelihood and impact.
Action:	Provide an updated position on the Specialist School Nursing risk, including assurance regarding service impact and mitigation actions.
Action:	Review alternative approaches to presenting the Organisational Risk Register to improve readability and accessibility for Members.
5.3	Audit Recommendations Tracker Update Report G Watts provided an update on the Audit Recommendations Tracker, noting that progress continues to be made in reducing the number of overdue recommendations, with a number of actions proposed for closure following review. It was highlighted that audit performance and progress meetings are ongoing with Care Groups and corporate directorates, which are supporting improved ownership, visibility and accountability for outstanding actions.

	Members noted that, whilst progress has been made, there remain a number of aged recommendations, and emphasised the importance of ensuring that actions are realistic, achievable and, where appropriate, reviewed for continued relevance. K Palmer, C Donoghue and P Roseblade agreed that the current pie chart presentation does not clearly demonstrate the level of progress being made and encouraged the team to continue the work, thanking the team for their efforts. It was suggested that alternative methods of presenting progress, such as the use of Statistical Process Control (SPC) charts, could be explored to provide greater clarity and visibility of trends over time. K Palmer also raised concern regarding the Audit Wales Quality Governance Follow-Up recommendation, which is now over 1,100 days old, querying at what point it should be reviewed to determine whether it remains appropriate. In response, N Couch confirmed that he would work with G Watts to review and progress a number of these older recommendations, with a particular focus on ensuring that historic actions are either completed or appropriately closed following reassessment. He noted that increased focus will be placed on following up longstanding recommendations going forward. C Donoghue raised concern regarding the number of instances where "no update" had been recorded across multiple reporting cycles, noting that this was not acceptable and queried how this is being escalated to ensure appropriate action and accountability. In response, G Watts acknowledged the concern and confirmed that this would be escalated to Executive colleagues to reinforce the importance of providing timely and meaningful updates. P Roseblade referred to the focused reports, noting that some recommendations are three to four years old and questioned whether this length of time indicates a lack of prioritisation. She acknowledged the challenges faced by operational staff, recognising the pressures of delivering services, but emphasised the importance of ensuring that audit actions are taken seriously and progressed in a timely manner. P Roseblade further highlighted the importance of ensuring that both internal and external audit recommendations are realistic and achievable.
Resolution:	The Committee NOTED the report and AGREED that where applicable the progress updates provide Members with sufficient assurance, particularly in relation to closed recommendations.
Action:	G Watts to escalate to Executive colleagues where audit updates are not being provided, to reinforce accountability.
Action:	Explore alternative methods of presenting audit progress (e.g. SPC charts) to improve clarity and trend visibility.
Action:	G Watts and N Couch to review and progress historic audit recommendations, ensuring that longstanding actions are either completed or appropriately closed following reassessment.

5.4	NWSSP Internal Audit Progress report
	P Dalton presented the Audit Progress Report, summarising the current position against the Internal Audit plan and highlighting key areas for Members' attention. It was noted that a significant number of audit reports had been brought to the Committee on this occasion, with a summary approach adopted to provide an overview of findings, particularly for those reports providing substantial or reasonable assurance. P Dalton highlighted that, whilst overall progress against the audit plan is on track, there are ongoing challenges in relation to the timeliness of management responses to draft reports, which is impacting reporting timelines. P Roseblade and K Palmer acknowledged that the current position regarding turnaround times is not acceptable and noted that this had been raised outside of the meeting with Executive colleagues and the Chair. It was anticipated that increased focus and escalation would support improvement in this area going forward. The Committee also noted the benefit of maintaining a more balanced flow of audit reports throughout the year, to ensure sufficient time for detailed review and discussion. K Palmer noted that the Long-Term Strategy Internal Audit, which received reasonable assurance, would be beneficial to be presented at the Strategic Development Committee (SDC).
Resolution:	The Committee NOTED the report
Action:	The Long-Term Strategy Internal Audit report to be presented to the Strategic Development Committee.
5.5	Internal Audit Review Reports
5.5.1	IA Review – Savings Centrally Led Programmes
	E Samways presented the report, highlighting the key matters with a particular focus on the medical and nursing programmes and the associated workstreams supporting delivery of the savings schemes. It was acknowledged that the centrally led schemes are intended to drive and enable savings, rather than directly deliver them, with accountability for delivery sitting within Care Groups and budget holders. Governance arrangements are in place, but there are opportunities to strengthen: • Planning and documentation of schemes, • Clarity of financial targets and delivery expectations, and • Alignment between programme oversight and operational delivery. The Committee recognised that this work is part of the organisation's core financial management responsibilities, and that further maturity is required to ensure schemes are robust, deliverable and supported by clear processes.



C Donoghue welcomed the report and queried whether the organisation has sufficient capacity to implement the agreed actions within the proposed timescales, noting that they appeared ambitious. She clarified that her concern was not in relation to additional resource, but rather the time and effort required to develop the necessary understanding and capability to deliver the savings schemes effectively.

In response, S May advised that the solution cannot be to increase resource, noting that these are not new savings schemes and that the organisation has been delivering such programmes for many years. She acknowledged that whilst the centrally led schemes were introduced with a level of ambition, the report provides a helpful foundation to strengthen delivery. She emphasised that this work forms part of the core responsibility of managers to deliver within agreed budgets.

In response, D Hurford acknowledged that delivering the savings programme requires time to embed, noting that many of the processes being introduced are relatively new and represent a shift in approach. He advised that the focus in the previous year had been on establishing the foundations, with the current year aimed at strengthening delivery. He also highlighted that some schemes, such as job planning, are inherently time-intensive and require meaningful engagement to ensure they deliver value. He emphasised that this work is not about additional resource, but about embedding improved practices, prioritisation and engagement within existing clinical and managerial processes, which will deliver benefits over time.

K Palmer queried whether the report would also be presented to the Operational Delivery Committee (ODC), given its role in overseeing in-year savings. She also noted that she did not feel she had sufficient understanding of the distinction between centrally led schemes and Care Group delivery and queried how Board oversight of savings could be strengthened, including whether additional time should be allocated to this area.

P Roseblade explained that existing finance reports are presented to Committees and Board, noting that these contain detailed information on savings performance.

S May noted that centrally led schemes are intended to enable and support savings, rather than directly deliver them, as accountability for delivery sits within Care Groups where the budgets are held. She further emphasised that detailed savings performance is reported regularly through finance reports, and highlighted that greater scrutiny, including potential deep dives into underperforming areas, may support improved understanding and oversight going forward.

K Palmer suggested that a dedicated session for Board Members may be beneficial, which could be discussed further with the Chair. G Watts advised that

	further clarity would be required regarding the specific ask before determining the most appropriate route for Board engagement and confirmed this could be taken forward outside of the meeting. P Roseblade noted that it was positive that the savings programme is not solely led by the Finance Director, emphasising that delivery must sit with budget holders across the organisation. She also suggested that a six-monthly deep dive on savings could be considered. P Roseblade further highlighted that finance reporting is often positioned at the end of the ODC agenda, limiting the time available for detailed discussion, and suggested that this should be reviewed to enable more meaningful scrutiny. She acknowledged the importance of continuing to develop understanding of savings delivery, whilst also recognising the positive progress made in the previous year.
Resolution:	The Committee NOTED the report
Action:	This report to be presented to Operational Delivery Committee
Action:	G Watts to discuss with K Palmer and the Chair whether any elements of the centrally led savings programme should be escalated to Board level including consideration of increased scrutiny and potential deep dives into underperforming areas.
Action:	Review the positioning of finance reporting within the ODC agenda to ensure sufficient time is allocated for detailed discussion of savings performance.
5.6	NWSSP Internal Audit Plan 2026 -2027
	P Dalton presented the Internal Audit Plan for 2026/27, highlighting the key matters for Members' attention. He advised that the plan is risk-based, developed following engagement with Board Members, and remains flexible, with the ability to be revised in response to changes in the risk landscape throughout the year. P Roseblade welcomed the inclusion of staff overpayments within the plan, noting from Counter Fraud reporting that this remains a recurring issue. She also welcomed the inclusion of Primary Care Dentistry, although expressed disappointment that this is not scheduled until Quarter 3 given the issues that are continually reported. P Roseblade further referred to the proposed review of Electronic Prescribing and Medicines Administration (EPMA), noting that the system had only recently been introduced and queried whether sufficient time had elapsed for the system and associated processes to embed before audit review. In response, P Dalton acknowledged that the plan is at an early stage and reiterated its flexibility. He confirmed that he would liaise with relevant colleagues to review the timing of the EPMA audit to ensure it is appropriate and would also explore whether there is capacity to bring forward the Primary Care Dentistry review.
Resolution:	The Committee NOTED the report
Action:	None Identified
5.6.1	NWJCC Internal Audit Plan 2026 -2027



	P Dalton advised that this has been presented separately to provide greater clarity on the scope of internal audit work relating to hosted bodies. P Roseblade acknowledged the importance of maintaining clear oversight of hosted body arrangements and ensuring that audit coverage is appropriately aligned to key risks.
Resolution:	The Committee NOTED the report
Action:	None Identified
5.7	Audit Wales Progress Report
	M Jones provided an update on the Audit Wales Progress Report, advising that work on the annual accounts audit is progressing as planned, with regular engagement taking place with Finance colleagues. He also noted that the charitable funds audit is scheduled to commence later in the year. N Couch provided information on the performance audit work, noting that the Digital Transformation review has been completed and presented to the Committee. A number of reviews are currently in progress, including Unscheduled Care, Outpatients, Estates and Cancer, with reports expected to be brought to a future meeting. The Committee noted the update and the ongoing programme of audit work.
Resolution:	The Committee NOTED the report
Action:	None identified.
5.8	Audit Wales Report – Digital Transformation
	This item was discussed in the closed session of the Committee
Resolution:	The Committee NOTED that the report would be discussed in the closed session.
Action:	None Identified
5.9	Audit Wales – Audit Plan 2026
	M Jones and N Couch presented the report and noted that the plan includes consideration of key audit risks, including management override and related party transactions, with appropriate levels of audit testing applied. Members were advised that these areas are assessed in line with professional audit standards, with increased scrutiny applied where risks are not rebutted. An overview of the performance audit programme, noted that work will include the Structured Assessment, Diabetes review, and follow-up work on workforce planning, including agency spend.
Resolution:	The Committee NOTED the report
Action:	None Identified
5.10	Clinical Audit Update Report
	D Hurford presented the report, advising that it provides an overview of progress against the national clinical audit programme and highlights areas where delivery has been delayed. It was noted that the majority of audits have been completed; however, three had been delayed, primarily due to challenges in identifying and maintaining



	appropriate clinical leadership. D Hurford advised that this position is being addressed, with actions in place to ensure completion. K Palmer queried whether the themes and learning arising from clinical audits would be presented to the Quality, Safety & Experience Committee (QSEC). In response, Dom Hurford confirmed that detailed learning is reviewed through the Clinical Effectiveness Group, with regular deep dives undertaken and summary reports escalated through to QSEC and onwards to Board. P Roseblade noted that the purpose of the report is to provide assurance on the process and completion of audits, rather than the quality outcomes, and to highlight any risks associated with non-completion. P Roseblade sought assurance on the timelines for completion of the outstanding audits to which D Hurford confirmed that the majority are expected to be completed imminently, although rheumatology remains under review pending further confirmation.
Resolution:	The Committee • NOTED the current position regarding National Clinical Audit compliance • ACCEPTED the reasons provided for audits delayed • Took ASSURANCE from the mitigating actions and governance arrangements in place
Action:	None Identified
6.	CONSENT AGENDA
6.1	Items for Approval
6.1.1	Unconfirmed minutes of the meeting held on 3 February 2026 were APPROVED
6.1.2	Unconfirmed minutes of the In Committee meeting held on 3 February 2026 were APPROVED
6.2	ITEMS FOR NOTING
6.2.1	Audit Wales Annual Report 2025 / 2026 was noted
6.2.2	Audit Wales Structured Assessment was noted
6.2.3	Outcome of the Committee Referral to Quality, Safety & Experience Committee Wales Eye Care Services Report was noted .
6.2.4	Counter Fraud Steering Group Highlight Report
6.2.5	Committee Annual Cycle of Business 2026
6.2.6	Committee Forward Work Plan – Non-Routine Business
7.	CLOSE OF BUSINESS
7.1	Any Other Urgent Business None identified
7.2	Committee Highlight Report The Committee Chair advised that this would be drafted outside the meeting by the Governance Team and should include reference to Speaking Up Safely.
7.3	How did we do in this meeting? The Committee Chair advised that, if Committee Members had any comments on how the meeting had gone, they could raise these with her and the Corporate Governance Team outside the meeting.
8.	PRIVATE IN COMMITTEE SESSION



	• CTM Fraud Annual Report 2025-2026 • CTM Draft Annual Accounts 2025-2026 • Audit Wales – Audit of the Financial Statements – verbal update • CTM Audit enquiries Letter • Organisational Risk Register - Business Sensitive Risks • Financial Control Procedure - Medical Variable pay - Summary of Authorised Breaches • Local Counter Fraud Report – Individual Cases
9.	DATE AND TIME OF NEXT MEETING
	24th June 2026 at 9.00am



Agenda Item

Unapproved Minutes of the CLOSED CTMUHB Audit, Risk & Assurance In Committee

Date and Time of Meeting	Tuesday 19 th May 2026 15:30 -17:00
Venue	Virtual via Microsoft Teams

Members Present	Patsy Roseblade	Independent Member, CTMUHB (Committee Chair)
	Carolyn Donoghue	Independent Member, CTMUHB
	Dilys Jouvenat	Independent Member, CTMUHB
	Kath Palmer	Health Board Vice Chair, CTMUHB
	Aaron Fowler (Items 1.1 - 2.3)	Committee Secretary/Deputy Director of Corporate Services - NWJCC
	Adele Lewis	Senior Finance Manager - Financial Accounting
	Darren Griffiths	Auditor - Audit Wales
	Dom Hurford	Executive Medical Director, CTMUHB
	Emma Samways	NWSSP Deputy Head of Internal Audit
	Emma Walters	Head of Corporate Governance & Board Business, CTMUHB
	Gareth Watts (Items 1.1 - 3.4)	Director of Corporate Governance/Board Secretary
	Gwen Kohler (Items 1.1 - 2.3)	Deputy Director of Finance - NWJCC
	Louise Stait	Interim Assistant Director Governance and Risk, CTMUHB (Minutes)
	Mark Jones	Finance Lead – Audit Wales
	Nathan Couch	Audit Wales - Audit Manager (Performance)
	Neil Jones	Local Counter Fraud Specialist
	Owen James	Head of Corporate Finance, CTMUHB
	Paul Dalton	Head of Internal Audit NWSSP
	Rachel Wetherill (Items 1.1 - 2.3)	Head of Financial Accounting & Governance - NWJCC
	Sally May	Executive Director of Finance, CTMUHB



	Stuart Morris	Director of Digital, CTMUHB

Agenda Item	Meeting Business
1.	PRELIMINARY MATTERS
1.1	Welcome and Introductions
	P. Roseblade, Committee Chair welcomed everyone to the meeting. Noted that R Wetherill and G Kohler were attending on behalf of S Taylor
1.2	Apologies for Absence
	Apologies were received from: • Kathy Mason, Independent Member, CTMUHB • Rhys Goode, Independent Member, CTMUHB • Stacey Taylor, Director of Finance & Information - NWJCC
1.3	Declarations of Interest
	No declarations were identified.
2.	DRAFT ANNUAL REPORT AND ACCOUNTS 2025-2026
2.1	CTMUHB Draft Annual Report 2025-2026
	G Watts presented the draft Annual Report for 2025–2026, prepared in line with Welsh Government and HM Treasury guidance. The draft had been submitted to Welsh Government on 8 May 2026, with minor comments received to date. The Committee was asked to focus on the Accountability Section, comprising: • Corporate Governance Report • Remuneration and Staff Report • Financial Accountability Report • National Assembly for Wales Accountability and Audit Report • Governance statements from hosted organisations: ◦ NHS Wales Joint Commissioning Committee (NWJCC) ◦ National Imaging Academy Wales (NIAW) K Palmer noted that the Chair and Chief Executive’s Foreword did not reference community services, care closer to home, and the ‘left shift’ agenda (prevention and earlier intervention), although these themes were reflected later in the Care Group sections. G Watts advised that a “Conclusion and Forward Look” section was in development. He would ensure these themes were appropriately reflected, potentially within that section. Kath Palmer agreed to share further observations to inform this drafting. P Roseblade queried whether an accessible public summary would be produced. G Watts confirmed that, while a separate summary was not planned, work was ongoing to improve accessibility and explore more engaging formats, including digital content. Opportunities to highlight key messages, including at the Annual

	General Meeting, were noted. P Roseblade highlighted the positive reception of short social media videos in previous years.
Resolution:	The Committee: • ENDORSED the draft Annual Report for 2025–2026 • NOTED the governance statements from hosted organisations (Appendices 2 and 3)
Action:	G Watts to ensure that feedback is incorporated into the final draft. K Palmer to provide detailed comments to G Watts.
2.1.1	Draft Head of Internal Audit Opinion and Annual Report 2025-26
	P Dalton presented this draft report, which set out the Head of Internal Audit opinion, summarised internal audit activity for the year, and included an assessment of audit performance and conformance with the Global Internal Audit Standards. The draft overall opinion for 2025/26 was Reasonable Assurance; this would inform the Board's Annual Governance Statement within the Annual Report. No questions were asked.
Resolution:	The Committee NOTED the Draft Head of Internal Audit Opinion and Annual Report 2025-26
Action:	None
2.2	CTMUHB Draft Annual Accounts 2025-2026
	S May presented the draft Annual Accounts for 2025–2026, noting that they had been prepared in line with Welsh Government guidance and were subject to ongoing external audit by Audit Wales. The accounts confirmed that the Health Board had met its statutory financial duties, including revenue and capital resource limits and creditor payment targets. It was noted that overall reported expenditure had reduced compared to 2024/25, largely due to changes in impairment charges; however, underlying expenditure had increased, with expenditure on hospital and community services rising by 7.2% when impairments were excluded. The accounts include the consolidated position for the NHS Wales Joint Commissioning Committee (JCC), alongside separate figures for CTMUHB where appropriate. The Statement of Financial Position showed increases in asset values, reflecting investment and revaluation movements, alongside increases in liabilities, including trade and other payables. These movements included changes related to timing of payments in 2024/25. Total provisions had increased, primarily due to the provision for the Band 2/3 retrospective and corrective payment, alongside other provisions such as employment-related claims and accruals.



	It was emphasised that the accounts include a number of significant accounting judgements and estimates, including provisions, accruals and the Band 2/3 payment, all of which are subject to ongoing review. S May reminded colleagues that the report should be read alongside the Audit Plan, which sets out the areas of focus for the external audit. The final position remains subject to audit, which will determine the final opinion. In discussion, Members sought clarification on the impact of impairments. It was noted that impairment charges had reduced significantly compared to 2024/25, which had included major one-off impairments, and that reversals had been recognised in 2025/26. Members acknowledged that such movements are typical in the context of a large capital programme. In relation to the consolidated Joint Commissioning Committee position, it was noted that the JCC accounts are less complex, with fewer assets and related accounting adjustments. The Chair welcomed the reported compliance with all statutory financial duties, noting that this remained subject to audit confirmation.
Resolution:	The Committee: • NOTED the draft Annual Accounts for 2025/26
Action:	None
2.2.1	Audit Wales: Audit of the Financial Statements – Verbal Update
	M Jones (Audit Wales) provided a verbal update on progress with the audit of the financial statements. It was noted that the Joint Commissioning Committee (JCC) accounts had been received on 24 April 2026, enabling CTMUHB to meet its submission deadline for the draft accounts. The Performance Report and Accountability Report, including the Remuneration Report, were subsequently received in early May. The audit was in its third week, with routine queries arising as expected. Audit Wales confirmed that they were working closely with Finance and Governance colleagues throughout the process. Overall, progress was reported to be on track, with no significant concerns raised at this stage. No further questions were raised.
Resolution:	The Committee NOTED the update and that detailed audit findings would be reported at a later stage.
Action:	None
2.3	Audit Enquiries Letter

	Gareth Watts advised that the Audit Enquiries Letter, issued by Audit Wales on behalf of the Auditor General, had been included within the papers in error as a blank template. He confirmed that the completed response had been submitted to Audit Wales by the required deadline of 13 April 2026, and would be circulated to Members for information.
Resolution:	The Committee NOTED the update
Action:	G Watts to circulate the completed Audit Enquiries Letter to Members.
	<i>A Fowler, G Kohler and R Wetherill (NWJCC) left the meeting.</i>
3.	GOVERNANCE / OTHER MATTERS
3.1	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. Noted that the risk description and narrative for the Keir Hardie Health Park fire safety risk (Datix ID 4958) did not clearly articulate the nature of the risk. Members also queried the presentation of newly escalated risks on the heat map, noting that some appeared with static scores despite being new to the Organisational Risk Register. Clarification was provided that risks included on the ORR represent a moderated subset of directorate risks, and therefore may not necessarily be new risks, but rather existing risks escalated for visibility. P Roseblade asked for more explanation of this process outside the meeting. Members queried whether the risk concerning access to electronic whiteboards by non-NHS staff (Datix ID 6426) represented a potential data breach risk.
Resolution	The Organisational Risk Register was REVIEWED and DISCUSSED .
Action	• L Stait to follow up on the level of detail within Risk ID 4958. • L Stait to provide further clarification outside the meeting regarding the escalation of risks to the Organisational Risk Register. • D Hurford and S Morris to review Risk ID 6426 and provide an update to the Committee
3.2	Financial Control Procedures - Medical Variable Pay - Summary of Authorised Breaches
	D Hurford presented the report, outlining actions being taken to strengthen control over medical variable pay and reduce reliance on agency and bank usage. It was noted that a revised system and rate card approach would be implemented from Quarter 2, with tighter controls on rate escalation. In addition, forthcoming changes to locum engagement arrangements would introduce a revised approval process, with exceptions subject to formal oversight. Members were advised that workforce gaps in key areas, including Haematology, Stroke and Gastroenterology, continued to drive higher-cost



	agency usage, with underlying challenges relating to recruitment and availability of suitably qualified staff. In discussion, Members explored the reasons for use of higher-cost agency staff, including whether choice or limited market availability was the primary driver. It was confirmed that, in many cases, there are limited suitable candidates and a highly competitive agency market. A structured escalation process is in place, prioritising internal cover and approved providers, with use of high-cost agencies remaining exceptional. Members also sought clarification regarding governance and oversight arrangements, specifically the role of the Medical Workforce Productivity Programme (MWPP) Delivery Group. It was confirmed that this group provides operational oversight of workforce productivity measures and cost control, and does not replace the Committee's assurance role. The Chair noted that the revised reporting format, which provides a higher-level summary rather than detailed line-by-line data, was an improvement and aligned with previous Committee feedback. Members agreed that this approach should be maintained.
Resolution:	The Committee NOTED the report.
Action	None
3.3	Local Counter Fraud Investigations Report (Individual Cases) N Jones presented this report. It was noted that the majority of the report had been considered in the public session, with the closed session focusing on elements containing potentially identifiable information. N Jones advised that the Counter Fraud Team had experienced some operational challenges during the year-end period, and that a number of case referrals had been received during the year, with some progressing towards potential legal proceedings. P Roseblade sought clarification on a specific case relating to salary overpayment (ref. INV/25/0104), including whether the individual was engaging with the repayment process. It was confirmed that this would be followed up, with an update to be provided at a future meeting. The Committee reiterated its expectation that material updates between reporting periods should be clearly highlighted within future reports.
Resolution	The report was NOTED and DISCUSSED.
Action	- Counter Fraud Team to respond to ARAC query its next update on case ref. INV/25/0104. - Counter Fraud Team to ensure key updates are clearly highlighted in future reports
3.4	Reportable Data Lapses / Data Losses / Updates to the Information Commissioner's Office (ICO)

	S Morris presented the report. It was noted that there had been no new incidents reported to the Information Commissioner's Office (ICO) during the period, with one previously reported incident remaining open. The Committee was advised of a number of ongoing developments, including progression of the Supplier Management Policy through governance processes, and further work to strengthen digital and data business continuity arrangements and organisational self-sufficiency. It was also noted that cyber risk management continued to be reviewed in light of the evolving threat landscape. Members queried the presentation of matters for escalation within the report, noting that the use of "ask" could imply a requirement for Committee approval. It was clarified that these reflected actions being progressed by the Digital team, rather than requests for decision by the Committee. Members also noted the temporary resourcing arrangements within the cyber function.
Resolution:	The report was NOTED .
Action:	None identified.
	<i>G Watts and N Jones left the meeting.</i>
2.2.1.	Audit Wales: Digital Transformation Report
	<i>The Chair advised that this item had been moved from the Main ARAC agenda so that the Executive Lead could be present for the discussion, however it was not deemed a confidential item.</i> N. Couch presented the report outlining the scope of the review, which considered the Health Board's approach to digital transformation, including strategy, leadership, collaboration and risk management. The review drew on document analysis, stakeholder interviews, including the Chief Executive and Director of Digital, and observation of Board and Committee discussions. Audit Wales had highlighted a range of findings, noting that the issues identified were not unique to the Health Board and reflected wider system challenges. The Audit Team extended their thanks to Digital colleagues for their engagement throughout the review process. S Morris welcomed the report, noting it provided a fair reflection of progress and challenges. He highlighted ongoing work with partners to develop a longer-term digital approach aligned to the Health Board's strategic direction, with a further paper planned for Board consideration later in the year. He also welcomed the report's observations regarding Board visibility of digital transformation. Members welcomed the report and found it helpful and relevant, including to wider Committee agendas, albeit P Roseblade noted that while constructive, it



	could have also given greater recognition to the wider challenges and progress made. Discussion focused on the recommendation relating to development of a costed infrastructure plan. It was noted that while greater clarity on costs would be helpful, there are inherent challenges in providing accurate costings in advance of procurement, and financial planning is constrained by annual capital allocations. Members acknowledged the complexity of aligning organisational, national and Welsh Government prioritisation processes in this context. Audit Wales advised that it was considering a future national review to draw together learning across Health Boards, including system leadership, investment planning and partnership arrangements.
Resolution:	The report was NOTED .
Action:	S Morris to consider sharing the report with the Strategic Development Committee (SDC)
4.	ANY OTHER URGENT BUSINESS
	No further items were identified.
5.	DATE AND TIME OF NEXT MEETING
	24 th June 2026 at 10:00 am
6.	CLOSE OF BUSINESS

Unapproved Minutes of the Extra Ordinary Audit, Risk & Assurance Committee

Date and Time of Meeting	Wednesday 29 June 2026 at 13:00 pm
Venue	Virtual via Microsoft Teams

Members Present	Patsy Roseblade	Committee Chair / Independent Member
	Jonathan Morgan	Health Board Chair
	Kath Palmer	Health Board Vice Chair
	Dilys Jouvenat	Independent Member
	Neil Mesher	Independent Member
	Rhys Goode	Independent Member
In Attendance	Sally May	Executive Director of Finance
	Richard Hughes	Executive Director of Nursing
	Hywel Daniel	Executive Director for People
	Gethin Hughes	Chief Operating Officer
	Lauren Edwards	Executive Director of AHP's and Health Sciences
	Aaron Fowler	Committee Secretary, NWJCC
	Stacy Taylor	Director of Finance & Information NWJCC
	Matthew Edwards	Assistant Committee Secretary Governance and Business NWJCC
	Mark Jones	Audit Wales
	Steve Stark	Audit Wales
	Paul Dalton	Head of Internal Audit NWSSP
	Owen James	Head of Corporate Finance
	Louise Stait	Interim Assistant Director of Governance & Risk
	Emma Walters	Head of Corporate Governance & Board Business
	Kathrine Davies	Corporate Governance Manager
Meeting Observers		

Agenda Item	Meeting Business
1.	PRELIMINARY MATTERS
1.1	Welcome and Introductions
	P. Roseblade, Committee Chair welcomed everyone to the meeting, particularly colleagues from the Joint Commissioning Committee, Internal Audit and Audit Wales.



	The format of the proceedings in its virtual form was 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.
1.2	Apologies for Absence Apologies were received from : • Gareth Watts - Director of Corporate Governance/Board Secretary (L. Stait Deputising) • Kathy Mason - Independent Member • Carolyn Donoghue - Independent Member
1.3	Declarations of Interest R. Hughes declared an interest in Agenda Item 2.1.1 as one of the acting Executive Directors referenced in the report relating to additional remuneration exceeding approved Welsh Government pay bands.
2.	ANNUAL REPORT & ACCOUNTS 2025-2026
2.1	CTMUHB Annual Report & Accounts / Hosted Organisations Accountability Report and/or Governance Compliance Statement
2.1.1	CTMUHB Annual Report & Accounts 2025-2026 S. May presented the Annual Report and highlighted material amendments since the previous Committee review on the 19th May 2026 primarily within the performance and accountability sections. S. May confirmed that corrections had been made to the financial statements as detailed in the ISA 260 report with no uncorrected misstatements remaining. S. May advised that the report includes financial performance at Chapter 3 and incorporates the Joint Commissioning Committee (JCC) Annual Accounts and Governance Statements from both JCC and the National Imaging Academy Wales (NIAW). A key issue flagged for escalation was that Audit Wales intends to issue an unqualified "true and fair" audit opinion but a qualified regularity opinion due to irregular expenditure linked to additional remuneration of £9,083 paid to two acting Executive Directors above approved pay bands and £11,929 total excess cost when including associated on costs. S. May confirmed that the financial impact of this irregularity was limited in value, transparently disclosed and does not affect the overall "true and fair" audit opinion. M. Jones confirmed that the accounts were materially accurate supporting an unqualified "true and fair" audit opinion. He reiterated that there is a qualified regularity opinion ("except for"), relating to remuneration paid to two Executive Directors above approved Welsh Government pay bands with no other regularity issues identified.



M. Jones confirmed that Appendix 2 contains a small number of routine audit adjustments, all appropriately addressed with no outstanding or material concerns.

M. Jones advised that the audit process for the financial statements went very smoothly with good records and co-operation and was completed ahead of schedule and confirmed that there were no uncorrected misstatements with a low volume of audit adjustments which was positive for an organisation of this size.

M. Jones emphasised the Health Board's strong financial position with the Three-year revenue and capital resource limits met and an Approved Three-year financial plan in place to March 2028, noting that Cwm Taf Morgannwg University Health Board was the only Health Board in Wales in this position.

M. Jones outlined the finalisation process and timelines and advised that the audit certification was scheduled for tomorrow (30 June 2026), following which the accounts would be submitted to Welsh Government and laid before the Senedd shortly after.

K. Palmer commended the teams involved in preparing the accounts and report, recognising the significance of achieving a Three-year balanced budget. K. Palmer referred to the Welsh Government approval process and queried what steps would be taken to ensure that approval is obtained in advance for future years and particularly in relation to acting Executive Directors remuneration.

H. Daniel, in response, acknowledged the point made by K. Palmer and advised that following this, two key corrective actions would be undertaken with work underway to:

- Develop a clear control document/Standard Operating Procedure (SOP) for Executive appointments to ensure appropriate approvals are obtained in future, and;
- Improve on historical record keeping which had contributed to the issue and audit delay

H. Daniel advised that this would be reported through this Committee and Remuneration Committee in the coming weeks.

M. Jones formally thanked all Officers across the Health Board and the JCC who had supported the audit process and recognised the broad organisational effort behind the audit and expressed his appreciation for the cooperation that enabled its successful completion.

P. Roseblade also formally extended her thanks and appreciation to everyone involved in the preparation of the Annual Report and Accounts, which was a significant task, noting that timeframes and were tightening and requirements increasing with each year.

Resolution: The Committee:

	• ENDORSED APPROVAL of the CTMUHB Annual Report & Accounts for 2025-2026
Action:	None identified
2.1.2.	Joint Commissioning Committee (JCC) Accountability Report 2025-2026 A Fowler presented the report and advised that there were no changes since it was last shared with the Committee in May 2026 and confirmed that the report had been through the JCC's full internal governance process, including Sub Committee and Joint Committee approval before coming to the Committee today.
Resolution:	The report was NOTED .
Action:	None identified
2.1.3	Joint Commissioning Committee Accounts 2025-2026 S. Taylor presented the report and confirmed that the JCC had met its financial duties, including developing a plan and delivering a net nil balance financial position in line with risk-sharing arrangements. S. Taylor advised that all audit findings requiring amendments or corrections had completed with only those already referenced in the Audit Wales ISA 260 report remaining. S. Taylor expressed her thanks to the finance team and auditors for their support in reaching this position.
Resolution:	The report was NOTED .
Action:	None identified
2.1.4	National Imaging Academy Wales (NIAW) Governance Compliance Statement 2025-2026 The report was presented to the Committee. L. Edwards advised that she is the link Executive for the NIAW and meets with the Academy regularly in relation to this.
Resolution:	The report was NOTED .
Action:	None identified
2.2	NHS Wales Shared Services Partnerships Internal Audit Services
2.2.1	Head of Internal Audit Options and Annual Report for 2025-2026 P. Dalton presented the report and advised that this was the final version, incorporating work that was still in progress at the previous meeting held in May 2026 had now been completed and included and previous draft reports had now been finalised and reflected in this version. P. Dalton confirmed that the overall internal audit opinion remained unchanged as "Reasonable" Assurance and highlighted an update to the performance indicators table at section 4.2 within the report and provided continued confidence in governance and internal controls.

	P. Roseblade referred to paragraph 4.2 and the management response turnaround times and stated that she would like to see an improvement in the turnaround times for next year's report. She added that the presence of limited opinion reports was not a concern as it indicated the right areas were being audited but emphasised that response timeliness was the key issue to be addressed.
Resolution:	The report was NOTED .
Action:	None identified
2.3	Audit Wales
2.3.1.	Audit of the Financial Statement (ISA 260) Report (Including the Letter of Representation and Audit Opinion) M. Jones presented the report and highlighted the following key matters: - The qualified regularity opinion including a specific explanation of the qualification linked to remuneration exceeding Welsh Government approved pay bands for two Executive Directors. - Details of the audit adjustments to the corrections made to the accounts were contained within Appendix 2, all of which were addressed with no outstanding or uncorrected misstatements. - The accounts remain materially accurate with an unqualified "true and fair" opinion despite the limited regularity issue.
Resolution:	The report was Noted . The letter of Representation was Endorsed for Approval.
Action:	None identified
3.	ANY OTHER BUSINESS
3.1	No further items were identified.
4.	CLOSE OF MEETING
4.1	Date and time of next meeting: 4th August 2026 at 10:00AM



CTMUHB Public Board

Shared with Audit and Risk Assurance Committee for info via Consent Agenda – 4 August 2026

Board Assurance Framework Report – July 2026

Eitem yr Agenda / Agenda Item	
Dyddiad y Cyfarfod / Date of Meeting:	Thursday 30 July 2026 (Board) <i>(Then shared with ARAC for information on 4 August 2026)</i>
Statws Cyhoeddi / Publication Status:	Open/Public.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Louise Stait, Interim Assistant Director Governance and Risk
Cyflwynydd yr Adroddiad / Report Presenter:	Gareth Watts, Director of Corporate Governance / Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance/Board Secretary
Diben yr Adroddiad / Report Purpose:	For Approval by the Board <i>Then shared with ARAC for information on 4 August 2026</i>
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	The Board is asked to: • Approve amendments made to the existing risks and confirm that the updates provide adequate assurance and reflect recent discussions.
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>	All Strategic Pillars <i>If more than one applies please list below:</i> This report relates to the Board Assurance Framework as a whole and therefore aligns to all CTMUHB Strategic Pillars.
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>	The Board Assurance Framework supports delivery of the Integrated Medium Term Plan and Annual Delivery Plan by identifying, monitoring and reporting the principal strategic risks that may affect delivery of the Health Board's objectives, priorities and statutory duties. The report supports oversight of whether these risks remain appropriately articulated, scored,



treated and aligned to the organisation's strategic priorities.

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

Dechreuwch drwy **grynhoi'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 was submitted to the CTMUHB Board on 30 July 2026. Owing to the timing of the respective meeting cycles, it was not possible to present the report to ARAC in advance on this occasion. The usual reporting cycle will be reinstated for future iterations. The Board report is therefore presented here to ARAC for information via the Consent Agenda.

The Board Assurance Framework sets out the Health Board's principal strategic risks and provides a structured view of the controls, assurances, gaps and mitigating actions in place to manage those risks.

All risks have been reviewed and updated by the risk owners and handlers in June/July 2026.

For the July iteration, the front-page table has been strengthened by adding the target risk score; the target score date; and a short risk treatment narrative.

This is in response to feedback from Independent Members, who have sought greater clarity regarding the relationship between mitigating activity and risk movement, including projected timescales for risk reduction.

The report also responds to the Audit Wales Structured Assessment recommendation that the BAF should more clearly report the impact of actions being taken to mitigate strategic risks. In response, the final column in the action table has been amended from an indicators-focused field to "Actual Impact of Actions (following implementation)". This is intended to avoid duplication with the intended impact column and to provide space to record actual impact once actions have been implemented.

Felly, beth (*darparu dadansoddiad ystyrllon 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*)

A small number of risk owners have not yet updated this section, reflecting the fact that the new approach is still being embedded. Further refinement is expected as risk owners review and update their risks through future reporting cycles.

All changes to the BAF since the May 2026 version are indicated in **red type**.

Summary of the Health Board's "Top Risks"

The Board Assurance Framework is a collectively agreed statement of the organisation's principal strategic risks. Health Boards are now routinely being asked to share their highest-rated strategic risks through emerging NHS Performance & Improvement assurance arrangements.

At present, CTMUHB's highest-rated BAF risks are:

1b	Enough capacity to meet emergency demand (20)
8.	Prevention and early Intervention to support Healthy Life Expectancy (20)
9.	Failure to deliver a sustainable plan and manage revenue resources within the Revenue Resource limits set by Welsh Government (20)

Summary information on target risk scores and approach

The enhanced summary table is intended to support more active strategic scrutiny of the Board Assurance Framework by making the current position, planned approach and expected trajectory of each risk more visible at a high level.

By including target scores, target dates and risk treatment / status information, readers are better able to assess not only the current level of risk, but also whether the risk has been articulated appropriately, whether the proposed mitigation approach is likely to deliver the intended reduction in risk, and whether the anticipated timescales are realistic.

As part of this exercise, the target score for two risks has been increased from 8 to 12 to reflect a more realistic and deliverable position:

- **Risk 6:** Ability to maintain a safe and fit for purpose estate infrastructure



	- Risk 11: Delivery of an Integrated Care Model
Beth Nesaf (<i>crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud</i>) What Next (<i>summary of intended action and benefits supporting the choices and recommendation(s) being made</i>)	The BAF will be considered through the relevant Committee cycle during July / August 2026. Further work will continue to enhance the readability and assurance value of the BAF. This includes testing whether key strategic risk entries can be reduced in length while retaining clarity, evidence and assurance. The next presentation of this report to the Board will be on 24 September 2026.
Argymhelliad (<i>Wedi'i gysylltu â'r adran "Beth Nesaf" uchod</i>). Recommendation (Linked to the "What Next" section above).	The Board is asked to: • Approve amendments made to the existing risks and confirm that the updates provide adequate assurance and reflect recent discussions.

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)	All Strategic Risks on the BAF This report relates to the Board Assurance Framework as a whole and therefore has relevance to all strategic risks included within the BAF.

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	All applicable The Board Assurance Framework supports consideration of the Health Board's strategic risks across all relevant Wellbeing Goals. Individual strategic risk entries identify specific implications where relevant.

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	All applicable The Board Assurance Framework supports oversight of strategic risks that may affect all Enablers of Quality. The specific relevance of each enabler is



	reflected within individual strategic risk entries where appropriate.

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	Yes - Applicable
	The report itself does not propose a new service change or operational decision with a direct environmental impact. However, the Board Assurance Framework includes strategic risks relating to environmental and social duties, estate infrastructure, financial sustainability, population health and service transformation, all of which may have environmental and sustainability implications. These are considered within the relevant strategic risk entries.

Asesiad Effaith Impact Assessment	
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg (Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.) Equality & Welsh Language Impact Assessment Outcome (Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)	A separate Equality Impact Assessment has not been undertaken for this covering report, as it provides an assurance update on the Board Assurance Framework rather than proposing a new policy, service change or decision. Equality implications are considered within individual strategic risks and associated programmes where relevant. A separate Welsh Language Impact Assessment has not been undertaken for this covering report, as it provides an assurance update on the Board Assurance Framework. Welsh Language implications are considered within individual strategic risks and associated programmes where relevant. If no, please select a reason below: Not required — assurance report only / no new policy, service change or decision proposed. Named Executive/Board member sign off for no EWLIA completion: Director of Corporate Governance / Board Secretary



Canlyniad Asesiad Effaith Ansawdd (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)	A separate Quality Impact Assessment has not been undertaken for this covering report, as it provides an assurance update on the Board Assurance Framework rather than proposing a new service change or operational decision. Quality implications are captured within individual strategic risk entries where relevant, particularly where risks relate to patient safety, experience, outcomes, workforce, access, estates, digital infrastructure and service sustainability.
Cyfreithiol / Legal	Yes (Include further detail below) Legal and regulatory implications are captured within individual strategic risk entries where relevant.
Enw da / Reputational	Yes (include further detail below) The Board Assurance Framework is a key public assurance document and may influence internal, external and national understanding of the Health Board's principal strategic risks. Reputational implications are therefore relevant.
Effaith Adnoddau (Pobl /Ariannol) / Resource Impact (People / Financial)	Yes (include further detail below) This report does not request additional resource. However, workforce, financial and other resource implications are captured within individual strategic risk entries where relevant. The Board Assurance Framework supports oversight of whether resource-related risks are appropriately reflected, treated and monitored.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Strategic risk owners and risk handlers	June 2026	Updates requested to support the July 2026 BAF refresh, including target score, target score date and risk treatment information.
Executive Leadership Group	July 2026	Risks reviewed and management sign off received.
Executive Leadership Group, Board and Committees (ongoing)	Various	Previous iterations of the BAF have been reviewed through the established governance cycle. The document is iterative and continues to respond to Executive, Board and Committee feedback.



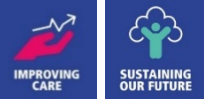
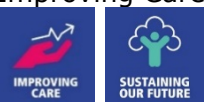
Audit Wales feedback / Structured Assessment recommendation	2025/26	BAF template amended to strengthen reporting of the actual impact of mitigating actions, in response to the recommendation that the BAF should more clearly report the impact of actions taken to mitigate strategic risks.

Acronyms / Glossary of Terms

BAF	Board Assurance Framework
CTMUHB	Cwm Taf Morgannwg University Health Board
ELG	Executive Leadership Group
IMTP	Integrated Medium Term Plan
P&I	Performance and Improvement

CTMUHB - BOARD ASSURANCE FRAMEWORK REPORT

Section 1 – Summary

Risk no	Strategic Goal	Strategic / Principal Risk	Lead(s) for this risk	Assurance committee	Current score	Target Score	Target Score Date	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)	12 (C4xL3)	2030	Treat with elements tolerated. We are actively managing this risk and expect a reduction in score over time through planned care recovery and improvement programmes; however, progress remains uneven and is currently constrained in key pathways (notably Orthopaedics) by workforce, operational and system pressures, which are being tolerated in the short term.
		b) Enough capacity to meet emergency demand			20 (C4xL5)	12 (C4xL3)	2030	Treat with elements tolerated. We are actively managing this risk and expect improvement through urgent and emergency care programmes and system-wide actions; however, our ability to reduce the score is constrained by sustained demand, patient flow challenges and system pressures, meaning the pace of improvement is currently being tolerated.
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)	12 (C4xL3)	TBC	Treat. We are actively managing this risk and expect a reduction in score over time through embedding a consistent, system-wide approach to improvement; however, delivery remains dependent on local capacity, capability and alignment across care groups.
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	16 (C4xL4)	8 (C4xL2)	March 2029	Treat with elements tolerated. This risk will continue to be treated through targeted action under the CTM People Plan, workforce planning, recruitment, retention, and wellbeing, and productivity programmes. A reduction is expected over time, but remains constrained by national workforce supply, sickness absence, variable pay, affordability pressures and the pace of service change.
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)	8 (C4xL2)	Dec 2026	We will need to tolerate the fact that management of the risk will need to be ongoing while the organisation actively treats the risk by recruiting additional engagement capacity; implementing a standardised approach to service change; implementing a new tool to manage social media, digital engagement and insights; developing and implementing the SE Wales Regional Engagement Plan.
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)	12 (C4xL3)	TBC	Treat with elements tolerated. We are actively managing this risk and expect reduction over time through delivery of digital transformation and infrastructure programmes; however, progress is constrained by resource limitations, competing organisational priorities and the evolving cyber risk landscape.
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) 	8 (C4xL2) 12 (C4xL3)	2031	Treat with elements tolerated. We have reviewed the target risk score and revised it to 12 to reflect a more realistic and deliverable position. We are actively managing this risk and expect improvement over time through prioritised capital investment and maintenance programmes; however, progress is constrained by limited capital availability and the scale of backlog maintenance, meaning the pace of risk reduction is currently limited

7.	 Click Here for Risk 7	Fulfilling our Environmental and Social Duties and ambitions	Executive Director of Strategy & Transformation	Strategic Development Committee	16 (C4xL4)	8 (C4xL2)	2030	Treat with elements tolerated. We are actively managing this risk and expect reduction over time through delivery of the Climate Action Plan and strengthened governance arrangements; however, progress is constrained by workforce and financial capacity, limiting the pace at which environmental ambitions can be realised.
8.	 Click Here for Risk 8	Prevention and early Intervention to support Healthy Life Expectancy	Executive Director of Public Health	Strategic Development Committee	20 (C5xL4)	8 (C4xL2)	TBC	Treat with elements tolerated. We are actively managing this risk through prevention and population health programmes; however, progress is dependent on wider system alignment, funding and capacity, and current delivery constraints limit the pace at which improvement in outcomes and inequalities can be achieved.
9.	 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)	12 (C4xL3)	TBC	Treat. We are actively managing this risk and expect progress through delivery of the IMTP and savings programmes; however, the level of financial challenge and delivery risk remains significant.
10.	 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)	8 (C4xL2)	2031	Treat with elements tolerated. We are actively managing this risk and expect improvement over time through development of the estate strategy and capital schemes; however, progress is dependent on funding availability and the pace of infrastructure investment.
11.	 Click Here for Risk 11	Delivery of an Integrated Care Model	Chief Operating Officer	Strategic Development Committee	16 (C4xL4)	12 (C4xL2)	TBC	Treat. We are actively managing this risk and expect reduction over time through delivery of transformation programmes and strengthened partnership working across the system, although progress is dependent on alignment across organisations.

Section 2 Strategic Risk Heat Map

Current risk scores in **black**

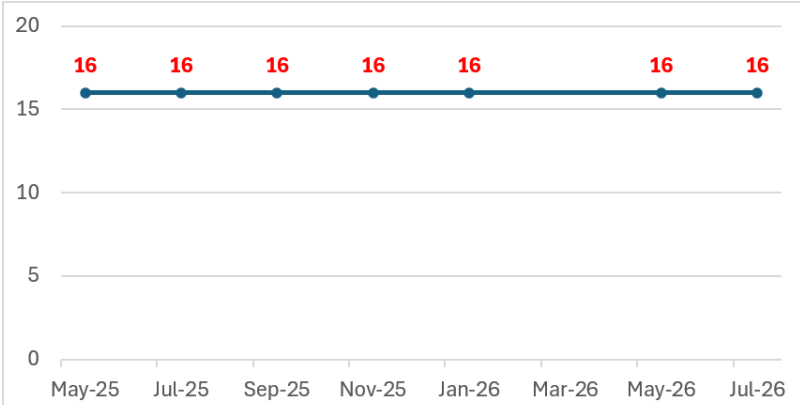
Target risk scores in *grey italic*

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				6	
	2					
	1					
CxL		1	2	3	4	5
		Likelihood				

SECTION 3 – STRATEGIC RISKS

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: 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>				>104 weeks has increased in month in line with the IMTP trajectory. This is caused by the recurring gap in Orthopaedics and the transfer of Neurology from C&VUHB. - Regional orthopedic plan developed to support reduction in waiting times until 2030. - Progress is maintained in all areas with HBS outpatient programme delivering 0 patients >52 weeks. Neurology >52 weeks has transferred over from C&VUHB driving the current position. - Cancer SCP (Suspected Cancer Pathway) maintained >60% and the service received automatic de-escalation to level 1 routine monitoring. With CTMUHB maintaining the top position in Wales for 4 months. Trajectory has been submitted. - The national Red heat warning restricted the use of theatres due to the high humidity levels. >250 procedures were postponed over the 3 days of the red alert. - CTM now has all theatres operational across the 3 sites with a new theatre timetable launched in April 2026, based on demand and capacity. - Progress made in theatre start times and in outpatient SOS (See on Symptom) and PIFU (Patient Initiated Follow- Up) rates.

	- Progress made on >104 week. All specialities aim to maintain <104 weeks with the exception of Orthopaedics and neurology - 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. (High Volume Low Complexity) - Endoscopy recovery plan commencing August 2026 to maintain the improved position. - PIT (Productivity, Improvement and Transformation) Board refocussed on delivery of key actions for each group, with focus of all specialities on PIFU and SOS. - 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. - Workforce recruitment continues across the care group to enable a sustainable capacity model. There continues to be a reduction of ADH (Additional Hours) and WLI (Waiting List Initiative) activity attributed to standardisation of pay. - Regional working continues and the positive and negative impact of this will be continuously reviewed. 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: - Effective Waiting List Management Systems: clear national pathways; focused treat in turn; effective booking processes; robust demand management - Outpatient & Preoperative Modernisation: utilisation of SOS and PIFU; additional advice & guidance services; virtual preoperative clinics - Theatre Capacity: reduction of fallow lists; efficient scheduling; increased utilisation; improved productivity	

4. **gGiRFT (Getting It Right First Time)** & 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 are focusing 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.

Integrated Medium Term Plan (IMTP) – investment agreed by Board.

Specific Improvement Groups/Boards

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

All updates feed into the Improving Care Board.

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

~~**Annual Planning Process**~~

Recovery Planning post critical incident at POW.

Lessons learnt from ~~seasonal Winter~~ planning process forms part of business as usual.

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.
- Tactical Intervention (TI) meetings

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Indicators of Success (following implementation of mitigating actions) Actual Impact of Actions (following implementation)
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 - Welsh Patient Referral Service (WPRS) full roll out	- Theatre metrics seeing a decreased CAN/DNA rate - Monitoring of all speciality Increased utilisation and highlighting non compliance. - Decreased missed opportunities - Reduction in referral demand - Reduction in waiting list	This column to be left blank for now, and populated once actions are complete.
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. - Canise—CANISC (Cancer Network Information System Cymru) replacement ongoing. Implementation of Breast, Urology & lower GI datasets - Training undertaken for all cancer trackers to ensure consistency and compliance with new guidance	Observed an Increase in performance SCP over 6 months and focus on 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.	- Increase in activity - Reduced fellow sessions - Reduction in waiting times - Reduction in >104 week wait across all specialities except that with a recurring gap.	

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

CTMUHB Board Assurance Framework Report

July 2026

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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:

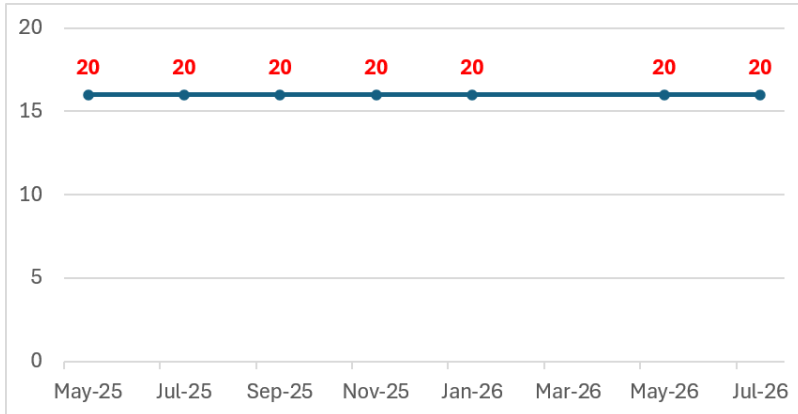
None

Associated Risks escalated to the Organisational Risk Register

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
6280	Suspension of the Regional Hepato-Pancreato-Biliary service model.	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: 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>				• 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 some improvement against trajectories for emergency demand. Specifically, 45-minute ambulance handover, 12-hour ED performance and a total reduction of lost ambulance hours. • ~~There has also been significant reallocation of internal capacity at POW and RGH to respond to the critical incident declared at Princess of Wales on 9th October 2024 re. roof integrity issues.~~ • ~~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 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 have 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 Additional Hours (ADH) and Waiting List Initiative (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 static 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

Urgent & Emergency Care Programme: The National Urgent and Emergency Care (UEC) Improvement Plan sets out priorities, delivery and assurance expectations needed to stabilise and improve urgent and emergency care. The whole system priorities are: - Strengthen community capacity and alternatives to admission - Reduce risk of harm and restore patient safety - Deliver consistent models of care at front door, particularly for acute frail elderly patients - Improve access and flow across the UEC pathway via consistent 7-day clinical pathways - Focus on in-hospital flow and discharge as a core driver of timely clinical care ~~Six Goals for Urgent and Emergency Care Programme (signed off by Executive Leadership Group (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.

3. 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.
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 high-quality care and minimising harm.
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.

Programme Governance

- Urgent & Emergency Care Programme Board Diabetes Programme Board
- ~~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
- Urgent and Emergency Care Collaborative (previously UNITE), incorporating Strategic Transformation of Acute Medicine (STAMP)
- ~~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 ~~is the overarching governance framework~~

Annual Planning Process

Recovery Planning post critical incident at POW

Lessons learnt from Seasonal Winter Planning process ~~forms part of business as usual~~ ~~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~~ - UEC Programme Board/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)				
- Executive Integrated Performance Meeting - Directorate Integrated Performance Meeting - UEC Programme Board - 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. - Same Day Emergency Care (SDEC) Programme - Optimise - Ambulance Handover and ED Improvement Plan - Escalation processes leading to Chief Operating Officer Report to Quality, Safety and Experience Committee including Care Group performance review meetings. - Organisational Risk Register via Care Group Risk Registers. - Planning, Performance & Finance monthly report. - Targeted Intervention (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	Indicators of Success (following implementation of mitigating actions) Actual Impact of Actions (following implementation)
1. Improvements being made in urgent care trajectories albeit not fully embedded.	- Unscheduled Care SMT attended 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:	- Improved performance - Reduction in patients >12hrs - Improved community response		This column to be left blank for now, and populated once actions are complete.

	○ GIRFT recommendations ○ SDEC Review ○ Ambulance Patient Handover Guidance ○ ED Quality Statement ○ Ministerial Advisory Group (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. • ED Flow Action Cards (45-minute handover, 12-hour ED waits, time to triage and time to first assessment) live in draft June 2026. Wider Care Group collaboration underway to target ED 12-hour performance. • Sprint learning analysis to understand if this has an impact on emergency demand capacity. • Engagement in a health board session reflecting on resilience/seasonal winter-planning, site flow teams, and extraordinary Business Continuity Incident (BCI) actions. • Ambulance escalation cards live. • ED 12-hour Action Plan completed • CTM Safe Transfer of 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. • Strategic Transformation of Acute Medicine Programme (STAMP) roll out across all sites including remodelling of acute medicine footprint/flow in POW and implementation of a Same Day Emergency Care (SDEC) First model for GP expected patients at PCH – Quarter 21 2026/27 • Unscheduled Collaborative (Unscheduled Care Transformation Programme, formally UNITE) 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.	• Reduced Length of Stay (LoS) in the Emergency Department • Reduced harm associated with increased waiting times • Improved patient experience	

	- 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 (April 2026) 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 March 2027 ~~October 2025~~ - Zero tolerance for any ED wait over 12 hours by October 2025 - Continuous improvement of patients waiting over 12-hours and not exceed 1000 by March 2027 Access to Timely Planned Care Services in USC As per Planned Care BAF			
Current Performance Highlights			

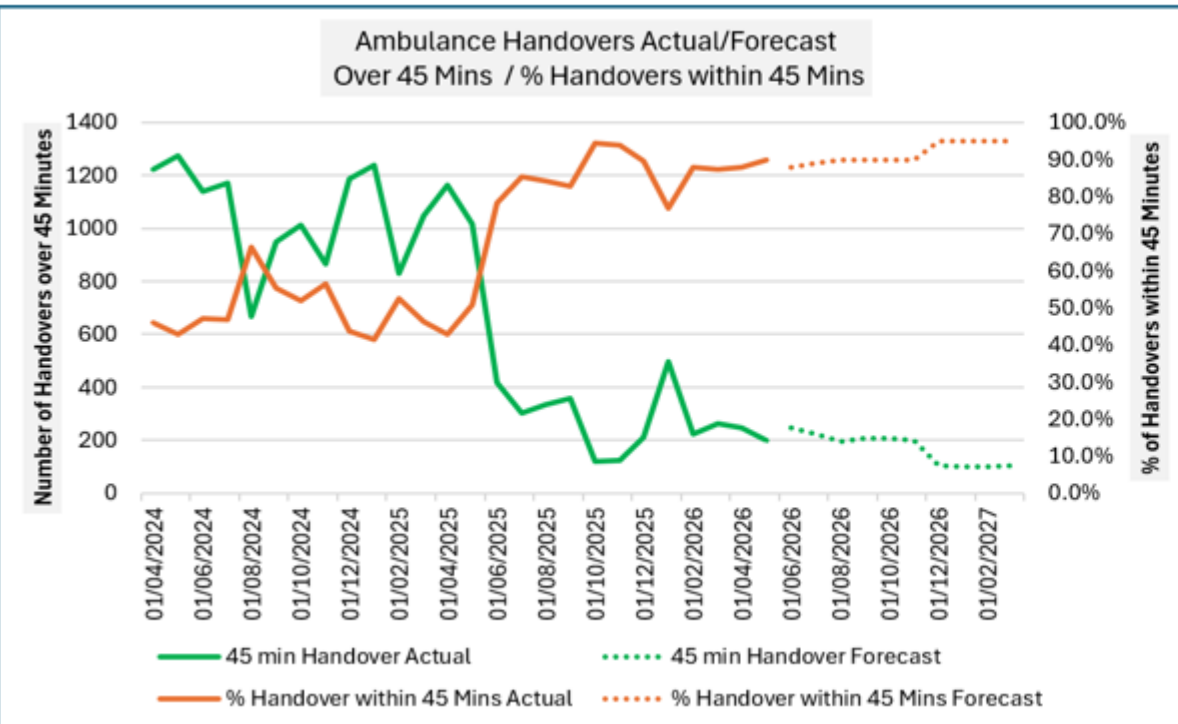
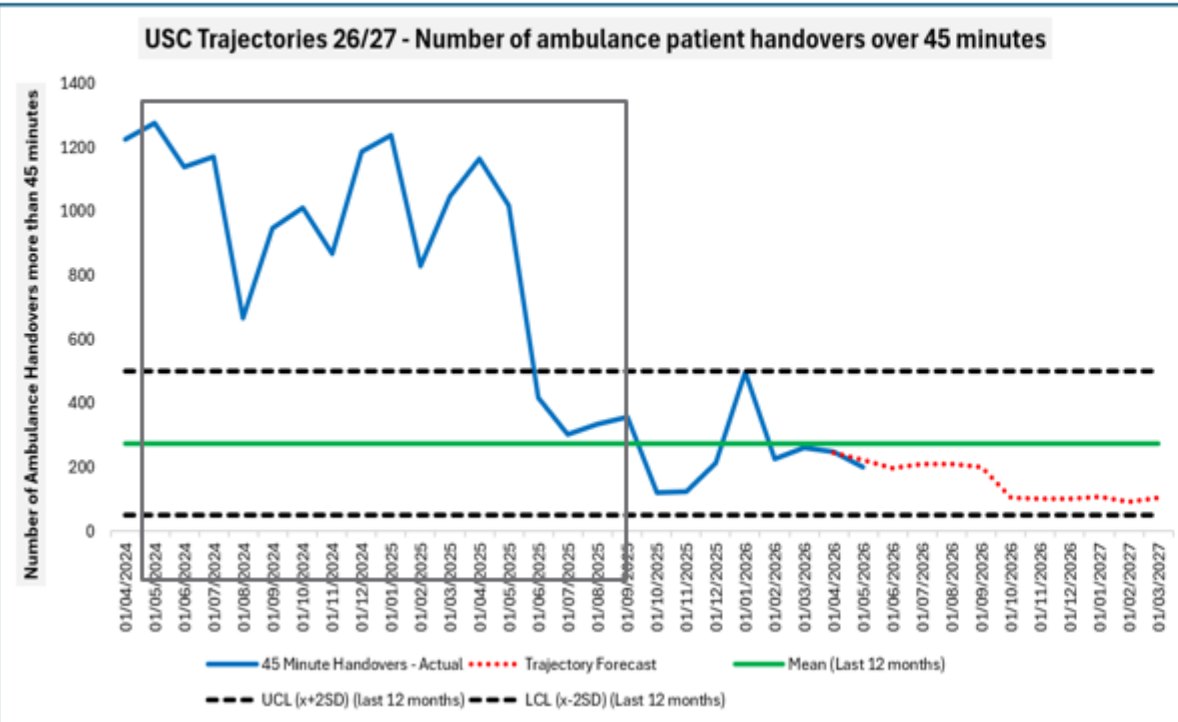
Handover 45 Report (Hospital Emergency Department Handovers)

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

Hospital Name	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26
Bronglais General Hospital Aberystwyth	40%	55%	75%	59%	63%	61%	49%	71%	60%	50%	53%	60%	59%
Glangwili Hospital Carmarthen	34%	36%	43%	54%	78%	80%	61%	59%	47%	58%	60%	57%	46%
Grange University Hospital Cwmbran	41%	41%	45%	37%	68%	65%	50%	43%	36%	43%	49%	44%	49%
Morriston Hospital Swansea	37%	73%	84%	87%	82%	82%	81%	66%	58%	49%	45%	51%	60%
Prince Charles Hosp Merthyr	42%	64%	88%	96%	99%	95%	97%	89%	77%	89%	84%	94%	97%
Princess Of Wales Bridgend	67%	77%	75%	74%	70%	95%	89%	85%	74%	90%	83%	82%	70%
Royal Glamorgan Hosp Pontyclun	50%	91%	87%	79%	76%	93%	94%	92%	77%	86%	92%	85%	95%
University Hospital Of Wales Cardiff	60%	62%	64%	92%	95%	87%	86%	83%	79%	74%	90%	89%	95%
Withybush Hospital Haverfordwest	52%	47%	48%	51%	56%	64%	71%	72%	75%	83%	86%	60%	64%
Wrexham Maelor Hospital Wrexham	29%	34%	52%	29%	30%	28%	29%	48%	26%	32%	29%	46%	42%
Ysbyty Glan Clwyd Hospital	50%	41%	43%	55%	47%	55%	37%	66%	42%	45%	44%	37%	49%
Ysbyty Gwynedd	30%	36%	33%	33%	27%	30%	27%	37%	29%	31%	29%	35%	27%

* part month

USC Trajectories 26/27 - Number of ambulance patient handovers over 45 minutes



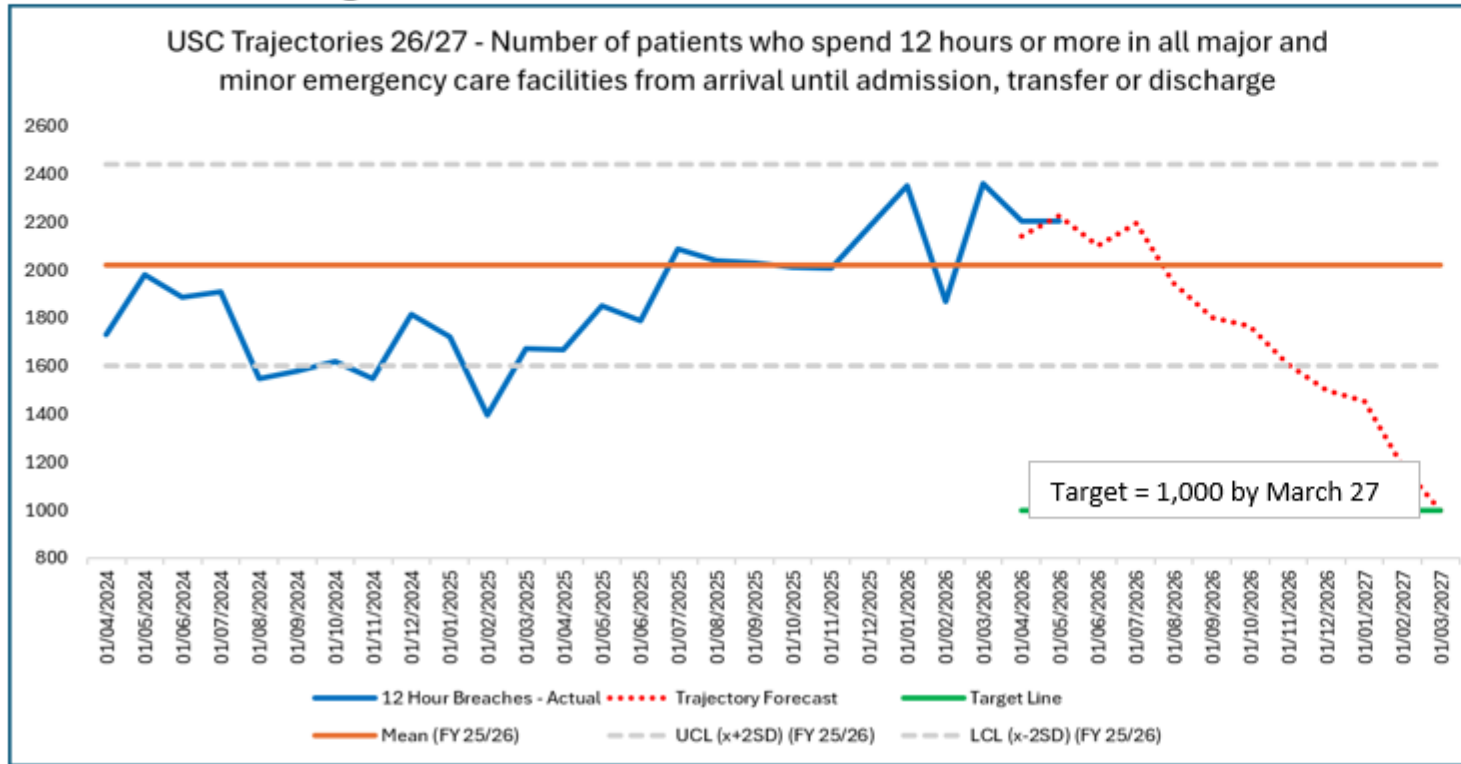
Number of ambulance patient handovers over 45 minutes by Site

MonthDate	Prince Charles Hospital Merthyr	Princess Of Wales Hospital Bridgend	Royal Glamorgan Hospital Pontyclun	Grand Total
2024-04	529	331	364	1224
2024-05	524	351	400	1275
2024-06	470	357	311	1138
2024-07	462	328	381	1171
2024-08	337	194	136	667
2024-09	377	218	353	948
2024-10	490	164	357	1011
2024-11	392	161	313	866
2024-12	457	246	483	1186
2025-01	452	187	598	1237
2025-02	307	138	384	829
2025-03	366	192	488	1046
2025-04	423	201	540	1164
2025-05	440	118	458	1016
2025-06	248	98	70	416
2025-07	90	96	116	302
2025-08	27	115	192	334
2025-09	7	142	207	356
2025-10	37	25	57	119
2025-11	20	52	51	123
2025-12	75	70	66	211
2026-01	165	120	211	496
2026-02	71	43	111	225
2026-03	114	75	72	261
2026-04	45	78	123	246
2026-05	22	136	42	200

Actual v Forecast

	Actual FY 2024/25	Actual FY 2025/26	Actual 2026/27	Forecast 26/27
April	1,224	1,164	246	245
May	1,275	1,016	200	221
June	1,138	416		195
July	1,171	302		208
August	667	334		208
September	948	356		200
October	1,011	119		103
November	866	123		101
December	1,186	211		101
January	1,237	496		106
February	829	225		93
March	1,046	261		103

USC Trajectories 26/27 - 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 v Forecast

	Actual FY 2024/25	Actual FY 2025/26	Actual 2026/27	Forecast 26/27
April	1,729	1,668	2,205	2,140
May	1,982	1,853	2,204	2,227
June	1,888	1,788		2,100
July	1,911	2,087		2,197
August	1,546	2,040		1,945
September Q2	1,579	2,032		1,800
October	1,618	2,013		1,766
November	1,546	2,007		1,607
December Q3	1,815	2,177		1,500
January	1,720	2,352		1,453
February	1,396	1,868		1,180
March Q4	1,673	2,361		1,000

Number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge

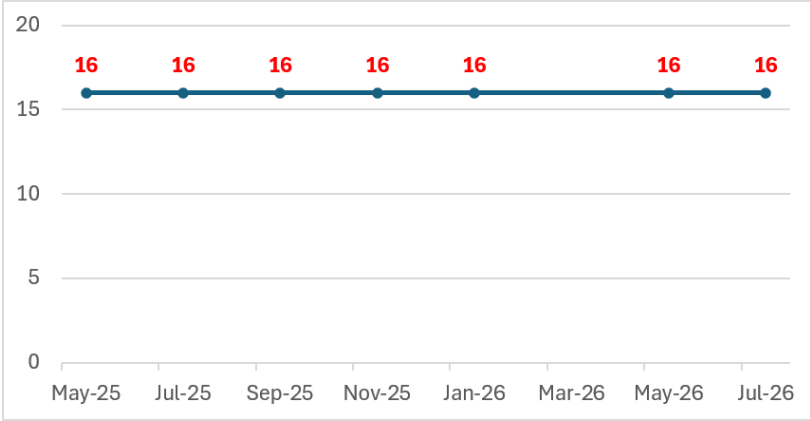
MonthDate	Prince Charles Hospital	Princess Of Wales Hospital	Royal Glamorgan Hospital	Community Hospitals	Grand Total
2024-04	553	693	482	1	1729
2024-05	657	764	561	0	1982
2024-06	582	765	541	0	1888
2024-07	685	669	557	0	1911
2024-08	561	525	460	0	1546
2024-09	540	568	471	0	1579
2024-10	561	521	536	0	1618
2024-11	554	502	490	0	1546
2024-12	654	580	581	0	1815
2025-01	590	506	624	0	1720
2025-02	419	467	510	0	1396
2025-03	534	547	591	1	1673
2025-04	551	529	588	0	1668
2025-05	606	574	673	0	1853
2025-06	675	517	596	0	1788
2025-07	761	621	705	0	2087
2025-08	728	648	664	0	2040
2025-09	699	655	678	0	2032
2025-10	715	663	635	0	2013
2025-11	667	673	667	0	2007
2025-12	689	736	752	0	2177
2026-01	750	772	830	0	2352
2026-02	646	620	602	0	1868
2026-03	848	747	766	0	2361
2026-04	756	770	679	0	2205
2026-05	724	766	714	0	2204

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

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 (Reviewed and score reduced from 20 to 15)	~~20~~ 15
4632	Provision of an effective and comprehensive stroke service across CTM (encompassing prevention, early intervention, acute care and rehabilitation).	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 16
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	No change to risk scores this period.
Current	4	4	16	
Target	4	3	12	
Risk Appetite	Cautious (quality and safety; trust and confidence; legal and regulatory)			Risk Score Trajectory 
Rationale for assessment of risk score: Including where risk score remains unchanged and for any changes			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. 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) 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: groups included are: hydration, nutrition, falls, and pressure damage. 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) Risk Assessment, Delivery and Assurance Review (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; monitoring of compliance shared with the Care Groups g) Medicines Management Group chaired by the Assistant Medical Director 3. Learning from Experience & Engagement a) People’s Experience Framework: Operational forums with bi-annual reports to QSEC. b) 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. Patient Reported Experience Measures (PREMs) live in Emergency Departments. ii. Patient Reported Outcome Measures (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) 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 Quality Improvement (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) 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) 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 **Electronic Prescribing and Medicines Administration (EPMA) system**

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 the inspection, Healthcare Inspectorate Wales (HIW) identified a number of areas of concern which were assessed as having the potential to present an immediate risk to patient safety. These findings were discussed at the inspection feedback meeting with senior members of the team.

An immediate improvement plan was subsequently developed and submitted to HIW, setting out the actions taken and those planned, together with associated timescales and designated responsible officers. Progress against these actions has continued in accordance with the agreed plan.

The draft inspection report has now been received and reviewed for factual accuracy. In response, a comprehensive Improvement Plan has been prepared and submitted to HIW for consideration. Subject to HIW being assured that the actions identified adequately address the concerns raised, the Improvement Plan will be published alongside the final inspection report.

~~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 – People's 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.
- GMC Survey

- Improvement to be reported through Improving Care Board / Change to be reported through Strategic Transformation Board.
- ICTM (Improvement and Innovation) Annual Report
- 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.
- RADAR Reports.
- Improvement portfolio report.

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.
- 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.
- 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.
- 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 was 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 **by the to**-British Society of Echocardiography for **Transthoracic Echocardiography (TTE)**, training, stress echocardiography, and **Transoesophageal Echocardiography (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 the three Deputy Directors, Assistant Director of Quality & Safety, 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.
- 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 the National Duty of Candour Safety & Learning Network, including currently chairing the Network meetings.
- Partnership Working with Cardiff & Vale University Health Board 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 AmAT Inspection Module is fully implemented for assurance and monitoring of HIW Inspection Recommendations with bi-monthly reports received at the Quality, Safety & Experience Committee,
- 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 Accreditation and Assurance Programme. Ward assurance provides ongoing confidence that core standards of care and safety are being met, identifying risks and areas for improvement. There are regular point prevalence audits conducted on a regular basis.	Rolling programme commenced. This will now extend into a yearly assurance programme which will encompass all data repositories. Ward Accreditation programme: This program is currently on hold as there is an All Wales implementation program to allow for a consistent approach across Wales.	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)	Currently 35 wards completed. 8 White (This means that focus work is required to reach the minimum data sets required) 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

Ward accreditation ~~offers is~~ a more formal assessment that confirms a ward has met and can sustain agreed quality standards, ~~and is conducted on a yearly basis~~.		Extending program into Mental Health and Maternity.	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 Development and implementation of a safeguarding dashboard	Complete in terms of Safeguarding Strategy. Timeframe for Safeguarding dashboard to be implemented by the end of June 2026 (currently being piloted)	The Safeguarding strategy and framework give a comprehensive approach to Safeguarding. ~~They It~~ ~~provide~~ 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 platform 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 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 ~~S~~safeguarding ~~E~~xecutive ~~C~~ommittee. Work continues in line with strategic plan. The risk associated with previous backlog of looked ~~ed~~ after children health assessments ~~is~~ 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 CTMUHB's position in relation to NRI (Nationally Reportable Incident) 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 (March 2027). Work in progress for other areas.	• Improved decision making and therefore improved patient care. • Improved oversight of patient care form ward / team to Board against evidence-based standards and local indicators • Stimulate clinical team discussion and quality improvement areas. • Decision making	Action complete for Maternity. This action will be revised to reflect other areas across CTM in due course.

		Real time insights to ensure mobilisation of support, adjustments and actions where needed	
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 (a digital staff ideas and improvement platform) 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 a Value-Based Healthcare (VBHC) approach.
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. 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.	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: - 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

		Framework agency reduction: to achieve a 20% reduction in the use of framework agency registered nurses	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 (Organisational Change Programme) 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	- 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. - 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 Coroner's 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 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 Officer's 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 1 April 2026 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:

Nationally Reportable incidents (NRI) 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.

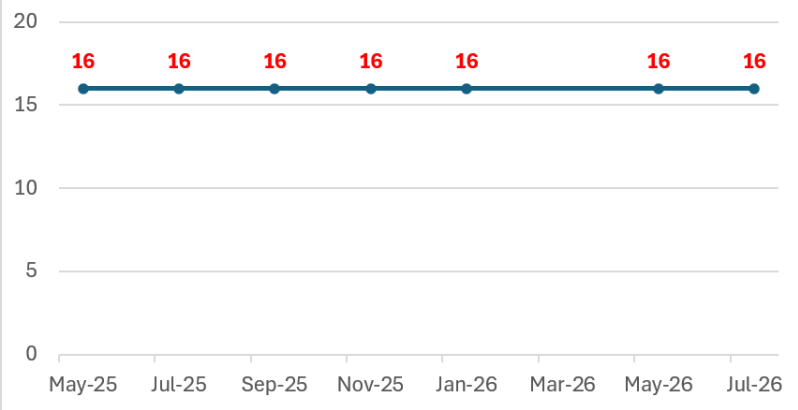
Associated Risks escalated to the Organisational Risk Register

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
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
6232	Stability of the Legal Services Function.	15
4691	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: Including where risk score remains unchanged and for any changes	This ~~The~~ workforce risk remains significant due to ongoing recruitment challenges, national supply constraints, sickness absence, variable pay reliance and workforce implications linked to service change. While turnover and sickness are showing improvement, gaps remain in hard to fill roles, job planning compliance and sustainable workforce models. The score remains unchanged at 16 because workforce challenges continues to affect service resilience, staff wellbeing, delivery of planned activity and a reliance on temporary staffing. ~~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 from 8.79% in December 2025 to 8.32% in January 2026 to 7.55%7.50% in April 2026 in February 2026. This is an increase of 0.4857% on the February April 2025 rate of 7.076.93%. The rolling 12 months sickness rate was to April 2026 was 7.4102%7.50% and is slightly higher than the equivalent rolling 12 month period of the previous year (6.93%). The in-month April 2026 sickness rate is 7.02% which is higher than April 2025 (6.61%). ForecastedM&D -agency agency spend for M12 M2 20252026/2026 2027 is £9.422.1889k with a year to date spend of £1.473mm which is a 3.8% for M&D. For Nursing and Midwifery agency spend, (bank and agency) including HCSWs, the position for the year to date at M2 is a forecasted reduction of 38% £13.3m at M12 2025/2026was reported as ££2.391.652m. Turnover reduced furthercontinues to fall, being 8.09% in May 2026, compared to 9.23% in May 2025 from 8.50% in January 2026. Job Planning compliance as at May 2026 was 47%, a slight increase on April 2026's's 44%. There is considerable variation between Ccare Ggroups and efforts to increase Job Planning figures continue to be addressed via the Medical Workforce Productivity Programme and new Recruitment Controls linking authorisation of Consultant Recruitment to speciality job planning rates. This is being addressed by the Medical Workforce Productivity Programme 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 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 <u>is being treated through</u> will continue to be treated through targeted action under the CTM People Plan, <u>working with Care Groups and professional leads to strengthen workforce planning, recruitment, retention, and wellbeing, and embed improvements into business-as-usualproductivity programmes.</u> 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. A reduction <u>is expected over time, but remains constrained by factors noted above including -national workforce supply, sickness absence, temporary spend, affordability pressures and the pace of service model change.</u> 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 workforce controls

[CTM People Plan](#), [Integrated Medium-Term Plan \(IMTP\)](#), [Education & Training Plans \(ETPs\)](#), [and national workforce planning frameworks](#) and [Welsh Government/ NHS P&I drivers \(e.g. Enabling Actions\)](#) provide the strategic controls for aligning workforce requirements with CTM2030, service change and national workforce priorities.

Recruitment and Resourcing

• [Job Evaluation](#), Vacancy Scrutiny Panel, – delivered via Trac and supported by NWSSP Recruitment Services.

Medical Workforce Recruitment Planning, [retention programme](#), [lateral moves scheme](#), [flexible working policy](#), and [onboarding/exit insight](#) are used to manage workforce supply, improve fill rates and [support retention](#). 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.](#)

Workforce Productivity and Temporary Staffing

- Nursing & Midwifery Productivity Programme (NMPP) – 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, [targeted](#) medical recruitment, [bank expansion](#) and agency reduction plans.
- HCRG new Managed Service Provider contract awarded to provide M&D Bank and Agency service (and AHP, PST and HCS agency requirements) – [Go Live July 2026](#).
- 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.

Workforce Planning

[Strategic Workforce Planning](#), [establishment reporting](#), [ESR](#), [HealthRoster](#), [HCRG](#), [workforce dashboards](#) support workforce visibility, planning, monitoring and decision making. –

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% \(Oct – Dec 2025\).](#)

People Dashboard

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 \(Feb-25\)](#)
- [Patchwork Dashboards](#)
- Job planning compliance
- Audit Updates

- [Medical & Dental Variable Pay Audit and M&D Job Planning Audit- recommendations on Audit Tracker \(updated for April/May 2026\)](#)
- [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.](#)
- [Final report of Medical Job planning Re-Audit circulated with outcomes of the audit will be presented at the Audit, Risk and Assurance committee meeting in August 2026](#)
- [Medical & Dental Medical Rostering Audit – this process is being revisited in light of the implementation of the new Resident Doctor contract.](#)
- [Medical & Dental Sickness Audit –management response July 2026](#)
- [M&D Job Planning Re-Audit, final report June 2026 and refreshed action plan](#)
- SAS doctors regrading process in place.
- [Resident Doctor contract changes CTM Implementation Group in place, alongside CTM membership at both NWSSP and NHS Employers led All Wales groups.](#)

Nursing and Midwifery Productivity Programme Board

Internal Assurance

- Nurse Productivity Programme Board [and associated datasets](#)–Agency spend reduced YTD from £20.04m TO £12.47m as at M11 2025/2026. 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. [updates](#)

[Agency usage trending report – RN and HCSW agency usage for since January 2026 continues to show a downward trend.](#)

[Bank usage remains steady across RN and HCSWs.](#)

[Health Roster optimisation and data quality improvements continue as one of the workstreams for NMPP 2026/2027.](#)

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](#)

Workforce Planning

Internal assurance

- Executive Leadership Group (ELG) approval of ETP Commissioning submission (Mar-26) to HEIW [and regular updates relating to Student Streamlining April -June 2026.](#)
- Audit Tracker oversight of actions.

External assurance

- [Audit Wales SWP audit- six recommendations tracked via ARC. Only one action remaining for completion.](#)
- [Participation in HEIW All-Wales SWP Network \(access to standards, guidance, peer comparison\).](#)
- [Engagement with All-Wales PA/MAPs frameworks and recruitment groups.](#)
- HEIW feedback on Education Training Plan (ETP) submission (on receipt).
- [\(SCPs\) to ensure adherence to all Wales governance and employment standards.](#)
- [Representation at the newly formed HEIW Workforce Supply Oversight Group \(WSOG\) from February 2026 focussed currently on nurse student streamlining vacancies for CTMs allocated graduating students for September 2026](#)
- [LHP OBC submitted to Welsh Government on 7 Dec 2025 which includes a Workforce Planning and OD section; \[workforce section\]\(#\) for the \[joint LHP/SEW\]\(#\) region OBC/FBC is in development for completion \[ready for sharing with CTM/CAV/AB Boards in July 2026.\]\(#\)in June 2026 and? or submission to WG in September in July 2026.](#)

Attraction, Resourcing and Recruitment

Internal assurance

- [Recruitment & Selection Policy \(under review\) and SOPs; monitored compliance via People governance.](#)
- [Time-to-Hire performance: reduced from 80.1 days in Jan-26 to 78.9% in March 2026 vs target 71; Year-to-date \(YTD\) 2025/2026 increased from 74.3 in January 2026 to 26 days \(AfC + M&D combined\).](#)
- [Recruitment action plan in place](#)
- [Attraction & Resourcing Working Group; senior oversight for key/critical posts.](#)
- [Pathways to Employment \(Project Search/Supported Internships, apprenticeships, Network75, JGW+, graduate schemes\).](#)

External assurance

- [Attraction questionnaire \(125 AfC new-starter responses\) to inform strategy; extension to M&D starters.](#)

Retention

Internal assurance

- ~~Monthly Retention Dashboard (turnover, attrition, stability) March 2026 turnover 8.29% (down from 8.50% January 2025).~~
- ~~Lateral Moves Scheme monitoring: 370 eligible applications at April 2026. Time to hire has reduced significantly from 77 days (August 2025) to 51 days (April 2026).~~
- ~~Reasons-for-leaving data quality actions (definitions, guidance) via intranet; Retention pages updated regularly.~~

External assurance

- ~~(Where available) triangulation with HEIW retention insights / all-Wales benchmarks.~~

Culture, Values and Behaviours

Internal assurance

- NHS Staff Survey results reported to Board and CTM committees, local action plans in Care Groups and **progress reported in integrated performance meetings. Staff attending survey briefings agreed (87%) with our corporate priority areas to tackle.**
- Partnership forums: LPF and LNC listening and engagement reviews.

External assurance

All-Wales NHS Staff Survey benchmarks: **response rate in 2024 was 26.8% (CTM) vs 21.8% (Wales), local target for improvement 40%; Employee Index 70.4% (CTM) vs 72% (Wales).** Our focus on the NHS Wales Staff Survey has achieved a sustained improvement in response rates, from 18.1% in 2023, to 26.8% in 2024 to 35.6% in 2025, against a national average of 30%. This represents an additional 1,407 respondents in 2025. Our staff engagement index score increased to 70.5%, up marginally from 70.4%, but note one of only three NHS Wales organisations to improve at all.

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Indicators of Success (following implementation of mitigating actions)
Strategic Workforce Planning			
~~Workforce plans are not yet consistently developed, embedded or aligned across all services to CTM2030, IMTP priorities and service transformation programmes.~~ ~~Absence of clear, sustainable workforce plans aligned to CTM2030.~~	~~Absence of clear, sustainable workforce plans aligned to CTM2030~~ <u>Development of local workforce plans.</u>	A sustainable and skilled workforce capable of delivering CTM2030 priorities with reduced reliance on agency staff. To support better alignment between service transformation and workforce capacity.	Implementation of workforce planning strategy with agreed KPIs to support sustainable workforce plans aligned to CTM2030.
Regional Service & Site Workforce Planning			
Lack of coordinated regional workforce plans.	• Development of LHP Workforce Plan (FBC (draft March 2026) due July 2026). • Workshops to develop Perinatal, Ophthalmology and Theatres workforce plans.	Ensure right skills, roles and staffing models across regional services.	<u>LHP and priority regional workforce plans completed and agreed through relevant governance routes, with identified workforce requirements, risks, assumptions and affordability implications.</u> ~~Ensure right skills, roles and staffing models across regional services.~~
New and Extended Roles			
Inconsistent governance for new and extended roles: Physician Associates (PAs), Advanced Clinical Practitioners (ACPs), and Registered Nursing Associates (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 <u>25/26</u>~~26/27~~ vs 24/25.
Workforce Data and Analytics			

Limited establishment reporting and analytics capability.	- Developed Nursing & Midwifery establishment reports. - Developing dashboards and robotics strategy. Developing timeline and strategy for roll out of Establishment Control.	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			
Retention data and exit intelligence are not yet consistently captured or used to inform targeted interventions, and the retention programme is not yet fully embedded across services. Low participation in exit process and limited retention data.	Relaunch of lateral moves, development of Moving On process, re-establishment of Retention Steering Group and improved retention dashboard/data quality. ~~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.	Increased exit feedback response rate, improved retention metrics by staff group/service, reduced voluntary turnover and evidence of targeted retention actions in priority area. ~~Higher exit feedback response rate (target 30%).~~ ~~Visible retention metrics.~~ ~~Reduced voluntary turnover.~~
Retention Programme Plan established but not agreed.			
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)~~ ~~Workforce Planning: LHP Phase 2 Workforce Planning workforce section and workforce demand numbers 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 into be finalised in June for sharing with HB Board Meetings in June/July 2026~~ Productivity & Agency Reduction: Tender for the Launch of new Managed Service provision for M&D/ AHP bank and agency staff contract awarded July 2026 ~~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.
- ~~Recruitment: international recruitment for hard-to-fill medical roles 2025/26 with NWSPP progressed, with two specialist grade psychiatrist started. An further Haematology doctor onboarding and four two ITU doctors have has been offered via NWSPP's overseas campaign and joined in June 2026. in Jan/Feb 2026 with first Dr to join in June 2026.~~
- Able to meet majority of commitments to Student Streamlining numbers for Summer 2026 recruitment

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.	20
4973	Clinical Medical Cover within CTM Adult Mental Health Services.	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

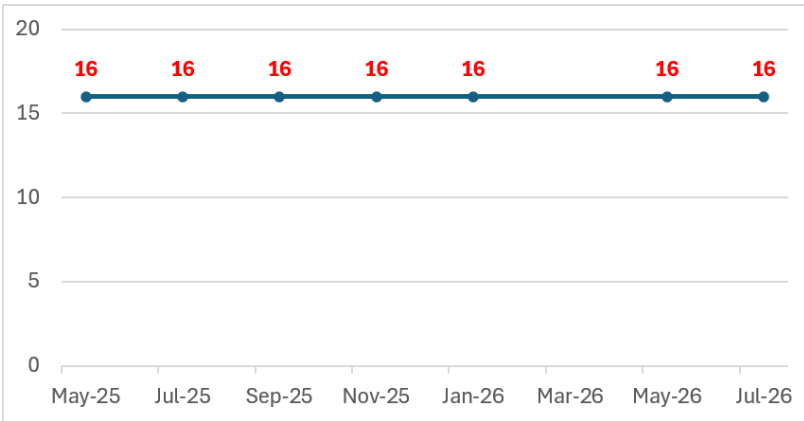
- Becoming a green organisation
- Ensuring our Services financial sustainability Embedding value-based healthcare
- Ensuring our estate is fit for the future

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:
Initial	4	5	20	No change to risk score this period.
Current	4	4	16	
Target	4	2	8	
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>				
				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 while the organisation actively treats the risk by addressing the capacity, capability and technical gaps.

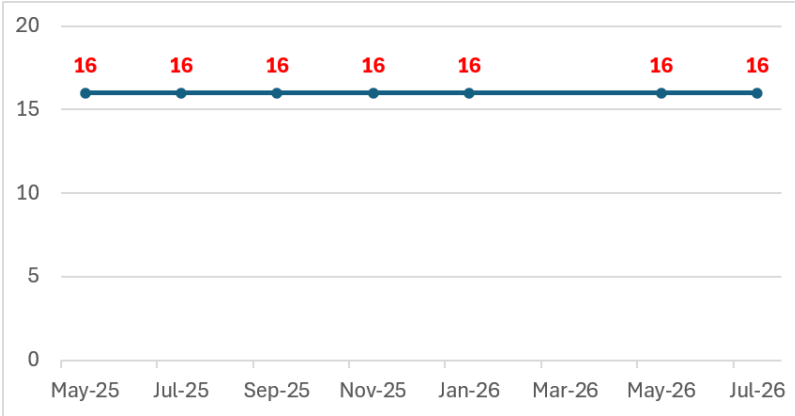
Current Control Measures			
Strategies & Plans - Strategic delivery framework - Standard Operating Procedure for service change - Social media strategy 2026 - CTMUHB Clinical Services Plan - Regional Communications & Engagement Plan - Service change and issue-specific communications and engagement plans (various) - Creating Health PID - Strategic Equality Plan Engagement Forums - Regional Partnership Board - Public Service Board - Stakeholder Reference Group - Llais/CTMUHB Partnership Meetings - Regional Engagement Group - All Wales Engagement Group - CTMUHB Strategic Engagement Forum - CTM Leaders’ Network - Community Voluntary Councils (Interlink RCT, BAVO, VAMT) - OPAG (Older Person’s Advisory Committee) - CTM 50+ Forums - Llynfi Valley Stakeholder Reference Group - Staff Q&A - Leaders’ Forum - Armed Forces Health Partnership - Health and Community Vaccination Working group			
Sources of Assurance (Internal and External)			
ELG CTMUHB Board Stakeholder Reference Group Community Leaders’ Forum Regional Engagement Group CTMUHB Strategic Engagement Forum Llais/CTMUHB Partnership Meetings Llais issue specific engagement Welsh Government Heads of Communications Welsh Government service change submission RPB			
Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Actual Impact of Actions (following implementation)
Implementation of SOP for service change	SOP completed with cross-department input. Work underway to implement.	Consistency of approach to service change across health board will ensure better	

		management of change, resulting in greater credibility and effectiveness of engagement activities and more useful insight. • Earlier development and implementation of engagement plans will enable more effective prioritisation of resources and capacity.	
Capacity within engagement function	Securing funding with Public Health to recruit additional engagement role. Role developed and recruitment anticipated to take place summer 2026.	• Improved understanding and engagement response to population health priorities, enabling insight- and intelligence-led planning and delivery. • More proactive response to engagement requirements will increase reach and public/partner confidence in the health board and enable the development of campaigns, resources and priorities that match population need. • Improved capacity will enable health board to further develop relationships with community groups, third-sector partners, and hard-to-engage groups, resulting in richer-data, and greater insight to inform effective public engagement methods and resources. • Additional capacity to manage unexpected engagement need, e.g. for urgent service change, will lead to more effective, meaningful and timely engagement that maintains credibility and trust.	•
Technical ability and capacity to coordinate engagement efficiently, manage insights and manage social media as a resource for engagement.	Identification of platform for social media management, social listening and public engagement: Orlo	• Significantly enhanced ability to produce, manage and monitor social media will enable health board to use these key channels to engage with, target, influence, understand, and respond to public and stakeholders.	•

		- Significantly improved insight into population sentiment, behaviour, trust and confidence will enable the health board to be far more responsive and informed in the management of change, and reach and impact of campaigns for behaviour change. - Significantly enhanced, AI-supported capability and capacity will enable greater reach, more impactful and more valuable public engagement, resulting in more useable and influential data and insight.	
Positioning of CTM engagement as part of Southeast Wales regional priorities	Development of regional engagement plan and associated resources with partners in AB and CAV	- More visibility of regional working will increase confidence amongst staff, stakeholders and public in the value of regional working. - Joint planning and delivery of communications and engagement across the region will be more efficient, making best use of limited and capacity and enabling greater reach. 'Story-telling' and messaging at regional-level will help to frame population need and system/service requirements.	
Linked National Priority Measures			
Nil			
Current Performance Highlights			
- Securing funding for Orlo social media management, social listening and digital survey platform - Commencement of recruitment process for Engagement Lead Officer (Public Health)			
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
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: 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. 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 (Clinical Large Language Model) 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. 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 (Senior Information Risk Owner), Caldicott Guardian, and DPO (Data Protection Officer); 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 Audit Wales 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. 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. 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	We currently do not have a formal Digital and Data training function. Resources are 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.	Developing capabilities to support service change enabled by digital and data technology, as well as building our wider Digital skills and capability to 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	.

	Additional business change facilitators will support this activity. ~~The Chief Nursing Information commenced on 1 April 2026.~~ ~~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.~~	practice to ensure that our colleagues feel confident in the increased reliance of technology in their day-to-day practice.	
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.	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. A forward testing schedule has been agreed for the next three months	Improved cyber posture via greater insight into digital assets and understanding of risk profile	
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. 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	Improved cyber posture via greater insight into digital assets and understanding of risk profile	

	effective way. Procurement activity is underway.		
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 Organisational Change Process (OCP). 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 and 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. Timeframe: N/A - Rolling Annual Replacement. There remains a gap in the required Capital and Revenue to meet several core system deliveries and wider	Sufficiently sized Digital and Data function able to meet the needs of the UHB whilst enabling Digital Transformation. Leading to: 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.	

	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 2027. 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 2 2026/2027	Improved data driven decision making, enabling 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 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 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)	Improved working relationships with critical suppliers Improvement in timescales for delivery of functionality Improved system availability Increased productivity	
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	Successful delivered transformation through the implementation of digital solutions. Increased capacity facilitated through various Digital programme	

	Unable to recruit some technical roles to support programme roll out.		
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. 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.	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.	
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. The procurement for the technical solution has commenced, with contract award planned within Q1 26/27. Timeframe: 2-3-year programme of work.	Improved productivity, and reduction in paper-based processes – undertaking process re-engineering replacing process with automated clinical workflow. Reusable digital data to enhance decision making. 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 recurrent funding is still a challenge for some of the National/Local Programmes.	Adequate resourcing pool within Digital and Data. Reduction in contingent staff costs.	
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 the Acute Clinical Services Plan (ACSP).	We have now received Welsh Government to approve the contract. Welsh Government had originally approved 5-year funding but now are waiting for outcome of Welsh Government's Pause and Review exercise to determine if the funding approved in early 2025 is still available for the Health Board. 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. Leading to: 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)** - ePMA went live at Princess of Wales Hospital in May 2026 (with an early adopter pilot in March 2026). Planning is now underway for go live in Royal Glamorgan Hospital on the 25th of July & 26th July (Sat & Sun). **Implementation Timescale:** March 2026 and throughout 2026
- **NHS Wales APP** - A Ministerial priority in October 2025 was to 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 47.6% increase in CTM patients registered on the NHS Wales app, rising to 112,112 CTM patients* data as of 21/06/2026
- **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. When PoW was merged into CTM's WPAS there was a known risk around ~100k duplicate records. Posts that were funded last year have been extend temporarily to continue to tackle the outstanding duplicate records. A sustainable medium- and long-term approach is needed to minimise the risk of patient safety related to medical duplicate medical records.
- **Llantrisant Health Park (LHP) Digital Workstream** - The LHP Digital Workstream has now defined a set of indicative costs for digital and data capabilities for inclusion in the Phase 2 full business costs. A phase 2 programme and business as usual resource plan has also been developed.
- **Mental Health Procurement** - WG approval to award the contract has been given, however this is programme is being considered under the WG DPIF Pause and Review process, outcome of that process is outstanding.
- **Radiology** - RISP programme transitioned to stable operations, with ongoing investigation into service-led reporting discrepancies and national result notification issues.
- **Pathology** - CTMUHB has undertaken significant work to respond to the proposed change in LIMS deployment sequencing. This change introduces increased delivery complexity and risk, and has been escalated to the Chief Executive via the Executive Sponsor and SRO for LIMS2.
- **Pharmacy** - Pharmacy automation improvements delivered, including stable deployment of the RGH pharmacy robot and enhanced monitoring capability through new dashboards.
- **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.
- **Core infrastructure progress:** Network core replacement progressing across major sites (PoW completed; RGH and PCH underway). No further major incidents linked to core failures; strengthened change processes now in place to reduce downtime risk.
- **Legacy technology reduction:** iGel thin client estate fully retired (0 devices), reducing reliance on Citrix and modernising end-user computing. WiFi and connectivity upgrades advancing: Significant progress across sites including PoW and PCH, with remaining remediation nearing completion.
- **PSTN migration progressing:** 84% of circuits resolved, with ongoing migration to SIP and modern connectivity solutions ahead of 2027 switch-off.
- **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.
- **Resourcing** - Resourcing constraints impacting delivery, with delays in vacancy approvals increasing pressure on existing teams and affecting both project initiation and BAU support.
- **WPAS** - WPAS cloud migration remains a significant risk, with concerns relating to business continuity, untested architecture and integration complexity.

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.

Associated Risks escalated to the Organisational Risk Register

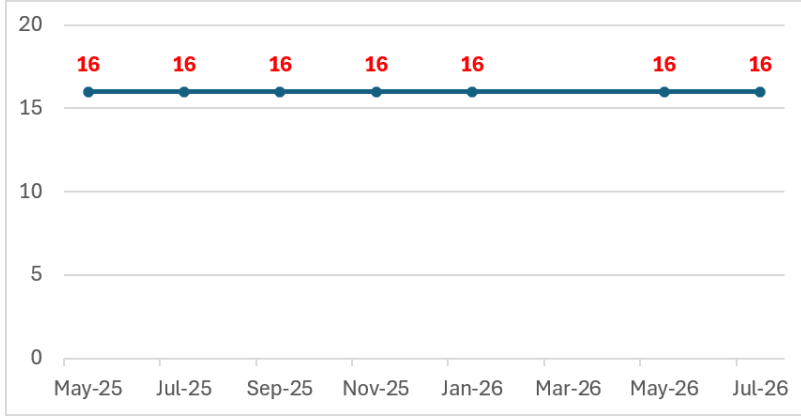
5276	Failure to deliver replacement Laboratory Information Management System, LIMS Programme, by summer 2025.	20
4664	Ransomware attack resulting in loss of critical services and possible extortion	20
4671	NHS Computer Network Infrastructure unable to meet demand	16
3337	Lack of a Single Electronic Patient Record in Mental Health Services including 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 <table><thead><tr><th>Date</th><th>Risk Score</th></tr></thead><tbody><tr><td>May-25</td><td>16</td></tr><tr><td>Jul-25</td><td>16</td></tr><tr><td>Sep-25</td><td>16</td></tr><tr><td>Nov-25</td><td>16</td></tr><tr><td>Jan-26</td><td>16</td></tr><tr><td>Mar-26</td><td></td></tr><tr><td>May-26</td><td>16</td></tr><tr><td>Jul-26</td><td>16</td></tr></tbody></table>	Date	Risk Score	May-25	16	Jul-25	16	Sep-25	16	Nov-25	16	Jan-26	16	Mar-26		May-26	16	Jul-26	16
Date	Risk Score																					
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Mar-26																						
May-26	16																					
Jul-26	16																					
Initial	4	4	16																			
Current	4	4	16																			
Target	4	~~2-3~~	~~8-12~~																			
Risk Appetite	Cautious (<i>quality and safety; trust and confidence; legal and regulatory</i>) July 2026: We have reviewed the target risk score and revised it to 12 to reflect a more realistic and deliverable position. We are actively managing this risk and expect improvement over time through prioritised capital investment and maintenance programmes; however, progress is constrained by limited capital availability and the scale of backlog maintenance, meaning the pace of risk reduction is currently limited																					
Rationale for assessment of risk score: <i>Including where risk score remains unchanged and for any changes</i>																						

	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) results in staffing challenges to deliver the estates functions.</i>	• 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	• Improved recruitment and retention across Estates roles, increasing capacity to deliver core maintenance and compliance activity and supporting a more stable and sustainable estates function.	<i>This column to be left blank for now, and populated once actions are complete.</i>

	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.		
2. Increasing Backlog Maintenance position.	- Secured Targeted Estates Funding (TEF) - Proactive in securing additional funding from Welsh Government when available.	Reduction in backlog maintenance and estate-related risks through delivery of prioritised schemes, resulting in a safer, more compliant estate and an improved environment for patients and staff.	
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.	Securing capital investment to modernise infrastructure, reduce backlog maintenance and address statutory compliance risks.	
4. Deliver schemes within a live environment	- Dialogue with service leads. - Secure decant where appropriate.	Safe delivery of capital works with minimal disruption to services, ensuring continuity of care and operational resilience during construction activity.	

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

6235	Insufficient funding to address backlog maintenance across the estate.	16
4417	Management of Security Doors in all Hospital settings.	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

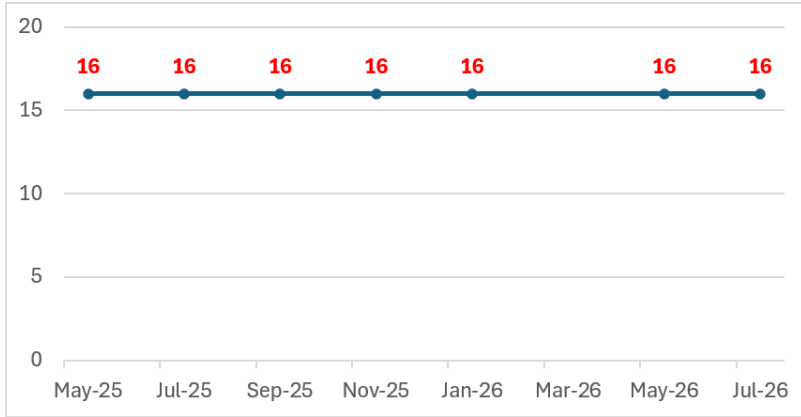
- Becoming a green organisation
- Ensuring our Services financial sustainability Embedding value-based healthcare
- Ensuring our estate is fit for the future.

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 static 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
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, i.e. using its role as a major local employer and purchaser to support the local economy and improve population wellbeing.
- Socio-economic duties are also considered as part of the controls and impact captured within the following Strategic Risks: 3 (Workforce); 4 (Engagement) and 8 (Prevention and early intervention)

Environmental Sustainability – Net Zero

- Climate Action Plan will be presented to March 2026 Board for approval and was formally endorsed.
- '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 – Funding of £11.4m received to improve energy efficiency, including solar panels (PV), LED lighting, building energy controls (BMS optimisation), and small-scale heat pump 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.

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 Public Service Board (PSB) have developed a Climate Change Risk Assessment (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.	
2. Procurement framework to reduce carbon footprint of goods and services purchased from outside the organisation.	The procurement team are included within the 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.	
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.	
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.	
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.	
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.	

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.
- The annual CTMUHB Annual Report & Accounts have 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 national innovation programmes (SBRI and SFIS) programmes to develop solutions to waste sustainability challenges.
- All 3 of the emergency departments (EDs) 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

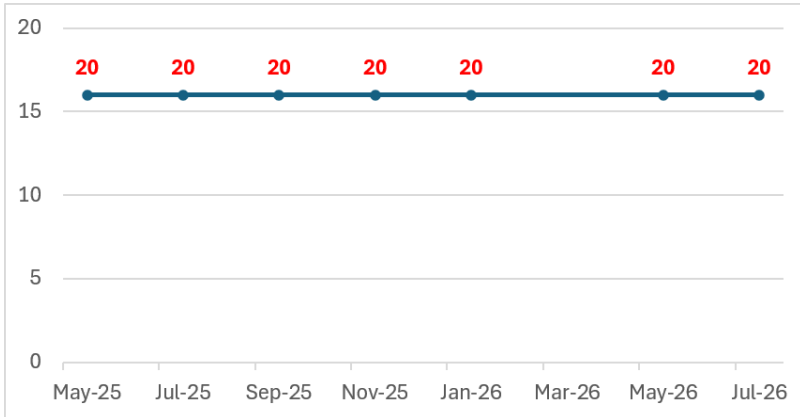
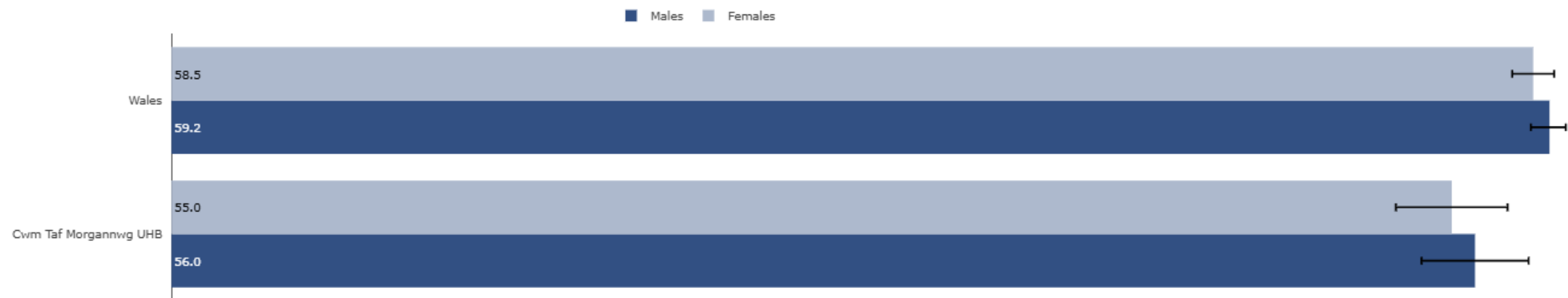
	Consequence	Likelihood	Score	Risk Score Trend this Period: *The consequence score has reduced for the target score assessment, as there will be an element of both mitigation and adaptation. The Health Board aims to reduce the behaviour and health risks (primary, secondary, tertiary prevention); however, the organisation will still need to adapt as appropriate. No change to risk scores this period. Risk Score Trajectory 
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, due to 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.~~ The most recent data published in June 2026 by Public Health Wales shows that: - In CTM, Healthy life expectancy at birth is 55.0 years for females, and 56.0 years for males in 2022-2024; both significantly lower than the average in Wales (58.5 and 59.2 years respectively). - Healthy life expectancy has been decreasing in recent years across CTM and Wales, for both males and females. - In 2022-2024, the gap in Healthy life Expectancy at birth between the most and least deprived across Wales has increased from 15.3 years to 18.1 years for males, and from 18.5 years to 19.0 years for females.

Figure: Healthy life expectancy at birth, years, males and females, Wales, Health Board, 2022-24

Produced by Public Health Wales using data published by ONS



Recent analysis from the Office of National Statistics (ONS) shows the following:
[Healthy life expectancy at birth by sex across local areas of the UK, between 2011 to 2013 and 2022 to 2024](#)

	2011/12 Males	2022/24 Males	2011/12 Females	2022/24 Females
Bridgend	60.1	57.9	60.7	57.2
RCT	57.3	56.0	57.5	54.9
Merthyr Tydfil	55.7	51.7	55.6	50.1

HLE has dropped in all males and all females over this period. In particular, the drop in female HLE is now lower than males in each LA. Since this is represents the whole population, this is important in relation to the sustainability of the NHS.

The current data demonstrates that Healthy Life Expectancy in CTM is reducing, leaving people living a longer period in ill health, utilising additional health care services and raising further questions about the sustainability of effective health care within the limited budget available. Some mitigations have been slow to implement and have impacted the speed at which the trajectory will change, for example, due to inability to fund the children’s weight management service, the opportunity to influence weight and subsequent risk of diabetes and other comorbidities is limited. The level 2 and 3 adult weight management service cannot meet the demand, with excessive waiting lists of many years.

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 **has** 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 are 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 is being 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”; Well-being of Future Generations (Wales) Act (WBFGA), Marmot Nation Principles - 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 and approved 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 since 2022.
- Smoking Cessation Service
- All hazards Health protection Service
- Pipyn Service
- **Making Every Contact Count**

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 £1.06m ^s , however, total allocation remains below the 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.~~	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. 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.

	An unsuccessful case made to Welsh Government for additional funding to further close the gap in funding per head between CTM and the rest of Wales.		
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 completed and submitted to board for approval Health Protection Strategy. Vaccine equity strategy CTM Population Health Framework no longer under development but to be included in the refresh of CTM 2030.	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.
3. Capacity for population health management	Population health management programme maturing alongside primary care clusters; implementation within health board. Work to pilot a shared clinical record yet to be prioritised.	The use of Population Health Management (PHM) data to inform strategic planning and operational delivery maximised. The current focus is on pilots in primary care clusters.	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. • 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 • Diabetes Strategic Plan	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. 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. With insufficient funding approved for the service across CTM, the uplift was directed to expanding the Pipyn programme.	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: Regional Partnership Boards (RPBs), Public Service Boards (PSBs), Leaders groups.	Improved collaboration and partnerships to adopt a whole system approach to impact wider determinants of health for the CTM population. Adoption of the Marmot Nation Principles across the PSB. MTCBC successful as a Marmot National Pilot and RCTCBC as an early adopter.	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 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)

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

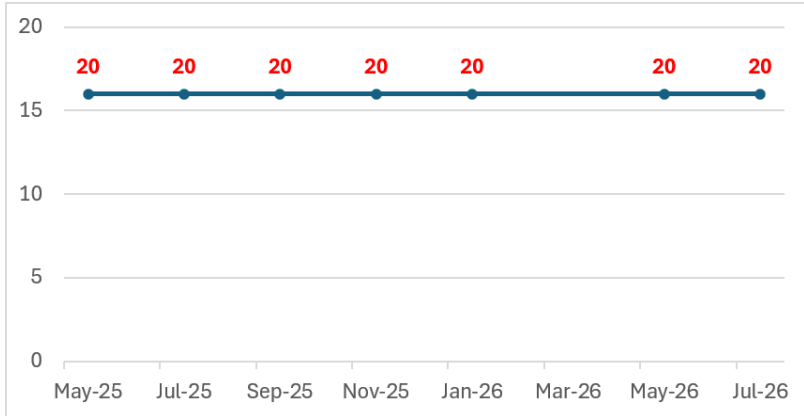
6179	High and increasing prevalence of overweight and obesity in children and adults	20

5579	Rising childhood obesity rates resulting in an increase in obesity related conditions and poorer health outcomes.	16
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 month 2 year to date position is reporting a £5.2m deficit with a savings shortfall of £4.4m. Further cost pressures of £1.2m have been partially offset by £0.3m of unplanned additional income relating to the EPMA programme.

	The recurrent position will be reviewed following month 3 reporting.
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 treated until there is confidence that the Health Board can achieve the planned break-even position.

Current Control Measures

Financial Management - Financial Accountability letters to be 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. - 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~~
- The M2 YTD position is reporting a £5.2m deficit against plan.
- Latest savings plans have only identified ~~£14m~~ £14.5m of the £31.3m savings plan required.
- There is a high risk to delivering a balanced financial plan for 2026/27

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

~~To be confirmed – awaiting Month 1 reporting.~~
Non delivery of savings remain the most significant cause for the year to date deficit and the forecast remains significantly below the planned level.

Associated Risks escalated to the Organisational Risk Register

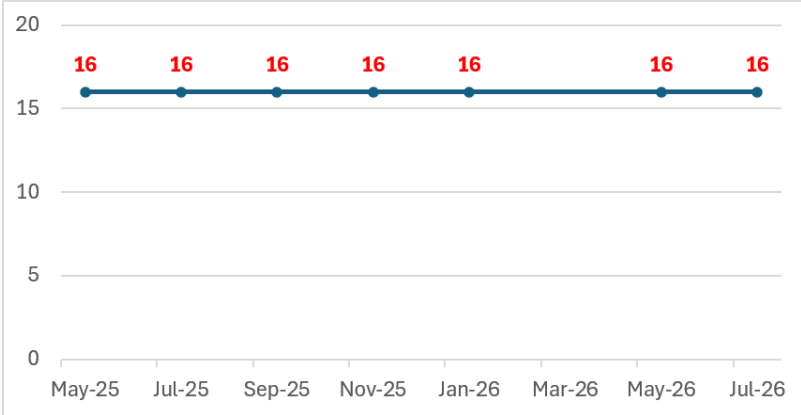
6596	Failure to reduce the £9.2m recurrent deficit at the start of 26/27 down to the planned £0.3m recurrent surplus at the end of 26/27	20
6597	Failure to achieve the planned break-even position in 2026/2027	20

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 July 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) ~~Actual Impact of Actions (following implementation)~~
1. Estate strategy to be developed on completion of the Clinical Service Strategy.	Delivering against IMTP priorities in the interim.	Continued investment targeted at highest-risk areas to maintain safe, operational estate infrastructure and support delivery of services while the longer-term estate strategy is being developed.	<i>This column to be left blank for now, and populated once actions are complete.</i>
2. Enough Funding to deliver Capital Schemes.	Delivering against IMTP priorities in the interim.	More effective use of available capital funding to progress priority schemes, supporting improvements to estate condition and enabling services to operate from safe and appropriate facilities.	

Linked National Priority Measures

Current Performance Highlights

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

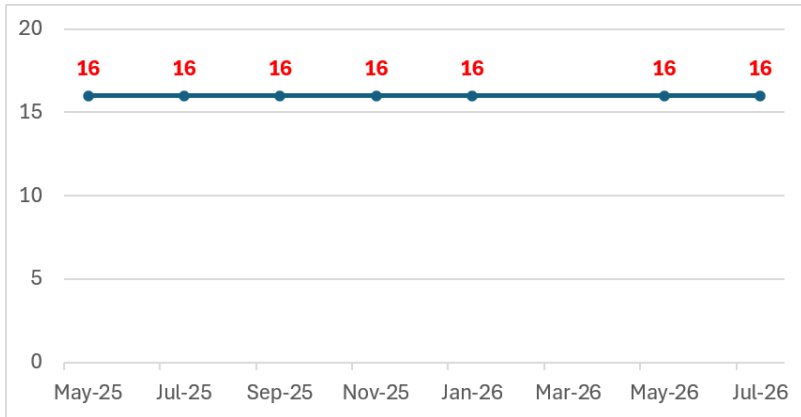
Associated Risks escalated to the Organisational Risk Register

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.

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 in 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.
- 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
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
5579	Rising childhood obesity rates resulting in an increase in obesity related conditions and poorer health outcomes.	16



Audit, Risk & Assurance Committee

Committee Annual Cycle of Business

Eitem yr Agenda / Agenda Item	6.2.1
Dyddiad y Cyfarfod / Date of Meeting:	4 August 2026
Statws Cyhoeddi / Publication Status:	Open/Public.
	Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	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
Diben yr Adroddiad / Report Purpose:	For Noting
Argymhelliad (<i>Wedi'i gysylltu â'r adran "Beth Nesaf" uchod</i>). Recommendation (Linked to the "What Next" section above).	The Committee are asked to NOTE the Cycle of Business

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 Annual Cycle of Business for further detail.

4. Assessment

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)	Not applicable	
	If more than one applies please list below:	
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable	
	If more than one applies please list below:	
Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	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:	
Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please select a reason below.



(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.) Equality & Welsh Language Impact Assessment Outcome (Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)	Not applicable Summary of impact: Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact:	Choose an item. Named Executive/Board member sign off for no EWLIA completion:
Canlyniad Asesiad Effaith Ansawdd (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)	Not applicable	
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report	
Effaith Adnoddau (Pobl / Ariannol) / Resource Impact (People / Financial)	There is no direct impact on resources as a result of the activity outlined in this report	

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	

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 BAE	
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. • 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		
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
22 January 2026	Internal Audit Progress Report	Internal Audit	IA Review – Medical Job Planning – Re-audit – Final	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	August 2026	This item is on the agenda for the August 2026 meeting
22 January 2026	Internal Audit Progress Report	Internal Audit	IA Review – Outpatient Booking Process	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	August 2026	This item is on the agenda for the August 2026 meeting
22 January 2026	Internal Audit Progress Report	Internal Audit	IA Review – Commissioned Packages of Care – Final	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	August 2026	This item is on the agenda for the August 2026 meeting
27 July 2026	Internal Audit Progress Report	Internal Audit	IA Review – PCH Refurbishment Community Benefits	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	August 2026	This item is on the agenda for the August 2026 meeting
27 July 2026	Internal Audit Progress Report	Internal Audit	IA Review – PCH Refurbishment Section 3	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	August 2026	This item is on the agenda for the August 2026 meeting
27 July 2026	Internal Audit Progress Report	Internal Audit	IA Review – Welsh Risk Pool	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	August 2026	This item is on the agenda for the August 2026 meeting
23 July 2026	Annual Cycle of Business	Interim Assistant Director of Governance and Risk	Outcome of the Committee Annual Self Effectiveness Review 2025-26	Agreed to defer until 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.	Louise Stait Interim Assistant Director of Governance and Risk	Gareth Watts, Director of Governance/Board Secretary	Deferred from August 2026	This item is on the agenda for the November 2026 meeting.
July 2026	Audit Wales	Audit Wales Performance Lead	Audit Wales Report – Estates	Agreed to defer to November meeting	Audit Wales	Director of Governance/Board Secretary	Deferred from August 2026	This item is on the agenda for the

				due to not being finalised in time.				November 2026 meeting.
July 2026	Audit Wales	Audit Wales Performance Lead	Audit Wales Report – Follow Up Outpatients	Agreed to defer to November meeting due to not being finalised in time.	Audit Wales	Director of Governance/Board Secretary	Deferred from August 2026	This item is on the agenda for the November 2026 meeting.
22 January 2026	Internal Audit Progress Report	Internal Audit	Internal Audit Review – Risk Management – Final	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	August 2026	This item is on the agenda for the August 2026 meeting
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:

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	Received at the May 2026 meeting - Closed
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	Received at the May 2026 meeting - Closed
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	Received at the May 2026 meeting - Closed
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	Received at the May 2026 meeting - Closed
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	Received at the May 2026 meeting - Closed
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	Received at the May 2026 meeting - Closed
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	Received at the May 2026 meeting - Closed
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	Received at the May 2026 meeting - Closed
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	Received at the May 2026 meeting - Closed

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	Received at the May 2026 meeting - Closed
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	Received at the May 2026 meeting - Closed
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	Received at the May 2026 meeting - Closed
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	Received at the May 2026 meeting - Closed
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	Received at the May 2026 meeting - Closed
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	Received at the May 2026 meeting - Closed
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	Received at the May 2026 meeting - Closed
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	Received at the May 2026 meeting - Closed
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	Received at the May 2026 meeting - Closed
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	Received at the May 2026 meeting - Closed
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	Received at the May 2026 meeting - Closed
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	Received at the May 2026 meeting - Closed

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	Received at the May 2026 meeting - Closed
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