Chief Operating Officer

Access to Cancer Services (COO)

Key Finding Ref	Key Findings	Impact	Recommendation	Priority	Management Response	Responsible Officer	Deadline	Comments	Milestone Date
3.1	Review of Cancer performance papers to Performance and Finance Committee and the Board demonstrated that the health board has developed detailed actions reflecting a mix of capacity, workforce, and pathway enhancements to support SCP and waiting list recovery. In reviewing the actions, we noted: **Gynaecology** – Of the nine actions listed, four did not include a clear timescale for delivery. One action held a review of PMB pathway where benefits were listed, but no measurable target included. No specific action owners were listed. **Urology** – Of the 13 actions listed eight did not include a clear timescale for delivery. Seven contained improvements to pathways but no specific target set. Only 1 action had a specific lead. **Lower GI** – Of the 15 actions listed 11 held no timescale for action. Eight contained forecast benefits but not a target measure. The Urology cancer plan format included mapping actions against NOP targets, average and longest waits, action outline, forecast impact in days, owner, timescale and RAG status. It also included a column outlining resource or associated	Lack of clarity of action timescale and ownership.	The health board should agree a format for the development of cancer recovery plans to ensure clarity of timescale and ownership, and consistency of approach.	H	Agreed - Formal action plans in a standard format will be introduced and monitored through the monthly Cancer Performance Group meeting.	Deputy COO	31/07/2023	**July 2025:** Action plans for each specialty are now on Cancer Teams Chanel	
6.1	We reviewed the frequency and content of cancer performance reports provided to Management Board, Performance and Finance Committee, and the Board. We note that whilst detail is provided on current actions, papers do not include detail of the status of previous actions, their completeness or whether outlined gains were realised. Our request for evidence of action progress or completion highlighted a number where evidence of actions was not provided by the service.	Enhance assurance provided through updates on action completeness.	Cancer performance reports should include updates on progress or completeness of previously reported actions.	M	Agreed - The format of reports presented to the Management Board and Performance and Finance Committee will be reviewed to ensure they include progress and completeness of previously reported actions.	Deputy COO	30/09/2023	**July 2025:** Formal reports are provided to P&F Committee including an update on any action	

Mental Health 111#2 Service

Key Finding Ref	Key Findings	Impact	Recommendation	Priority	Management Response	Responsible Officer	Deadline	Comments	Milestone Date
4.1	We had oversight of a 'Activity and Access' report that have been produced since January 2024 and are presented to the Service Group Management Board The reports outline key telephony performance for the 111#2 service but, as noted in Matter Arising 2, there is limited reference to targets or comparative data from other NHS Wales organisations. Review of the papers and minutes for the Service Group Management Board noted that there is limited discussion on the performance and the service as a whole.	The Board are not provided with assurance that the service is operating as intended	Performance reporting should be regularly issued and discussed at an appropriate forum within the Service Group; with concerns and issues escalated to a Health Board Sub Committee to ensure appropriate oversight and scrutiny.	H	Performance will be reported on a monthly basis at the Service Group's Weekly Business Meeting and at a quarterly basis at the Mental Health Division's performance review with the Senior Team. Performance will be reviewed at HB level at the quarterly performance review meetings with the Executive Team.	Associate Service Director for Mental Health	31/07/2024	**August 2025:** Reopened at the request of NWSSP A&A, pending the supply of evidence to confirm performance monitoring as part of performance review meetings with the SG Senior Team	31/08/2025

Waiting List Management

Key Finding Ref	Key Findings	Impact	Recommendation	Priority	Management Response	Responsible Officer	Deadline	Comments	Milestone Date
1.1	The Patient Access Policy details it was approved by ABMUHB's Executive Team and has a review date of June 2018. There were some revisions to the Policy during 2022, however we have been unable to obtain a copy. There are national rules relating to Referral to Treatment (RTT) rules which staff can refer to, but the Patient Access Management (PAM) Team have been updating the Policy (using the 2018 version as a baseline) and Standard Operating Procedures (SOPs) are being reviewed and standardised within the health board to assist with staff awareness and understanding with an appropriate framework designed to approve them. Revisions were near to completion, but recent training feedback has resulted in further revisions to the Policy and to the SOPs. The 'Access to Cancer Services' audit identified that the Cancer Waiting Times and Escalation Policy details a review date of July 2022. The Policy is currently being reviewed and documented procedures to support the Policy will need to be developed.	Staff are unclear of waiting time management processes resulting in non-application of RTT and SCP rules. This could impact data quality, patient communication, and result in longer delays for appointments or treatments.	Management should ensure that all policies and procedures that relate to the management of waiting lists (including procedures that relate to cancer performance), are developed or updated as soon as possible to provide clarity over the processes to be followed and the rules to be complied with.	H	Patient Access Team to provide the Patient Access Management (PAM) Group with a list of all Policies and Procedures (relating to waiting lists) with review dates included. Patient Access Team to provide a detailed update in regards to: • which SOPs have been reviewed / approved • plan for reviewing the remaining SOPs and expected timeframe for approval	Patient Access Management Team	30/06/2024	**August 2025:** The Patient Access Management Support (PAMS) Team has established a Policies & Procedures Working Group which will report to the Patient Access Management Steering Group, on all non-clinical policies, procedures and protocols relating to Planned Care Patient Access Management. The purpose of the group is to ensure the development, approval and governance of policy and procedures and identify any practice changes required as a result. The group will be responsible for ensuring that all non-clinical documents are received, reviewed and escalated to the Patient Access Management Steering Group for approval. All approved documents will be communicated in a manner that ensures their effective implementation. A structure is being agreed whereby Cancer SOPs will be signed off via their existing governance structure and will then come through the Patient Access Management Support team for noting and adding to the asset registers for SOPs. They will then be added to the central SharePoint repository. Meetings are currently being scheduled to discuss and agree the process in detail.	31/10/2025
1.2	The Patient Access Policy details it was approved by ABMUHB's Executive Team and has a review date of June 2018. There were some revisions to the Policy during 2022, however we have been unable to obtain a copy. There are national rules relating to Referral to Treatment (RTT) rules which staff can refer to, but the Patient Access Management (PAM) Team have been updating the Policy (using the 2018 version as a baseline) and Standard Operating Procedures (SOPs) are being reviewed and standardised within the health board to assist with staff awareness and understanding with an appropriate framework designed to approve them. Revisions were near to completion, but recent training feedback has resulted in further revisions to the Policy and to the SOPs. The 'Access to Cancer Services' audit identified that the Cancer Waiting Times and Escalation Policy details a review date of July 2022. The Policy is currently being reviewed and documented procedures to support the Policy will need to be developed.	Staff are unclear of waiting time management processes resulting in non-application of RTT and SCP rules. This could impact data quality, patient communication, and result in longer delays for appointments or treatments.	Once approved, policies and procedures should be circulated to all staff and retained in a central location.	H	Patient Access Team to: • Ensure all approved policies and procedures are communicated via the PAM SharePoint page. • Agree a launch date for the page and communicate to all staff. • Be responsible for version and control and review of the policies and procedures on an ongoing basis.	Patient Access Management Group	31/07/2024	**August 2025:** The newly created Patient Access Management Hub Site contains a Document Library, which will contain all approved patient-access related documents. Population of the library has commenced. A structure is being agreed whereby Cancer SOPs will be signed off via their existing governance structure and will then come through the Patient Access Management Support team for noting and adding to the asset registers for SOPs. They will then be added to the central SharePoint repository. Meetings are currently being scheduled to discuss and agree the process in detail.	31/10/2025
1.3	Two training sessions were delivered to staff during January 2024, but course delivery was paused as outlined to the Outpatients Board in February 2024. The plan is to resume training by the end of May 2024 to support the finalised policy and SOPs, and some of the transformation funding available will be repurposed for recruitment to enable a digital platform to be developed to enhance training. While the above training will signpost to cancer performance processes, it is not intended to provide a detailed overview as there are different pathway events and systems used. No recent training has been provided of this area.	Staff are unclear of waiting time management processes resulting in non-application of RTT and SCP rules. This could impact data quality, patient communication, and result in longer delays for appointments or treatments.	The training programme should be finalised and rolled out to improve knowledge of key principles and guidance in relation to waiting time management and provide clarity on cancer performance processes.	H	Patient Access Management to provide: • An update to the PAM Group in each meeting regarding the completion of the on-line modules. • The timelines and detail of the roll out of the training programme The above to commence July 2024	Patient Access Management Team	31/07/2024	**August 2025:** The PAM team has developed a planned care academy programme consisting of 10 modules. These cover Inpatient and outpatient RTT rules and WPAS functionality, complex pathways, stand-alone diagnostic and clinical modules. Modules are currently live within ESR. The remaining modules are on hold pending the national programme and updated RTT rules policy publication. Meetings are currently being scheduled to discuss and agree systems and processes in respect of training on systems relating to cancer services. Training currently in place within ESR which will be promoted, but it is recognised that something more local needs to be developed. It should also be noted that NHS Performance & Improvement have requested a review SCP guidelines by WG.	31/10/2025
1.4	Two training sessions were delivered to staff during January 2024, but course delivery was paused as outlined to the Outpatients Board in February 2024. The plan is to resume training by the end of May 2024 to support the finalised policy and SOPs, and some of the transformation funding available will be repurposed for recruitment to enable a digital platform to be developed to enhance training. While the above training will signpost to cancer performance processes, it is not intended to provide a detailed overview as there are different pathway events and systems used. No recent training has been provided of this area.	Staff are unclear of waiting time management processes resulting in non-application of RTT and SCP rules. This could impact data quality, patient communication, and result in longer delays for appointments or treatments.	The health board should ensure that all key staff involved in the process complete the required training.	H	Patient Access Management to provide an update to the PAM Group in each meeting. The report to include: • Completion rate of the training modules • Attendance of each module by speciality • Areas of low attendance to be escalated The above to commence July 2024	Patient Access Management Team	31/07/2024	**August 2025:** As each module within the Planned Care Acadamy becomes live, it is delivered via the ESR system which records and is able to report on completion. Meetings are currently being scheduled to discuss and agree systems and processes in respect of training on systems relating to cancer services. Training currently in place within ESR which will be promoted, but it is recognised that something more local needs to be developed. It should also be noted that NHS Performance & Improvement have requested a review SCP guidelines by WG.	31/10/2025
3.4	Performance Dashboards: Several performance dashboards have been made available to staff to enable them to monitor waiting list data. As staff have cited capacity issues impacting their ability to carry out checks of the waiting list, this may also result in staff being unable to review dashboards frequently. Performance reporting to Outpatients Board (15 February 2024) also highlighted inconsistencies of these multiple tools being used with no scrutiny of data accuracy nor governance to approve the development of dashboards. The issue was also discussed at the PAM Steering Group (28 February 2024) where it was decided to review the list of dashboard users to confirm last access, and to explore the feasibility of amalgamating the dashboards. The Ophthalmology Service Manager highlighted that the Vitals dashboard and the RTT report does not extract the Eye Care Measures Ophthalmology grading on Health Risk Factor (e.g. R1, R2, R3). This explains why the Vitals dashboard is reporting 6,020 patients as 'awaiting grading' where the actual figure is 279. The Deputy Chief Operating Officer explained that Welsh Government reporting, and that carried out internally, would not use the data contained within Vitals dashboard so should not affect the accuracy of reporting. However, reporting between monitoring tools should be aligned or fully integrated where possible to prevent confusion, particularly in the absence of key staff. Action Plans: While action plans are used to assist with monitoring improvements with waiting lists, there is not a consistent template used across services to confirm that the necessary actions have been undertaken and to assist with identifying measures to sustain improvement. Note: a similar enhancement was raised in our 'Access to Cancer Services' review. Reporting: Waiting list data for Planned Care is categorised on the Vitals dashboard as 'Reported', Non-RTT' and 'Unreported' (there is also an 'Excluded' categorisation for patients not on pathways and are therefore not RTT -reportable) to clarify what data is RTT-reportable to Welsh Government. For gynaecology, there are 219 patients that are categorised as 'Unreported' and 522 patients for ophthalmology. The COVID pandemic impacted waiting lists, which got longer and increased waiting times, but there has been no recent check of the 'Unreported' to confirm that patients have been correctly categorised, e.g. if the RTT element of their pathway is triggered correctly.	Ineffective monitoring resulting in no action being taken to address poor performance; Inability to make improvements to address waiting list issues; Inaccurate reporting or significant issues not being escalated promptly.	A review of patients categorised as 'Unreported' should be undertaken to confirm that any RTT-reportable element of a patient's pathway is being triggered appropriately.	M	Each month, the Patient Access Management Team to review an "unreported" waiting list and confirm that any RTT reportable element is being triggered appropriately (Monthly - Immediate).	Service Managers	30/06/2024	**June 2025 (TP):** The Health Board is reviewing the current performance measures in line with the Cabinet Secretary enablers. If agreed, this will be actioned appropriately. The RTT Policy was updated in 2025 which has resulted in changes in reported / unreported conditions and this will be considered in due course and actioned appropriately.	31/10/2025
				M	Any issues identified to be reported to the Service Manager and addressed asap. A record of the issues identified to be recorded and discussed at the Performance Scrutiny Meetings (Bi-Weekly - Immediate).	Performance Manager	30/06/2024	**June 2025 (TP):** The Health Board is reviewing the current performance measures in line with the Cabinet Secretary enablers. If agreed, this will be actioned appropriately. The RTT Policy was updated in 2025 which has resulted in changes in reported / unreported conditions and this will be considered in due course and actioned appropriately.	31/10/2025

Service Group Governance - MH&LD

Key Finding Ref	Key Findings	Impact	Recommendation	Priority	Management Response	Responsible Officer	Deadline	Comments	Milestone Date
6.1	The health board Standards of Business Conduct Policy ('the Policy') section 6.4 includes that Service Group Directors are responsible for the review of registers of declarations of interest (D.O.I). D.O.I returns were available for Service Group Directors, but none were available for the LD Division Senior Management Team.	Undisclosed conflicting interests compromise the Health Board's integrity, impartiality and transparency.	Declarations of interest should be completed by senior management teams within the Service Group on an annual basis, and included within a register for Service Group Director review.	M	Divisional compliance registers will be constructed to evidence all senior staff (8A and above) have completed an annual D.O.I. and regularly reviewed by Service Group Director. This will be included in the work programme in 1.1.	MHLDSG Director, in conjunction with Divisional General Managers	31/10/2024	**August 2025:** Work on gathering appropriate declarations of interest within the Mental Health Division is continuing.	30/09/2025
6.2	The Standards of Business Conduct policy also requires all consultants to complete a standard D.O.I, with an additional declaration required when undertaking private practice (s.18.2). We were informed this is considered as part of the annual job planning process, and a review of records within one directorate within the LD Division (Cwm Taf Morgannwg directorate) confirmed that additional employment and practice are recorded within the job planning software, however standard D.O.I. forms are not retained.	Undisclosed conflicting interests compromise the Health Board's integrity, impartiality and transparency.	Declarations of interest should be completed by consultants and retained by divisions, as required by the health board policy.	M	Consultant compliance registers will be constructed to evidence all consultants have completed an annual D.O.I – this can be amalgamated with the divisional register for ease of access.	Divisional General Managers: Mental Health Learning Disabilities Secure Services and Recovery	31/10/2024	**August 2025:** Work on gathering appropriate declarations of interest within the Mental Health Division is continuing.	30/09/2025

Primary Care Cluster Plans

Key Finding Ref	Key Findings	Impact	Recommendation	Priority	Management Response	Responsible Officer	Deadline	Comments	Milestone Date
2.1	Review of the delivery status, included within the highlight reports, noted that that it was not clear what action would be required to take PCP schemes / priorities and Cluster IMTP GMOs to completion, specifically for those which had been assigned a red / amber RAG rating. We acknowledge that progress may be hindered by available funding, or the issue of external guidance, yet such is not always defined within the narrative.	Objectives and targets are not met due to inadequate monitoring and scrutiny mechanisms.	The delivery status of PCP schemes / priorities and Cluster IMTP GMOs should be enhanced to include the defined actions, owner and timescale to progress towards completion.	M	Following the audit recommendations in 2021 (prior to the existence of a Pan Cluster planning Group/ plan) Local Clusters developed a comprehensive performance management tool – which clearly tracks the progress of actions and the owner of the actions. This will be further enhanced to include suggested actions for red/ amber schemes (wherever possible). It should be noted however that clusters include a wide range of ambitious projects in their plans not all of which will come to fruition due to external influences/ lack of funding. It is important that the PCPG which is very new and is only developing its partnership approach to planning and the clusters are encouraged to continue to innovate. The overall level of achievement of the cluster plans is very high.	Head of Cluster Development & Planning	30/11/2024	**June 2025:** An additional column has been included in cluster highlight reports to insert mitigating actions, to facilitate discussions at cluster level.	
3.1	From our review of the PCP priorities, there was an absence of quantitative performance measures against the programmes/projects/schemes included within each of the Tiers, and more latterly the priority areas. We acknowledge that there is a considerable amount of narrative updates on performance via the communications plan, however, this does not extend to a baseline (where they are/were) and target (where they want to be) and the timeline for achievement of the target.	Impact of outcomes on performance not known.	Quantitative and qualitative performance measures, for PCP priorities, should be identified to measure the impact of the implementation of any programme / project / goals that demonstrate the positive impact.	M	The Pan Cluster planning groups (across Wales) are still developing – this is recognised nationally – they are still new groups and evolving their planning approach in a complex environment – whilst trying to align with and respond to WG/RPB/HB/PSB priorities. A discussion will be held with the Pan Cluster Planning Group about the inclusion of quantifiable measures in the 25/26 plan. (It should be noted that priority areas at Pan Cluster planning Group level are often developmental – such as mapping current activity for an area or forge new relationships which may always not lend itself to quantifiable measures.)	Associate Service Group Director Chair of the Pan Cluster Planning Group	30/11/2024	**June 2025:** A detailed delivery plan is being developed for 2025/26, with quantifiable performance measures where possible. This is due to be finalised in a workshop in July and ratified by PCPG in September.	30/09/2025
4.1	The PCPG is a sub-committee of the Executive Management Board. As per the ToR for the PCPG, the group will report to the executive management board of the Health Board. It does not specify what will be reported, or the frequency of reporting. Whilst Management Board have received the two updates in 2023-24, there is currently no reporting to either the Board or its Committees on the Pan Cluster Plan, including any performance reporting or year-end report highlighting the progress against the PCPs. Reporting to Service Group Management Board is high-level, setting out the key areas of risk/quality discussed at the monthly Primary Care Contracts meeting; with an annual highlight report also presented. We would expect regular reporting on PCP progress at the PCTSG Management Board but acknowledge that the current arrangements have been determined as appropriate by the Service Group. We also note that Audit Wales, in its Primary Care Follow Up Review (January 2023) noted that there is limited oversight and scrutiny of the challenges facing primary care at Board, and consideration at committees could be more systematically embedded within routine business	The Board and its Committees are not informed of cluster issues and risks due to ineffective reporting arrangements.	The expectation of what will be reported (as a minimum the plans and the year-end reports), to which forum, the frequency of such reporting and route for escalation, where appropriate, should be agreed with the Executive Management Board and the Terms of Reference for the PCPG updated accordingly.	H	Agreed. A regular reporting framework will be discussed and agreed and the PCPG Terms of Reference amended.	Service Group Director Chief Operating Officer Interim Director of Strategy	31/12/2024	**June 2025:** Reporting schedule to management board agreed by Chief Operating Officer. Revised TOR will be submitted to PCPG for ratification in July 2025.	31/08/2025

CAMHS Transition

Key Finding Ref	Key Findings	Impact	Recommendation	Priority	Management Response	Responsible Officer	Deadline	Comments	Milestone Date
2.2	Discussion with CAMHS Management confirmed that the Directorate has yet to fully map out its capacity requirements. The continued fragility in the CAMHS workforce was included in a report to the Workforce and Digital Committee in April 2024, including seeking approval for the continued use of 7.4 WTE agency nurses, however the paper was deferred due to time constraints within the meeting. In June 2024 the WBM approved a proposal to substantively recruit three CAMHS nurses within the ATT, to be funded through identified non pay savings. The paper noted this would reduce agency use by 4WTE from its then position of 8.4WTE. Current agency agreements are in place until March 2025. We are informed that there were no applicants to these posts, and a paper to set out further agency extensions is to be submitted to the health boards Management Board. We are informed that a full review of job plans and team capacity is to follow the Directorates benchmarking against the NHS Wales CAMHS Service Specification issued by NHS Wales Executive in July 2024. A concern highlighted within the baseline assessment undertaken in 2023 related to the low number of patients in receipt of care and treatment plans. A downward trend has continued from 70 patients at time of transfer to 34 patients (June 2024). CAMHS management note the benchmarking undertaken against the service specification will also consider this, but review of the presentation did not include reference to this.		The outcome of the workforce review, and development of a workforce plan should be shared at an appropriate committee. This should include any continued reliance on external agency, and, where possible, timescales for addressing this.	M	Accepted. Develop a CAMHS workforce plan and share via the appropriate committees (CAMHS Directorate Board Meeting, Mental Health Division Board, and Mental Health Legislation Committee).	CAMHS Directorate Manager	31/05/2025	**August 2025:** The workforce plan has been further updated for 2025/26, given a change in the workforce plan position between March, April and May.	30/09/2025
3.1	In July 2023, a report to the Performance and Finance Committee highlighted initial performance had been hampered by a lack of defined processes and responsibilities within the administrative team. Noting this evidence was obtained to confirm the completeness of actions related to the creation of booking guidance to support administrative team duties, with three separate process documents provided, in reviewing these we noted: • One document 'Updating a CAMHS referral following triage or review from SPOA or ADHD colleague' was listed as draft. • None of the three documents included contained detail of version control, author or issue date.	Guidance documents lack sufficient document control, which could lead to outdated processes being implemented.	Management should ensure any guidance or 'how to' documents are finalised and contain detail in relation to version number, author and approval.	L	Accepted. Ensure good version control on Directorate documentation in a manner with is proportionate to the formality of the document.	CAMHS Directorate Business Support Manager	31/12/2024	**June 2025:** Principles of good record keeping will be embedded as they arise. TOR developed with good record keeping principles in mind.	30/09/2025
4.1	ADHD diagnosis has been subject to recent national investment from Welsh Government; however funding has not been similarly available to support monitoring, despite there being a suspected linked increase in demand. Following service repatriation, the Directorate undertook a detailed review and comparison of patient letters, and data held on both CTMUHB and SBUHB clinical systems for 695 patients. This identified that 147 patients were in breach of their review dates, including 54 who were overdue by over a year. Additional resource was approved by WBM in December 2023 to assist in stabilising the service, although the validation of data estimated that there remained a possible shortfall of around 800 appointments per year even with this support. A recommendation of the validation paper to WBM included intention to review ADHD medication monitoring capacity in a further 6 months, however the subsequent review has yet to be undertaken	Clinical risk to patients where they are not reviewed in line with national guidance. Lack of ongoing monitoring of service performance in addressing above risk.	The Directorate should undertake a follow up review of ADHD medication monitoring capacity to identify the current gap within demand and capacity.	M	Accepted. Conduct an immediate review of young people open to the ADHD Medication Monitoring Service to identify the number of breaches and consider demand and capacity.	CAMHS Directorate Manager	31/12/2024	**August 2025:** Demand and capacity review for ADHD and the whole CAMHS Directorate is underway. This will be reported by the Mental Health Division Q&S Committee in September 2025.	30/09/2025
5.1	Review of scorecards for the period February 2024 – July 2024 noted no service user/carer feedback or patient safety indicators (e.g., incident types) included from April 2024 onwards.	Lack of appropriate indicators could reduce their effectiveness as a performance management tool. Lack of consistency in the reporting of key indicators may reduce their effectiveness.	There should be consistent inclusion of service user/carer feedback and patient safety indicators within the CAMHS performance scorecard.	M	Accepted. Embed the Experience of Service Questionnaire feedback form requested as part of the NHS Wales Service Specification within CAMHS practice and report via the CAMHS Directorate Q&S Report / CAMHS Scorecard which features in the Mental Health Division Q&S Committee / CAMHS Directorate Board Meeting.	CAMHS Lead Nurse	31/12/2024	**June 2025:** Use of the 'Experience of Service Questionnaire' has been embedded via MS FORMS and is reported via the MH Division S&Q Committee. Further plans this year to automate data collection in line with other Service Group Service User data capture.	30/09/2025
5.3	The CAMHS Directorates initial review against the NHS Wales CAMHS Service specification had highlighted 12 performance metrics as either amber (signifying partial or non-automated collation), or red (no current collation), noting the challenge of extracting required data from systems, some of which remain paper based.	Lack of appropriate indicators could reduce their effectiveness as a performance management tool. Lack of consistency in the reporting of key indicators may reduce their effectiveness.	The health board should support the Service Group in working towards reporting against all the performance metrics listed within the NHS Wales CAMHS Service Specification.	M	Accepted. CAMHS Directorate to escalate Digital support requirements to fulfil the performance metrics identified within the NHS Wales CAMHS Service Specification via the MH&LD Service Group Digital meeting to obtain health board support.	CAMHS Directorate Manager	31/05/2025	**August 2025:** An unpublished/closed (draft) dashboard has been created. Work is currently ongoing to ensure that the data it contains is both accurate and aligned to service needs.	31/10/2025

Discharge Planning 2025

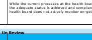
Key Finding Ref	Key Findings	Impact	Agreed Management Action	Priority	Expected Evidence of Implementation	Responsible Officer	Deadline	Comments	Milestone Date
1	National discharge guidance is available to support health board staff, which establishes responsibilities across ward, management and integrated care teams, but does not include reference to documentary, quality or audit requirements to ensure consistency of application. Additionally, external reviews have highlighted where further health board guidance or protocols are required which could be incorporated into the health boards resources once developed and approved: • Health board wide internal professional standards, • Clinical criteria to reside, • Escalation frameworks (both internal and those agreed with partners) • Trusted Assessor standards/responsibilities, and • Revised Patient Choice policy.	Lack of clarity, consistency, and staff awareness.	The health board recognises there is a need to develop a local policy to ensure consistency across acute sites whilst retaining alignment with national guidance. The revised policy will include supporting documents outlined, and these will be available through the health board SharePoint for staff awareness and use. As part of the UEC programme of work the Health Board is commissioning a piece of work to develop its D2RA pathways against the national standard commencing in January 2025. The health board will be holding its 3rd UEC summit in March 2025 which will be completely focussed on discharge processes and policy.	M	Development of a health board discharge policy, and approval at an appropriate forum. Policy and supporting guidance/documents communicated to staff and uploaded to the health board SharePoint.	Associate Service Group Director PCTSG Associate Director UEC	30/06/2025	**June 2025:** In April 2025, a test of change was implemented to develop an Integrated Discharge Hub focussed at the 'front doors' of Morriston to promote admission avoidance and early supported discharge in line with the D2RA principles. Due to the overwhelming success if this test of change, the hub has continued in its temporary arrangement. However, plans are in place to designate a Strategic and Operational Lead for the D2RA Hub this will allow for a formal organisational change process to be applied to the affected staff from across the Health Board. In addition, a work programme has been developed with a number of workstreams to address the following: - Trusted assessment model and training needs - Revised discharge policy with supporting policies and procedures to include: patient choice and reluctant discharge (based on the WG 2025 guidance) - D2RA demand profile for the pathways - Review of the Pathway 2 bed pool and pathways In parallel to this work, there is community and integrated teams review to explore the resources available in the community, their activity, cost and opportunities to reduce duplication, increase productivity and remodel available resources to provide a consistent Pathway 1 offer.	
2	A Criteria Led Discharge (CLD) Protocol has been introduced within both Morriston and Singleton Hospitals. This allows a designated member of a multidisciplinary team to accept discharge responsibility for a patient, based upon a criteria agreed by the consultant responsible for the patients care. The protocol does not have an approver/authoriser indicated and is not available within the health board's clinical library. Whilst a positive tool, we note that there are a limited number of patients in receipt of a CLD and wider MDT engagement could support its wider use.	Opportunities to expedite discharge may be lost, resulting in increased length of stay.	Approval of Criteria Led Discharge protocol at an appropriate forum, inclusion within the health board discharge policy, and identification of leads to promote its use across sites.	M	Approval of the Criteria Led Discharge protocol. Inclusion within the health board policy Confirmation of CLD leads for each site.	Associate Director Urgent and Emergency Care Group Nurse Director NPTSSG	31/03/2025	**June 2025:** The wards at Singleton undertaking CLD have all now transferred to Morriston under the AMSR work. Action therefore closed for NPTSSG. Criteria Led Discharge protocol in place. Test of change in progress focussing on medical wards, Morriston with oversight from a Matron who is working weekends to promote weekend discharge using the CLD protocol	31/08/2025
3	Resources are available to assist in the planning of discharges, however since the conclusion of the SAFER roll out in Morriston Hospital, there has been no formal health board training available to support the embedding of discharge planning principles and procedures. We are informed that the NHS Executive is developing resources aligned to the Optimal Patient Flow Framework which may assist in this area, although the timescale for release had not been confirmed at time of fieldwork closing. Similarly, we identified that ad-hoc support was available to support wards to refresh awareness of SAFER principles, however this was not consistent across the health board.	Lack of staff training may result in inconsistent or ineffective planning processes.	Following receipt of national training resources, there should be circulation to wards and uptake of training monitored. The principles established within the SAFER roll out programme will be adopted across other sites. SAFER principles and Criteria to Reside will form a major part of the D2RA implementation referenced within Key Finding 1.	M	Evidence to confirm uptake of training. Evidence of SAFER audits undertaken across all sites.	Associate Director Urgent and Emergency Care Associate Service Group Director PCTSG	31/07/2025	**June 2025:** Band 6 x 2wte and Band 8a x 1wte funding confirmed June 2025 to support roll out of the optimal hospital flow framework as part of the Six Goals national programme. Recruitment process in place.	
4	Of the 30 patients sampled: • 17 had not had an initial EDD set within 24 hours in line with WG guidance. • had no D2RA pathway assigned. • held no evidence of discharge planning discussions within WNCR. • held limited reference to discharge planning discussions. • 13 had no detail within the patient recorded under 'What Matters to Me' which should inform the development of discharge plans. Changes to EDD are recorded within SIGNAL but this does not capture reasons for change, although it can be cross referenced with WNCR by date, we did not see changes to EDD referenced directly. These points highlight that there are opportunities to address non-compliance and improve the detail recorded within clinical records	Inaccurate or incomplete information retain impacting on the safe and timely discharge of patients.	The development of a health board policy will include direction on the completeness of records, including in relation to setting of expected discharge dates, and communication with patients and carers. This will also include arrangements for periodic review of records to support quality improvement, and identification of outliers in respect of records completeness.	M	Approved policy with associated guidance. Evidence to support regular review of the accuracy and completeness of patient records.	Head of Patient Flow & Site Services MSG Head of Nursing Medicine Division MSG	31/03/2025	**June 2025:** Rolls will focus on HB wide roll out of the optimal hospital flow framework, underpinned by the SAFER flow principles and development of robust Board Round processes with clear task allocation, follow-up and escalation.	31/08/2025
5	Several externally facilitated diagnostic reviews have examined the health boards discharge planning and patient flow pathways. These have highlighted where further health board guidance or protocols are required, including: • Health board wide Internal Professional Standards; • Clinical Criteria to Reside; and • A revised Patient Choice policy. Action plans to address the above diagnostic reviews have been received at the UEC Programme Board. There have also been actions developed based upon the Management Board UEC Summit held in October 2024. While there is good crossover between both of the above, we noted the action plan from the Multi-Agency Discharge Event (MADE) lacked specific timescales. We were also informed that whilst progress has been made against the UEC Summit actions, some timescales in relation to the areas above would not be achieved. The above action plans have yet to be shared with the Quality and Safety Committee.	Failure to address identified weaknesses could extend the cycle	The health board will incorporate outstanding actions from recent diagnostic reviews and those identified as relating to discharge planning from within the UEC Summit, and collate these into one discharge/patient flow improvement plan with agreed timescales and action leads. Progress against the plan will be shared with the UEC Programme Board and Quality and Safety Committee.	M	Development and approval of the improvement plan. Evidence of progress being reported within appropriate forums.	Associate Service Group Director PCTSG Associate Director Urgent and Emergency Care	30/06/2025	**June 2025:** There is an organisational change document in development to support the centralisation of patient flow. This will focus the resource in Morriston and will provide HB wide bronze cover. Singleton and Neath Port Talbot sites will have a proportionate flow resource on site who will report into the bronze Clinical Site Matron Morriston. 'Your Next Patient' has been launched Health Board wide which identifies areas within wards where patients can be safely nursed whilst awaiting a bed. This allows patients to gain earlier access to the specialist care they need as opposed to waiting for a bed in the Emergency Department or within Admission Units. Significant progress has been made in relation to tactical patient flow management, data collection and reporting. In relation to the three specific points raised in the summit, updates are as follows: - Health board wide Internal Professional Standards: relaunched as part of the Anglesey Ward test of change supported by Associate Medical Directors - no formal measurement or escalation reporting available. - Clinical Criteria to Reside: test of change in progress as from 16th June 25 in Morriston - no reportable findings available. - A revised Patient Choice policy: drafted as part of the revised HB Discharge Policy	
6	UEC Programme 3 highlight reports have provided regular updates against the roll out of productive ward initiatives within Morriston Service Group. However, there has not been similar detail related to other health board sites.	Lack of oversight relating to discharge processes across the wider health board.	Future reporting to the UEC Programme Board on UEC Programme 3 will include updates for all sites.	M	Amended UEC Programme highlight reports.	Assistant Director of Operations Urgent & Emergency Care UEC Programme Manager	31/03/2025	**June 2025:** There is an organisational change document in development to support the centralisation of patient flow (which will work across all acute hospital sites). Furthermore 'Your Next Patient' has been launched Health Board wide which identifies areas within wards where patients can be safely nursed whilst awaiting a bed. This allows patients to gain earlier access to the specialist care they need as opposed to waiting for a bed in the Emergency Department or within Admission Units. These changes will allow for linked up reporting across sites (and in turn be able to reported up at UEC Programme Board) and provide Health Board wide assurance re; discharge processes. To support said changes 2x B6 'Improvement facilitators - Optimal hospital flow & D2RA' are being recruited on a pilot basis funded by NHS Executive until end of financial year 25/ 26. This to trial an enhanced level of resource focussing solely on flow and discharge across the Health Board. These roles working with ward staff to support optimal hospital flow/ D2RA principles and encourage timely recording of information which in turn can be reported upon.	31/08/2025
7	UEC Programme 3 highlight reports contain UEC programme metrics, but there are no measures or indicators reported through Programme 3 itself. The National Six Goals Programme Optimising Patient Flow guidance includes 12 suggested measures to assess pathways of care and patient flow, six of these feature within current health board dashboards. There could also be benefit in development of reporting indicators linked to the use of SIGNAL which could identify any variation in use at ward level. Following the agreement of Internal Professional Standards, there is a need to establish monitoring arrangements to ensure they are embedded - this could also support the measurement of productive wards	Lack of ward focussed metrics could prevent identification of areas of poor performance.	Metrics to support monitoring of discharge planning performance will be developed for inclusion in UEC Programme 3 reporting.	M	Amended UEC Programme highlight reports.	Assistant Director of Operations Urgent & Emergency Care UEC Programme Manager	31/03/2025	**June 2025:** Regarding the use of SAFER, D2RA and Pathways of Care Delays (POCD), appropriate dashboards have already been developed. These being relevant to the roll-out of 'productive wards' initiatives and align with national optimal hospital flow and D2RA principles/ frameworks. As noted, 2x B6 'Improvement facilitators - Optimal hospital flow & D2RA' are being recruited on a pilot basis funded by NHS Executive until end of financial year 25/ 26. This to trial an enhanced level of resource focussing solely on flow and discharge across the Health Board. These roles working with ward staff to support optimal hospital flow/ D2RA principles and encourage timely recording of information which in turn can be reported upon. It is anticipated that any improvement of data recording will have a significant improvement on the data quality currently available via SAFER, D2RA and POCD dashboards - and in turn can be used more effectively to drive improvements/ change.	31/08/2025

Service Group Governance Arrangements - NPTS

Key Finding Ref	Key Findings	Impact	Agreed Management Action	Priority	Expected Evidence of Implementation	Responsible Officer	Deadline	Comments	Milestone Date
7	The HB's SFI's state that where the management of a budget is delegated, this must be in writing, in the form of an accountability letter, which must be signed. Within NPTSSG, generic financial letters were issued to divisions that detailed the budgetary process for the financial year (2024/25), but did not specify the amount of the budget delegated to the division nor did the letter need to be signed.	Budget accountability is not formally agreed, as required by the SFIs.	Divisional budgets will be set out in 25/26 accountability letter when agreed. The requirement for the letter to be signed will be set out in the 25/26 accountability letter.	M	Copy of divisional letter.	Service Group Director	30/06/2025	**August 2025:** Letters have been sent to Assistant Service Group Directors, with a request to sign.	30/09/2025

Director of Corporate Governance

Safety Notices & Alerts

Key Finding Ref	Key Findings	Impact	Recommendation	Priority	Management Response	Responsible Officer	Deadline	Comments	Milestone Date
2.1 b	Review of Datix identified that only 195 of the 964 alerts and notices between 1st April 2019 to 1st April 2022 were recorded as closed in the system. In addition, we selected a sample of 30 alerts and notices for confirmation that they had been distributed and actioned, and found the following: 	• Safety notices and alerts are not acted upon in a timely manner. • Missing actions remain undetected.	We also recommend that compliance with actions be proactively monitored, evidenced and the related audit trail is maintained to support the completion of actions.	H	Detail regarding monitoring and reporting requirements, together with the management trail to be maintained and retained in respect of compliance with required actions will be set out in the relevant Procedure document(s)	Director of Corporate Governance	31/10/2022	**August 2025:** A Task & Finish Group has been set up to consider the remaining Audit & Assurance Report recommendations, recognising the need to review processes for cascading and gaining assurance. This matter will be considered as part of the work of that Group.	31/10/2025
4.1 a	Overall, we note that no Key Performance Indicators (KPIs) had been set, monitored and reported across the various areas. As such, there is risk that the quality of the monitoring may not be sufficient and / or consistent across the different types of alerts / notices.	• Failure to provide timely assurance could result in patient harm, reputational damage and financial implications.	A more robust monitoring and reporting process should be put in place, including setting up KPIs for each alert type, and monitoring them, especially in the compliance area.	M	Monitoring and reporting processes, including the setting of any relevant KPI, will be set out with the relevant procedure documents as part of the update and development process.	Director of Corporate Governance	31/10/2022	**August 2025:** A Task & Finish Group has been set up to consider the remaining Audit & Assurance Report recommendations, recognising the need to review processes for cascading and gaining assurance. This matter will be considered as part of the work of that Group.	31/10/2025
5.1	While the current processes at the health board aim to reach compliance in relation to all safety notices and alerts, once the adequate status is achieved and compliance is established, no further check or reporting takes place. As a result, the health board does not actively monitor on-going compliance with the safety alerts and notices.	• Absence of a mechanism to demonstrate ongoing compliance with the alerts and notices.	Management should consider how on-going compliance related to safety notices and alerts can be assured, such as inclusion of alerts and notices within any internal quality assurance inspections.	M	Systems and processes capable of providing assurance in respect of compliance with safety notices and alerts at both a Service Group and Corporate level will be developed and documented as part of the Procedure review and update process.	Director of Corporate Governance	31/10/2022	**August 2025:** A Task & Finish Group has been set up to consider the remaining Audit & Assurance Report recommendations, recognising the need to review processes for cascading and gaining assurance. This matter will be considered as part of the work of that Group.	31/10/2025

Follow Up Review

Key Finding Ref	Key Findings	Impact	Recommendation	Priority	Management Response	Responsible Officer	Deadline	Comments	Milestone Date
1.2	We previously highlighted that the tracker could be extended to capture recommendations from other assurance providers/inspection bodies, including Healthcare Inspectorate Wales, Counter Fraud and the Health and Safety Executive, and note that this was also raised by Audit Wales in their recent Structured Assessment report.	Failure to implement agreed audit recommendations in a timely manner Increased financial, clinical, statutory and reputational risk for the health board	The health board should ensure appropriate oversight of recommendations raised by other external inspection and review bodies.	M	The Health Board intend to use AMaT to monitor recommendations raised by other external inspection and review bodies.	Director of Corporate Governance	31/10/2023	**July 2025:** The revised External Inspections SOP, supplemented by a new desktop SOP on the use of the AMaT system, was presented to the July 2025 meeting of the Management Board and approved. Work on adopting the system for the input and monitoring of HIW inspections is ongoing, with all inspections reported from 2024 onward being entered. Inspection information from Natural Resources Wales has also been added. Work on reviewing the suitability of other inspection types for inclusion on the system has commenced.	30/09/2025

Risk Management & Assurance

Key Finding Ref	Key Findings	Impact	Recommendation	Priority	Management Response	Responsible Officer	Deadline	Comments	Milestone Date

2.1	**Risk Assessment and Approval:** It was not always clear from reviewing the Datix system who was involved in assessing and approving the risk, and the rationale for risk inclusion was not always evident. **New Risks:** Further analysis across the entire risk registers for each of the SGs identified a lack of evidence to demonstrate the review and approval of ten new risks. Seven related to the risk type "Controlled Drugs - PHARMACY & MEDS MANAGEMENT ONLY" where access to the risk is restricted to the Pharmacy team. The setting of access levels impacted three other risks where the speciality field was blank. The Assistant Head of Risk & Assurance explained that it is acceptable to leave the field blank, e.g. if a risk spans more than one specialty or even more than one SG. While access has been amended in these instances, a wider review may be required to ensure that there is an appropriate level of access for risks where the speciality field is blank. **Controls & Mitigating Actions:** Analysis of the risk registers identified that there were 26 risks that did not detail a control. All twelve risks in our sample detailed controls, but only four had actions recorded. The actions for NPTS and Morriston did not record a timescale or action owner. Analysis of the risk registers for each of the four SGs indicated a lack of evidence to demonstrate that actions were subject to a regular review. **Risk Scoring:** There is nothing on the Datix system to prompt for the rationale for the scoring to be detailed. Out of the twelve risks tested, we identified issues with the scoring of ten risks across all SGs. When reviewing the entire risk registers for each of the SGs, there were 107 risks where the current risk had been scored higher than the initial risk score. **Risk Register Updates:** Analysis of the whole risk registers for each of the SGs identified that the 'review date' field had not always been updated despite there being evidence that the risk had been reviewed regularly. Similarly, while a closed date was recorded, our analysis identified that the risk was not always marked as 'closed'.	Risks are not identified and monitored effectively with inconsistent escalation of key risks that impacts adversely.	We recommend that the health board considers arrangements to promote and monitor the consistency and completeness of operational risk registers (evidencing assessment and approval of risks; controls and mitigating actions; updating review date and closed fields; confirming that risks have been scored appropriately; and access rights to risks are correct).	M	Review of arrangements to promote and monitor the consistency and completeness of operational risk registers in other Health Boards to be completed and options presented to the Risk Management Group for consideration and approval.	Assistant Head of Risk Management	30/11/2024	**August 2025:** Presentations from SGs to the RMG which took place during May and June included a summary of how risks were being managed. In July 2025, the RMG received a dashboard of Risk Register data. Following this initial review of the dashboard, an executive subgroup is scheduled to meet during August 2025 in order to select priority KPIs to focus review of SG risk register management going forward. These will subsequently be presented to a future meeting of the RMG for ratification.	31/10/2025
3.1	Oversight - SGs do review high level risks but further work is needed on other risks to ensure they are regularly reviewed, reported and escalated as required. The ability to do this could be impacted by the sheer volume of SG risks. - Risks were often reported within quality & safety meetings which may mean that there is insufficient focus on other types of risks, e.g. financial, regulatory, etc. - There was a lack of oversight of risk by SG Management Boards, as some were only starting to put in place mechanism for the reporting of risk. Having a consistent report template for the reporting of operational risks to management boards, other forums/groups and the corporate Risk Management Group, similar to the format presented at Board and Committees, would provide clear oversight and enhance monitoring arrangements. - Meeting minutes for SG Management Boards do not always reflect the level of discussion and scrutiny of risks, and that risk monitoring and scrutiny may not be allowed sufficient time due to busy agendas. As noted by Deloitte, there is a lack of reporting from Service Group Management Board to Corporate Management Board. - Not all SGs have carried out annual reporting of their risks to the corporate RMG.	Inconsistent monitoring, management, and escalation of risks within the health board.	A summary risk report, similar to the format presented to the Health Board and Committees, should be developed for the reporting of operational risks. The report should include themes, age of risk, risk changes (new/closed risks, risk score amendments), issues identified (no progress, unapproved risks, risk scoring issues, highlighting where fields have not been completed or updated).	M	Review of operational reporting of risks to be carried out in the Health Boards and options presented to the Risk Management Group to consider and approve.	Assistant Head of Risk Management	30/11/2024	**August 2025:** Presentations from SGs to the RMG which took place during May and June included a summary of how risks were being managed. SG Risk Registers, centrally produced by the Assistant Head of Risk and Assurance, were also included within the papers, these broke down all risks scored 15 and above into various categories e.g., •Risk type analysis •Specialty Level Risks •Aged Risks •Analysis of last progress note This approach, adapted following discussions on KPIs, will be a periodic feature of RMG meetings, with data received no less that twice yearly	31/10/2025

Director of Digital

End of Life Care

Key Finding Ref	Key Findings	Impact	Recommendation	Priority	Management Response	Responsible Officer	Deadline	Comments	Milestone Date
2.1a	A dashboard was developed by the Quality Information Manager in October 2022, which includes metrics for the health board as a whole and each of the service groups individually. However, the dashboard does not include metrics around performance against the five priorities for care for the last days of life.	Failure to demonstrate a pattern or year on year performance.	The Health Board should develop performance measures that align to the five priorities of care and the NACEL Action Plan.	M	Identify gaps in existing data which are required to align our measures to the five priorities of care and NACEL action plan	Director of Digital	31/07/2023	**August 2024:** Currently in discussion with national colleagues to understand where digital support for EOLC sits amongst other national priorities.	
				M	Present plan to Quality Priority Programme Board with timescales for implementation of measures	Director of Digital	30/09/2023	**April 2024:** To be scheduled for Q2 2024/25.	

Technical Resilience

Key Finding Ref	Key Findings	Impact	Recommendation	Priority	Management Response	Responsible Officer	Deadline	Comments	Milestone Date
1.1	Not all sites containing core infrastructure items have fire suppression. We note that this is partly due to those areas which are not within a data centre having dual use. Without fire suppression there is an increased risk of loss of service, in particular during out of hours.	Loss of service	Consideration should be given to installing fire suppression. Potentially using a system that can be turned off when the room is in use by staff.	M	Fire suppression is installed in the data centre at Morriston Hospital but not in the data centre at NPT Hospital. This is planned for 2023/24 and capital funding is agreed.	Assistant Director of Digital Technology	31/03/2024	**August 2025:** Further to environmental checks a design has been agreed. SBU have agreed costs and have asked the PFI to commence the work the original capital amount set aside was less than the cost provided but the funds have been agreed. Timescales to be agreed.	31/12/2025

Signal

Key Finding Ref	Key Findings	Impact	Recommendation	Priority	Management Response	Responsible Officer	Deadline	Comments	Milestone Date
3.2	Whilst testing range checks which ensure data falls within set parameters, we observed that there is no such control over manual entry of a patient's date of birth. As such we were able to add a patient of 222 years of age and also a date in the future without any flags. Whilst SIGNAL will not permit clinical patients to be admitted on the system without a linked demographics record, and by default dates of birth must match, we established that this is not the case for Mortuary patients. Implementing range validation through defined lower and upper boundaries for reasonable values helps to reduce the margin of error caused by mistypes and prevent outliers that may skew data analysis. Duplication checks are in place to prevent more than one active admission of a patient once they have been linked to a demographics record, however, the same checks have not been applied to manual patient entry. During testing we were able to manually enter the same patient details as two separate records without flags.	Inaccurate data held in the system; and Inaccurate data reported from the system.	Management should consider implementing duplication controls for patients entered manually within SIGNAL.	L	When Signal is able to process ADTs from WPAS, it is anticipated that patients would no longer need to be entered manually other than in Mortuary. Patients who would need to be entered manually are those who cannot be identified at admission and, as per the current Unknown Patients process, they will have a temporary record in WPAS and be admitted in Signal under that record. ADT functionality in Signal is scheduled to be developed in Q4. If the functionality to create patients manually outside of Mortuary is still required post the implementation of ADT functionality, then we will incorporate duplication controls as per this recommendation.	Interim Head of Digital Applications Assistant Director of Digital Transformation	31/03/2025	**August 2025:** Further delays in commencing this work have been caused by new requirements taking priority. Version 4 is currently planned for delivery in Q4.	31/03/2026

Clinial Coding

Key Finding Ref	Key Findings	Impact	Recommendation	Priority	Management Response	Responsible Officer	Deadline	Comments	Milestone Date
3.1a	The non achievement of the Welsh Government target for clinical coding is recorded on the Digital Services Risk Register. Actions have been identified to address the issues impacting on clinical coding, some of which are currently underway. However, there is no formal service improvement plan which sets out all the actions to be undertaken, resource and timescale and responsibilities. Without a formal plan in place the health board may find it hard to effectively move forward and track actions.	Non-compliance with WG targets	A formal service improvement plan should be developed, and progress against this monitored. The plan should include actions to address all the issues and include responsible officers, targeted deadlines and an identification of resources required.	M	Appointment of a Band 6 Service Improvement lead responsible for creation and enabling of a service improvement plan following recruitment freeze.	Assistant Director of Digital Intelligence	30/11/2024	**August 2025:** Recruitment to this post will take place following the conclusion of the OCP currently being undertaken. This conclusion will occur during August / September 2025.	30/09/2025

Records Management

Key Finding Ref	Key Findings	Impact	Recommendation	Priority	Management Response	Responsible Officer	Deadline	Comments	Milestone Date
3.1	Due to the lack of coordinated management for storage of records, as noted above there are a number of external providers holding health board records. The costs vary between the providers as such the health board may not be sourcing the best value storage.	Mishandling or loss of records	A review of the storage of records should be undertaken in order to establish the full health board need and to identify the most suitable locations for storage of records which should take into account the needs once appropriate disposal of records as noted in MAS has been undertaken.	H	A Multi-Disciplinary Project Group will be established following the centralisation of the acute health records service to Ty Samlet, which will be completed by the 1/4/25. The project group will review the Health Board' wide storage requirements and will encompass all the associated security/retention and disposal of records aspects highlighted within the audit report.	Head of Health Records & Clinical Coding	31/05/2025	**August 2025:** All services have been met with, and the action plan has been developed and regular updates are being provided. Task and Finish Group no longer required as regular updates are provided by the Services and updates are provided to IGCAG and DDRI. Scoping exercise initiated.	30/09/2025
3.2	The HB utilises Transmedia for external record storage from multiple departments, including Workforce. However, our review noted that the only contract in place with Transmedia is for the storage of Pathology materials. Spend with the company is more than double than the contracted value, which may leave the health board open to legal challenge. We also note that the lack of a formal contract for storage other than Pathology items introduces uncertainty regarding Transmedia's responsibilities in managing personal records, raising potential GDPR compliance concerns.	Mishandling or loss of records	The arrangements for storage of records other than Pathology at Transmedia should be formalised with a contract or agreement that clearly states the requirements and responsibilities for records storage.	H	A contract/agreement will be developed to formalise the storage of all other records stored at Transmedia which clearly defines the requirements and responsibilities for storage of all records if SBHB continues to store records within this third-party storage facility	Head of Health Records & Clinical Coding	30/06/2025	**August 2025:** First project Group established 12/8/25 following a full inventory of HB services that store records being provided by Transmedia. All service leads have been invited, and Procurement will also be in attendances.	31/08/2025
5.2c	During the review, it became evident that some departments are retaining records beyond the designated retention periods partly due to the lack of health board guidance. The Occupational Therapy department has not destroyed any records since 2019 and continues to retain records dating back to 2010. Similarly, the Workforce and Organisational Development (WOD) team has also refrained from destroying records. The retention of records past defined removal dates may result in a breach of the GDPR requirements and exacerbates storage pressures.	Breach of GDPR	All departments should be reminded of the need to destroy records appropriately in accordance with retention periods.	H	A Multi-Disciplinary Project Group will be set up to review the destruction programme across all SBUHB record services.	Head of Health Records & Clinical Coding	28/02/2025	**August 2025:** The requirement to destroy records appropriately in accordance with Retention and Destruction periods forms part of the agenda being taken forward by the Multi-Disciplinary Project Group, which has representation from all the Services that were audited. Since completion of the audit, an action plan has been developed by the Head of Health Records, and progress has been made across the services. In addition, a wider scoping exercise will be undertaken across the Health Board to quantify the number of records stored and any backlogs in destruction	30/09/2025

Data Quality DoD

Key Finding Ref	Key Findings	Impact	Agreed Management Action	Priority	Expected Evidence of Implementation	Responsible Officer	Deadline	Comments	Milestone Date
1	Whilst the Welsh Patient Administration System (WPAS) benefits from proactive and comprehensive data quality checks and monitoring, other clinical systems within the health board do not have equivalent oversight, with limited data quality reporting and dashboarding. Whilst Product Specialists are in place for clinical systems, data quality issues in these systems are primarily identified and reported by users which can lead to inconsistent data quality management, and delayed identification and resolution of data quality issues.	Poor decision making Failure to achieve performance measures and organisational objectives Patient harm Exposure to financial loss and reputational damage.	The Product Specialists carry out various data quality tasks as part of their day-to-day duties and data quality forms part of their job description. The data quality measures for the systems managed by Digital Services will be formalised, documented and monitored to allow reporting and therefore improved oversight. A process will be implemented to agree data quality measures for new systems/ modules or upgrades to existing systems and these will form part of the transition to business-as-usual following implementation. SBU has a mixed economy of systems managed centrally within Digital Services and others that are managed within specialty/ service areas, such as Radiology, Pathology, Cardiology, where digital subject matter experts manage, maintain and monitor the service-specific systems in those areas. The subject matter experts provide quarterly updates to the Digital Services Management Group (DSMG). Taking a pragmatic approach to reporting from the specialty/ service areas, Data Quality will be added to the standard reports that these services provide to DSMG.	M	Data Quality reporting to Information Governance Learning & Operational Group (IGLOG) for systems managed within the Clinical Systems and Data Quality team in Digital Services. Data Quality reporting to Digital Services Management Group (DSMG) for service specific clinical systems.	Head of Digital Applications / Head of Digital Operations Service Modernisation and Transformation	30/06/2025	**August 2025:** The next IGLOG is scheduled for September and Data Quality will be included on the agenda as a standing item from this meeting onwards. Data Quality is now included on the standard reporting template for DSMG.	30/09/2025
2	Linked to key finding 1, not all clinical systems within the health board are proactively monitored for data quality issues. Whilst we note that the Information Governance Learning & Operational Group (IGLOG) will receive quarterly validity and consistency reports, this pertains to WPAS data only. As IGLOG includes data quality as a key agenda item, it is essential that it receives data quality updates and improvement plans across all clinical systems, not limited to just one. This approach ensures comprehensive oversight and facilitates consistent monitoring and improvement of data quality across the entire clinical system landscape.	Poor decision making Failure to achieve performance measures and organisational objectives Patient harm Exposure to financial loss and reputational damage.	As per Key Finding 1, provide data quality updates and improvement plans: •To IGLOG for systems managed within the Clinical Systems and Data Quality team in Digital Services, and •To Digital Services Management Group (DSMG) for service specific clinical systems	H	IGCAG minutes reflecting Data Quality reporting to IGCAG for systems managed within the Clinical Systems and Data Quality team in Digital Services. DSMG minutes reflecting Data Quality reporting to Digital Services Management Group (DSMG) for service specific clinical systems.	Head of Digital Applications / Head of Digital Operations Service Modernisation and Transformation	30/06/2025	**August 2025:** Linked to comments above	30/09/2025

Director of Finance

Morriston Hosp Burns ICU & Theatre 7

Key Finding Ref	Key Findings	Impact	Recommendation	Priority	Management Response	Responsible Officer	Deadline	Comments	Milestone Date
3.1	Whilst an NEC contract was being utilised for the main contractor, it was noted that for several of the advisors, Service Level Agreements (SLA's) had been used instead. The HB Capital Manual does not acknowledge the Public Sector Framework policy (NHS SBS, and Welsh Procurement Alliance Frameworks) requires use of SLA's. It was noted that consideration had been given by the Health Board to inclusion of NEC clauses, however guidance in the SBUHB Capital Manual should be reviewed to ensure alignment with NEC SCP contracts when considering framework selection and SLA/ NEC Professional Services use.	Conflicting performance objectives and resolution options across contracts than had NEC Professional Services contracts been used	The SBUHB Capital Manual, Section 6.0 should be reviewed to ensure that guidance relating to use of NEC contracts versus Service Level agreements is appropriate.	L	Accepted - As a result of advanced procurement processes and a varied market of available Public Sector Frameworks, the Capital Planning department will amend the Capital Manual to reflect the various types of contracts that can be accepted as part of SCP appointments. This will consider the interaction of advisor and consultant contract types, and impact on change and resolution management etc. when using an NEC contract for the SCP/ main contractor.	Assistant Director Capital Planning	31/12/2024	**August 2025:** The Capital Manual had been updated and will be presented to the September meeting of the Capital & Estates Board for approval.	30/09/2025

Asset Management

Key Finding Ref	Key Findings	Impact	Agreed Management Action	Priority	Expected Evidence of Implementation	Responsible Officer	Deadline	Comments	Milestone Date
1	Both the SFIs and FCP 15 require review and update. In line with the findings arising from this report, there are opportunities to better reflect and provide more clarity on current practices in particular areas of asset management, including asset verification and reconciliation processes.	Inconsistent and/or incorrect application of guidance, leading to inaccurate asset records, loss or misappropriation of assets and/or misstatement of asset values	FCP 15 will be updated in Q1 2025/26 to reflect the agreed changes in this report.	M	Approval by Audit Committee.	Assistant Director of Finance	30/06/2025	**August 2025:** FCP 15 has been updated and is currently awaiting approval via the Audit Committee.	30/09/2025
2	The FCP states that: "… the basic information for equipment purchases should be extracted from the Purchase Order and/or invoice, but advice should be sought from the appropriate manager where clarity is needed." This is a different process to some other NHS Wales organisations where an additions form is completed by the relevant manager confirming purchase cost and location of the asset for inclusion in the fixed asset register. We note that where purchases are through an electronic capital prioritisation bid, the essence of the additions form is reflected; however, further enhancement to the details recorded for those purchases made outside of this bid process is required. Further, noting the number of assets that could not be located during the course of the physical verification exercise (for the 2023/24), compliance with the expectations of the FCP regarding verification of asset information is not evident across Directorates.	The record of the equipment in the asset register is incomplete.	It should be noted that advice provided by the MEMS, is that it is rare for medical equipment to be moved to a totally different location on a permanent basis and is most likely moved around local areas on the same site as part of the normal business of running a hospital – for example items of equipment are shared between departments on a need to have basis. Agreed that the verification process will be enhanced with the completion of full equipment details on addition to the Fixed Asset Register by the quarter following addition – including make, model, serial number, department, MEMS E-Quip system reference and going forward the possible addition of passive tags to some appropriate items of medical equipment. Part of this work will review how to enhance the use of technology to collect this information.	M	Updated FCP 15 and from Q1 2025-26, an on-going reconciliation and sign-off process to ensure a complete asset record on RAM.	Assistant Director of Finance	31/07/2025	**August 2025:** Asset Information being collected at source from new Capital Prioritisation Group Bids. FCP 15 has been updated and is currently awaiting approval via the Audit Committee.	30/09/2025
3	For 2023/24, the annual non-physical verification exercise was undertaken only in respect of IT assets rather than all equipment assets as the FCP defines – and we note that this has been the case since 2019/20. The 'status' field within the e-Quip system is populated for the location of the asset. Whilst we were informed that it is reviewed by the Capital Finance Team, there is no documentary evidence to support that this is currently used as part of the verification exercises.	Inconsistent and/or incorrect application of guidance, leading to inaccurate asset records, loss or misappropriation of assets and/or misstatement of asset values.	The outstanding assets from the 2023/24 verification process have been incorporated into the 2024/25 verification process. A download/reports from the E-Quip system will be maintained as part of the reconciliation process.	H	Reconciliation report for annual verification exercise reviewed by the Assistant Director of Finance. Update FCP 15	Assistant Director of Finance	30/06/2025	**August 2025:** FCP 15 has been updated and is currently awaiting approval via the Audit Committee.	30/09/2025
5	Whilst capital acquisitions are recorded on the ledger throughout the year, the requirement of the monthly reconciliation to the fixed asset register as per the FCP (and as is undertaken at other health boards) is not completed. This is due to the RAM only being updated on an annual basis. We note that it is the health board's intention to move to a quarterly reconciliation in 2025/26, noting that the Projects Module that was used within the RAM system (until 2022/23) prevented completion of reconciliations more frequently than an annual basis.	Misstatement of physical asset holdings within the RAM.	A quarterly upload from the ledger to the RAM Fixed Asset register will commence in 2025/26. Update FCP15.	M	Quarterly reconciliation signed off by the Assistant Director of Finance. Update FCP 15.	Assistant Director of Finance	31/07/2025	**August 2025:** Quarterly upload process has commenced. Best practice information was being sought from other Health Board as there is not one consistent way of what information is being uploaded. A Beta upload is taking place in August and will be reviewed at a team time out in September. FCP 15 has been updated and is currently awaiting approval via the Audit Committee.	30/09/2025

Energy Management

Key Finding Ref	Key Findings	Impact	Agreed Management Action	Priority	Expected Evidence of Implementation	Responsible Officer	Deadline	Comments	Milestone Date
2	Recognising the UHB's existing UHB Energy Management Systems, there are opportunities to enhance the current process. It is understood that there are a number of possible add on's that could add value and reduce elements currently undertaken manually. Although noting these would complement and not replace controls such as manual meter reads which are required to reconcile against.	The UHB are not exploiting all opportunities to embrace benefits that technology can provide.	Review with TEAM SIGMA their software APP for recording meter reads. Evaluate with TEAM implementation of STARK consumption data supplied directly into TEAM database. Noting manual reads to be retained. Electronic bill receipt and automatic payment to be considered.	M	Feasibility review to be undertaken - noting electronic billing is significantly bigger project.	Technical Services Officer Energy & Carbon	28/02/2025	**August 2025:** We have progressed with the current Gas half hourly data. We have submitted an LOA between Total Energies and CCS as this is required by Total to deliver AMR Data. We are awaiting AMR data to be delivered into a dedicated mailbox and resolve outstanding AMR issues.	30/09/2025

Estates Condition Governance

Key Finding Ref	Key Findings	Impact	Agreed Management Action	Priority	Expected Evidence of Implementation	Responsible Officer	Deadline	Comments	Milestone Date
3	The detail at the Health Board Risk Register in respect of HBRR98 ('Overall condition and suitability of the Health Board estate') and HBRR93 ('Reduced Capital Funds') could be improved in the following areas: **HBRR98** •'Assurances': Consideration should be given to the use of data from the 6-facet survey programme to quantify whether high/significant backlog is reducing; •Reference was not made to the work being done to develop the long-term revenue model, noting the outcome of this review and future approvals to increase revenue funding for maintenance would be a key control in managing this risk; •'Gaps in Assurance': the detail provided did not appear relevant to the question posed. **HBRR93** •The presentation of this risk as "reduced capital funds" should be revisited, recognising a better description may be that there is "insufficiency of funds" to address the Health Board's needs, with increased competition for funds across NHS Wales. We note the Health Board's discretionary capital allocation is in fact expected to increase in 2025/26.	Members are not appropriately informed and cannot exercise appropriate scrutiny. Appropriate action to reduce risks may not be taken.	Narrative contained within relevant Health Board Risk Register entries will be reviewed and updated, taking into account the issues highlighted in this report. This will be done as part of a wider piece of work that is currently ongoing to reset the Health Board risk management processes, which includes the creation of a Strategic Risk and Assurance Register.	M	Reviewed and updated entries in the Health Board's Strategic and Corporate Risk Registers	Assistant Director of Strategy - Capital	30/06/2025	**August 2025:** A strategic level risk relating to the maintenance of our estate within both primary and secondary care has been drafted for inclusion in the Health Board's new Strategic Risk Register (SRR). The process of finalising the entry is currently ongoing. Once complete, the current Health Board Risk Register (HBRR) will be reviewed as the starting point for the creation of the Corporate Risk Register, which will underpin the SRR.	31/10/2025
4	The Board Assurance Framework (BAF) captured the estate condition risk under Objective 3: 'Care is Delivered in Safe and Appropriate Settings'. This objective also encompassed a health and safety risk. The majority of narrative in the BAF related to the health and safety risk (including the reference to the responsible committee, which differs for the two risks), with minimal reference to the estate condition risk (despite the latter having the higher risk score). Likewise, the Reduced Capital Plans risk captured under BAF Objective 6: 'The Health Board is a resilient, financially sustainable organisation' focused on the deficit risk, and did not provide any narrative in relation to the Reduced Capital Plans risk.	Members are not appropriately informed and cannot exercise appropriate scrutiny. Appropriate action to reduce risks may not be taken.	Narrative currently contained within relevant Board Assurance Framework entries will be reviewed and updated, taking into account the issues highlighted in this report. This will be done as part of a wider piece of work that is currently ongoing to reset the Health Board risk management processes, which includes the creation of a Strategic Risk and Assurance Register.	M	Reviewed and updated entries in the Health Board's Strategic and Corporate Risk Registers.	Assistant Director of Strategy - Capital	30/06/2025	**August 2025:** A strategic level risk relating to the maintenance of our estate within both primary and secondary care has been drafted for inclusion in the Health Board's new Strategic Risk Register (SRR). The process of finalising the entry is currently ongoing. Once complete, the current Health Board Risk Register (HBRR) will be reviewed as the starting point for the creation of the Corporate Risk Register, which will underpin the SRR.	31/10/2025

Director of Workforce & OD

DBS Checks

Key Finding Ref	Findings	Impact (Internal Audit)	Recommendation	Priority	Management Response	Responsible Officer	Deadline	Comments	Milestone Date
2 (D)	The WODC action plan has an action to "Commence roll out of DBS plan" but no milestones or target date for its completion. There is a lack of quantitative detail in the high level WODC action plan updates. Progress reported to WODC through the action plan does not include key information such as the number of DBS checks that have been completed against those required, the numbers in progress, or are yet to be started.	Without this core information it is difficult for members of the WODC to gain an insight into the progress of checks.	We recommend that: i) Additional milestones and a target completion date be agreed for the completion of DBS clearance of staff currently employed but not previously checked. ii) Future reporting to WODC record progress against these milestones/targets including clear quantitative information such as the number of DBS checks that are required; have been completed; are in progress; or are yet to be started.	H	i) Additional milestones and a target completion date has been agreed for the completion of DBS clearance of staff currently employed but not previously checked for end of March 2020. Documentation will be reviewed and amended in line with recommendations. ii) Future reporting to WODC will record progress against these milestones/targets including clear quantitative information such as the number of DBS checks that are required; have been completed; are in progress; or are yet to be started.	Ruth George (Senior HR Manager) / Kathryn Jones (ADOWOD)	28/02/2020	**July 2025:** A paper setting out options to address the backlog in DBS checks was presented to the June 2025 meeting of the Management Board. Management Board has supported/agreed to the creation of a workforce compliance Task & Finish Group to focus on high-risk posts first, addressing the issue in a phased way within current budget and resources. Monitoring and reporting processes, together with a timeline for completion, are currently being agreed	31/10/2025

Agency Staff Management

Key Finding Ref	Key Findings	Impact	Recommendation	Priority	Management Response	Responsible Officer	Deadline	Comments	Milestone Date
1.1	There is no policy or procedure in place for the management of medical and non-medical agency staff within the health board. The review did note that the Nurse Rostering policy has a checklist in place for temporary staff decision making, however the policy has surpassed it December 2022 review date and failed to rectify gaps previously highlighted.	Non-compliance with Health Board policies and procedures	The health board should look document roles and responsibilities, processes, controls and record-keeping requirements in a policy and/or procedure document for the management of both medical and non-medical agency staff. The document should be communicated appropriately to the staff involved in the process.	M	The Health Board will create an agency procedure which confirms the process including roles and responsibilities. This will be in line with procurement procedures.	Head of Workforce Effectiveness & Analytics	30/09/2024	**August 2025:** The Head of Compliance has met with the Interim Head of Workforce Effectiveness & Analytics (Workforce, Digital & Data), to explore options to address these recommendations. A further meeting will now be held with the Head of Workforce Effectiveness & Analytics (Workforce Development), to agree a way forward.	31/10/2025
2.1	Whilst framework suppliers are prioritised for escalation, sample testing has noted that the health board has used non-framework suppliers to fill shifts where necessary. Whilst recognising that non-framework agency use may be unavoidable to protect patient safety, it would not be appropriate to enter a formal contract with this agency. Such spend is non-compliant with Standing Orders and the Public Contract Regulations 2015 and should be highlighted to the Board.	Legal challenge arising from non-compliance with the Public Contract Regulations 2015, potentially resulting in reputational damage and/or financial loss.	Non-framework agency spend in breach of Standing Orders and the Public Contract Regulations 2015 should be reported to an appropriate Board committee.	M	We will develop and implement an agency approval form. We will also ensure that all spend reports include the identification of non-framework use	Head of Workforce Effectiveness & Analytics	31/07/2024	**August 2025:** The Head of Compliance has met with the Interim Head of Workforce Effectiveness & Analytics (Workforce, Digital & Data), to explore options to address these recommendations. A further meeting will now be held with the Head of Workforce Effectiveness & Analytics (Workforce Development), to agree a way forward.	31/10/2025
3.1	From our review of a sample of shifts, gaps were identified in formal authorisation for the approval of agency staff. Further, where 'off-contract' agencies have been used, there was no documented evidence available to support the authorisation of its use, or of the rates to be applied.	Inappropriate or unnecessary expenditure on additional resources, resulting in additional financial cost pressures for the Health Board	The health board should ensure that all shifts issued to agency has an audit trail that ensures authorisation was approved prior to agency cover being obtained.	H	We will develop and implement an agency approval form.	Head of Workforce Effectiveness & Analytics	31/07/2024	**August 2025:** The Head of Compliance has met with the Interim Head of Workforce Effectiveness & Analytics (Workforce, Digital & Data), to explore options to address these recommendations. A further meeting will now be held with the Head of Workforce Effectiveness & Analytics (Workforce Development), to agree a way forward.	31/10/2025
4.1	NWSSP Procurement appointed Audit & Assurance to undertake work to confirm nurse agency compliance with the All-Wales Agency Nurses contract specification. We note that eight agencies have been reviewed since April 2023, four of which were used for shifts sampled at this audit. Whilst assurance can be taken from no significant issues being raised in relation to pre-employment checks for the applicable agencies, there is no evidence of reporting of such within the health board.	Use of agency workers who are not appropriately skilled / screened which could result in patient harm.	Reporting on the output of the contract specification compliance checks should be reported to an appropriate forum within the health board.	M	Outcome of the checks undertaken to date will be reported within the health board.	Head of Workforce Effectiveness & Analytics	30/11/2024	**August 2025:** The Head of Compliance has met with the Interim Head of Workforce Effectiveness & Analytics (Workforce, Digital & Data), to explore options to address these recommendations. A further meeting will now be held with the Head of Workforce Effectiveness & Analytics (Workforce Development), to agree a way forward.	31/10/2025
4.2	The appointment Audit & Assurance to undertake work to confirm nurse agency compliance with the All-Wales Agency Nurses contract specification was to cover 2022/23 and 2023/24. It has not been determined how this will continue going forward, noting that the contract specification states that such work can be undertaken by the Health Boards and/or NWSSP as Agent for Health Boards.	Use of agency workers who are not appropriately skilled / screened which could result in patient harm.	To further address the recommendation by the Local Counter Fraud Services team, consideration should be given at both a local and national level as to how continued compliance will be measured and reported.	M	To consider how assurance on continued compliance will be measured and reported, this will be raised at national forums to determine consistent approach.	Head of Workforce Effectiveness & Analytics	30/11/2024	**August 2025:** The Head of Compliance has met with the Interim Head of Workforce Effectiveness & Analytics (Workforce, Digital & Data), to explore options to address these recommendations. A further meeting will now be held with the Head of Workforce Effectiveness & Analytics (Workforce Development), to agree a way forward.	31/10/2025
7.1(a)	The health board is currently reporting on agency use and cost at both a local level and at Board and Committee level. However, from review of reporting undertaken at other NHS Wales organisations, there is an opportunity to enhance reporting by breaking down the spending further to show 'on-contact' and 'off-contract' spend.	Agency use and spend not appropriately monitored and controlled, potentially resulting in additional financial pressure for the health board.	The health board should look to enhance the reporting detail into agency spend by breaking down total spend to show 'on-contact' and 'off-contract' spend.	M	We are reviewing reporting agency reporting arrangements and will break down the information to on-contract and off-contract and report into relevant committees.	Head of Workforce Effectiveness & Analytics	31/08/2024	**August 2025:** The Head of Compliance has met with the Interim Head of Workforce Effectiveness & Analytics (Workforce, Digital & Data), to explore options to address these recommendations. A further meeting will now be held with the Head of Workforce Effectiveness & Analytics (Workforce Development), to agree a way forward.	31/10/2025
7.1(b)	There are opportunities to explore the functionality within the Health Roster system to enable more formal real-time reporting and analysis of agency use, including by whole time equivalent and hours, % of shifts filled by substantive, bank and agency staff, rationale for agency use etc.	Agency use and spend not appropriately monitored and controlled, potentially resulting in additional financial pressure for the health board.	The health board should also look to enable more formal real-time reporting and analysis of agency use.	M	We are reviewing reporting agency reporting arrangements and will break down the information to on-contract and off-contract and report into relevant committees.	Head of Workforce Effectiveness & Analytics	31/08/2024	**August 2025:** The Head of Compliance has met with the Interim Head of Workforce Effectiveness & Analytics (Workforce, Digital & Data), to explore options to address these recommendations. A further meeting will now be held with the Head of Workforce Effectiveness & Analytics (Workforce Development), to agree a way forward.	31/10/2025

Job Evaluation

Key Finding Ref	Key Findings	Impact	Agreed Management Action	Priority	Expected Evidence of Implementation	Responsible Officer	Deadline	Comments	Milestone Date
1	Current practice at the health board is for staff side representatives to utilise their Facilities Time to participate in job evaluation panels, which we are advised can be a barrier to participation. However, the latest NHS Job Evaluation Handbook does not expressly state that use of Facilities Time for attendance at panels is a requirement. Accordingly, we consider that the health board may wish to broaden their options for staff side representatives.	Limited numbers of individuals are available for participation in panels which increases the risk of a conflict of interests.	We will share the audit findings at Health Board Partnership Forum to reinforce the request for additional staff side representatives to be consistency and job match trained. This will broaden the pool of staff side representatives available.	M	Health Board Partnership Forum Key Points/Action Log Consistency & Job Match Training schedule - attendees	Assistant Director of Workforce	19/07/2025	**August 2025:** As part of the formal presentation delivered recently, the issue concerning training uptake and accessibility has been escalated for further consideration. In response, a number of potential options are currently being explored to enhance engagement and ensure adequate coverage across all relevant staff groups. To support this initiative, additional communications have been issued through our established engagement channels to promote the remaining training sessions. These include both Job Match Training and Consistency Panel Training, which are essential components of the Job Evaluation (JE) process. We continue to monitor attendance and feedback, and will use this insight to inform future planning and delivery	30/09/2025
4	Whilst we understand the close nature of the working arrangements between the JE Lead and line management, there is an expectation that an annual report from CAJE be generated and reported. However, we note that the report for 2024 has been delayed.	Limited opportunities to measure, communicate and benchmark performance for the year.	Generate an Annual Report utilising Power BI – reportable April – to – April. The Annual Report will be presented at Health Board Partnership Forum and also WOD In-Committee on an annual basis.	M	Annual Report	Assistant Director of Workforce	19/07/2025	**August 2025:** Dashboard Development and Historical Data Integration – The JE Dashboard, initially developed to monitor progress prior to May 2025, has now been expanded to include data spanning a three-year period. This comprehensive dataset has enabled us to identify key trends and patterns in JE activity, including variations in demand and engagement across different Service Groups. The dashboard provides a valuable evidence base to support planning and resource allocation. Annual and Mid-Year Reporting – A detailed report has been drafted and circulated, offering an overview of JE activity for the calendar years 2022, 2023, and 2024, as well as the first six months of 2025. This report highlights volume, and service group contributions, and serves as a useful reference for evaluating progress and identifying areas for improvement.	30/09/2025
5	KPIs are not outlined by the Handbook. The development of the new dashboard (Power BI) report by the Job Evaluation Lead is being developed to include KPIs however we are cognisant that the health board is still defining what those KPIs should be. Accordingly, there is no performance data in relation to the job evaluation process currently reported at Committee level.	Limited opportunities to accurately measure performance and progress. Reduced opportunities for improvement.	The Annual Report utilising Power BI, as per key finding 4, will include KPIs. Performance against KPIs included in the Annual Report to be reported to Health Board Partnership Forum and WOD In-Committee on an annual basis.	M	Annual Report	Assistant Director of Workforce	19/07/2025	**August 2025:** Future Integration and Digital Enhancement – As we continue to use the dashboard to monitor JE activity, we are exploring opportunities to integrate additional digital tools. These enhancements will support a more sophisticated understanding of capacity, processing times and demand, enabling us to better align resources with organisational needs and improve the efficiency of the JE process.	30/09/2025

Director of Nursing

Quality Management System

Key Finding Ref	Key Findings	Impact	Recommendation	Priority	Management Response	Responsible Officer	Deadline	Comments	Milestone Date
5.2	The Health Board arrangements in seeking continuous improvement (as per the Quality Strategy p46-47) have not had the opportunity to reflect on its success or lessons learnt on its reporting.	Unclear roles and responsibilities or ineffective reporting could result in poor decision making and a lack of accountability and oversight. Resources being used inefficiently if boards and groups duplicate in their undertaking of roles and responsibilities.	Once the governance structure has been reviewed, a mechanism to enable post-implementation learning should be developed to completely capture and report good practice and lessons learnt relating to quality management system reporting.	M	Report to be sent to Q&S Group in March 2025 regarding the updated Governance Structure and identifying good practice and lessons learnt.	Head of Quality & Safety Deputy Head of Quality & Safety	31/03/2025	**August 2025:** This issue will be addressed in a paper being written by the Director of Corporate Governance for presentation to the Management Board	30/09/2025

Director of Planning & Partnership

Continuing Healthcare

Key Finding Ref	Key Findings	Impact	Recommendation	Priority	Management Response	Responsible Officer	Deadline	Comments	Milestone Date
1.1	The health board is required to comply with Continuing Healthcare, The National Framework for Implementation in Wales (the Framework). Whilst management explained the requirements of the Framework are adhered to, formal, written policies and procedures outlining the processes to be followed for evaluating CHC packages (e.g. undertaking assessments and the approval process by panel) are not in place at a local level and across the whole of the health board.	Non-compliance with the requirements of the framework which may result in penalties being incurred.	The health board should develop formal procedures clarifying how its service groups will meet the Framework requirements for CHC cases.	H	Management Board approved engaging the National Commissioning Collaborative Unit (NCCU) to work with the health board to plan the transition to a centralised CHC commissioning model to include clarifying responsibilities of service groups in meeting Framework requirements.	Interim Director of Strategy	30/11/2023	**August 2025:** First iteration of SOP drafted and considered by CHC programme board in August 2025. It is acknowledged by the group that the SOP will continue to evolve as the Central Commissioning Function develops and strengthens. Roles redesigned in current Corporate Commissioning Team to take on CHC functions and successful appointment of manager to lead the new team- will take up post in October/ November. Corporate commissioning team have started to be integrated in commissioning discussions and processes especially where joint working with LA is required. Member of staff due to transfer from Service Group is on long term sick-corporate commissioning team are working with Service Group to pick up the work and fill the gap during this period. Acting ADoPP is providing leadership and support to the Service Groups on the commissioning side of CHC and has introduced a joint performance reporting process which will inform the quarterly performance reports for PFC (1st report to be presented September 2025). First meeting of the high-cost oversight panel also scheduled for September 2025, which will provided added scrutiny at Exec level to high-cost cases.	30/09/2025

Tertiary Services

Key Finding Ref	Key Findings	Impact	Agreed Management Action	Priority	Expected Evidence of Implementation	Responsible Officer	Deadline	Comments	Milestone Date
1	There is a Memorandum of Understanding (MoU) between the health boards that supports the Regional and Specialised Services Provider Planning Partnership (RSSPPP) programme and includes the terms of reference for the partnership board. The MoU covers key elements expected of a partnership agreement including objectives, roles and responsibilities, and governance arrangements. However, the intended outcomes of the RSSPPP programme along with the monitoring, risk and financial arrangements, including the recharge of costs between the health boards, are not clearly defined. While the MoU details the principles for collaboration, there has been no reflection to consider whether the RSSPPP is meeting them.	Unclear roles and responsibilities could lead to the partnership's objectives not being delivered, ineffective use of resources and a lack of value for money.	We will develop an appendix to the Memorandum of Understanding to further define the areas that are not currently included, e.g. review of principles for collaboration, outcomes, financial, risk and monitoring arrangements. These will be signed and approved by the RSSPPP and SBUHB Management Board.	M	Additional appendix to existing MoU	Associate Programme Director for Tertiary & Specialist Services Planning Partnership	10/12/2024	**July 2025:** Amendments to the MOU have been drafted and are currently with the Governance functions of both health boards for review and comment. The Associate Programme Director will again approach both Health Boards for a position update.	30/09/2025

Director of Allied Health Professions & Health Science

Additional Learning Needs

Key Finding Ref	Key Findings	Impact	Recommendation	Priority	Management Response	Responsible Officer	Deadline	Comments	Milestone Date

Key Finding Ref	Key Findings	Impact	Agreed Management Action	Priority	Expected Evidence of Implementation	Responsible Officer	Deadline	Comments	Milestone Date
2.2	To provide consistency and clarity in complying with the ALN Act, a number of policies and procedures have been developed in conjunction with the health board's partners, but have not been finalised.	Process being managed inconsistently which are not compliant with the ALN Act and cause confusion to staff and partners. Roles and responsibilities are unclear resulting in a lack of accountability and oversight.	Guidance should be finalised and approved by an appropriate forum, communicated to all key individuals involved in the process, and subject to a regular review with the date recorded.	M	On completion, all guidance documents / Standard Operating Procedures will be brought to the ALN Steering Group via the Operational Group for approval and for direction regarding any other fora at which approval is required. Approval / ratification will then be sought through the appropriate forum as needed. Review arrangements and the mechanism for review for all documents will be formally documented.	Director of Therapies & Health Sciences DECLO	30/09/2024	**June 2025:** EQI screening assessments have been completed, and these documents are currently going through the relevant review/approval process. It is anticipated that the SOPs will be presented at the September 2025 Steering Group meeting.	30/09/2025
4.1c	The DECLO is a shared resource employed across three health boards, but we were unable to obtain documentation to confirm the agreement for the recharge.	The Health Board is unable to meet its duties under the ALN Act resulting in an increase in complaints and Educational Tribunals. Children and young people not getting the support required leading to poor outcomes.	The written agreement that records the basis for the DECLO's salary recharge should be retained in a central location.	H	There will be liaison between Swansea Bay, Hywel Dda and Powys Health Boards to formally document the agreement that the DECLO post for the three Health Boards, hosted by Swansea Bay University Health Board, is jointly funded by the three Health Boards with salary recharge arrangements in place.	Director of Therapies & Health Sciences Director of Finance & Performance	30/06/2024	**August 2025:** Response from neighbouring Health Boards remains outstanding.	30/09/2025

Mortuary Services

Key Finding Ref	Key Findings	Impact	Agreed Management Action	Priority	Expected Evidence of Implementation	Responsible Officer	Deadline	Comments	Milestone Date
1.1	Roles and responsibilities have been clearly documented within the Transitional MoU and Mortuary Service MoU. While the Transitional MoU has been approved by both health boards in May 2024, no signed version of the document could be located during our review.	Unclear roles and responsibilities could lead to the regional pathology programme not being delivered, ineffective use of resources and a lack of value for money.	We will ensure the Transitional MoU is signed and the document is easily accessible.	M	Signed Transitional MoU document	Regional Pathology Programme Manager	31/03/2025	**August 2025:** The transitional MOU is not yet ready to move to 'final' stage as originally planned. Therefore, a paper is going to both Boards to seek approval to continue with the Transitional MOU. If this is approved, then signatures can be added	30/09/2025
1.2	The Mortuary Service MoU has been reviewed and approved by the Chief Executives of both health boards in March 2024. However, the contact point for SBUHB is not recorded within the document; and we have been unable to confirm the reporting of the MoU within the health boards and its communication to mortuary staff.	Unclear roles and responsibilities could lead to the regional pathology programme not being delivered, ineffective use of resources and a lack of value for money.	The Mortuary MoU will be reviewed and updated to ensure key contact information is included, and we will ensure the final version is circulated appropriately within both health boards and communicated to mortuary staff.	M	Revised Mortuary MoU	Regional Mortuary Manager	31/03/2025	**August 2025:** The transitional MOU is not yet ready to move to 'final' stage as originally planned. Therefore, a paper is going to both Boards to seek approval to continue with the Transitional MOU. If this is approved, then signatures can be added	30/09/2025
3	We note that the development of the Operational Delivery Network (ODN) has been impacted by capital funding and the delivery plan is behind schedule, however, the ODN Service Specification and commissioning arrangements have not been finalised. This would assist in determining how the ODN, including leadership roles, will be financed. In relation to the regional mortuary service provision, there is a spreadsheet that details the basis for the sharing of staffing costs between the health boards. However, current arrangements need to be more explicit to confirm the basis of the recharge.	Financial arrangements are unclear leading to disputes in relation to recharges.	We will formally document the agreement between the health boards of shared costs for the provision of the regional mortuary service and ODN.	M	SLA document developed detailing financial arrangement between the Health Boards to establish the Mortuary service.	Deputy Finance Business Partner Morriston Hospital	31/03/2025	**August 2025:** The SLA was discussed in a meeting in July 2025, but has still not progressed to a place where it can be agreed. A further meeting will need to be scheduled in September 2025.	30/09/2025
4.1	Originally, regionalisation of the mortuary services was conceived as a separate workstream within the programme focusing on the capital build. The scope was extended to encompass staffing issues at HDUHB and the ODN, but mortuary now forms part of the Regional Pathology Cellular Pathology Working Group. This has resulted in gaps within the project management process as there is no clearly defined project scope outlining roles and responsibilities.	Unclear roles and responsibilities leading to a lack of accountability and failure to deliver the regionalisation of the mortuary service.	We will ensure that the scope of the regionalisation of the mortuary services is clearly detailed along with roles and responsibilities. Review existing HTA regional and regional meetings and focus on HTA issues and utilise new operational groups to discuss regional mortuary operational matters.	H	Regional Management Meeting and Regional Mortuary Operations meeting structure to be adopted. Revised ToR and meeting agenda and papers to provide the evidence	Cellular Pathology Service Manager HDU	31/03/2025	**August 2025:** Terms of Reference's created for the following meetings; • Regional HTA Assurance committee. • HD HTA Operational Group Meeting. • HD HTA Assurance Group Meeting. • Regional DI Meeting. • Regional Mortuary Operational Management Meeting. Regional Mortuary Operational Management meeting established with the senior leaders from HD and SBU.	31/08/2025
4.2	Additionally, the terms of reference provided for the cellular pathology working group are dated 2022 and would benefit from a review as the document details that, "arrangements shall be reviewed on at least a 6 monthly basis."	Unclear roles and responsibilities leading to a lack of accountability and failure to deliver the regionalisation of the mortuary service.	Terms of reference for the cellular pathology working group will be reviewed and approved.	H	Revised ToR and meeting agenda and papers to provide the evidence	Cellular Pathology Service Manager HDU	31/03/2025	**August 2025:** Terms of Reference's created for the following meetings; • Regional HTA Assurance committee. • HD HTA Operational Group Meeting. • HD HTA Assurance Group Meeting. • Regional DI Meeting. • Regional Mortuary Operational Management Meeting. Regional Mortuary Operational Management meeting established with the senior leaders from HD and SBU.	31/08/2025
5	The Transitional MoU details key leadership roles for ODN delivery, including the Regional Pathology Network Director; Network Clinical Director and the Pathology Transformation Programme Director. While job descriptions have been prepared, there has been no recruitment into these posts which will result in a lack of continuity when the Regional Pathology Programme Director's two-year secondment ends in February 2025. It may also result in the health boards being unable to go live with the ODN from April 2025 as planned (a review is currently being undertaken to assess the readiness of the Network). During our audit, there was a reliance on the Regional Pathology Programme Director to provide operational documentation rather than the wider programme evidence he was responsible for. Key issues and lessons learnt relating to the programme have not been documented.	Loss of knowledge and lack of resources to deliver the programme and ODN.	We will ensure that all key issues and lessons learnt relating to the programme are documented. These will be shared at the Regional Management Meeting and Regional Mortuary Operations meeting (see key finding 4) to ensure they are considered and amendments made / changes embedded as the programme progresses.	H	Lessons learned reflection report to be completed.	Programme Director Regional Pathology ARCH	31/03/2025	**August 2025:** The extension of the MOU and task to present a preferred option to September Board meetings has delayed the lessons learnt report. This will now coincide with end of the secondment of the programme director in September 2025.	30/09/2025
6	Finding 4 highlighted gaps in how the mortuary element was incorporated in the wider programme. This also includes not having a clear plan for the joint mortuary service that includes timescales to deliver the following: • Standardisation of processes • Mechanisms to share information • Use of technology • The regional workforce plan for future mortuary service provision • Identifying training needs of the mortuary staff • Communication and engagement	Performance is not effectively monitored leading to a failure to deliver the joint mortuary service.	A dedicated delivery plan will be developed for the regionalisation of the mortuary service that will incorporate SMART criteria to define success and provide realistic timescales for delivery.	H	A SMART plan to be developed documenting year 1 achievements of the regional mortuary service and a delivery plan for year 2 as part of the annual planning exercise currently ongoing in both Health Boards.	Interim Directorate Manager, Pathology SBU Regional Mortuary Manager	31/03/2025	**August 2025:** The Regional Mortuary Manager confirms that a Draft SMART Action Pla (Year 2) has been completed	31/08/2025
7	Operational mortuary service risks are documented separately by each health board. There is no overall project register that documents the risks to delivery of the regionalisation of the mortuary service. There is a Programme RAID log detailing both strategic and operational risks, including funding risks, but mortuary service risks are not detailed. We also note that the Cellular Pathology workstream's RAID log does not detail any risks at all.	Inconsistent management with inadequate escalation of key risks.	A dedicated risk register will be developed to incorporate risks relating to the regionalisation of the mortuary service. A Regional Mortuary Operational Management Group will be formed whose terms of reference will include oversight of this risk register, which will be a standing agenda item. Risks will be escalated to the ODN Operational Group, where appropriate.	M	SBU Risk Register review undertaken. Monthly SBU Mortuary (and Cell Path) risk register review. Feeds into monthly CGRM Pathology meeting. HDU Risk register updated regularly. Shared with HDU Pathology wide monthly risk register meeting. Regional Risk management update as part of the existing Regional HTA meeting (monthly). Terms of reference for the Regional Mortuary Operational Management Group meeting. Agendas for the Regional Mortuary Management Group.	Cellular Pathology Service Manager, HDU	31/03/2025	**August 2025:** A regional Risk Register is being created and will be reviewed as part of the newly established Regional Mortuary Management Operational Group. Regional Mortuary Management Operational Group agenda has been created, and review of this regional risk register will be a standing agenda item.	30/09/2025
8	A Communications & Engagement Plan was developed in July 2022 to ensure there is regular engagement of the Regional Pathology Programme. Thirteen actions are detailed within the Plan, but there are no clear timescales for delivery. Noting the passage of time from the release of the Plan, there is scope for such to be reviewed and updated as well as to confirm the reasonableness of the actions included.	Opportunities to raise internal and external awareness may be missed.	To review Communications and Engagement plan as part of the review of the ODN implementation progress during March 2025.	M	Revised communications plan and actioning of that plan in 2025/26.	Programme Director Regional Pathology ARCH	31/03/2025	**August 2025:** Communication and engagement to staff re the pathology ODN has been paused pending the review of the strategic direction agreed at the March 2025 Board Meetings. A plan is being developed to relaunch that prior to the September Board meetings subject to the regional joint committee meeting agreeing the updated approach principles in the August meeting	30/09/2025
9.1	The governance structure that incorporates the ODN, ARCH and HTA Assurance does not provide sufficient oversight of arrangements in relation to the mortuary element of the Programme. We identified the following issues during our testing: • There has been no recent reporting to the "quality and safety and finance and performance committees" at either health board, as required by the Transitional MoU • Recent ODN Delivery Board meetings have been cancelled, resulting in there being no robust reporting structure to escalate key issues from the sub-groups. • The cellular pathology workstream reports into the ARCH Regional Pathology Programme Board, but there is insufficient oversight over arrangements in relation to the mortuary element of the workstream. • Differences in the level of ARCH reporting to each health board. • Terms of reference for each of the HTA meetings (SBUHB, HDUHB and regional) have recently been reviewed, but we note that several verbal updates are provided for agenda items at the regional HTA Assurance meetings instead of written reports.	Ineffective reporting could result in poor decision making and a lack of accountability and oversight.	Re-establishment of ODN Board.	H	Revised ODN Board meeting papers as evidence and ODN Operational Group. March 2025 Health Board papers.	Programme Director Regional Pathology ARCH	31/03/2025	**August 2025:** The ODN Board does not have an operational function in overseeing operational delivery. ARCH reporting and infrastructure is being superseded by the establishment of the Regional Joint Committee as a formal subcommittee of both boards	30/09/2025
9.2			Establishment of agreed ODN Operational Group and separation of mortuary and cellular pathology under this structure to provide focus to mortuary issues.	H	Revised ODN Board meeting papers as evidence and ODN Operational Group. March 2025 Health Board papers.	Programme Director Regional Pathology ARCH	31/03/2025	**August 2025:** The ODN Board does not have an operational function in overseeing operational delivery. ARCH reporting and infrastructure is being superseded by the establishment of the Regional Joint Committee as a formal subcommittee of both boards	30/09/2025
9.3			Written reports to be standard practice in Health Board HTA assurance meetings.	H	Development of HTA assurance process over recent months to include move from verbal to written papers has been implemented with templated approach across both HBs. Copies of HTA papers (HDU and SBU).	Programme Director Regional Pathology ARCH	31/03/2025	**August 2025:** Written reports from HTA assurance group meetings are available	30/09/2025

Executive Medical Director

Controlled Drugs

Key Finding Ref	Key Findings (reflecting outcomes of Scrutiny Panel)	Impact (Internal Audit) or Intended Outcome/Benefit (External Audit)	Recommendation	Priority	Management Response	Responsible Officer	Deadline	Comments	Milestone Date
1.1a	For a sample of CD orders, order and register documents were examined for compliance with requirements. This highlighted instances where: • the order had been raised and received by the same individual; • the ward signature in the 'Received by' section of the order slip was illegible or absent • the delivery bag seal number was absent from the orders' entry in the ward/theatre CD register; • the signature in the order entry section of the ward/theatre CD register was illegible; and • the second (witness) signature section on the CD register was illegible. Further testing identified instances where ward signatures in the register dispensing entries were illegible	Potential risk that loss or misappropriation of CDs may go undetected.	We recommend that these exceptions are addressed and that rules requiring double signatories for all CD register movements are applied without exception (signatures should always be accompanied by printed names in order that they may clearly identify the individual signing).	M	Where exceptions have been noted to Health Board policy/SOPs, the Service Group Controlled Drug Lead will direct the Service Group's response to this recommendation. This will include as a minimum: • Making all staff involved in the management of controlled drugs aware of these findings in order to help staff reflect on current practice. • Drawing staff attention to the Health Board's controlled drug policy and in particular the relevant sections relating to this recommendation, with the aim of improving adherence to policy requirements. • Ensuring performance relating to this recommendation is re-audited by the Service Group within 6 weeks to provide the Service Group, the Executive team and the Controlled Drug Accountable Officer with the necessary assurance that mitigating action has been successful and that practice is fully compliant with policy. • Ensuring that the findings and recommendation are discussed at the relevant Service Group controlled drug governance and quality & safety forums together with the outcome of mitigating actions.	Service Group Controlled Drugs Leads & Controlled Drugs Accountable Officer	06/01/2023	**March 2025:** Given the service changes which have taken place since the original recommendations were made, management have requested that a follow-up review of the current position against these actions is included as part of the 2025/26 Controlled Drugs audit.	31/12/2025
1.1b	We also noted that some of the wards/ theatres sampled recorded a second (witness) signature in the 'Received by' section of order slips. Whilst this is not at present a requirement stated in the policy or procedure documentation, the health board should consider introducing into the CD order documentation this good practice step to strengthen further the existing controls.	Potential risk that loss or misappropriation of CDs may go undetected.	Additionally, we recommend that the health board consider introducing the requirement to provide a second (witness) signature on CD order stationery to strengthen further the existing controls.	M	The Controlled Drug Accountable Officer will work with Service Group Controlled Drug Leads to review controlled drug policy in respect of witness signatures for the receiving of CDs and for existing controls in place.	Service Group Controlled Drugs Leads & Controlled Drugs Accountable Officer	31/03/2023	**March 2025:** Given the service changes which have taken place since the original recommendations were made, management have requested that a follow-up review of the current position against these actions is included as part of the 2025/26 Controlled Drugs audit.	31/12/2025
2.1	Testing confirmed that hospital pharmacy teams were conducting and documenting periodic CD audits; however instances were noted where Pharmacy CD balance checks had not been evidenced in the ward / theatre CD register (six of eight cases).	Potential risk that loss or misappropriation of CDs may go undetected.	We recommend that hospital pharmacy team CD balance checks are recorded on the individual drug pages of the CD registers and in the Pharmacy CD dashboard tool for all audits undertaken. The latter should then be used to support a more formal management review of the audit findings, the results of which could be shared with stakeholders across the health board.	M	Pharmacy Leads will work with Service Group Controlled Drug Leads to ensure as a minimum: • All staff involved in the joint controlled drug checks are made aware of these findings in order to help staff reflect on current practice. • Staff are made aware of the requirements around undertaking the joint controlled drug checks, including appropriate recording of such checks. • The results of such audits are being captured and acted upon accordingly to improve controlled drug governance. • Ensuring performance relating to these recommendations is re-audited by pharmacy leads and the Service Group following the next scheduled joint CD checks, to provide the Chief Pharmacist, the Service Group, the Executive team and the Controlled Drug Accountable Officer with the necessary assurance that mitigating action has been successful. • Ensuring that these findings and recommendations are discussed at the relevant Pharmacy and Service Group controlled drug governance and quality & safety forums together with the outcome of mitigating actions.	Pharmacy Leads & Service Group Controlled Drugs Leads	31/03/2023	**March 2025:** Given the service changes which have taken place since the original recommendations were made, management have requested that a follow-up review of the current position against these actions is included as part of the 2025/26 Controlled Drugs audit.	31/12/2025
2.2	In a broader sample of pharmacy CD audits, we noted some instances where documentary records were not retained to support that the audit and balance check had been undertaken.	Potential risk that loss or misappropriation of CDs may go undetected.	Pharmacy should retain original audit documentation for all audits they perform in order that they are available for examination in the event of enquiry.	M			31/03/2023	**March 2025:** Given the service changes which have taken place since the original recommendations were made, management have requested that a follow-up review of the current position against these actions is included as part of the 2025/26 Controlled Drugs audit.	31/12/2025
3.1	CDMAPS are not routinely reviewed and updated at CD management group / Quality & Safety meetings by all Service groups. • Mental Health & Learning Difficulties: actions were not dated and there were many of amber status denoting that they were not completed. • Singleton / NPT: the document has a narrative format without clear actions or target dates so it wasn't possible to determine status of the former. • Morriston: the latest revision of the CDMAP was dated April 2022 and we noted actions of the action plan largely completed, excepting three where revised target dates had expired (implementing a comprehensive training programme, structured review of the CD "Potential Diversion" Log, developing and implementing a comprehensive performance monitoring framework.)	Potential risk that some of the CD related management responsibilities of Service Groups are not delivered.	We recommend that all Service Groups review and update their CDMAP action plans to give clarity over those actions that are outstanding, their significance rating and target dates for completion and going forward, that these should be monitored and updated at each of the respective Service Group CD management group review meetings.	H	The Service Group Controlled Drug Lead will direct the Service Group's response to these recommendations. This will include as a minimum: • Ensuring that the Service Group reviews their Controlled Drug Management & Assurance Plan (CDMAP) in line with these recommendations. • Discussing the Service Group's updated CDMAP, or latest draft if ongoing, at the Service Group Controlled Drug Lead/Controlled Drug Accountable Officer biannual meeting in late November/early December 2022, to provide the Controlled Drug Accountable Officer with the necessary assurance that mitigating action has been successful. • Ensuring that these findings and recommendations are discussed at the relevant Service Group controlled drug governance and quality & safety forums, together with the outcome of mitigating actions.	Service Group Controlled Drugs Leads	06/01/2023	**March 2025:** Given the service changes which have taken place since the original recommendations were made, management have requested that a follow-up review of the current position against these actions is included as part of the 2025/26 Controlled Drugs audit.	31/12/2025
3.2	There is no evidence that CDMAP scopes have been reviewed against legislation to ensure all key aspects are covered (an action raised in our previous advisory review).	Potential risk that some of the CD related management responsibilities of Service Groups are not delivered.	CDMAPs scope should be reviewed against current legislation to ensure that all key aspects are covered, and against the findings reported in this audit and updated where necessary.	H			06/01/2023	**March 2025:** Given the service changes which have taken place since the original recommendations were made, management have requested that a follow-up review of the current position against these actions is included as part of the 2025/26 Controlled Drugs audit.	31/12/2025

Consultant Job Planning

Key Finding Ref	Key Findings	Impact	Recommendation	Priority	Management Response	Responsible Officer	Deadline	Comments	Milestone Date
3.2	The Allocate system includes a section to document personal outcomes in respect of job plans. 22 of the 39 job plans in our sample did not detail personal outcomes. Where personal outcomes had been completed, these were not always SMART with some simply referencing brief general activities, such as completion of statutory and mandatory training, and to take annual and study leave in a timely manner.	Operational risk of job plans not reflecting responsibilities, outcomes and expectations.	The health board should run an Allocate exception report to identify instances where personal outcomes are not included and escalate where necessary.	H	Report to be run on a monthly basis to identify non-compliant job plans with and those which are to be highlighted to the service manager to address and provide an exception report to the Medical Workforce Group as part of the escalation process	Service Group Medical Directors	01/04/2025	**August 2025:** Personal outcomes will be included in appraisal and personal development plans which are managed through the MARS system. Board outcomes have been pre-populated onto Allocate and service outcomes are in the process of being agreed.	30/09/2025
7.2	For the sample of 39 job plans reviewed on the Allocate system, no Board Outcomes were detailed and only two of the job plans included narrative on Service Outcomes. Personal Development Plans on MARS were not reviewed as part of this audit.	Operational and strategic risk of job plans not reflecting responsibilities, outcomes and expectations; and Failure to achieve the required quality improvement.	Reporting should be undertaken to confirm compliance with quality improvement priority requirement.	H	Report to be run on a monthly basis to confirm job plans include at least one quality improvement priority to the service manager to address and provide an exception report to the Medical Workforce Group as part of the escalation process	Service Group Medical Directors	01/04/2025	**August 2025:** Board outcomes have been pre-populated onto Allocate and service outcomes are in the process of being agreed. The latter will also support the delivery of quality improvement priorities which can also be identified as part of the PDP process.	30/09/2025
9.3	For our sample, we sought to confirm whether the intensity banding as per the job plan agreed to the payment as per the payslip. Differences were identified for six of the 16 job plans that had intensity bandings included: • Two payslips had no intensity payments yet the job plans had on-call duties recorded; • Three intensity payments made were less than that recorded on the job plan; • One intensity payment made was higher than that recorded on the job plan.	Financial loss and/or reputational damage as a result of over or underpayments to Consultants or SAS Doctors.	The health board should quantify, report and escalate any under/overpayments identified.	H	Intensity banding payments to be compared with jobs plans and anomalies investigated and reported to the Medical Workforce Group.	Service Group Medical Directors	01/04/2025	**August 2025:** These are automatically reported to Payroll when change form submitted. We now have access to payroll dashboard and overpayments will be reported to the Medical Workforce Group.	30/09/2025

Mortality Reviews

Key Finding Ref	Key Findings	Impact	Recommendation	Priority	Management Response	Responsible Officer	Deadline	Comments	Milestone Date
4.1	The review of the Service Groups identified a lack of reporting of Mortality Reviews: • Divisional reports to Morriston's Quality, Safety & Patient Experience Group are to include detail of mortality reviews, however, we noted minimal reporting of such for the period September 2023 to July 2024. • Review of the minutes of the Singleton/NPTSG Quality Safety & Risk meetings between January – June 2024 noted a lack of reporting and discussion relating to mortality reviews. • From 9 September 2024 the law is changing to include undertaking a Mortality Review by the Medical Examiner for all deaths within Primary Care as a statutory requirement.	Ineffective monitoring resulting in no action being taken to address poor performance; Inability to make improvements to address issues with mortality reviews; Inaccurate reporting or significant issues not being escalated promptly.	Routine reporting to the Service Group designated groups should be undertaken through which the mortality review process is appropriately discussed and scrutinised. Monitoring of actions plans in place and communication of lessons learned should also be evidenced through these groups.	H	Service groups will ensure the mortality review process/serious incident process, including any learning and actions from cases, is considered at an appropriate forum within its governance structure to ensure progress is made with any implementation plans.	Service Group Medical Directors	27/02/2025	**March 2025:** This is now a standing item on divisional board meetings for the Morriston SG and reported to service group QPSE meetings (minutes attached). Currently awaiting further info for other service groups. **June 2025:** Within MH&LG, reviews are considered during monthly Serious Incident Group meetings. Within PCTSG, Head of Service present updates to monthly Clinical Outcomes & Effectiveness Group meetings. Processes at NPTSSG for presentations to the Quality Safety & Risk Group are currently embedding. **August 2025:** Work is continuing to support the NPTS SG to incorporate mortality reviews in their governance structure	31/10/2025