Audit and Assurance Committee Meeting

17 November 2020, 09:00 to 12:30
Microsoft Teams

Agenda

1. Welcome and Introductions — John Union

2. Apologies for Absence — John Union

3. Declarations of Interest — John Union

4. Minutes of the Committee meeting held on 8th September 2020 — John Union

- 4 Draft Public Audit Mins - Checked SR.pdf (8 pages)

5. Action log following meeting held on 8th September 2020 — John Union

- 5 Public Action Log - 17.11.2020 - A&A Checked SR v4.pdf (2 pages)

6. Any Other Urgent Business: To agree any additional items of urgent business that may need to be considered during the meeting — John Union

7. Items for Review and Assurance

7.1. Internal Audit Progress and Tracking Reports — Ian Virgill

- 7.1 Internal Audit Progress Cover Report November 2020.pdf (2 pages)
- 7.1 Internal Audit Progress Report November 20.pdf (22 pages)

7.2. Audit Wales Update — Wales Audit

- 7.2 C&VUHB AC Update (November 2020) 1996A2020-21.pdf (12 pages)

7.3. Annual Structured Assessment Report — Wales Audit

- 7.3 Structured Assessment Report FINAL 1999A2020-21 CVUHB.pdf (26 pages)
- 7.3 Appendix 1 Management Response - CVUHB 2020 Structured Assessment.pdf (3 pages)

7.4. Management of Clinical Coding Across Wales — Wales Audit

- 7.4 Management of Clinical Coding Across Wales.pdf (36 pages)

7.5. 10 Opportunities for Planned Care

Wales Audit

7.5 Ten Opportunities for Planned Care.pdf (22 pages)

7.6. The National Fraud Initiative in Wales 2018-20

Wales Audit

7.6 National Fraud Initiative.pdf (25 pages)

7.7. Welsh Community Care Information System

Wales Audit

7.7 Welsh Community Care Information System.pdf (54 pages)

8. 8. Items for Approval / Ratification

8.1. Declarations of Interest and Gifts and Hospitality Tracking Report

Nicola Foreman

8.1 Standards of Behaviour Report.pdf (4 pages)

8.1 Declarations of Interest Register 2020 - 21.pdf (1 pages)

8.2. Regulatory Compliance Tracking Report

Nicola Foreman

8.2 Regulatory Compliance Covering Report.pdf (6 pages)

8.2 Regulatory Heat Map - November.pdf (12 pages)

8.3. Internal Audit Tracking Report

Nicola Foreman

8.3 Internal Audit Tracker Covering Report November 2020.pdf (3 pages)

8.3 Internal Audit Summary Tables - Appendix 1 v2.pdf (3 pages)

8.3 Internal Audit Tracker - Nov 2020.pdf (6 pages)

8.4. Audit Wales Tracking Report

Nicola Foreman

8.4 External Audit Recommendation Tracking report covering report.pdf (2 pages)

8.4 External Audit Summary Table - Appendix 1.pdf (1 pages)

8.4 External Audit - WAO Nov 2020 1.pdf (3 pages)

8.5. Review Losses and Special Payments

Christopher Lewis

8.5 Report of the Losses and Special Payments Panel Nov 2020.pdf (2 pages)

8.5 Appendix 1 Minutes of the October 2020 Losses Special Payments Panel.pdf (7 pages)

8.6. Proposed Changes to Governance Arrangements

Nicola Foreman

8.6 Proposed Amendments to Governance Arrangements Covering Report.pdf (2 pages)

8.6 Appendix 1 - Proposed Amendments to Governance Arrangements 08 10 20.pdf (2 pages)

8.6 Appendix 2 - COVID 19 Report Template.pdf (3 pages)

8.6 Appendix 3 -COVID 19 Board Governance Group Terms of Reference.pdf (3 pages)

8.6 Appendix 4 - UHBGovernance Structure Covid 19V11NF.pdf (1 pages)

9. Items for Information and Noting

Ian Virgill

9.1. Internal Audit reports for information:

9.1.1. Pre-Employment Checks - Reasonable assurance

9.1 (1) Pre-Employment Checks Final report.pdf (22 pages)

9.1.2. Surgery CB – Theatres Directorate Sickness Absence Management – Reasonable assurance

9.1 (2) Surgery CB Theatres Directorate - Final report.pdf (18 pages)

9.1.3. Regional Partnership Board – Reasonable assurance

9.1 (3) Regional Partnership Board - final report.pdf (16 pages)

9.1.4. Sustainability Reporting – Reasonable assurance

9.1 (4) Sustainability Reporting Final report.pdf (12 pages)

9.1.5. Management of Serious Incidents – Reasonable assurance

9.1 (5) Serious Incidents Final report.pdf (17 pages)

9.1.6. Governance During COVID-19 – Advisory

9.1 (6) Governance Arrangements during Covid 19 Final report.pdf (31 pages)

9.2. Business of other Committees and Review of Inter-relationships

Nicola Foreman

9.2 Committee Interrelationship Report.pdf (6 pages)

9.3. Self-Assessment of Committee Effectiveness

Nicola Foreman

9.3 Self Assessment of Committee Effectiveness Report.pdf (2 pages)

9.3 Appendix 1 Committee Effectiveness Results.pdf (18 pages)

9.3 Appendix 2 Committee Effectivness Action Plan.pdf (2 pages)

9.4. Job Planning Update

Stuart Walker

9.4 Job Planning Audit Follow up Report Nov 2020.pdf (2 pages)

9.4 E-Job Planning Audit Presentation.pdf (17 pages)

10. Review and Final Closure

10.1. Items to be deferred to Board / Committee

John Union

10.2. To note the date, time and venue of the next Committee meeting: Tuesday 9th February 2020 at 9.00am

Unconfirmed Minutes of the Public Audit and Assurance Committee
Held on Tuesday 8th September 2020 09:00am – 11:00am
Via Skype

Chair		
John Union	JU	Independent Member – Finance
Present:		
Eileen Brandreth	EB	Independent Member – ICT
Dawn Ward	DW	Independent Member – Trade Union
In Attendance:		
Bob Chadwick	BC	Executive Director of Finance
Nicola Foreman	NF	Director of Corporate Governance
Craig Greenstock	CG	Counter Fraud Manager
Darren Griffith	DG	Audit Wales
Mark Jones	MJ	Audit Wales
Chris Lewis	CL	Deputy Finance Director
Mike Usher	MU	Audit Wales
Ian Virgil	IV	Head of Internal Audit
Secretariat		
Raj Khan	RK	Corporate Governance Officer
Apologies:		
Len Richards	LR	Chief Executive Officer
Martin Driscoll	MD	Executive Director of Workforce & OD / Deputy Chief Executive Officer

AAC 20/09/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the public meeting. CC also welcomed Darren Griffiths, Audit Wales who had taken over from Anne Beegan.	**ACTION**
AAC 20/09/002	**Apologies for Absence** Apologies for absence were noted.	
AAC 20/09/003	**Declarations of Interest** There were no declarations of interest.	
AAC 20/09/004 Khan Raj 11/10/2020 10:24:19	**Minutes of the Committee meeting held on 7th July 2020** **Resolved that:** (a) The Committee approved the minutes of the meeting held on 7th July 2020 as a true and accurate record.	
AAC 20/09/005	**Action Log following the Meeting held on 7th July 2020**	

	The Committee reviewed the action log and the following updates were provided: **AAC 19/12/015** – It was agreed that the Internal Audit tracking report would be brought back to the Committee in November; the Director of Corporate Governance (DCG) commented that Internal Audit were validating to check if work had been completed. **AAC 20/04/010** – The Head of Risk and Regulation had met with the Director of Digital Health Intelligence and responses would be provided for a future meeting. **AAC 20/04/015** – set up a dedicated landing page for Covid learning and link to be provided for members to have view of this. **AAC 20/05/007** – Query raised by Independent Member – ICT in previous meeting, happy with comment provided by the Deputy Director of Finance. **Resolved that:** (a) The Committee reviewed and noted the action log and the updates provided.	
AAC 20/09/006	**Any Other Urgent Business** There were no items raised.	
AAC 20/09/007	**Internal Audit Progress and Tracking Reports** The Head of Internal Audit (HIA) introduced the report and stated that its main focus was to update Committee in relation to delivery of the Internal Audit Plan for 2020-2021. The HIA highlighted that 5 reports due for the September Committee had been delayed. The first two of these reports were in draft and the final three work in progress due to due to availability of UHB staff and supply of information in addition to Covid-19 related delays. The HIA then highlighted reports relating to the 2019-20 plan that had been finalised and would be presented in today's meeting as a final report in relation to strategic planning and IMTP. The report on pre-employment checks had been delayed due to staff changes so was still in the process of being finalised therefore this final report would be brought to the next meeting. HIA then reported delays in relation to the Internal Audit Plan 2020-21 and advised that these reports would be brought to the November/February meetings with the caveat that another Covid spike could potentially cause further delays. The HIA confirmed that they were working with the Director of Audit Assurance (DAA) to explore what items could potentially be removed from the audit plan whilst still allow an overall audit opinion to be provided for the UHB for the year. It was	**IV**

	confirmed that the DAA had held conversations with the Board Secretaries Group to remove from their opinions some of the normal domains they would include, to instead provide one formal opinion across the 8 domains (All Wales approach). CC queried whether we were in the same place as other UHBs in terms of delays. HIA confirmed that other Heads of Internal Audit had voiced similar positions. HIA revealed that the Covid governance audit had taken up time and impacted on delivery of other work however it had given a better view of governance arrangements and controls over the past few months which could provide an overarching piece of work to form an opinion on. DCG welcomed what HIA mentioned in terms of looking at a plan but commented that it needed to be recognised that 6 months had been lost due to Covid and an increased amount of staff leave had hindered matters, also in respect of work that should have been completed, a plan would need to be formulated to ensure appropriate audits were completed to give that overall HIA opinion. **Resolved that:** (a) The Committee considered the Internal Audit Progress Report; (b) The Committee approved the amendments to the timing of specific audits within the Internal Audit Plan for 2020-21.	
AAC 20/09/008	**Audit Wales Update** Darren Griffith (AW) firstly updated the Committee with regards to the work undertaken for the structured assessment for 2020. He explained how their approach had been adapted this year to consider governance arrangements, managing financial resources, and operational planning in the context of Covid-19. As mentioned in previous meetings, AW had been working closely with Internal Audit to coordinate work as much as possible to minimise the burden placed on the UHB and provide added value from sharing work. This had resulted in a draft report being prepared and issued for consideration and a feedback meeting would be held at the end of the month. AW then referred to TTP, which was a national high level piece of work which would look at the whole systems governance arrangements as well as the local Covid-19 response plans. Field work was currently underway and the Executive Director Public Health would also be interviewed as part of the process, being the regional lead for C&V. AW aimed to publish the report and its findings by October. AW would also be publishing an All Wales summary around clinical coding which would be brought to the next meeting. They were also aiming to publish their national follow up study on elective waiting times as well as a draft report on orthopaedic services.	**AW** **AW**

	AW then discussed their work in relation to Covid-19 learning and good practice exchange. A learning project had been established to share learning during the pandemic and public bodies were encouraged to share information and new ways of working via a dedicated landing page on their website in various output forms such as blogs, articles, etc. **Resolved that:** (a) The Committee noted the Audit Wales Update.	
AAC 20/09/009	**The 2019-20 Audit of Accounts Addendum Report** AW explained how this report is the final output that comes to Committee each year at the end of September in regards to the audit of the annual accounts. The report was shorter this year which reflected well on overall quality plans and underlying processes. This year only 3 areas were reported compared to 10 last year, indicating a positive outcome where recommendations were taken on board and implemented. The following areas were reported: Area 1 – Level of manual adjustment that sits outside financial ledger This was reported on 2 years ago where the recommendations were partially accepted at the time. The report was similar to how it was two years ago with minor changes. Area 2 – Information which sits outside of the Ledger AW described how some information rightly sat outside the ledger however a lot of the information was complex and inefficient to prepare and audit. The recommendation was just for the Health Board to simplify this information. Area 3 – Premature Party Returns AW advised that last year's recommendations had all been implemented by management as intended which showed a positive outcome and reflected well on the UHB. CC was pleased to see all of last year's recommendations agreed and implemented and with reduced recommendations this year and thanked all for the work done. **Resolved that:** (a) The Committee noted the Audit Wales 2019-20 Audit of Accounts Addendum Report.	
AAC 20/09/010	**Effectiveness of Counter-Fraud Arrangements Report** AW provided their review together with management response. The national report made 15 recommendations and built on the report from last year which provided a landscape description of arrangements in	

	place to tackle fraud across the Welsh public sector, and highlighted variability in arrangements and found NHS Wales ranked the highest above other public bodies with local and national counter fraud arrangements. This year's National report was a more in depth review of how effective these arrangements were in practice (across all Welsh Public Bodies). AW advised that Public Bodies in general could do more in the following areas: 1. Strengthening strategic leadership, coordination and oversight for counter-fraud across the Welsh public sector; 2. Increasing counter-fraud capacity and capabilities, especially across local government, and exploring the potential for sharing resources and expertise across public bodies; 3. Getting the right balance between proactive and reactive counter-fraud activities; 4. Improving awareness-raising and staff training in counter-fraud; and 5. Better evaluation of fraud risks and sharing of fraud information, both within and across sectors. AW referred specifically to the last recommendation, aimed at all committees recognising this very wide variation of existing practice across the public sector, albeit NHS Wales is in a better place than others. AW then discussed the local report which identified that the UHB had suitable arrangements to support the prevention and detection of fraud and was able to respond appropriately where fraud occurs. Some areas for improvement were identified which should be considered alongside the themes identified in the national report. The Committee were happy with the current findings, CC noted that this was to be kept under review and should any items of concern arise in regards to mandatory training or resources then it could be escalated. **Resolved that:** (a) The Committee noted the Audit Wales 2019-20 Effectiveness of Counter-Fraud Arrangements Report.	
AAC 20/09/011 Khan Raj 11/10/2020 10:24:19	**Declarations of Interest and Gifts and Hospitality Tracking Report including Declarations of Interest and sign off in relation to Ysbyty Calon Y Ddraig** The DCG introduced the report and advised Committee that the current number of declarations were very low compared to the last report where good numbers of DOI had been sent in throughout the year and progress made on previous years. The reason for the lower numbers were due to the fact that the end of year chasers had not been sent due to Covid-19, this was usually done at the end of April but had been deferred to October so by then the numbers should start to increase again through the reporting cycle.	

	Going forward, a communications plan would be put in place around DOIs. Communications would be issued around Christmas and key events to remind people to declare The DCG assured the Committee in terms of all the gifts and hospitality received through Covid-19, these had been reported to the Charitable Funds Committee. CC was pleased with the update. **Resolved that:** a) The Committee noted the ongoing work being undertaken within Standards of Behaviour. b) The Committee noted the update in relation to the Declarations of Interest, Gifts, Hospitality & Sponsorship Register.	
AAC 20/09/012	**Regulatory Compliance Tracking Report including Ysbyty Calon Y Ddraig** DCG advised that regulatory compliance tracking was paused during Covid and that this current report was now an up to date position of inspections that had taken place since the beginning of the year. The DCG added that this report was new to the Committee and was continually developing, there was now a dedicated Risk and Regulation team to focus on all trackers and standards of behaviour and therefore better progress was expected from October. CC queried regulatory inspection number8, where there was a recommendation around fire doors. He queried whether the role of the Audit Committee was to check that works had been carried out satisfactorily. The DCG clarified that the role of audit was to reassess works carried out, if works were not carried out then the DCG would flag these occurrences. Independent Member - TU flagged that the Teddy Bear nursery did not have a rating and number 10 in the report did not specify a location, the DCG will amend accordingly. **Resolved that:** a) The Committee noted the inspections that had taken place since the last meeting of the Audit Committee in September 2020 and their respective outcomes. b) The Committee noted the continuing development of the Legislative and Regulatory Compliance Tracker.	**NF**

AAC 20/09/013	**Internal Audit Tracking Report** The DCG introduced the Internal Audit Tracker and stated how her team had started to again chase and progress these. The summary tables provided with the report showed progress being made, the recommendations from 2017/18 had reduced significantly, 2018/19 were also reducing and 2019/20 had remained stable. Due to the fact that all the internal audits for the end of the year had been added on, it might seem like nothing had progressed but the DCG assured the Committee that progress was still being made. DCG mentioned that the figures for 2020/21 would soon be received and reported on, Internal Audit would also check on completed items to confirm that they had been completed in full providing further assurance to the Committee. The CC highlighted that the trackers showed we were keeping a note of the recommendations, that they were also being internally audited and that excellent progress was being made. **Resolved that:** (a) The Committee noted the tracking report now in place for tracking audit recommendations made by Internal Audit. (b) The Committee noted that progress would be seen over coming months in the number of recommendations completed/closed.	
AAC 20/09/014	**Audit Wales Tracking Report** The DCG confirmed that the report showed where we were with Audit Wales recommendations and that the ones from today would also be added to the tracker. The overall percentages provided showed progress made since previous meetings, this would continue to be monitored to ensure that areas were doing what they had committed to when signing up to the recommendations. The Independent Member - TU commented that the internal audit tracker used actual numbers but percentages in the external audits tracker and queried the reason why. The DCG responded that there was no specific reason other than there being more recommendations internally and therefore easier to use numbers but would provide numbers in both for consistency going forward. **Resolved that:** (a) The Committee noted the progress made in relation to the completion of AW recommendations. (b) The Committee noted the continuing development of the AW Recommendation Tracker.	**NF**
AAC 20/09/015	**Items for Information and Noting - Internal Audit reports for information** The Committee received the following 2 reports: • Strategic Planning / IMTP – Reasonable assurance	

	• Annual Quality Statement – Substantial assurance **Resolved that:** (a) The Committee noted the Internal Audit reports.	
AAC 20/09/016	**Items to bring to the attention of the Board / Committees** There were no items to be brought to the attention of the Board / Committees.	
AAC 20/09/017	**Review of the Meeting** The CC thanked everyone for their attendance and contribution to the meeting.	
AAC 20/09/018	**Date and Time of Next Meeting** To note the date, time and venue of the next Committee meeting: **Tuesday 17th November 2020 at 9.00am, Via Skype**	

Action Log
Following Audit & Assurance Committee Meeting
8th September 2020

REF	SUBJECT	AGREED ACTIONS	LEAD	DATE	STATUS/COMMENTS
Completed Actions					
AAC 20/04/008	Declarations of Interest	A report detailing Declarations of Interest in relation to Ysbyty Calon Y Drraig be brought to a future meeting	Nicola Foreman	08.09.20	**Complete**
AAC 20/04/009	Regulatory Compliance Tracking Report	A report detailing all visits and sign off for Ysbyty Calon Y Ddraig be brought to a future meeting	Nicola Foreman	08.09.20	**Complete**
AAC 20/04/010	Internal Audit Tracking Report	Work be carried out with the Director of Digital & Health Intelligence to improve transparency and detailed responses	Aaron Fowler	08.09.20	**Complete**
AAC 20/04/015 20/09/005 20/09/008	Annual Audit Plan – Impact of COVID-19	Work undertaken on an All Wales Level relating to learning from the pandemic be shared with the UHB	Mike Usher	08.09.20	**Complete** Link to dedicated page containing the learning will be shared with UHB.
AAC 20/05/006	Internal Audit Progress	Draft Internal Audit reports presented at the May meeting to be followed up with managers and confirmed action plans to be brought to a future meeting	Ian Virgil	08.09.20	**Complete**
AAC 20/05/007	Losses and Special Payments	To provide Committee members with information on how much debt write off had been referred to a collection agency and what percentage of this became a write off	Chris Lewis	June 2020	**Complete** In 2019/20 circa £250k was referred to the debt collection agency and of this circa 40% was written off.
AAC 20/05/008	Internal Audit Reports	To congratulate areas on positive assurance findings.	John Union	08.09.20	**Complete**
AAC 20/09/012	Regulatory Compliance Tracking Report including Ysbyty Calon Y Ddraig	The DCG to amend so that Teddy Bear Nursery has a rating & number 10 a location.	Nicola Foreman	17.10.20	**Complete** tracker amended as suggested

AAC 20/09/014	Audit Wales Tracking Report	Use numbers in both internal and external reports instead of percentages for better consistency.	Nicola Foreman	17.10.20	**Complete** reports amended as requested
AAC 20/07/009	Regulatory Compliance Tracking Report	Re-assessment and new targets be agreed for trackers	Nicola Foreman	17.11.20	**Complete** – Review undertaken as to what people are saying and will in future ensure that dates and timescales are set for initial responses.
Actions in Progress					
AAC 20/09/007	Internal Audit Progress and Tracking Reports	Report on pre-employment checks to be brought to the next meeting.	Ian Virgil	**17.11.20**	On Agenda for November, item 9.1
AAC 20/09/008	Audit Wales (AW) Update	AW reports on clinical coding, TTP & national follow up study on elective waiting times to be brought to the next Committee meeting.	AW	**17.11.20** 09.02.21	Clinical Coding & Planned Care on Agenda for November, items 7.4 & 7.5 Update on TTP to be provided at February 2021 meeting.
AAC 19/12/015	Internal Audit Tracking Report	The Head of Internal Audit to provide sample of validation from Clinical Boards to test for accuracy in a future Internal Audit and Review	I Virgil	**17.11.20**	On Agenda for November, item 7.1
AAC 20/03/008 **AAC 20/04/005**	Consultant Job Planning Follow-up: Limited Assurance Report	An update to be presented to the Committee in February 2021. It was agreed a follow up Internal Audit Report would be carried out at an appropriate time agreed with Stuart Walker	Stuart Walker	**17.11.20** TBC	On Agenda for November, item 9.4 March 2021
AAC 19/12/012 **AAC 20/05/005**	Effectiveness of Clinical Audit Report	To consider arrangements to deliver effective programme of Clinical Audit To clarify plans to progress post COVID-19 with AW	S Walker Nicola Foreman	17/11/20	To be brought to February 2021 meeting. Considered as part of the Self-Assessment of Current Quality Governance arrangements - May 2020

Report Title:	**Internal Audit Progress Report**								
Meeting:	Audit & Assurance Committee						**Meeting Date:**	17/11/20	
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**	**X**	**For Information**		
Lead Executive:	Director of Governance								
Report Author (Title):	**Head of Internal Audit**								

Background and current situation:

The NHS Wales Shared Services Partnership (NWSSP) Audit and Assurance Service provides an Internal Audit service to the Cardiff and Vale University Health Board.

The work undertaken by Internal Audit is in accordance with its plan of work, which is prepared following a detailed planning process and subject to Audit Committee approval. The plan sets out the program of work for the year ahead as well as describing how we deliver that work in accordance with professional standards and the process established with the UHB and is prepared following consultation with the Executive Directors.

The progress report provides the Audit Committee with information regarding the progress of Internal Audit work in accordance with the agreed plan; including details and outcomes of reports finalised since the previous meeting of the committee and proposed amendments to the plan.

The progress report highlights the conclusion and assurance ratings for audits finalised in that period.

Reports that are given Reasonable or Substantial assurance are summarised in the progress report with the reports given Limited or No Assurance included in full. There are no reports that have been given a Limited or No Assurance rating during the current period.

Appendix A of the progress report sets out the Internal Audit plan as agreed by the committee, including details of postponed / removed audits, commentary as to progress with the delivery of assignments and outcomes from completed audits.

Executive Director Opinion/Key Issues to bring to the attention of the Board/Committee:

The progress report includes further proposed amendments to the agreed 20/21 Internal Audit plan.

A first round of adjustments to the plan was formally approved by the Audit Committee in July.

However, due to the impact of the pandemic to date and the likelihood of continued disruption through the winter, it is anticipated that we will not be able to deliver the current revised plan. It is therefore proposed that a number of additional audits are removed from the plan. These reflect areas of lower risk or where the Health Board has identified that work can't progress at the current time.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc.):

The progress report provides the Committee with a level of assurance around the management of a series of risks covered within the specific audit assignments delivered as part of the Internal Audit Plan. The report also provides information regarding the areas requiring improvement and assigned assurance ratings.

Recommendation:

The Audit & Assurance Committee is asked to:

- **Consider** the Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit reports.
- **Approve** the proposed amendments to the Internal Audit Plan for 2020/21.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term	x	Integration	x	Collaboration	x	Involvement	

Equality and Health Impact Assessment Completed:	~~Yes~~ / ~~No~~ / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Cardiff and Vale University Health Board

Internal Audit Progress Report

Audit & Assurance Committee November 2020

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

CONTENTS

1. INTRODUCTION

1.1. This progress report provides the Audit & Assurance Committee with the current position regarding the work to be undertaken by the Audit & Assurance Service as part of the delivery of the approved 2020/21 Internal Audit plan.

1.2. The report includes details of the progress made to date against individual assignments, outcomes and findings from the reviews, along with details regarding the delivery of the plan and any required updates.

1.3. The plan for 2020/21 was agreed by the Audit & Assurance Committee in April 2020 and is delivered as part of the arrangements established for the NHS Wales Shared Service Partnership - Audit and Assurance Services.

2. ASSIGNMENTS WITH DELAYED DELIVERY

2.1. Full details of the current year's audit plan along with progress with delivery and commentary against individual assignments regarding their status is included at Appendix A. The assignments noted in the table below are those which had been planned to be reported to the September Audit Committee but have not met that deadline.

Audit	Current Position	Draft Rating	Reason
Asbestos Management	Draft Report	Reasonable	Delay in completion of fieldwork due to availability of HB staff and supply of information
Specialist CB – Patient Assessment & Provision of Equipment in ALAS	Draft Report	Reasonable	Delay in completion of fieldwork due to availability of Internal Audit resource
IM&T Control & Risk Assessment	Work in Progress		Delay in completion of fieldwork due to availability of HB staff and supply of information
Integrated Health Pathways	Work in Progress		Delay in commencing fieldwork due to the availability of Internal Audit resource
MH CB – Outpatient Clinic Cancellations	Work in Progress		Delay in commencing fieldwork due to the availability of Internal Audit resource
CD&T CB – Ultrasound Governance	Planning		Delay in commencing fieldwork due to the supply of information by HB and availability of Internal Audit resource

2.2. Whilst the table above provides a brief reason for the delay to each individual assignment, it should also be noted that there continues to be a general delay in progressing with delivery of the plan. This is due to delays in being able to meet with Health Board managers and staff and receive required information, due to the on-going effects of the pandemic.

3. OUTCOMES FROM COMPLETED AUDIT REVIEWS

3.1. Six assignments have been finalised since the previous meeting of the committee and are highlighted in the table below along with the allocated assurance ratings.

3.2. The final report from the 2018/19 plan, which was reported to the audit committee in draft in May, has now been finalised and is detailed below. We have not however been provided with management responses for all of the findings within this report.

3.3. A summary of the key points from the finalised assignments are reported in Section six. The full reports are included separately within the Audit Committee agenda for information.

FINALISED AUDIT REPORTS (2019/20 Opinion)	ASSURANCE RATING	
Pre-Employment Checks	Reasonable	

FINALISED AUDIT REPORTS (2020/21 Plan)	ASSURANCE RATING	
Surgery CB – Theatres Directorate Sickness Absence Management	Reasonable	
Regional Partnership Board		
Sustainability Reporting		
Management of Serious Incidents		
Governance During COVID-19 (Advisory Review)	Not Rated	

4. DELIVERY OF THE 2020/21 INTERNAL AUDIT PLAN

4.1. From the table in section three above it can be seen that five audits have been finalised since the Committee met last.

In addition, there are two further audits that have reached the draft report stage with five others currently work in progress.

4.2. The 20/21 Internal Audit plan was formally approved by the Audit & Assurance Committee at its April 20 meeting. It was however noted that the content of the plan and the proposed timing of individual audits, would be subject to adjustment to reflect the Health Board's changing risk profile and the availability of key management and staff during the COVID-19 pandemic.

A first round of adjustments to the plan was formally approved by the Audit Committee in July.

However, due to the impact of the pandemic to date and the likelihood of continued disruption through the winter, it is anticipated that we will not be able to deliver the current revised plan. It is therefore proposed that a number of additional audits are removed from the plan. These reflect areas of lower risk or where the Health Board has identified that work can't progress at the current time.

4.3. Full details of the proposed updated Internal Audit plan are provided within Appendix 1.

The key proposed adjustments for agreement by the November Audit Committee are summarised below:

<u>Audits to be removed from the 20/21 plan</u>

- **Whistle Blowing Policy**

  The Director of Governance has proposed that this audit is deferred to the 21/22 plan as work is currently ongoing to update the Health Board's Raising Concerns process which incorporates whistle blowing.

- **Strategic Performance Reporting**

  Proposed that this audit is postponed to the 21/22 plan as formal performance reporting requirements have been paused by Welsh Government.

- **Directorate Level Financial Control**

  The Acting Director of Finance has agreed that this audit should be removed from the plan as it represents a lower risk area.

- **ITIL Service Management**

  The Director of Digital has requested that this audit be deferred to the 21/22 plan due to the current pressures on key IT staff.

- **Departmental IT System**

  The Director of Digital has requested that this audit be removed from the plan due to the current pressures on key IT staff.

- **PCIC CB – GP Access**

  The PCIC Clinical Board have requested that this audit be deferred to the 21/22 plan as the introduction of reporting on the new GP access standards has been postponed by Welsh Government.

- **Fire Safety**

  The Director Capital, Estates & Facilities has requested that this audit be deferred to the 21/22 plan due to current pressures on key staff including focus on the development of the additional surge capacity at UHW.

- **Major Capital Scheme – UHW II**

  Proposed that this audit be removed from the plan as the scheme has not progressed due to delays in Welsh Government providing approval of the business case.

- **Major Capital Scheme – UHW New Academic Avenue**

  Proposed that this audit be removed from the plan as the scheme has not progressed due to delays in Welsh Government providing approval of the business case.

- **Capital Systems Management**

  The Director Capital, Estates & Facilities has proposed that this audit be removed from the plan and replaced with the audit of the UHW Surge Facility detailed below.

<u>Audits to be added to the 20/21 plan</u>

- **UHW Surge Facility**

  The Director Capital, Estates & Facilities has requested a review of the new 400-bed surge facility currently being delivered at UHW, with a focus on the approval, governance and procurement arrangements applied for the new facility.

- **Post Contract Audit of DHH Costs**

  The Acting Director of Finance has requested that Internal Audit carry out this review. Completion of a post contract audit is a recommendation from the recent KPMG audit of the DHH.

The adjustments identified above, combined with those previously agreed, mean that there will be 35 audits remaining for delivery within the 20/21 plan. As it stands, this will still allow sufficient coverage for the provision of a full Head of Internal Audit annual opinion at the end of the year.

It has however been agreed that the annual opinion will not follow the established domain approach, as has been the case in previous years, but will be a single overall opinion taking the aggregate of evidence from the revised risk based plan.

The ongoing situation will continue to be monitored and any further impact on the Internal Audit plan will be communicated to future meetings of the Audit Committee.

4.4. Appendix B highlights the times for responding to Internal Audit reports. Appendix C shows the Audit & Assurance Key Performance Indicators.

5. ASSURANCE ON RECOMMENDATION TRACKING

5.1. Since September 2019 the Corporate Governance team have been developing an Internal Audit Recommendation Tracker. The tracker provides the Audit Committee with information on the current progress that has been made towards the implementation of outstanding Internal Audit recommendations. The information within the tracker is based on responses provided by Health Board management confirming the current progress.

5.2. It was agreed that Internal Audit would introduce a process for reviewing a sample of the entries within the tracker, in order to validate the stated position and provide additional assurance to the Audit Committee.

5.3. Appendix D provides detail of the entries from the tracker that have been validated to date and the outcome of that validation. The validation completed to date has focused on the 2017/18 recommendations detailed within the tracker that was presented to the September 20 Audit Committee. The overall outcome can be summarised as follows:

- The tracker included a total of 22 recommendations from 2017/18;
- A sample of 13 of the recommendations was selected for validation;
- We were able to obtain evidence to confirm that the stated progress for 11 of the 13 sampled recommendations was accurate; and
- We are still waiting for evidence to be supplied for the remaining 2 recommendations.

5.4. The outcome of the validation process means that the Audit Committee can be assured that the progress information detailed within the tracker for the 2017/18 recommendations represents an accurate position.

5.5. If the Committee is satisfied with this validation process then it will be extended to cover the 2018/19 recommendations and the outcome will be reported to the February Committee.

6. FINAL REPORT SUMMARIES

6.1. Pre-Employment Checks (2019/20 Opinion)

RATING	INDICATOR	DEFINITION
Reasonable assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.

Overall, the controls in place to manage the risks associated with the systems and processes tested within the review are of a reasonable standard. However, we have identified a number of weaknesses in the areas reviewed.

We identified a number of issues concerning the Health Board and NWSSP's procedural guidance and process flow charts. Testing of pre-employment checks found some overall non-compliance with the six NHS Standards. We identified some weaknesses in communication between the Health Board and NWSSP concerning internal appointments.

The testing undertaken identified that pre-employment checks for both internal and external candidates are not always completed within the target timescales. It is however noted that the reasons for the delays generally relate to external issues that are outside the control of both NWSSP Recruitment and the Health Board.

One high priority issue was identified in this review concerning pre-employment checks undertaken for bank staff.

6.2. Surgery CB – Theatres Dir Sickness Absence Management

RATING	INDICATOR	DEFINITION
Reasonable assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.

Overall the processes in place that underpin sickness management in accordance with the All Wales Managing Attendance at Work Policy are working effectively across the majority of the six sampled staff groups within the Theatres Directorate.

All sickness absence stated on Rosterpro reconciled to individual ESR accounts in all six areas and mechanisms for sickness absence monitoring and reporting of sickness 'hot spots' are in place as a standing agenda item of the Surgery Clinical Board meetings.

For the majority of areas, the key findings relate to minor elements of non-compliance in respect of inconsistent completion or retention of Sickness Notification Forms, Self-Certification Forms, Return to Work Interview Forms and GP Fit Notes.

Whilst the majority of areas actively monitor, manage and document short term sickness absence, there are small incidences of non-recording of 'Short Term Review Prompts'.

Generally, long term sickness is being fully managed and required interviews are being undertaken, with evidence of Occupational Health liaison where required.

However, testing identified major shortfalls in compliance within the Trauma Theatres, UHW in respect of completion of sickness notification, key sickness documentation, short term sickness absence monitoring and long term sickness management. This included the use of social media as a means of ongoing communication for a long term sickness episode without any formal documentation of the required processes as stated in the All Wales Managing Attendance at Work Policy.

6.3. Regional Partnership Board

RATING	INDICATOR	DEFINITION
Reasonable assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.

We identified that overall the arrangements in place within the Health Board relating to the Regional Partnership Board are of a reasonable standard, with good practice noted across the majority of areas reviewed, including:

- Effective governance structures are in place for overseeing the work of the Integrated Health & Social Care Partnership.
- Appropriate financial management and monitoring arrangements are in place for the Integrated Care Fund.

The review highlighted no high priority findings. However we did identify a number of areas where the governance arrangements relating to the RPB, Strategic Leadership Group (SLG) and ICF Programme Board meetings require strengthening. We also identified a lack of formal reporting within the Health Board of the outcomes of the RPB's activities.

It is acknowledged that a review of the governance arrangements for the Regional Partnership Board is already underway and is due to be completed by the end of 20/21.

6.4. Sustainability Reporting

RATING	INDICATOR	DEFINITION
Reasonable assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.

Our annual audit has confirmed that despite the disruption caused by Covid-19 restrictions, the 2019/20 Sustainability Development Report (SDR) was prepared in accordance with the guidance and revised deadlines published by the Welsh Government. The internal guidance document had also been updated and clearly sets out the process for compiling and generating the SDR.

However as recommended in last year's internal audit report, a timetable setting out deadlines for the submission of data and for the subsequent internal review, audit and approval of the SDR had not been drawn up prior to the commencement of the SDR compilation process.

In addition the revised approval and sign off arrangements require internal audit to be provided with evidence that the SDR has been retrospectively approved by the Environmental Management Steering Group / Health & Safety Group and signed off by the Director of Capital, Estates and Facilities. However to date no such evidence has been provided.

6.5. Management of Serious Incidents

RATING	INDICATOR	DEFINITION
Reasonable assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.

We identified that overall the arrangements in place within the Health Board relating to the management of Serious Incidents are of a reasonable standard, with good practice noted across the majority of areas reviewed, including:

- Appropriate policies, procedures and other written documentation.
- The Datix system provides a platform for logging and tracking of serious incidents.
- Regular reporting was identified to both the Clinical Boards and Corporate Committees.

The review highlighted one high priority findings:

- We identified delays when completing and submitting the closure forms to Welsh Government.

6.6. Governance During COVID-19 (Advisory Review)

The Health Board's temporary governance arrangements operated effectively during the peak of the pandemic. The Health Board generally complied with the guidance and the principles issued by Welsh Government.

The Command Structure introduced by the Health Board operated efficiently and enabled the organisation to make decisions in an agile way so that it could effectively manage the delivery of its services during the pandemic. It is however noted that the decision to not formally operate under a Gold Command and Control structure may have impacted on the transparency of decision making and the opportunity for scrutiny and challenge by IMs and the wider community. There is an opportunity now for management to fully assess the appropriateness of the command structure and the transparency of decision making.

Board, Audit & Assurance Committee, Quality, Safety & Experience (QS&E) Committee and Finance Committee meetings continued during the peak and the business of those meetings was generally appropriate. There may however have been scope to further review the agendas of the committees to ensure appropriate focus on Covid-19 related issues whilst providing assurance on areas normally covered by other Committee meetings that were postponed. It is acknowledged that the April Audit and QS&E committee meetings were held just before Welsh Government guidance was issued. At the time of the next meetings of these committees, the Health Board had begun to return to business as usual

Regular briefing of IMs outside of the formal committee forums was undertaken. However, in the early stages of the pandemic, the process for engaging with the IMs could have been developed further.

'Virtual' meetings using Skype and latterly Microsoft Teams have developed over time, with initial teething troubles and connectivity problems nationally throughout the NHS. All planned meetings have gone ahead and the disciplines and etiquette involved is evolving.

Good financial governance was maintained during the pandemic with Covid-19 related expenditure being separately identified and reviewed.

The Health Board continues to adapt the temporary governance arrangements as the pandemic progresses and has commenced the process of moving from the emergency response phase to planning services going forward. This includes assessing opportunities to continue some of the new ways of organising and delivering services in order to realise a transformed health and care system focused on achieving the best outcomes..

CARDIFF AND VALE UHB INTERNAL AUDIT ASSIGNMENT STATUS SCHEDULE

Planned output.	No	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
Annual Quality Statement	**16**	**Nursing**	**Q2**	**Final – Issued August 20**	**Substantial**	**Sept**
Surgery CB – Theatres Directorate Sickness Absence Management	**29**	**COO**	**Q2**	**Final – Issued September 20**	**Reasonable**	**Nov**
Regional Partnership Board	**07**	**Strategic Planning**	**Q2**	**Final – Issued October 20**	**Reasonable**	**Nov**
Governance During COVID-19 (Advisory Review)	**46**	**Corporate Governance / Finance**	**Q2**	**Final – Issued October 20**	**n/a**	**Nov**
Sustainability Reporting	**38**	**Finance**	**Q2**	**Final - Issued November 20**	**Reasonable**	**Nov**
Management of Serious Incidents	**18**	**Nursing**	**Q2**	**Final – Issued November 20**	**Reasonable**	**Nov**
Specialist CB – Patient Assessment & Provision of Equipment in ALAS	28	COO	Q2	Draft – Issued October 20	Reasonable	Feb
Asbestos Management	40	Finance	Q2	Draft – Issued October 20	Reasonable	Feb
IM&T Control & Risk Assessment	01	Transformation & Informatics	Q2	Work in Progress		Feb
Integrated Health Pathways	20	Transformation & Informatics	Q2	Work in Progress		Feb
MH CB – Outpatient Clinic Cancellations	31	COO	Q2	Work in Progress (Brought forward from Q3)		Feb

Planned output.	No	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
CD&T CB – US Governance	33	COO	Q3	Work in Progress		Feb
Nurse Staffing Levels Act	17	Nursing	Q3	Work in Progress		Feb
Claims Reimbursement	02	Nursing	Q3	Planning		Feb
Health and Care Standards	03	Nursing	Q3	Planning		Feb
Engagement Around Service Planning	06	Strategic Planning	Q3			Feb
Charitable Funds	14	Finance	Q3	Planning		Feb
Clinical Board QS&E Governance	19	Nursing	Q3			Feb
Medicine CB – Bank & Agency Nurses Scrutiny Process	30	COO	Q3	Planning		Feb
Recruitment & Retention of Staff	35	Workforce	Q3			Feb
Commissioning	08	Strategic Planning	Q3			April
Public Health	12	Public Health	Q3			April
UHB Core Financial Systems	13	Finance	Q3			April
Infrastructure / Network Management	23	Transformation & Informatics	Q3			April

Planned output.	No	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
Risk Management	02	Corporate Governance	Q4			April
Data Quality Performance Reporting	10	Transformation & Informatics	Q4			April
Tentacle IT System Follow-up	26	Transformation & Informatics	Q4			April
Cyber Security System Follow-up	27	Transformation & Informatics	Q4			April
C&W CB – Rostering in Community Children's Nursing	34	COO	Q4			April
Management of Staff Sickness Absence	36	Workforce	Q3			April
Consultant Job Planning Follow-up	37	COO	Q4			April
Shaping Future Wellbeing in the Community Scheme	43	Strategic Planning	Q4			April
Development of Integrated Audit Plans	45	Strategic Planning	Q1-4			April
UHW Surge Facility	44	Strategic Planning	Q2	Added to the plan in place of the Capital Systems Management Audit - To be agreed by November AC.		April
Post Contract Audit of DHH Costs	47	Finance	Q4	Added to the plan following request from Director of Finance – To be agreed by November AC.		April

Planned output.	No	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
Reviews deferred / removed from plan						
Public Health Audit 1	11	Public Health		Removed to allow allocated days to be utilised for the COVID-19 Governance review – Agreed by July AC		
IT Strategy	22	Transformation & Informatics		Director of Digital requested deferral to the 21/22 plan. The COVID situation has impacted the timing of IT work so the strategy delivery / roadmap needs to be reassessed – Agreed by July AC		
Implementation of New IT Systems	24	Transformation & Informatics		Director of Digital requested deferral to the 21/22 plan. COVID has affected IT system implementations and the audit would need input from departments – Agreed by July AC		
Whistleblowing Policy	05	Corporate Governance		Director of Governance proposed deferral to the 21/22 plan. Work is currently ongoing to update the Health Board's Raising Concerns process which incorporates whistle blowing - To be agreed by Nov AC		
Strategic Performance Reporting	09	Transformation & Informatics	Q3	Proposed that this audit is postponed to the 21/22 plan. Formal performance reporting requirements have been paused by Welsh Government - To be agreed by November AC		
Directorate Level Financial Control	15	Finance		Deferral to the 21/22 plan agreed with the acting Director of Finance. Lower risk area and issues with accessing Directorate Managers during Covid – To be agreed by the Nov AC		

Planned output.	No	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
ITIL Service Management	21	Transformation & Informatics		Director of Digital requested removal from the plan due to the current pressures on key IT staff - To be agreed by November AC		
Departmental IT System	25	Transformation & Informatics		Director of Digital requested removal from the plan due to the current pressures on key IT staff - To be agreed by November AC		
PCIC CB – GP Access	32	COO		Deferral to 21/22 agreed with CB Management. GP Access monitoring paused due to Covid - To be agreed by the Nov AC		
Fire Safety	39	Finance		Director CEF requested deferral to the 21/22 plan due to current pressures on key staff - To be agreed by Nov AC		
Major Capital Scheme – UHW New Academic Avenue	42	Strategic Planning		Proposed that audit is removed from the plan as the scheme has not progressed - To be agreed by November AC		
Major Capital Scheme – UHW II	41	Strategic Planning		Proposed that audit is removed from the plan as the scheme has not progressed - To be agreed by November AC		
Capital Systems Management	*44*	*Strategic Planning*		Director CEF proposed that this audit be removed from the plan and replaced with the audit of the UHW Surge Facility - To be agreed by November AC.		

INTERNAL AUDIT REPORT RESPONSE TIMES								
Audit	**Rating**	**Status**	**Draft issued date**	**Responses & exec sign off required**	**Responses & Exec sign off received**	**Final issued**	**R/A/G**	
Annual Quality Statement	Substantial	Final	03/08/20	25/08/20	13/08/20	19/08/20	G	
Surgery CB – Theatres Dir Sickness Absence Management	Reasonable	Final	15/09/20	07/10/20	28/09/20	01/10/20	G	
Regional Partnership Board	Reasonable	Final	28/08/20	06/10/20	29/09/20	07/10/20	G	
Governance During Covid-19	n/a	Final	21/08/20	15/09/20	21/10/20	23/10/20	R	
Sustainability Reporting	Reasonable	Final	10/09/20	02/10/20	02/11/20	03/11/20	R	
Management of Serious Incidents	Reasonable	Final	23/10/20	16/11/20	02/11/20	02/11/20	G	
Specialist CB – Patient Assessment & Provision of Equipment in ALAS	Reasonable	Draft	22/10/20	13/11/20				
Asbestos Management	Reasonable	Draft	03/11/20	25/11/20				

Indicator Reported to NWSSP Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2020/21	G	April 2020	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported (to at least draft report stage) against plan to date for 20/21	R	67% 8 from 12	100%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100% 8 from 8	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	A	67% 4 from 6	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 6 from 6	80%	v>20%	10%<v< 20%	v<10%

Information from Recommendation Tracker							Validation Process	
Audit Reference	**Audit Log Reference No**	**Final Report Issued on**	**Audit Title**	**Audit Rating**	**Rec. Rating**	**Rec. status**	**Basis of validation**	**Outcome**
C&V-1718-28	IA11_1718	01/02/2018	WLI Payments Follow-up	Reasonable	Medium	Complete	Completion confirmed via subsequent audits	Recommendation confirmed as complete
C&V-1718-27	IA12_1718	01/02/2018	Residences	Reasonable	Low	Complete	Evidence received from Manager to confirm completion	Recommendation confirmed as complete
C&V-1718-23	IA13_1718	01/02/2018	Surgery CB – Anaesthetist Rota Management	Reasonable	High	Complete	Evidence received from Manager to confirm completion	Recommendation confirmed as complete
C&V-1718-38	IA14_1718	01/03/2018	Pilot Model Ward Review	Reasonable	Low	Complete	Confirmed as noted for any future projects	Recommendation confirmed as complete
C&V-1718-38	IA14_1718	01/03/2018	Pilot Model Ward Review	Reasonable	Low	Complete	Confirmed as noted for any future projects	Recommendation confirmed as complete
C&V-1718-07	IA17_1718	01/04/2018	Wellbeing of Future Generations Act	Reasonable	Medium	Partially Complete	Response still awaited from Dir of Communications	
C&V-1718-35	IA22_1718	01/11/2017	Nurse Revalidation	Reasonable	Medium	n/a	Completion confirmed via subsequent audit	Recommendation confirmed as complete
C&V-1718-35	IA22_1718	01/11/2017	Nurse Revalidation	Reasonable	Low	n/a	Completion confirmed via subsequent audit	Recommendation confirmed as complete

Information from Recommendation Tracker							Validation Process	
Audit Reference	**Audit Log Reference No**	**Final Report Issued on**	**Audit Title**	**Audit Rating**	**Rec. Rating**	**Rec. status**	**Basis of validation**	**Outcome**
SSuCV-1718-01	IA27_1718	01/04/2018	UHW Neonatal Development	Reasonable	High	Complete	Evidence received to confirm completion	Recommendation confirmed as complete
SSuCV-1718-01	IA27_1718	01/04/2018	UHW Neonatal Development	Reasonable	Low	Part Complete	Position confirmed as part of planned subsequent audit	Recommendation confirmed as partially complete
SSuCV-1718-01	IA27_1718	01/04/2018	UHW Neonatal Development	Reasonable	Medium	Part Complete	STAs are reported to the Audit Committee	Recommendation confirmed as partially complete
C&V-1718-05	IA29_1718	01/05/2018	Business Continuity Planning Follow-up	Reasonable	High	Part Complete	Position confirmed as part of subsequent audit	Recommendation confirmed as partially complete
C&V-1718-24	IA35_1718	01/11/2017	Internal Medicine Directorate Mandatory Training & PADRs	Reasonable	High	Complete	Response still awaited from Clinical Board	

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Audit Wales

Audit Committee Update – **Cardiff & Vale University Health Board**

Date issued: November 2020

Document reference: 1996A2020-21

This document has been prepared for the internal use of Cardiff & Vale University Health Board as part of work performed/to be performed in accordance with statutory functions.

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Contents

Audit Committee Update

About this document

1 This document provides the Audit Committee with an update on current and planned Audit Wales work. Accounts and performance audit work are considered, and information is also provided on the Auditor General's wider programme of national value-for-money examinations and the work of our Good Practice Exchange (GPX).

Accounts audit update

2 **Exhibit 1** summarises the status of our key accounts audit work to be reported during 2020-21.

Exhibit 1 – Accounts audit work

Area of work	Current status
Audit of the 2019-20 Funds Held on Trust Account	We are currently undertaking this audit with the aim of reporting the outcome in November. Trustee Members are scheduled to consider and approve the audited account and our audit report on 26 January 2021. If approved, the Audit General is scheduled to certify the account on 29 January, which would be ahead of the Charity Commission's deadline of 31 January 2021.
Audit of the 2020-21 Accountability Report and Financial Statements	Audit planning is scheduled to start in December.

Performance audit update

3 The following tables set out the performance audit work included in our current and previous Audit Plans, summarising:

- completed work since the last Audit Committee update (**Exhibit 2**);
- work that is currently underway (**Exhibit 3**); and
- planned work not yet started or revised (**Exhibit 4**).

Exhibit 2 – Work completed

Area of work	Considered by Audit Committee
Structured Assessment 2020	November 2020

Exhibit 3 – Work currently underway

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Follow-up of previous IM&T recommendations Executive Lead – Director of Informatics	In 2014, we carried out work to assess progress in addressing previous IM&T related issues and recommendations. We concluded that the Health Board had made some progress, but further work was needed. At that time, we made some additional recommendations. This work will follow-up progress against these recommendations.	Draft report in clearance February 2021
Follow-up of operating theatres Executive Lead – Chief Operating Officer	We have previously reviewed operating theatres in 2011 and again in 2013. Although our work had highlighted progress, we identified that there had not been a focus on improving service quality and addressing problems with staff engagement. We also made some additional recommendations. This work will follow-up progress against these recommendations.	Report being drafted February 2021
Structured Assessment 2020 - Supplementary Outputs	To support our annual structured assessment work, we are undertaking further work to pull together two short all-Wales summaries focusing on governance	All-Wales outputs being drafted February 2021

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Executive Leads – Director of Governance and Executive Director of Workforce & Organisational Development	arrangements during the COVID-19 pandemic, and arrangements to support staff risk and well-being.	
Orthopaedic Services – follow-up Executive Lead – Chief Operating Officer	This review will examine the progress made in response to our 2015 recommendations. The findings from this work will inform the recovery planning discussions that are starting to take place locally and help identify where there are opportunities to do things differently as the service looks to tackle the significant elective backlog challenges. Our findings will be summarised into a single national report with supplementary outputs setting out the local position for each health board.	Report being drafted February 2021
Review of WHSSC Executive Lead – Chief Executive Officer	This work uses aspects of our structured assessment methodology to examine the governance arrangements of WHSSC. Our findings will be summarised into a single national report.	Report being drafted February 2021
Test, Track and Protect	In response to the COVID-19 pandemic, this work will take the form of an overview of the whole system governance arrangements	Report being drafted February 2021

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Executive Lead – Director of Public Health	for Test, Track and Protect, and of the Local COVID-19 Prevention and Response Plans for each part of Wales.	

Exhibit 4 – Planned work not yet started or revised

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Quality Governance Executive Lead – Director of Nursing and Patient Experience	This work will allow us to undertake a more detailed examination of factors underpinning quality governance such as strategy, structures and processes, information flows, and reporting. This work follows our joint review of Cwm Taf Morgannwg UHB and as a result of findings of previous structured assessment work across Wales which has pointed to various challenges with quality governance arrangements.	Re-scoping / streamlining audit activities given ongoing social distancing restrictions and increasing transmission of COVID-19 April 2021
Review of Unscheduled Care Executive Lead – Chief Operating Officer	This work will examine different aspects of the unscheduled care system and will include analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. Once completed, we will use this data analysis to determine which aspects of the unscheduled care system to review in more detail.	Data analysis currently being completed. Module currently being developed focusing on Choose Well.

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
		Any further modules postponed to 2021 and replaced with work on Test, Track and Protect. TBC
Follow-up of radiology services Executive Lead – Chief Operating Officer	In 2016, we undertook a review of radiology services. The work examined the actions the health board was taking to address the growing demand for radiology services, and the extent to which those actions were providing sustainable and cost-effective solutions to the various challenges that existed at the time. We made a number of recommendations to the health board. This work will follow-up progress against these recommendations.	Scoping currently underway TBC

Good Practice events and products

4 In addition to the audit work set out above, we continue to seek opportunities for finding and sharing good practice from all-Wales audit work through our forward planning, programme design and good practice research.

5 **Exhibit 5** outlines the Good Practice Exchange (GPX) events which have been held since our last Committee Update. Materials are available via the links below. Details of future events are available on the GPX website.

Exhibit 5 – Good practice events and products

Event	Details
Cyber resilience in Wales (September 2020)	This webinar previewed the emerging findings from our national study, shared items of good practice, and discussed the future of cyber resilience in Wales.

6 In response to the Covid-19 pandemic, we have established a **Covid-19 Learning Project** to support public sector efforts by sharing learning through the pandemic. This is not an audit project; it is intended to help prompt some thinking, and hopefully support the exchange of practice. We have produced a number of outputs as part of the project which are relevant to the NHS, the details of which are available here.

NHS-related national studies and related products

7 The Audit Committee may also be interested in the Auditor General's wider programme of national value for money studies, some of which focus on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Accounts Committee to support its scrutiny of public expenditure.

8 **Exhibit 6** provides information on the NHS-related or relevant national studies published since our last Committee Update. It also includes all-Wales summaries of work undertaken locally in the NHS.

Exhibit 6 – NHS-related or relevant studies and all-Wales summary reports

Title	Publication Date
The Refurbishment of Ysbyty Glan Clwyd	September 2020
Cracking the Code: Management of Clinical Coding Across Wales	September 2020

Title	Publication Date
10 Opportunities for Resetting and Restarting the NHS Planned Care System	September 2020
Better law making: the implementation challenge	September 2020
The National Fraud Initiative in Wales 2018-20	October 2020
Welsh Community Care Information System	October 2020

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Archwilio Cymru
Audit Wales

Structured Assessment 2020 – **Cardiff & Vale University Health Board**

Audit year: 2020

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Contents

Summary report

About this report

1 This report sets out the findings from the Auditor General's 2020 structured assessment work at Cardiff and Vale University Health Board (the Health Board). The work has been undertaken to help discharge the Auditor General's statutory requirement, under section 61 of the Public Audit (Wales) Act 2014, to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency and effectiveness in their use of resources.

2 This year's Structured Assessment work took place at a time when NHS bodies were responding to the unprecedented and ongoing challenges presented by the Covid-19 pandemic. This was particularly the case for the Health Board, who faced numerous challenges following a significant demand from Covid-19 cases early in the first peak, which tragically led to some loss of life. On 13 March 2020, the Minister for Health and Social Services issued a framework of actions to help prepare the system for the expected surge in Covid-19 cases. The framework included the cessation of non-urgent planned activity and the relaxation of targets and monitoring arrangements across the health and care system. Emergency funding arrangements were also introduced to facilitate the wide range of actions needed to respond urgently to the Covid-19 pandemic.

3 Shorter planning cycles were agreed for 2020-21 and supported by quarterly guidance setting out key considerations for the planning of the next phase of the pandemic, for maintaining delivery of essential services, and a movement towards the gradual reinstatement of routine services.

4 Our work[1] was designed in the context of the ongoing response to the pandemic to ensure a suitably pragmatic approach to help the Auditor General discharge his statutory responsibilities whilst minimising the impact on NHS bodies as they continue to respond to the next phase of the Covid-19 pandemic. The key focus of the work is on the corporate arrangements for ensuring that resources are used efficiently, effectively and economically. Auditors also paid attention to progress made to address previous recommendations[2] where these related to important aspects of organisational governance and financial management especially in the current circumstances.

5 The report groups our findings under three themes:

- governance arrangements;
- managing financial resources; and

[1] The conduct of our work was coordinated with Internal Audit's rapid governance review which includes further testing of key controls noted in this report.

[2] Previous recommendations can be found in our 2019 report. The Health Board's management response to our 2019 recommendations can be found here.

- operational planning: to support the continued response to the pandemic balanced against the provision of other essential services.

Key messages

6 The Health Board quickly adapted its governance arrangements to support agile and rapid decision-making and ensure effective operational management during the pandemic. The Board and its Committees could have been maximised though to provide scrutiny and assurance on all relevant matters during this period, particularly in the areas of quality, safety, and workforce. Reasonable steps were taken to conduct Board business in an open way, yet there was scope for more detailed reporting in public on all relevant matters during the pandemic. Communication with staff, the public, and partners during the pandemic was effective. There has been a stable Board during the pandemic. Opportunities to support the development and enhance the role of Independent Members could have been pursued in full. A programme of learning has been instigated and the Board is yet to reflect on its experiences of governing during the pandemic.

7 The Health Board achieved financial balance for 2019-20. But, with a cumulative deficit of £37 million for the period 2017-20, it failed to meet its duty to have a three-year breakeven position. The Health Board has clear intentions to breakeven over the next three-years. Without additional funding, the year-end position for 2020-21 is now likely to be in significant deficit as a result of Covid-19. Effective financial controls, monitoring and reporting were maintained during the pandemic. Arrangements were also put in place to clearly track Covid-19 expenditure, yet there is scope for monitoring and reporting to be increasingly more transparent.

8 The Health Board's quarterly plans have been informed by robust data modelling and developed in a timely way, albeit with limited stakeholder engagement. The Board Governance Group considered the quarter one and two plans prior to submission, and retrospectively approved by the Board. The Health Board responded quickly to ensure sufficient resources were in place to deliver quarter one planning objectives. However, continued exclusive use of an independent hospital is a key dependency in the delivery of planned activity during quarter two, and risks remain in the event of a second Covid-19 peak. Streamlined performance reporting to the Board has operated during the pandemic. As performance management measures begin to be reinstated, there is a need to develop the Board reporting and scrutiny arrangements around the delivery of the operational plans.

Recommendations

9 Recommendations arising from this audit are detailed in **Exhibit 1**. The Health Board's management response to these recommendations is summarised in **Appendix 1**.

Exhibit 1: 2020 recommendations

Recommendations
Learning from governing during Covid-19 to strengthen future governance R1 Recognising the numerous challenges the Health Board faced during the first Covid-19 peak, the Board should reflect on its experiences of governing during that period in order to strengthen future governance both generally and in the event of a second Covid-19 peak. In reflecting on its experiences, the Board should focus in particular on: a. considering what worked well and what didn't work so well, and identifying what it would do differently in the event of a second Covid-19 peak; b. establishing which new ways of working introduced during the pandemic it wants to retain going forward; c. supporting the development of the whole cadre of Independent Members as well as enhancing their role and input; and, d. enhancing Board reporting and transparency.

Detailed report

Governance arrangements

10 Our structured assessment work considered the Health Board's ability to maintain sound governance arrangements while having to respond rapidly to the unprecedented challenges presented by the pandemic.

11 We found that **there has been good operational management and agile decision-making during the pandemic despite some limitations in the transparency of scrutiny, assurance, and oversight of overall governance.**

Conducting business effectively

Revised governance arrangements were quickly established to enable responsive decision-making and effective operational management, but public scrutiny and assurance at Board-level could have been enhanced during the period

Revised governance arrangements supported agile and rapid decision-making during the pandemic and ensured effective operational management

12 The Health Board moved quickly to revise its governance arrangements and management structures in response to the pandemic. The Health Board did not deploy a traditional top-down Gold Command and Control structure to manage and co-ordinate its response to the pandemic. Instead, it established a *COVID-19 Command Structure* in March 2020 to enable it to adopt a more sustainable, inclusive, flexible and bottom-up approach. This approach supported effective operational management, facilitated agile and rapid decision-making, and ensured a high degree of clinical ownership of decisions during the pandemic.

13 The Covid-19 Command Structure comprised:

- A *Strategic Group*, chaired by the Chief Executive Officer, which met twice a week to provide strategic direction and decision-making.
- An *Operational Group*, chaired by the Chief Operating Officer, which met on a daily basis to manage and co-ordinate the day-to-day response to the pandemic.
- A *Board Governance Group*, which operated as a Chair's Action Group and met weekly to provide scrutiny and governance over the decision-making process as well as to provide assurance to the Board that this was taking place. The membership of the group was limited to the Chair, Chief Executive Officer, and two Independent Members – the Independent Member (Legal), and the Independent Member (Finance) who were selected due to their expertise on legal and financial matters.

- Four site-based *Operational Command Groups* (which temporarily replaced the Clinical Boards), and a series of *Planning Cells* that focussed on specific issues such as workforce, capacity planning, and communications.

14 A number of changes to the Health Board's governance arrangements were approved by the Board Governance Group in March 2020, which were retrospectively approved by the Board in May 2020, including:

- agreeing temporary revisions to parts of the Standing Orders;
- introducing an authorisation framework setting-out the delegation of revenue expenditure and capital expenditure in line with the Health Board's Scheme of Delegation, Standing Orders, and Standing Financial Instructions (excluding the Dragon's Heart field hospital); and,
- an undertaking to keep the agendas of Board and Committee meetings to a minimum.

15 No changes were made to the Health Board's Scheme of Delegation. As a result, the Health Board continued to operate on the basis that deputies would act-up in the absence of Executive Leads and Committee Chairs.

16 In revising its governance arrangements, the Health Board did not reference the Welsh Government guidance on discharging Board Committee responsibilities during Covid-19[3] partly due to the fact they were not published until the end of April 2020.

The Board and its Committees were not fully maximised to provide scrutiny and assurance on all relevant matters during the pandemic

17 Whilst the roles and decision-making powers of the Board Governance Group, Strategic Group, and Operational Group were clear and well documented, the role of the Board and its Committees during the pandemic was less clearly defined.

18 The Board continued to meet on a monthly basis – alternating between Board Development Days and formal public meetings. From April 2020, the Board Development Days were largely used to highlight and discuss a range of topics relating to the pandemic. However, there is no public record of these meetings as they were held in private. Covid-19 related papers became available in the public domain when the Board formally met in May 2020. Several matters relating to the Health Board's response to the pandemic were dealt with by the Board Governance Group. The minutes of these meetings were shared with Independent Members (see paragraph 34 below) and included in the papers of private Board meetings.

19 The Finance Committee, the Audit & Assurance Committee, and the Quality, Safety & Experience Committee continued to meet as scheduled. The agendas of

[3] Guidance note: discharging board committee responsibilities during COVID-19 response phase

the Finance Committee were significantly adjusted to focus on Covid-19 expenditure and financial risks. However, the agendas of the Quality, Safety & Experience Committee were only partially adjusted to consider relevant Covid-19 matters, and the agendas of the Audit & Assurance Committee were not significantly adjusted to focus on essential business only. This is partly due to the fact these committees held some of their meetings before the Welsh Government guidance on discharging Board Committee responsibilities during Covid-19 was published in April 2020

20 All other Committee meetings were stood down, with meetings convened as necessary to consider specific matters during the pandemic. For example, a special meeting of the Health & Safety Committee was convened in April 2020 to specifically discuss Personal Protective Equipment (PPE). However, a record of the meeting has not been made available on the Health Board's website.

21 Attendance at Board and Committee meetings during the pandemic has generally been good. We observed that discussions were focussed and that meetings ran to time. We also saw evidence of effective scrutiny and challenge at Board and Committee meetings around Covid-19 related matters. Where reports on Covid-19 related matters have been prepared to support decision-making and provide assurance, they have been timely and comprehensive. The Board and Committees have continued to make use of Actions Logs and decisions were made to defer certain matters until a more appropriate time.

The Board took reasonable steps to conduct its business in an open way, but there could have been more detailed reporting in public on all relevant matters during the pandemic

22 Due to the pandemic, the Board and Committees have been unable to hold meetings in public. The Health Board, therefore, moved quickly to holding virtual meetings instead. However, virtual meetings have not been accessible to the public until July when the Board meeting was recorded and made available on the Health Board's YouTube channel within 24 hours.

23 Despite initial technical and connectivity issues, virtual meetings have operated reasonably well, with Board members observing virtual etiquette and using software features to raise questions and share information.

24 Papers for the Board and the Committees referred to in paragraph 19 above have continued to be published on the Health Board's website in the usual manner – ten days prior to Board meetings and seven days prior to a Committee meeting. Compliance with these standards during the pandemic has been good, with only a very small number of breaches.

25 As part of its commitment to facilitating as much transparency and openness as possible during the pandemic, the Health Board produced and published a record of Board meetings on its website within three days. However, it ceased this

practice in July 2020 when it provided a recording of the Board meeting on its YouTube channel.

26 Minutes provide a detailed summary of deliberations in Board and Committee meetings. Questions raised by Independent Members are captured well along with the responses provided by the relevant Executive Leads. Where verbal reports have been provided at meetings, the minutes provide a detailed summary of the main points covered by the verbal report and the subsequent deliberations of the Board or Committee.

27 The papers for Board Governance Group meetings have not been published on the Health Board's website thus limiting opportunities for public openness and transparency during the pandemic. Instead, the decisions taken by the Board Governance Group and Strategic Group have been presented to the Board as part of the Chair's Report for retrospective scrutiny and approval.

Communication with staff, the public, and partners during the pandemic has been effective, and plans are in place to enhance the Health Board's engagement with the CHC during the recovery phase

28 The Health Board used a range of communication approaches and platforms to keep staff, the public, and its partners informed during the pandemic.

29 Health Board representatives met on a weekly basis with their partners in the two local authorities, and briefings for local Members of Parliament and Senedd Members were provided on a fortnightly basis.

30 Regular informal communication was maintained with the CHC at Executive and Clinical Board levels. The CHC also participated in Board meetings and a log of service charges was shared with the CHC on a weekly basis. The Health Board has plans in place to enhance its engagement with the CHC during the recovery phase (see paragraph 86).

There has been a relatively stable Board during the pandemic, although opportunities to fully inform, engage, and utilise Independent Members, and to develop their knowledge and understanding were not pursued in full

31 There have been some changes to the composition of the Board over the past 12 months, including the appointment of the Vice Chair to the position of Chair on a substantive basis in June 2020, and the appointment of a new Independent Member (Capital & Estates) in February 2020. The Independent Member (Legal) is undertaking the role of Vice Chair on an interim basis. These changes have not adversely impacted the stability of the Board.

32 In order to maintain the stability of the Committees, the Independent Member (Finance) continued to Chair the Finance Committee until May and the Chair of the Board continued as Chair of the Strategy & Delivery Committee. The Independent Member (Capital & Estates) has now taken over as Chair of the Finance

Committee and the Interim Vice Chair has been appointed as Chair of the Strategy & Delivery Committee. Although steps have been taken to strengthen the capacity of committees by increasing their membership, attendance at some committee meetings could be improved.

33 Although the Chair appointed a first and second deputy (the Interim Vice Chair and Chair of the Audit & Assurance Committee respectively) to ensure business continuity, these arrangements were not formally documented and communicated to other Independent Members.

34 The Chair established a dedicated WhatsApp Group to facilitate communication and information sharing with Independent Members during the pandemic. The Chair also ensured minutes of the Board Governance Group were shared with them in a timely manner. Board Development days were used to brief Independent Members on a range of topics relating to the pandemic. Despite this, not all Independent Members feel they were briefed and updated on all relevant matters in a timely manner.

35 Opportunities to build knowledge, understanding and resilience across its cadre of Independent Members were not pursued by the Health Board in full by, for example, actively encouraging the members of committees which were stood down to participate in other committees during the period. Similarly, opportunities to build the knowledge and understanding of Committee Vice Chairs by, for example, involving them fully in the agenda setting process were not pursued. Furthermore, there was scope for the Health Board to make greater use of Board Champions to support its response to the pandemic. In reflecting on its experiences of governing during the pandemic, the Board should consider identifying opportunities to support the development of the whole cadre of Independent Members, as well as enhance their role and input.

A programme of learning has been instigated, but the Board is yet to reflect on its experiences of governing during the pandemic

36 The revised governance arrangements have been kept under review by the Board Governance Group with the support of the Director of Corporate Governance. However, there has been limited oversight of these arrangements at Board-level since the Board considered the revised governance arrangements in May 2020.

37 A Learning Programme has been established and the Health Board has started to reflect on new ways of working and innovation at an operational level during the pandemic. However, the Board is yet to reflect on its experiences of governing during the pandemic. There is scope for the Board to learn from its experiences in order to strengthen future governance, in general and in the event of a second Covid-19 peak.

38 The Board has produced its 2019-20 Accountability Report and the Committees have published their Annual Reports for the same period. However, due to the timing of the Covid-19 response, the Board has not yet been in a position to

complete all aspects of its annual governance review programme, such as the assessment of its compliance with the HM Treasury 'Corporate Governance in Central Departments: Code of Good Practice'.

Risk and Systems of Assurance

Effective risk management arrangements operated during the pandemic, although assurance reporting on quality, safety, workforce, and staff well-being could have had a stronger focus

Appropriate steps were taken to adapt risk management arrangements during the pandemic, but there is scope to strengthen corporate arrangements further

39 A separate Board Assurance Framework was introduced to capture, manage and mitigate the strategic risks relating to Covid-19. All of the strategic risks have an Executive Lead and have been assigned to the relevant Committees of the Board. Key operational risks relating to Covid-19 have been captured and managed via the Risk Registers maintained by the four Command Centres established to address operational demands during the pandemic. These Risk Registers were reviewed and updated on a weekly basis and reported to the Strategic Group.

40 Whilst the Covid-19 Board Assurance Framework has been subject to scrutiny by the Board Governance Group and the Board, the relevant Committees have not yet reviewed the strategic Covid-19 risks in detail. As a result, they have not been in a position to provide further assurance to the Board. In July 2020, the Board agreed to merge the Covid-19 Board Assurance Framework with the standard Board Assurance Framework to create a single repository of all strategic risks. No changes have been made to the Health Board's risk appetite.

41 The Corporate Risk Register, which enables the Board to maintain an overview of the key operational risks from the Clinical Boards and Corporate Directorates, has been expanded to include the key operational risks of the four Command Centres. The Corporate Risk Register includes those risks which are rated 15 and above, and each one is linked to the relevant strategic risk(s) in the Board Assurance Framework. The Corporate Risk Register was reviewed by the Board at its private meeting in July 2020. The Finance Committee has maintained effective oversight of the finance risk register and the specific financial risk register created for the Dragon's Heart Hospital (see paragraph 76 for further detail).

42 Risk management systems have been improved and comprehensive structures are now in place to identify and manage risk. However, there is scope to strengthen these arrangements further. The Health Board is aware of this and is putting arrangements in place to enhance and embed risk management across the Clinical Boards and Corporate Directorates by, for example, rolling out a programme of education and training around the Risk Management Policy.

While the Health Board has continued to track audit recommendations during the pandemic, the overall number of outstanding recommendations remains high

43 The Audit & Assurance Committee continued to receive and review tracker reports during the pandemic. The reports, which have not been adapted during the pandemic in line with Welsh Government guidance, outline the Health Board's progress in responding to all of the recommendations made by the Internal Audit Service and Audit Wales since 2017-18. However, these reports received little scrutiny and challenge by Independent Members.

44 Although some progress was made in addressing historic recommendations during the pandemic, the overall number of outstanding recommendations remains high. In June 2020, there were a total of 226 outstanding Internal Audit recommendations and a total of 31 outstanding Audit Wales recommendations.

45 The Audit & Assurance Committee continued to receive Internal Audit Progress Reports. The Committee considered and agreed adjustments to the programme as recommended by the Head of Internal Audit due to the impact of Covid-19. The Committee also continued to receive Internal Audit Reports during the pandemic. Some reports were presented in draft form due to the impact of Covid-19 on the capacity and working arrangements of the Internal Audit Service.

A strong focus on quality and safety was maintained at an operational level during the pandemic, but stronger assurances could have been provided to the Board

46 The Health Board maintained a strong focus on quality and safety at an operational level during the pandemic. Quality and safety matters were considered at every meeting of the Operational Group and Strategic Group, with the former escalating matters to the latter for a decision as required.

47 Daily situation reports were produced containing a range of quality indicators including mortuary capacity, PPE, sickness absence, testing, and medical / pharmaceutical supplies. The reports were submitted to the South Wales Local Resilience Forum to provide situational awareness for all partners and to inform Welsh Government on emerging issues and challenges.

48 The Patient Safety and Quality Team maintained the Health Board's operational quality assurance arrangements during the pandemic, including conducting mortality reviews, investigating complaints and serious incidents in accordance with Putting Things Right, monitoring compliance with the Nurse Staffing Levels (Wales) Act, and addressing annual reporting requirements.

49 The Health Board developed and implemented clear plans to maintain essential services, expand critical care capacity, and secure external capacity to ensure patients with non-complex cancer and other urgent conditions received appropriate treatment during the pandemic. Steps were also taken to create zones within hospitals to safely segregate Covid-19 patients and non-Covid-19 patients. These arrangements were reported to the Board in May 2020.

50 The focus on core quality, safety and experience issues at Board level has been less robust. Although regular assurance reporting was adjusted to reflect the Covid-19 situation, the Board and Quality, Safety and Experience Committee did not receive assurances on all of the quality areas outlined in the Welsh Government guidance. For example, there were significant gaps in providing assurance reports on infection prevention and control measures, as well as the risks of harm.

51 The Health Board maintained a strong focus on workforce and staff well-being issues at an operational level during the pandemic, with dedicated planning cells for PPE and Workforce established as part of the Covid-19 governance structure. However, the Strategy & Delivery Committee, which provides assurance to the Board on strategic workforce and staff well-being issues, was stood down during the height of the pandemic. As a result, matters relating to the workforce were reported either to the Board Governance Group or the Board. The Board received assurance reports on the following areas in May 2020:

- PPE supply, guidance and training.
- Resourcing including recruitment to increase workforce supply, staff well-being, staff risk assessments, and absence levels.
- Nurse staffing levels for adult acute medical and surgical wards (a verbal update was provided to the Board in July 2020).

52 Although the Strategy & Delivery Committee was reinstated in July 2020, it did not receive any updated assurance reports on matters relating to workforce and staff well-being. Routine reporting to the Committee on workforce key performance indicators has also been suspended until September 2020.

Managing financial resources

53 Our work considered the Health Board's financial performance, changes to financial controls during the pandemic and arrangements for monitoring and reporting financial performance.

54 We found that **effective financial controls, monitoring and reporting have been maintained throughout the pandemic, but the impact of Covid-19 is creating a significant risk to the Health Board's ability to breakeven.**

Achieving key financial objectives

The Health Board has clear plans in place to break-even for the next three-years, but uncertainty over Covid-19 costs raises significant risks to delivery

The Health Board broke-even in 2019-20 and met its financial duty to have an approved three-year Integrated Medium-Term Plan (IMTP). But, with a three-year rolling deficit of £37 million, it failed its duty to break-even over 2017-20

55 The Health Board achieved an in-year surplus for the financial year 2019-20 but failed to achieve its statutory duty to achieve a break-even position against a Revenue Resource Limit over the three-year period 2017-20. The outturn position at year-end was a surplus of £58,000 reducing its three-year rolling position to an overspend of £37 million[4].

56 To achieve the in-year position, the Health Board identified the need to deliver against a savings target of £31.2 million at the start of 2019-20. This was subsequently reduced to £26.1 million. At the start of the financial year, savings plans were in place to deliver £23 million which was substantially delivered by the year-end. Additional income generation and accountancy gains enabled the Health Board to meet its overall savings target of £26.1 million.

57 The Health Board had planned to reduce its underlying deficit of £36.3 million reported at the start of 2019-20 to £4.0 million by year-end. It was able to reduce the underlying deficit to £11.5 million which has been brought forward into 2020-21.

58 The Health Board remained within its Capital Resource Limit, and also met its requirement to have an approved three-year IMTP for the period 2019-22. This led to the Health Board being de-escalated to routine monitoring in September 2019[5].

The Health Board set a balanced financial plan for 2020-21, but without additional funding, it is now forecasting a significant deficit as a result of Covid-19

59 The Health Board submitted its IMTP for 2020-23 by the amended Welsh Government deadline of 31 January 2020. The Welsh Government identified the plan as approvable but due to Covid-19 the IMTP process was paused. The IMTP set out the Health Board's intention to deliver an in-year break-even position for 2020-21. The plan included a required savings target of £29 million for 2020-21 to enable the Health Board to further reduce the underlying deficit of £11.5 million.

60 Before the start of this financial year, the Health Board had identified savings plans totalling £14 million. However, due to the impact of Covid-19, this has now reduced to £4.1 million. This is made up of £3.3 million recurrent savings, and £0.8 million non-recurrent. At month four, it had achieved £1.3 million of savings, with a forecast year-end position of £4.1 million savings delivery.

61 The impact of Covid-19 has significantly changed the financial landscape of the Health Board. Despite maintaining a forecast year-end position of breakeven for its core operations, the Health Board is now forecasting a significant overall deficit of £131 million (a reduction from an initial forecast at month one of £182 million). At

[4] Following ministerial announcement in July 2020, historic debt will be written off by the Welsh Government, subject to the Health Board delivering its three-year break-even duty

[5] NHS Wales Escalation and Intervention Arrangements

month four, it reported a cumulative deficit of £53 million. Expenditure relating directly to Covid-19 was reported at £52 million, the majority of which relates directly to the costs associated with the Dragon's Heart Hospital.

62 The full year forecast Covid-19 cost pressures are the highest in Wales, largely due to the costs of the Dragon's Heart Hospital (the 2nd largest field hospital in the UK) and are predicated on being offset against reductions in spend associated with the cessation of elective work. The Health Board has clearly stated that its forecast figures for the year-end are highly volatile, and that funding from the Welsh Government to offset the full costs may or may not be forthcoming. The forecast, however, assumes no second or third Covid-19 peak but rather a steady pressure throughout the year. The forecast also assumes no additional costs for surge capacity beyond 31 October, as workforce is a key constraint. However, during July, it has subsequently been agreed that the Health Board will need to provide surge capacity of 400 beds, as a contingency against further peaks in demand, through the development of a semi-permanent field hospital on the UHW site following the decommissioning of the Dragon's Heart Hospital.

63 The Welsh Government has provided £21 million of Covid-19 funding to date. The Health Board remains focused on delivering its baseline plan and has not assumed any further funding from the Welsh Government. It is recognising the effect of reduced planned care expenditure to offset Covid-19 costs, minimising financial run rates and continually reviewing its forecast alongside quarterly operational plans. However, it is highly unlikely that the Health Board will be able to cover the ongoing Covid-19 costs without significant additional funding or a move to a planned deficit position.

The Health Board has clear intentions to maintain a break-even position over the next three years, but its plan was set out prior to the Covid-19 outbreak

64 As part of its IMTP, the Health Board has a longer-term financial plan for the period 2020-23. The plan forecasts a break-even position for 2021-22 and 2022-23 and is based on estimated inflationary and cost pressures, and Welsh Government allocation uplifts. The plan also assumes a reduction in the underlying deficit and planned savings of £20.5 million in 2021-22 and £16.5 million in 2022-23.

65 The plan recognises a number of key financial risks to delivery which will require concerted efforts to manage. These are:

- achievement of efficiency savings;
- management of operational pressures and containment of costs; and
- delivery of Referral to Treatment Times (RTT) and winter plans.

66 The three-year financial plan was established prior to the Covid-19 outbreak and, therefore, will be affected by the pandemic. As set out in paragraph 60, savings in 2020-21 are already significantly behind the original target, which is likely to lead to a year-end deficit, if not funded by the Welsh Government. This could have a

negative impact on the Health Board's ability to reduce its underlying financial deficit and deliver a break-even position over the next three-years.

Financial controls

The Health Board has operated within existing financial controls and put in place mechanisms to clearly track Covid-19 expenditure

67 At the start of the pandemic, the Health Board established weekly templates to record all additional costs incurred relating to Covid-19. These have been fed into a record of cumulative expenditure totals, and include all revenue and capital expenditure, and incorporate direct and indirect costs. The templates record the description, cost, justification and method of authorisation for each of the items of expenditure.

68 In May 2020, the Board and Audit & Assurance Committee received a paper setting out the financial governance arrangements during the pandemic. The paper set out that existing financial controls detailed in the Health Board's Scheme of Delegation, Standing Orders and Standing Financial Instructions would apply, with only minor amendments needed in relation to the referencing of the new groups established during the pandemic. The paper, however, did recognise that there was a risk of breaches against Standing Orders which would be addressed through variations which would require Board approval. To date, there have been no significant breaches.

69 The Health Board's Scheme of Delegation allows adequate delegation for most large purchases, but further approval was through the Strategic Group, Board Governance Group or full Board if necessary. The use of Chair's Action was also available for any urgent decision on significant expenditure if needed, for example expenditure for field hospital set-up, but this has largely been kept to a minimum.

70 Annual accounts preparation was completed by the revised deadline of 22 May 2020. Our audit of the financial statements did not identify any significant issues to suggest that financial controls were weakened or bypassed.

71 For the first three months of 2020-21, the Health Board has had access to additional independent hospital beds in the Spire Hospital to support the delivery of essential services. The commissioning of this capacity was undertaken on an all-Wales basis by the Welsh Health Specialised Services Committee (WHSSC) and funded by Welsh Government. Decisions relating to the longer-term availability of these beds has been approved via the Board Governance Group and ratified by the Board.

72 The Health Board has worked closely with the Welsh Government to establish the Dragon's Heart Hospital. Robust financial controls have been in place with a high degree of scrutiny of the spend incurred to establish the field hospital maintained through the Finance Committee and the Board. In June 2020, the Welsh Government commissioned KPMG to undertake reviews of field hospitals for due

diligence, including the Dragon's Heart Hospital. This review has recently been completed but at the time of our reporting, we had been unable to have sight of the final report.

73 During the pandemic, there has been a significant increase in the number of charitable gifts and donations. The Health Board has applied its Standards of Behaviour Policy to register gifts and donations, although ongoing communication to staff about the need to comply with the policy had been stood down. Donations received centrally have been recorded, and where reported to the Charitable Funds committee at its meeting in July 2020. A bid process has been developed to allocate funds to front line services. However, only a small proportion of the donations have been utilised to date.

74 Routine counter fraud arrangements have been maintained during the pandemic, although members of the Counter Fraud Team were redeployed to provide support in establishing the Dragon's Heart Hospital, thus reducing capacity in this area. These staff, however, were still available to respond to counter fraud issues, and a Counter Fraud Steering Group and Management Group met weekly to discuss counter fraud risks arising during the pandemic.

Monitoring and reporting

Comprehensive reporting has supported timely scrutiny and monitoring throughout the pandemic, although there is scope to increase public transparency

75 During the pandemic, the Board has maintained robust oversight of the Health Board's financial position through its Finance Committee which continued to meet on a monthly basis. The Board received timely reporting to each of its meetings. In addition, four of the members of the Board Governance Group have been present at the Finance Committee meetings.

76 Reporting on the financial position is comprehensive with information consistent with that provided to the Welsh Government through monthly monitoring returns. The reports provide a clear picture of the financial position, challenges and risks, and the mitigating actions being taken. They also include explanations of Covid-19 and non-Covid-19 expenditure and the level of savings the Health Board has been unable to make. A specific financial risk register has been established which covers both Covid-19 and non-Covid-19 related financial risks. This is also supported by a specific financial risk register for the Dragon's Heart Hospital, which is accounting for a significant proportion of the Covid-19 expenditure. The financial risk registers are overseen by the Finance Committee, although limited assurance is currently being provided against a number of the risks due to the volatile nature of the forecast financial position.

77 All papers of the Finance Committee are available on the Health Board's website, providing opportunity for pubic transparency. With the exception of month one and

two, the papers also included the Health Board's financial position, which were then also subsequently reported to Board. As part of its standard reporting, all Single Tender Actions have also been reported to the Audit & Assurance Committee relating to both Covid-19 and non-Covid-19 activity. These reports are however considered in the private meetings. To increase public transparency, the Health Board should look to consider papers relating to its financial controls within the public meetings of its committees.

78 During the pandemic, the Executive Performance Reviews were stood down. Clinical Board management teams were redeployed into the revised site structure put in place to respond to the pandemic. The Covid-19 financial control at an operational level has been the responsibility of the Operational Group, with financial decisions outside the scheme of delegation limits reported to the Strategic Group and the Board Governance Group for approval.

Operational planning

79 Our work considered the Health Board's progress in developing and delivering quarterly operational plans to support the ongoing response to Covid-19 and to provide other essential services and functions in line with Welsh Government planning guidance. At the time of our work, the focus was on essential services with the aim of restoring normal and routine activities when it is safe and practicable to do so.

80 We found that **operational plans have been informed by robust data modelling and developed in a timely way, and the Health Board is seeking to more fully engage stakeholders in future planning. However, risks remain in the event of a second Covid-19 peak, and arrangements to monitor delivery of the plan need strengthening.**

Developing the plan

The Health Board's quarterly plans have been developed in a timely manner and have been informed by robust data modelling processes

81 Cases of Covid-19 were first identified in Cardiff and the Vale of Glamorgan in early March 2020. Prior to this, the Health Board rapidly put in place a three-phase plan to mitigate the impact of the anticipated surge in demand. Phase one involved repurposing and reconfiguring a large proportion of its facilities in order to maximise the bed capacity available for Covid-19 patients. A zoning plan was established to provide segregated ward capacity for confirmed Covid-19 patients. Phase two involved identifying other suitable areas outside of the normal adult bed capacity to expand the available bed space. Phase three involved identifying additional capacity if the demand substantially exceeded the capacity available

within the Health Board's hospitals. As noted previously, a surge hospital was constructed in the Principality Stadium - the Dragon's Heart Hospital.

82 Whilst this preparation took place during quarter one to deal with the anticipated Covid-19 related demand, the Health Board also maintained a programme of essential services, delivering emergency surgery, cancer treatment and other cases, with utilisation of theatre capacity at the Spire Hospital. Clinicians have been supported to maintain services through the rapid introduction of GP clusters to ensure the timely access of urgent and emergency care.

83 Quarter one saw a transformation in the way that patients accessed general practice and mental health services. Planning is now being put in place to prepare for anticipated increases in the need for mental health services and support for children with complex needs returning to school in quarter two.

84 Both plans were produced quickly and submitted to Welsh Government on time. Both plans were considered and approved by the Board Governance Group prior to submission, and retrospectively approved by the Board. The quarter two plan was presented to the Strategy & Delivery Committee for retrospective scrutiny and challenge in July 2020. However, for future quarterly plans, Independent Members have asked the Health Board to establish a mechanism for allowing them to have greater input into the development of the plans before they are submitted to the Welsh Government.

85 Plans have generally been consistent with the NHS operational planning framework and the Health Board has responded to Welsh Government feedback. In some areas of the quarter one plan, the Welsh Government suggested that the Health Board undersold its achievements, so the quarter two plan has provided more detail in these areas.

86 As the Health Board needed to focus its resources on its emergency response to Covid-19, this impacted significantly on its stakeholder engagement activity in quarter one. Improvements are planned for engagement activity in quarter two, for example:

- Regular engagement with the CHC, including meetings at Chief Executive and Chair level and meetings to discuss specific issues including the Service Delivery Plan.
- A joint Management Executive with Local Authority partners held on a weekly basis.
- Regular meetings of key groups under the Regional Partnership Board to oversee the collaborative emergency response across the health and social care arena.
- Sharing a weekly Covid-19 Key Stakeholder Brief in confidence with trusted partners including the CHC, MSs and MPs, local councillors, LMC, PSBs, the Local Partnership Forum and Stakeholder Reference Group.

87 Data modelling has been an integral part of the Health Board's situational awareness and decision-making during the pandemic. It has worked at pace with

regional partners to develop a surveillance system, incorporating early warning indicators, to monitor the prevalence and impact of the virus at the local level. It has informed capacity/demand modelling for operational planning, particularly in the event of a second Covid-19 peak, and in conjunction with the Health Board's 'patient streams' and 'gearing' approach which forms its overall Covid-19 Operating Model.

88 The Health Board provides complex and tertiary elective surgery for the South Wales region. In the second quarter, the Health Board is working closely with commissioners and partner providers to ensure regional and tertiary services with the most challenges are protected. Focussed work is taking place in several specialities, including interventional radiology, upper GI cancer surgery, paediatric gastroenterology, and paediatric neurology. However, in order to provide all the surgery (and address backlog) it will be necessary for the Health Board to continue to utilise the Spire Hospital for the remainder of the financial year (see paragraph 93 for more detail).

89 The Health Board has also re-established its specialist and tertiary provider partnership with Swansea Bay UHB and is recommencing discussions with Cwm Taf Morgannwg UHB regarding a number of fragile services, where a collaborative/networked service will deliver a more sustainable service model. The Health Board also outlined in its quarter two plan a desire to progress regional discussions about high volume ophthalmology, in particular cataract surgery where there will be a significant backlog post-Covid-19.

Resources to deliver the plan

The Health Board responded quickly to ensure sufficient resources during quarter one, with continued independent hospital use a key dependency for delivering planned activity in quarter two, but risks remaining in the event of a another Covid-19 peak

90 Prior to the start of the pandemic, the Health Board's workforce was already identified as a significant risk with increasing challenges in being able to recruit healthcare professionals. The Health Board's corporate risk register included several medical and nursing workforce related risks. At the start of the pandemic, the Health Board faced a considerable resourcing challenge and a 'perfect storm' of high absence figures and approximately 650 staff members needing to shield. The Health Board brought recruitment in-house and was able to recruit 1,200 staff members in a very short period of time at a considerable additional cost.

91 Whilst additional recruitment assisted in dealing with the emergency phase of the pandemic, staff had to adapt quickly to the challenge by adopting new ways of working, redeployment to priority areas and responding to the infection prevention and control requirements. Going forward, workforce supply and availability remains a key area of risk for the Health Board as work continues to increase the delivery of

essential services and restarting routine activity and prepare for any second Covid-19 peak. It is not completely clear whether the Health Board's current workforce would be able to cope with demand in the event of a second peak in Covid-19. During quarter two, the Health Board is continuing to prioritise ongoing support for shielding staff, including working arrangements when shielding ends, protecting BAME staff groups and the provision of a range of support initiatives for staff well-being.

92 Going forward, the Health Board faces considerable challenges in balancing the need to ensure essential services are returned whilst ensuring the safety of patients and staff, whilst also managing the Covid-19 situation. The Health Board has established a Learning Programme and is exploring a range of options, including: new ways of working, a greater multi-disciplinary approach, increased recruitment, medical and professionals returning to work, changes to student nurses educational contracts, and greater reliance upon Health Care Support Workers to ensure all areas are staffed appropriately. Although the Health Board is planning to continue all essential services during quarter two, some areas will not be working to the same capacity they were before the pandemic. These include cardiac surgery, the major trauma centre, gastroenterology, paediatric inpatients and community, and urology cancer.

93 Throughout the pandemic, the Health Board has maintained level 1a and level 1b surgery and most level 2 surgery. Whilst the Health Board has the physical theatre capacity to also meet level 3 demand, there is likely to be a theatre staffing deficit unless theatre throughput can significantly improve closer to pre-Covid-19 levels. If the Spire Hospital is not available for the remainder of the financial year, this would lead to a direct reduction in the capacity for urgent and time-sensitive activity. Even with Spire Hospital, the Health Board does not anticipate having the capacity to treat level 4 patients in any significant volumes. In terms of surge capacity, there are plans in place to develop a semi-permanent field hospital on the UHW site to provide 400 beds following the decommissioning of the Dragon's Heart Hospital.

94 The focus for the Health Board in quarter two will be remaining vigilant to the threat of Covid-19 and proceeding with appropriate caution. The Health Board aims to 'transform at pace and focus on the long term'. Workforce supply and availability remains a key area of risk as work continues to increase the delivery of services and activity whilst preparing for any second Covid-19 peak.

95 The pandemic has accelerated some of the Health Board's longer-term plans, most significantly around the implementation of GP clusters and the use of digital platforms. There is emerging evidence from the Health Board's Stakeholder Reference Group (SRG) that access to some services has been better during the pandemic through the use of virtual triaging for instance in primary care. There has been positive patient feedback on virtual working. However, there is a need to remain mindful that some patients need to access services by non-digital means. The Health Board is also taking positive, proactive steps through the introduction of its CAV 24/7 initiative to try and avoid potential issues that will emerge as A&E attendances are expected to increase over quarter two.

Monitoring delivery of the plan

While streamlined performance reporting to Board has operated during the COVID response there is now a need to develop the reporting and scrutiny arrangements for operational plan delivery

96 At the start of the pandemic, the Welsh Government suspended performance monitoring arrangements. This largely remains the case, but some data submissions to Welsh Government were re-instated in June 2020. National publication of performance remains suspended until 30 September 2020 at the earliest.

97 The Welsh Government's national framework for responding to Covid-19 set out four types of harm which Health Boards needed to address in a balanced way, these are:

- Harm from Covid-19;
- Harm from an overwhelmed NHS and care system;
- Harm from a reduction of non-Covid-19 activity; and
- Harm from wider societal actions/lockdown.

98 From mid-March 2020, the focus of the Health Board switched to managing Covid-19 and maintaining essential services in line with national guidance. In April 2020, the Health Board clarified its performance management arrangements. In contrast with other Health Boards that are developing a performance management framework based around the four types of harm, the Health Board has instead focussed on only reporting performance for specific indicators in relation to essential services. These were: Cancer, Eye Care, and Accident and Emergency. From June 2020 onwards, this has been expanded to also include unscheduled care, referral to treatment times, mental health, and diagnostics and operations. Going forward, the Health Board should consider measures across all four quadrants of harm identified in the Welsh Government operating framework, such as the harm caused by the reduction in activity.

99 In terms of monitoring the operational plans, there is no indication of how the Health Board is performing against a set of measurable actions. The quarter two plan does not include a summary of progress against the quarter one plan. Whilst both quarter operational plans provide details of activity, there is no evidence of an action plan, with key milestones, measures and intended outcomes. The Health Board should consider including this information in future plans, as well as develop its scrutiny and oversight arrangements.

100 There remain challenges in the plan and there are still significant uncertainties that will need to be resolved during quarters three and four, particularly in relation to funding, maintaining the well-being of the workforce, meeting winter pressures, as well as the continuing impact of Covid-19 on the health and social care needs of the population.

Appendix 1

Management response to audit recommendations

Exhibit 2: management response [a completed management response will be added to the report prior to publication]

Recommendation	Management response	Completion date	Responsible officer
R1 Recognising the numerous challenges the Health Board faced during the first Covid-19 peak, the Board should reflect on its experiences of governing during that period in order to strengthen future governance both generally and in the event of a second Covid-19 peak. In reflecting on its experiences, the Board should focus in particular on:			

Recommendation	Management response	Completion date	Responsible officer
a. considering what worked well and what didn't work so well, and identifying what it would do differently in the event of a second Covid-19 peak; b. establishing which new ways of working introduced during the pandemic it wants to retain going forward; c. supporting the development of the whole cadre of Independent Members as well as enhancing their role and input; and, d. enhancing Board reporting and transparency.			

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Archwilio Cymru
Audit Wales

Management response

Report title: Structured Assessment 2020 – Cardiff & Vale University Health Board

Completion date: October 2020

Document reference: 1999A2020-21

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R1	Recognising the numerous challenges the Health Board faced during the first Covid-19 peak, the Board should reflect on its experiences of governing during that period in order to strengthen future governance both generally and in the event of a second Covid-19 peak. In reflecting on its	a. Key lessons captured and learning applied resulting in strengthened governance both generally and in the event of a second Covid-19 peak. b. New ways of	Yes	Yes	There has been a lot of work done on lessons learned within the Health Board covering many different functions and this learning has taken on board the comments made by WAO, Internal Audit and KPMG. This has included lessons learned from a	30th November	Director of Corporate Governance/ Chief Executive/ Chair

	experiences, the Board should focus in particular on: a. considering what worked well and what didn't work so well, and identifying what it would do differently in the event of a second Covid-19 peak; b. establishing which new ways of working introduced during the pandemic it wants to retain going forward; c. supporting the development of the whole cadre of Independent Members as well as enhancing their role and input; and, d. enhancing Board reporting and	working reviewed and rolled-out resulting in strengthened governance both generally and in the event of a second Covid-19 peak. c. Development of IMs supported, and their role and input enhanced both generally and during further peaks of Covid-19. d. Enhanced reporting to Board and committees resulting in greater	Yes Yes Yes		governance perspective and the governance arrangements for the next wave, and future waves of Covid 19. A report is being presented to ME, Board Governance Group, Audit and the Board to ensure that this learning is taken forward and implemented. This report will cover off items a,b,c and d of the recommendation		

	transparency.	openness and transparency.					

Archwilio Cymru
Audit Wales

Cracking the Code

Management of Clinical Coding Across Wales

September 2020

This report has been prepared for presentation to the Senedd under section 145A of the Government of Wales Act 1998 and section 61(3) (b) of the Public Audit Wales Act 2004.

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

Contents

Summary report

Key messages

1 Clinical coding is the process of translating medical information relating to a patient's hospital admission into standardised codes which can be used for a range of statistical, clinical and management purposes.

2 Timely and accurate clinical coding is essential given the role the data plays in the planning, management and oversight of NHS services. This has been especially true during the current pandemic, where clinical coding has played a key role in helping to understand COVID-19 related demand on healthcare services, and in informing decisions on which patients need to shield. Problems with either the timeliness or accuracy of coded data could result in shielding decisions being made on incomplete information, with potentially significant consequences for the patients involved.

3 In 2013-14 and again in 2018-19, we examined clinical coding arrangements in the seven Welsh health boards and Velindre NHS Trust. We published reports on our findings in each of the NHS bodies[1], and where relevant, drew on the findings from work undertaken by the NHS Clinical Classifications Team[2] in the NHS Wales Informatics Service (NWIS).

4 This report draws on our local audit work to highlight the current challenges and opportunities for clinical coding, including the potential to use COVID-19 related changes to working practices to secure new and more sustainable ways of delivering coding work.

5 Over the last six years, there have been improvements in the timeliness and accuracy of clinical coding data. However, there are backlogs of uncoded activity in some parts of Wales which can date back several years. The current target of a one-month turnaround time does not support the availability of clinical coded data on a close to real-time basis, something which has been shown to bring significant benefits in helping to understand patterns of demand on hospital services during the current pandemic.

1 Reports for each of the NHS bodies can be viewed on our website.

2 The NHS Clinical Classifications team develop policy and clinical classifications standards and guidance for clinical coding services in NHS Wales. The team maintain and organise the national clinical coding training schedule and provide a national clinical coding helpdesk function on behalf of NHS Wales. The team also maintain the NHS Wales Clinical Classifications Standards Dictionary and deliver the annual National Clinical Coding Audit Programme.

6 Our audit work has shown that clinical coding continues to have a low profile at board level and that current arrangements could be enhanced by critically examining the level of investment in coding resources, by ensuring the availability of good quality source information for coders and by increasing the extent to which medical staff are engaged in the coding process.

7 These challenges are not new but would benefit from some fresh attention, informed by changes to working practices that occurred during the current pandemic. Most notably, the significant step-change in the use of digital platforms during the pandemic creates an opportunity for NHS bodies to increase the extent to which digital records are utilised, increasing with it the scope to reduce the time it takes to code activity, and support smarter and more flexible working by clinical coding staff.

Adrian Crompton
Auditor General for Wales

> “Clinical coding is an important but often overlooked function of the NHS, providing the backbone to much of the information used to govern services, but its profile in NHS bodies is not yet where it needs to be. The importance of good quality information has come to the forefront during the coronavirus pandemic and with new ways of working being put to the test during the crisis, now is the ideal opportunity to ensure that clinical coding has the attention that it needs as services start to be reinstated.”

Key facts

Clinical coding applies to all health boards and Velindre NHS Trust, and applies to hospital admissions (episodes) and procedures undertaken in outpatient settings.

The clinical coding process requires the use of the International Classification of Diseases (ICD) and the Office of Population Censuses and Surveys (OPCS) Classification of Interventions and Procedures manual.

95% of all episodes have to be coded within one month of the episode end date and NHS bodies are expected to improve the accuracy of coding year on year.

It takes on average **18 months** to train as a clinical coder.

Approximately **£5.9 million per annum** is spent on the NHS clinical coding process across Wales. The majority of which is pay costs, with 180 whole time equivalent clinical coding staff employed across NHS bodies in Wales, with a further six employed in the NHS Clinical Classifications Team.

On average, there are about **1.1 million consultant episodes of care** each year that need to be coded, with an expectation of approximately **30 consultant episodes of care** to be coded each day per coder.

At the end of April 2020, **83% of consultant episodes of care had been coded within one-month** compared to the 95% target set by the Welsh Government. A total of **181,000 consultant episodes of care** were identified as backlog, of which **55% related to care provided between April 2017 and March 2019**.

The 2019-20 annual clinical coding audits undertaken by the NHS Clinical Classifications Team identified an **accuracy level of 94%**, against a nationally recognised standard of 90%[3].

3 The 90% standard relates specifically to primary diagnosis and procedure. A standard of 80% is set for secondary diagnoses and procedures.

An introduction to clinical coding

01

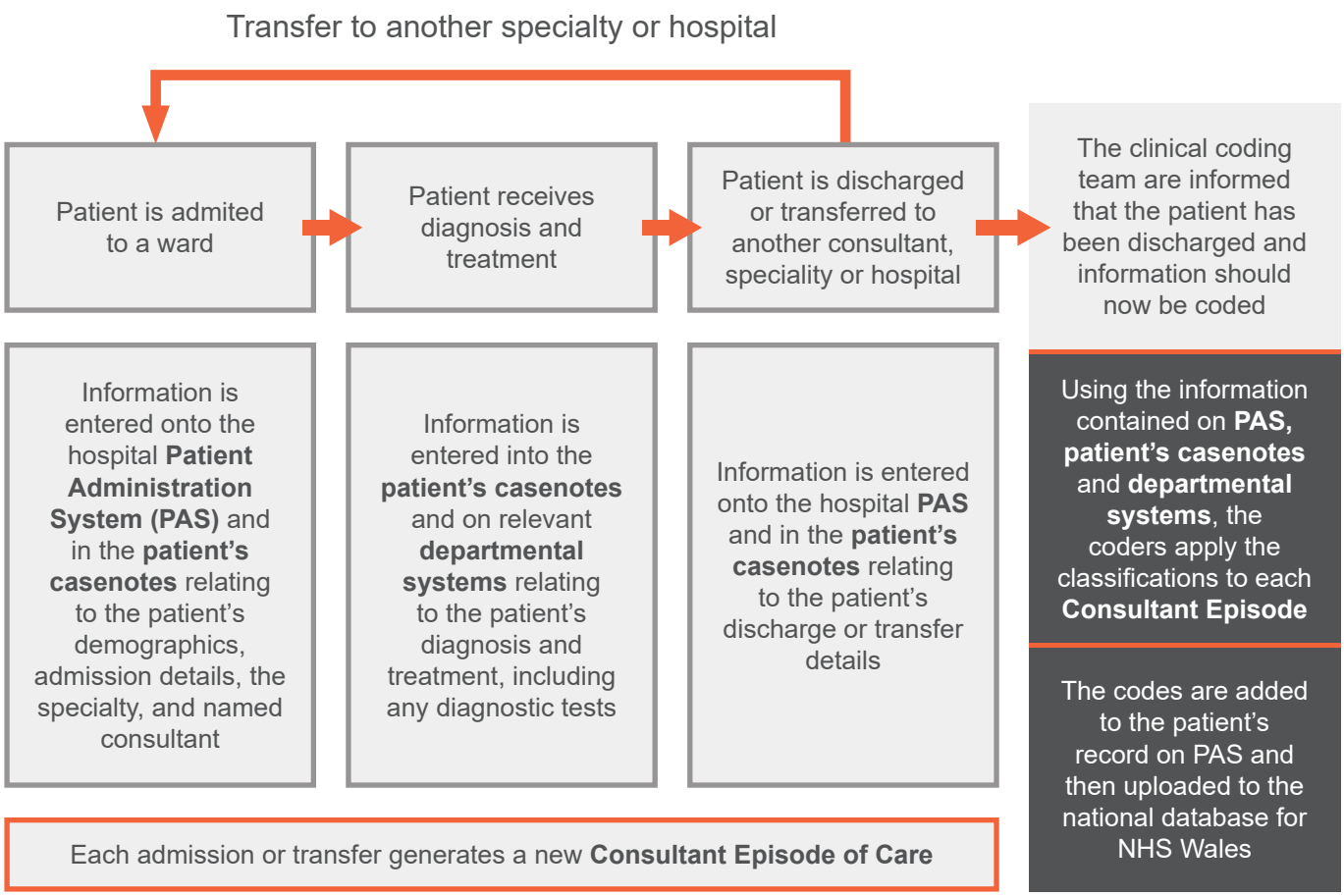
What is clinical coding?

1.1 Clinical coding is the process of translating medical information which describes a patient's symptoms, diagnosis and treatment into internationally and nationally recognised code which can then be used for statistical and clinical purposes.

1.2 Information relating to the patient's symptoms, diagnosis (both the main (primary) diagnosis and any secondary diagnoses) and treatment (both the main treatment (procedures) and any secondary treatments) are coded.

1.3 The clinical coding process applies to hospital admission activity (**Exhibit 1**) and procedures undertaken in an outpatient setting.

Exhibit 1: what does the clinical coding process involve?



Source: Audit Wales

1.4 Codes consist of a combination of numbers and letters and are set out in the International Classification of Diseases (ICD), and Office of Population Censuses and Surveys (OPCS) Classification of Interventions and Procedures manuals. For example, a diagnosis of acute appendicitis is represented by the code 'K35.8'.

1.5 Following the outbreak of COVID-19 in March 2020, a number of new ICD-10 codes of 'U07.1'and 'U07.2' for a diagnosis of COVID-19 and 'B97.2' to identify when coronavirus has resulted in other diagnoses[4] were introduced under emergency powers. An example of a coded consultant episode of care is shown in **Exhibit 2**.

Exhibit 2: example of coded data relating to a patient

Example extract from a patient's case-notes

Mrs A has known COPD and presented with cough and severe dyspnoea due to a suspected infection by COVID-19. Testing was positive for presence for COVID-19 and she was admitted to isolation ward C8. Unfortunately, while on the ward, she developed bilateral severe pneumonia leading to respiratory failure due to the COVID-19 which required invasive ventilation to support her breathing. After 5 days, her condition had improved to the point ventilation was no longer required. She was placed on a CPAP machine and after a further 17 days on ward C8, she was considered medically fit for discharge and able to return home. Her comorbidities include Hypertension, CCF and type 2 diabetes with retinopathy.

Diagnosis (ICD) codes:

U07.1	COVID-19 virus identified
J12.8	Other viral pneumonia
B97.2	Coronavirus as the cause of diseases classified to other chapters [viral pneumonia]
J44.0	Chronic obstructive pulmonary disease with acute lower respiratory infection
B97.2	Coronavirus as the cause of diseases classified to other chapters [chronic obstructive pulmonary disease]
J96.99	Respiratory failure NEC, type unspecified
B97.2	Coronavirus as the cause of diseases classified to other chapters [respiratory failure NEC]
I10.X	Primary (essential) hypertension
I50.0	Congestive heart failure
E11.3†	Type 2 diabetes mellitus with ophthalmic complications
H36.0*	Diabetic retinopathy

Procedure (OPCS) codes:

E85,1	Invasive ventilation
E85.6	Continuous positive airway pressure

Source: NHS Clinical Classifications Team

4 U07.1 COVID-19, virus identified, U07.2 COVID-19, virus not identified and B97.2 Coronavirus as the cause of diseases classified to other chapters. The coding of a single patient may include multiple references to B97.2 as the code is applied to reflect each diagnosis that has resulted as a direct impact of COVID-19.

What is required to undertake clinical coding?

1.6 NHS bodies in Wales are required to code 95% of all finished consultant episodes (FCE) of care within one month of the episode end date. On average, there are 1.1 million finished consultant episodes of care each year across Wales.

1.7 To undertake the clinical coding process, NHS bodies have a clinical coding team which is made up of a combination of trainees and clinical coders. To become a clinical coder, staff undertake a combination of classroom and on-the-job training provided by the NHS Clinical Classifications Team. It is estimated that it can take up to 18 months to become a clinical coder.

1.8 As well as the training provided by the NHS Clinical Classifications Team, it is recommended good practice that staff are supported to gain the National Clinical Coding Qualification from the Institute of Health Records and Information Management (IHRIM) to become an accredited clinical coder. It is also recommended good practice that teams should have access to clinical coding auditors and clinical coding trainers.

1.9 The main source of information to support the coding process is patient case-notes. To enable teams to code within the required timescales, it is important therefore that clinical coders have timely access to case-notes once patients are discharged or transferred. This requires a good working relationship with medical record departments and hospital ward staff.

1.10 It is also important that coders work closely with medical staff to ensure coders understand the clinical information relating to diagnoses and treatment contained in case-notes. The liaison between coders and medical staff also helps raise awareness of what information is needed from case-notes and the importance of good quality record keeping.

1.11 To support a focus on accuracy of coding, NHS bodies in Wales are also required to improve the accuracy of coding year-on-year. Accuracy is examined through annual coding audits undertaken by the NHS Clinical Classifications Team in NWIS.

Why is clinical coding important?

02

Why is clinical coding important?

2.1 Coded data is used for a variety of reasons to support effective governance arrangements in NHS bodies but is more commonly associated with Payment by Results[5] in England, and the Risk Adjusted Mortality Index (RAMI)[6] which provides a measure to highlight unexpected death rates.

2.2 In 2013, clinical coding featured in the Francis Report into the failings at Mid Staffordshire NHS Foundation Trust. Evidence presented to the second inquiry in to Mid Staffordshire care failings pointed to the fact that…'the Board had convinced themselves that the reported high mortality rate was due to poor quality of the coded data that underpinned it, rather than any failings in the care provided to patients.' The readiness to explain away the high mortality rates as being down to coding and data quality ultimately had tragic consequences for many patients at the Trust.

2.3 The Francis Report concluded that executives and independent members needed to be more aware of issues relating to coding, and their relationship to management information that is used to measure performance and outcomes. The report also recognised the importance that clinical coding has in management information and the need to understand the implications of good quality coded data.

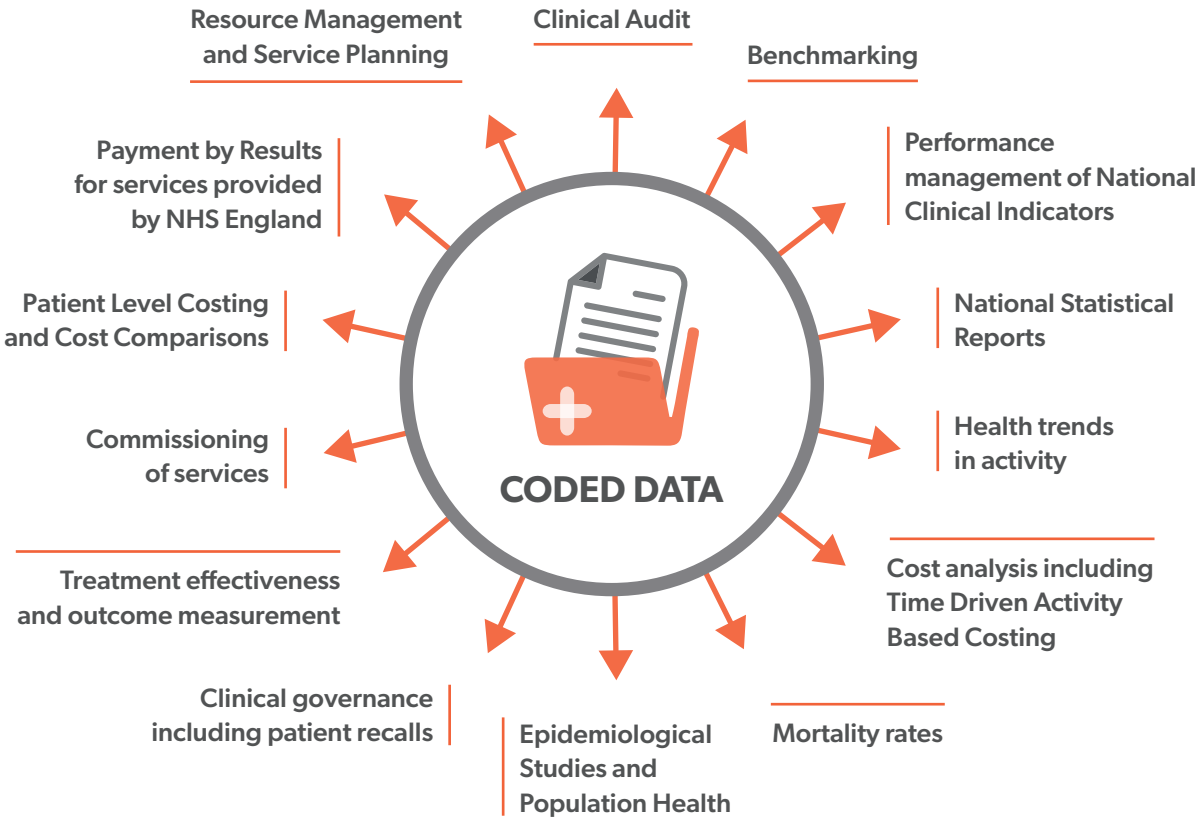
2.4 Clinical coded data is core to the information used by NHS organisations to govern the business and to ensure that resources are used efficiently and effectively. It is therefore important that clinical coding is timely and accurate. Although Payment by Results is not relevant to Wales, with the exception of where NHS England provides services to health boards on the English-Welsh border, coded data supports the monitoring of mortality rates for specific conditions (such as heart attacks, strokes and hip fractures), as well as a range of other performance and outcomes measures, and planning and management decisions. **Exhibit 3** details the range of uses of this data, and its importance to the NHS.

2.5 More recently, clinical coded data has been used to identify patients who have been required to shield during the COVID-19 pandemic. As the NHS starts to move into the recovery phase of the pandemic, the use of clinical coded data to understand the ongoing demand on services from patients diagnosed with the virus, as well as a reflection on how treatments have impacted on patient outcomes, will become the norm.

5 Payment By Results was introduced to the NHS in England in 2004 and is based around tariffs for different NHS treatments. Accurate and timely clinical coding is required to support quantification of activity by providers and hence payment.

6 RAMI was discontinued in Wales in July 2014 following recommendations made in a report by Professor Stephen Palmer.

Exhibit 3: uses of clinical coded data in Wales



Source: Audit Wales

The exhibit contains more information about the uses of clinical coded data in Wales which is displayed when hovering over each element.

Clinical coding performance

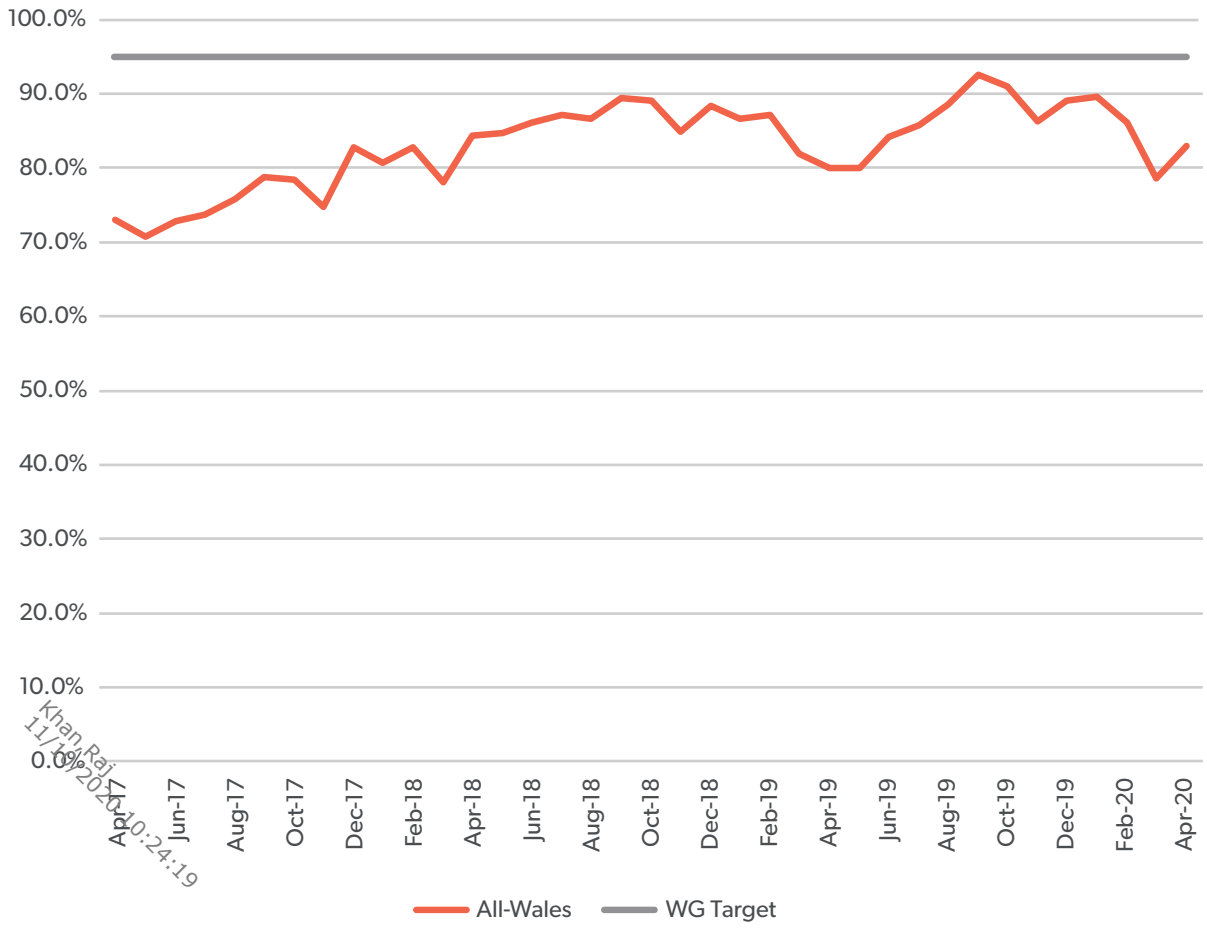
03

Timeliness of coded data

3.1 When we first reviewed clinical coding in 2013-14, NHS bodies had a three-month window to code. Since 2017, the window for coding has reduced to encourage timelier access to coded data. The current Welsh Government target is for NHS bodies to ensure that 95% of all FCEs are coded within one month of the episode end date. The 5% tolerance on the target recognises that there are sometimes legitimate reasons why an episode of care cannot be coded, for example, because the case-notes are needed to undertake a clinical investigation.

3.2 The all-Wales performance is set out in **Exhibit 4**. This indicates a steady increase in the timeliness of coding since the introduction of the revised Welsh Government target in 2017, with 92% of data coded within the recommended timescales by August 2019. However, this remained short of the Welsh Government target of 95%, and performance has since declined, dipping to 79% at the start of the COVID-19 pandemic in March 2020.

Exhibit 4: all-Wales compliance with the Welsh Government timeliness target



Source: NHS Clinical Classifications Team

3.3 Performance against the timeliness target varies across Wales. Some NHS bodies code episodes much quicker than others and have been able to maintain timeliness of coding in line with the Welsh Government target. However, others including Aneurin Bevan, Cwm Taf Morgannwg and Hywel Dda University Health Boards have struggled to meet the target. Performance at Cwm Taf Morgannwg and Hywel Dda University Health Boards significantly dipped to below 50% at the start of the pandemic, with performance in Cwm Taf Morgannwg University Health Board for March 2020 at just 25% completion.

3.4 Arguably, the timeliness target should be even stricter given that the daily reporting of COVID-19 admissions during the current pandemic would be significantly enhanced by clinical coding that was as close to real time as possible.

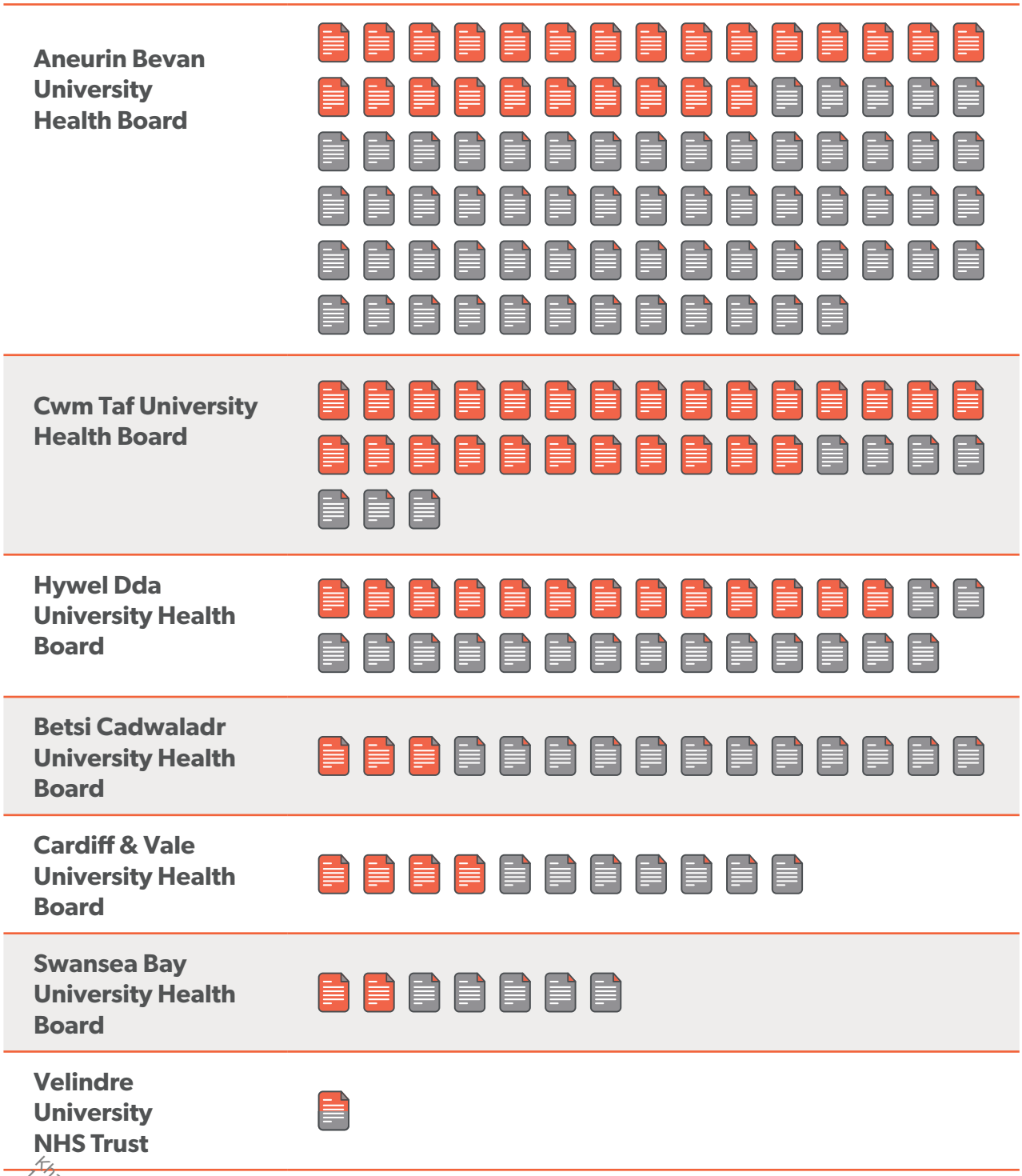
Backlogs of coded data

3.5 Episodes not coded within a month are classed as 'backlog'. Having a large backlog of uncoded episodes affects the robustness of the data and its usefulness, and it is therefore important to clear backlog quickly.

3.6 Extended gaps between the episode end date and when the information is coded also increases risks that medical staff are unable to respond to queries. This is either because of the elapsed time since they provided care for the patient in question impacting on their ability to recollect, or because staff may have moved on to new roles, particularly junior doctors.

3.7 At the end of May 2020, 181,294 FCE's were identified as backlog dating back to April 2017. Just under half of these were from Aneurin Bevan University Health Board (**Exhibit 5**).

Exhibit 5: backlogs of uncoded FCEs (thousands) at 31 May 2020, highlighting number of uncoded FCEs relating specifically to 2019-20 ( )*



Source: NWIS Clinical Classifications Team

* Powys Teaching Health Board reported no backlog at 31 May 2020

The exhibit contains more information about each health board's backlog which is displayed when hovering over each element.

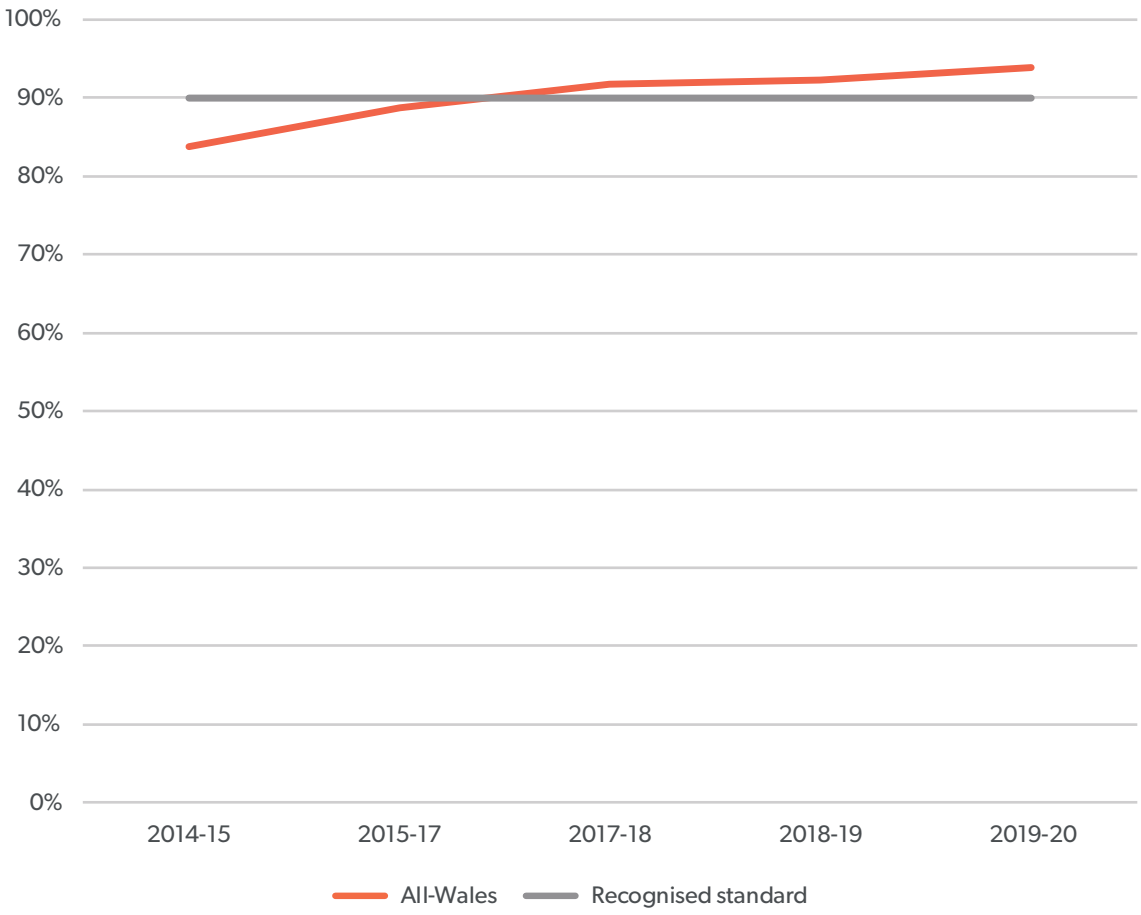
Accuracy of coded data

3.8 Each year, the NHS Clinical Classifications Team assess the accuracy of clinical coding by reviewing a sample of coded episodes against a patient's case-notes.

3.9 The nationally recognised standard for the accuracy of coding is 90%. NHS bodies are required to strive towards meeting the national standard, by demonstrating year-on-year improvement.

3.10 Over the last six years, there has been an improvement in the accuracy of clinical coding across Wales (**Exhibit 6**) with all NHS bodies now achieving the standard.

Exhibit 6: all-Wales accuracy of clinical coding[7]



Source: NHS Clinical Classifications Team

7 Due to capacity within the NHS Clinical Classifications Team, a single accuracy review at each NHS body was undertaken during the period 2015-16 and 2016-17.

3.11 The accuracy of clinical coding is based on a review of codes applied to primary and secondary diagnoses and procedures for a sample of patients. These are then summarised to provide an overall accuracy score for each NHS body.

3.12 The review of accuracy is complex in nature and considers three specific dimensions which are:

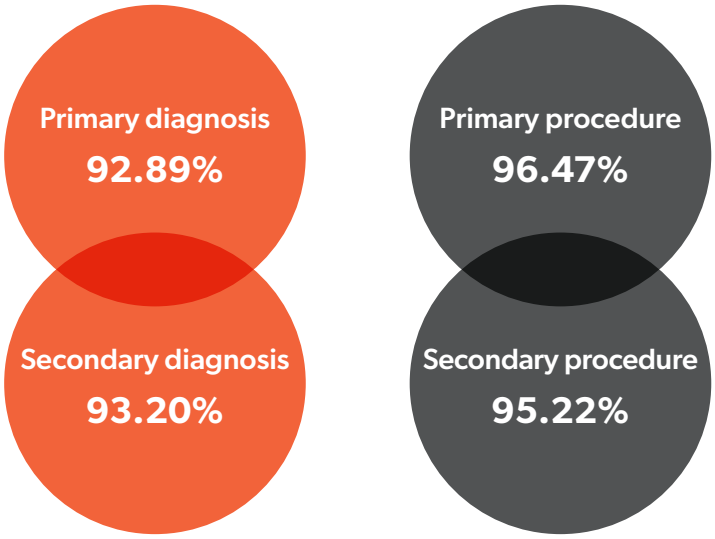
a the accuracy of the individual codes applied to each patient to ensure that they correctly reflect the relevant diagnoses and procedures set out in the patient's records;

b the accuracy of the totality or overall combination of codes applied to each patient to ensure that rules are being consistently applied, and that codes are not contradictory of each other; and

c the accuracy of the sequencing of codes to ensure that the most relevant code is applied to the primary diagnosis and procedure.

3.13 Across Wales, accuracy levels are generally higher for procedures than diagnoses (**Exhibit 7**), reflecting that procedures are generally more easily identifiable in patients' records through formal test results and theatre records. These are also more accessible through electronic systems whereby information relating to diagnoses is more commonly handwritten information.

Exhibit 7: all-Wales accuracy of diagnosis and procedure coding in 2019-20



Source: Audit Wales

3.14 Accuracy levels also vary depending on the type of activity being coded. More straightforward admissions, for example, elective day cases are invariably simpler to code as patients generally have less co-morbidities and the information needed to code is less. More complex admissions, for example, emergency admissions involving patients with multiple co-morbidities, are reliant much more on a greater degree of information contained in case notes and become more complex and time-consuming to code.

Key challenges for clinical coding

04

Awareness of clinical coding at board level

4.1 In England, clinical coding forms an important enabling function as part of Payment by Results funding regime. Consequently, clinical coding has a higher profile in the business of both NHS providers and commissioners within the NHS in England. The NHS in Wales does not use Payment by Results with the consequence that clinical coding has less profile, despite its contribution to a number of wider governance arrangements as set out in **Exhibit 3**.

4.2 In our more recent work, we found little reference to clinical coding in board business and a survey of board members identified that there was scope to raise awareness around the role that clinical coding has and the factors that are affecting the accuracy and timeliness of clinical coded data (**Exhibit 8**).

Exhibit 8: findings from our 2018 board member survey[8]

42% of board members were satisfied or completely satisfied with the information received on the robustness of clinical coding arrangements in their organisation.

Only **27%** of board members identified that they had full awareness of the factors that affect the robustness of clinical coding arrangements in their organisation.

47% of board members were satisfied or completely satisfied that their organisation was doing enough to make sure that clinical coding arrangements were robust.

80% of board members identified that they would find it helpful to have more information on clinical coding and the extent to which it affects the quality of key performance information.

Source: Audit Wales

8 A number of questions relating to clinical coding were included in the board member survey which formed part of our 2018 structured assessment work. A total of 96 responses out of a possible 172 responses were received.

Level of clinical coding resources

4.3 Over the last six years, NHS bodies across Wales have demonstrated a commitment to invest in their clinical coding teams. Staffing levels have gradually increased although many NHS bodies have struggled to get trained coding staff.

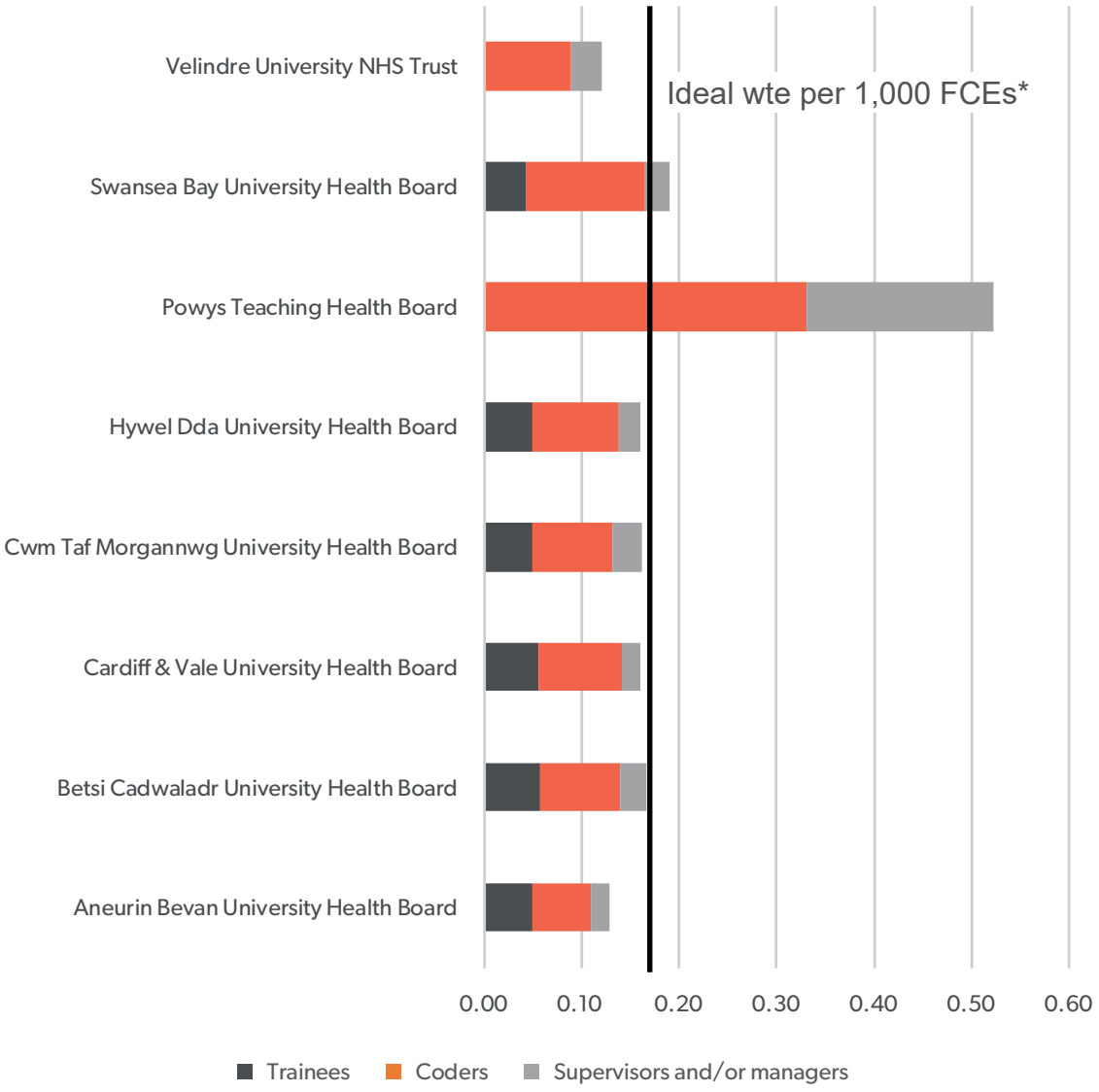
4.4 The 2019 annual report by NWIS on clinical coding across Wales highlighted the continued difficulties recruiting staff into coding roles. The higher profile of clinical coding across the NHS England brings with it a more attractive salary, and Welsh NHS bodies close to the England border in particular suffer as a result. In the absence of trained staff, many NHS bodies have recruited trainees which is positive as it develops staff into the coding role longer term. However, although this adds additional capacity into the system, the long lead in time to become a coder means that experienced staff have to support and mentor trainees for a considerable period of time before allowing them to work independently.

4.5 Across the Welsh NHS bodies, there is a total of 180 Whole Time Equivalent staff[9]. The majority are trained coders. In planning and managing their workforce, many NHS bodies work on the recognised expectation that coders will code on average 30 episodes of care per working day. This level of activity can be used to calculate an 'ideal' staffing level for benchmarking purposes[10]. Most NHS bodies in Wales are currently unable to achieve that benchmark (**Exhibit 9**). In three health boards we observed a heavy reliance on contract coders and the use of overtime to help meet workload demands.

9 Staffing figures exclude Band 2 support staff.

10 For the purposes of providing a comparison, a figure of 200 working days per full-time WTE has been used, allowing for leave and training commitments.

Exhibit 9: actual whole time equivalent clinical coding staff per 1,000 FCEs as at March 2020 by NHS body compared with the ideal level based on 30 FCEs per day per WTE



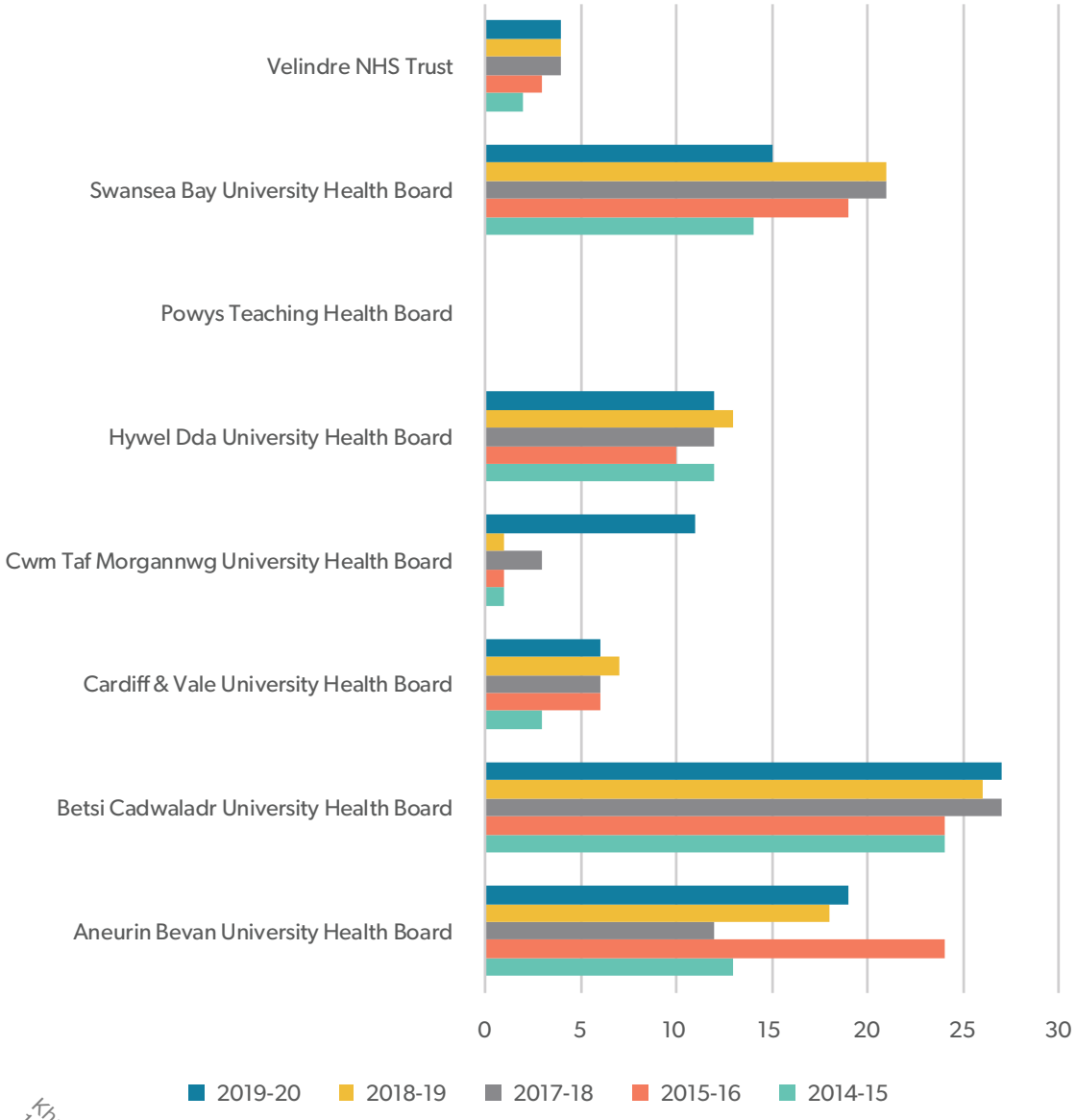
Source: NHS Clinical Classifications Team and Audit Wales

* Ideal levels based on an average of 30 FCEs coded per day for 200 working days per 1.0 WTE

4.6 As mentioned in **paragraph 1.8**, it is recommended practice for coders to gain the National Clinical Coding Qualification to become an accredited coder. This requires additional investment by NHS bodies for the initial training as well as ongoing membership subscriptions, although a number of NHS bodies require staff to cover the cost of annual subscriptions themselves. For some NHS bodies, the completion of the qualification has no impact on salary progression which means that there is no incentive for staff to undertake the qualification despite the positive impact it can have on the quality of clinical coding.

4.7 Positively, the number of accredited coders has increased over the last six years to 64% of all trained coders, but there are significant variations across NHS bodies with very few in place in Cardiff & Vale University Health Board, Velindre NHS Trust and the former Cwm Taf University Health Board areas of the now Cwm Taf Morgannwg University Health Board (**Exhibit 10**). There are no accredited clinical coders in Powys Teaching Health Board.

Exhibit 10: number of accredited coders by NHS body between 2014 and 2020



Source: NHS Clinical Classifications Team

4.8 The development of clinical coding trainers and auditors within local teams offers the potential to provide more ongoing and focused support to coding teams than the current central resource available through NWIS allows for. To date, only one qualified clinical coding trainer and five clinical coding auditors are in post across Wales, covering just two health boards – Aneurin Bevan and Swansea Bay University Health Boards, and Velindre NHS Trust. The staff fulfilling these roles are also managers or supervisors and are therefore unable to provide support to other NHS bodies due to workload commitments. This is with the exception of the clinical coding auditor in Velindre NHS Trust who does assist with the annual accuracy audits undertaken by the NHS Clinical Classifications Team.

4.9 Although significant reliance is placed on the accuracy reviews undertaken by the NHS Clinical Classifications Team, audit sample sizes equate to just 0.3% of total annual activity. An increase in clinical coding auditor capacity across NHS bodies would allow a significantly increased focus on the accuracy of clinical coding.

Quality of, and access to, clinical information

4.10 Patient case-notes are the main source of information for clinical coders and as legal documents, should be maintained to a high-standard.

4.11 Our work in 2013-14 identified poor quality record keeping with a direct correlation between the way in which information was recorded and stored in patient case-notes and the accuracy and timeliness of clinical coding. Our work found that:

a 14% of folders were not in a good state of repair;

b the handwriting in 18% of case-notes was illegible;

c 32% of case-notes had loose papers containing clinical information which could easily be misplaced;

d a discharge summary or letter corresponding to the episode reviewed was missing in 24% of case-notes; and

e there was no clear diagnosis for the episode reviewed recorded in 14% of case-notes.

4.12 The awareness and adoption of the Royal College of Physicians (RCP) standards for medical records[11] was also found to be variable across Wales, with little evidence of NHS bodies undertaking quality checks of their case-notes.

11 First approved in 2007, the standards set out expectations for general medical record keeping by physicians in hospital practice which have subsequently been adopted as good practice across all medical specialties.

4.13 Issues with availability and training of ward clerks to compile patient case-notes were found to be impacting on the quality of record keeping, and the use of temporary records in many NHS bodies also affected the integrity of case-notes, as key information was not always merged into master records. Despite high levels of clinical coding accuracy as identified in **Exhibit 6**, these issues are impacting on the ability of coders to meet the timeliness targets, as coders are having to spend time chasing, collating and cross-checking information.

4.14 We did not review case-notes in our 2018-19 review but our interviews with staff and reviews of documents including any local reviews of medical records identified that the quality of record keeping remained an issue.

4.15 Medical records training, particularly for junior doctors, can help promote an understanding of the importance of good record keeping, and awareness and adoption of the RCP standards. However, many NHS bodies have struggled to provide formal training for medical staff, and specifically to include as part of induction training for junior doctors.

4.16 Formal medical records groups in NHS bodies were limited during our earlier review of arrangements in 2013-14, reducing the opportunity for quality issues to be identified and addressed. These forums have started to be reinstated over recent years but involvement of clinical coding staff in discussions is variable, limiting the ability for coders to formally escalate any issues that they may identify during the course of their work.

4.17 Many NHS bodies are increasingly providing coders access to clinical information systems that enable them to complete their work using digital platforms, such as the Radiology Information System (RadIS) or relevant departmental systems such as those used within operating theatres. In addition, some NHS bodies are also moving to digitalising the contents of paper case-notes. Our 2013-14 and 2018-19 work found that usability of digitalised case-notes had both negative and positive aspects. Although coders are able to gain access to digitalised case-notes more quickly than physical case-notes, they are currently no more than a scanned version of the paper records which means that issues such as the ability to read handwriting remain.

4.18 During the COVID-19 pandemic, a shift to home working for many clinical coders, particularly for those who have been required to shield themselves, has meant that coders have become increasingly reliant on electronic systems. The limited extent to which digitalised case-notes has been rolled out across Wales, as well as the quality of them has, however, impacted on the coders ability to undertake their role from home with staff, where able to do so, having to return to the office within social distancing constraints to access case-notes.

Clinical engagement with coding

4.19 A report by Capita in 2014 considered the quality of clinical coding in the NHS. The report highlighted ten checklist areas that managers needed to look at to improve the quality of clinical coded data. One of these was regular clinical engagement as this would help clarify issues for both clinicians and coders on how care delivered should be described in source documentation to aid the coding process. The report also highlighted that routine validation of coding with clinicians helped to ensure accuracy.

4.20 Our original reviews in 2013-14 found that engagement of clinicians in the coding process was limited across NHS bodies. There were some examples of individual clinicians who took an active interest, but it was not widespread. A consistent theme identified was the lack of visibility and profile of clinical coders with clinical teams. The physical location of coding teams was a key factor with most teams located away from clinical areas, often in a separate location away from the main hospital building. The volume of workload for coders was also limiting their capacity to engage with clinical teams.

4.21 Our more recent work has identified an increase in engagement between coders and clinical staff, but this is largely through attendance at clinical meetings by the supervisor or manager, rather than on a case-by-case basis with coding staff which is where you would expect conversations about the care provided to individual patients to happen. Even with the potential benefits of using information based on clinical coded data to feed into the medical revalidation process[12] which allows clinical outcomes to be considered across clinical treatments, there has been little progress in this area.

12 Medical revalidation was introduced in 2012 as an evaluation of a doctor's fitness to practice. The process supports doctors in regularly reflecting on how they can develop or improve their practice. It gives patients confidence doctors are up to date with their practice and promotes improved quality of care by driving improvements in clinical governance.

The opportunities for clinical coding

05

Digital solutions

5.1 The COVID-19 pandemic has seen a significant shift in the availability of, and access to, electronic systems to enable NHS staff, both clinical and non-clinical, to work from home. This has included clinical coders but as mentioned in **paragraph 4.18**, there have been limitations on what coders have been able to do, because of the lack and quality of digitalised records. The increasing move to a digital platform however has provided a much-needed momentum to do things differently – both in terms of making increased use of electronic solutions and the location from which staff work.

5.2 The current need for clinical coders to access physical case-notes impacts on the ability for them to meet the current target to code FCE's within one month of the episode end date. Our 2013-14 work tracked the length of time it took for case-notes to reach the clinical coding teams, and whilst the target for coding completeness was longer at that time, it was clear that getting case-notes to the coding team was not a priority, with case-notes taking on average three weeks to arrive in the coding department. Once in the department however, the coding process was often completed within 24 hours and the case-notes returned to the medical records department.

5.3 Moving paper case-notes onto a digital platform, which is easily accessed by coders, would therefore create significant opportunities to shorten the elapsed time between the finished episode of care and completion of coding. Digital platforms also support the ability for coders to work from home. This introduces flexibility and smarter ways of working into the coding process, particularly in the context of social distancing requirements and supporting staff who continue to have to shield or self-isolate, although this does need to be balanced with the ability to engage with clinicians on a regular basis.

5.4 Digital solutions also provide the opportunity for clinical coding to be inbuilt into the system and to facilitate real-time clinical coding at the point of entry of information relating to the patient's care, rather than a process that is applied after the event. This would require clinical staff to be much more engaged in the coding process as it would be them who apply terminology codes[13] which identify diagnoses and procedures, which in turn, could support a more automated clinical coding process. This would reduce the need for coders to be manually applying the process to clinical information after the event, but instead would focus their role on the validation of codes to ensure that the process is being applied correctly.

13 Terminology codes are a set of standardised clinical terms applied using a system referred to as SNOWMED-CT (Systematized Nomenclature of Medicine – Clinical Terms)

Expanding the scope of clinical coding

5.5 Clinical coding currently only applies to hospital admission activity and procedures undertaken in some outpatient settings. But there is scope to apply the principles of clinical coding to other hospital activity, including GP referrals and more general outpatient attendances. The commitment to code outpatient procedures is variable but our previous work did identify that some NHS bodies are also coding more general outpatient activity. But this is only at a high-level in terms of broad condition groupings and does not go into the level of detail that clinical coding allows.

5.6 As NHS bodies start to put arrangements in place to recover from the COVID-19 pandemic, limited capacity due to the increased sterilisation procedures that need to be in place, will mean that NHS bodies will need to prioritise patients who have been referred into secondary care and are waiting to be seen based on clinical need.

5.7 Currently, the only information available to identify clinical need however is a priority categorisation of ‘urgent’ or ‘routine’ which is applied to the GP referral once it has been assessed following receipt in the hospital. Very little information is easily available identifying the patient’s diagnosis and symptoms without the need to trawl through case-notes. The application of clinical coding to GP referrals and outpatients would be a key enabler in identifying high risk symptoms and conditions that require timely access to clinical care. The information gained from clinical coding would also help to identify cohorts of patients that could safely and appropriately be managed through alternative provision such as physiotherapy for orthopaedic conditions.

A way forward

06

A way forward

6.1 Our work in 2013-14 raised a number of recommendations for NHS bodies to address. These broadly focused on:

a improving the management of medical records by raising the importance of good quality record-keeping, providing clarity on roles and responsibilities, implementing a programme of medical record audits, strengthening the relationship between medical records and clinical coding teams, and providing training for staff;

b strengthening the management of clinical coding teams to ensure succession planning, providing opportunities for staff to undertake the accredited clinical coder qualification, reviewing workloads, improving cross-site working between internal clinical coding teams, providing regular staff feedback from validation checks and implementing clinical coding audits;

c strengthening engagement with medical staff by raising awareness of the coding process through training sessions and attendance at meetings, improving lines of communication, and encouraging active engagement between clinical coders and clinical staff in the coding process; and

d raising the profile of clinical coding at board level by providing briefing materials, identifying when management information is supported by clinical coded data, and alongside the timeliness of clinical coding, reporting on the accuracy of clinical coding and the level of uncoded activity.

6.2 Our 2018-19 work did identify that NHS bodies were making progress against recommendations, but the pace of progress has been slow on some key areas – a likely reflection of the relatively low profile that coding continues to have.

6.3 The activity and thinking on ‘re-setting’ the NHS that is taking place in the wake of the pandemic creates an opportunity to consider what national actions are needed to help raise the profile of clinical coding and drive the improvements required. From the work we have done, we would identify four specific areas for attention:

National leadership and capacity	Ensuring that there is sufficient leadership and capacity at a national level to give clinical coding the profile it needs, including having a named national lead for clinical coding. Ensuring clinical coding is a key feature in relevant national NHS forums.
Training and awareness raising	Inclusion of clinical coding in the core training for junior doctors and the all-Wales induction material for new Independent Members.
Adopting recognised good practice	Embedding clinical coding and the quality of good record-keeping into the performance framework for NHS bodies. Formally identifying a mechanism to measure and identify clinical coding workloads which NHS bodies should adopt.
Using technology to drive improvements	Faster progress with digitisation of patients records and using IT systems to support code identification at point of entry and smarter, more flexible working by coding staff.

Appendix

Audit approach and methods

Audit approach and methods

Document review

For both our 2013-14 and 2018-19 work, we reviewed a range of documents. These documents included clinical coding policies and procedures, organisational structures, internal and external clinical coding audits, papers to senior management forums, workforce plans, minutes of meetings and training material.

Board member survey

A survey of board members was included in our structured assessment work for 2013 and again in 2018 across Wales. The survey included a number of questions specifically focused on clinical coding.

Interviews and focus groups

We carried out detailed interviews for both our reviewed. Interviewees included executive and operational leads for clinical coding, head of information, medical records manager, clinical leads, and the clinical coding managers and supervisors. Our 2013-14 work also included focus groups with clinical coding staff.

Data analysis

For our 2013-14 work, we analysed data relating to compliance with the data validity and data consistency standards submitted to NWIS. For both our 2013-14 and 2018-19, we also analysed data relating to compliance with the Welsh Government targets for completeness and timeliness of clinical coding, along with backlog positions provided by the NHS Clinical Classifications Team.

Case-note review

For our 2013-14 work, we reviewed a sample of case-notes for compliance with the RCP standards for medical records. Using the same sample, the NHS Clinical Classifications Team undertook a clinical coding audit to check the accuracy of coding. This work formed the basis for the now annual clinical coding audits. We also reviewed the medical records tracking system within each NHS body to assess the length of time case-notes took to arrive in the clinical coding department.

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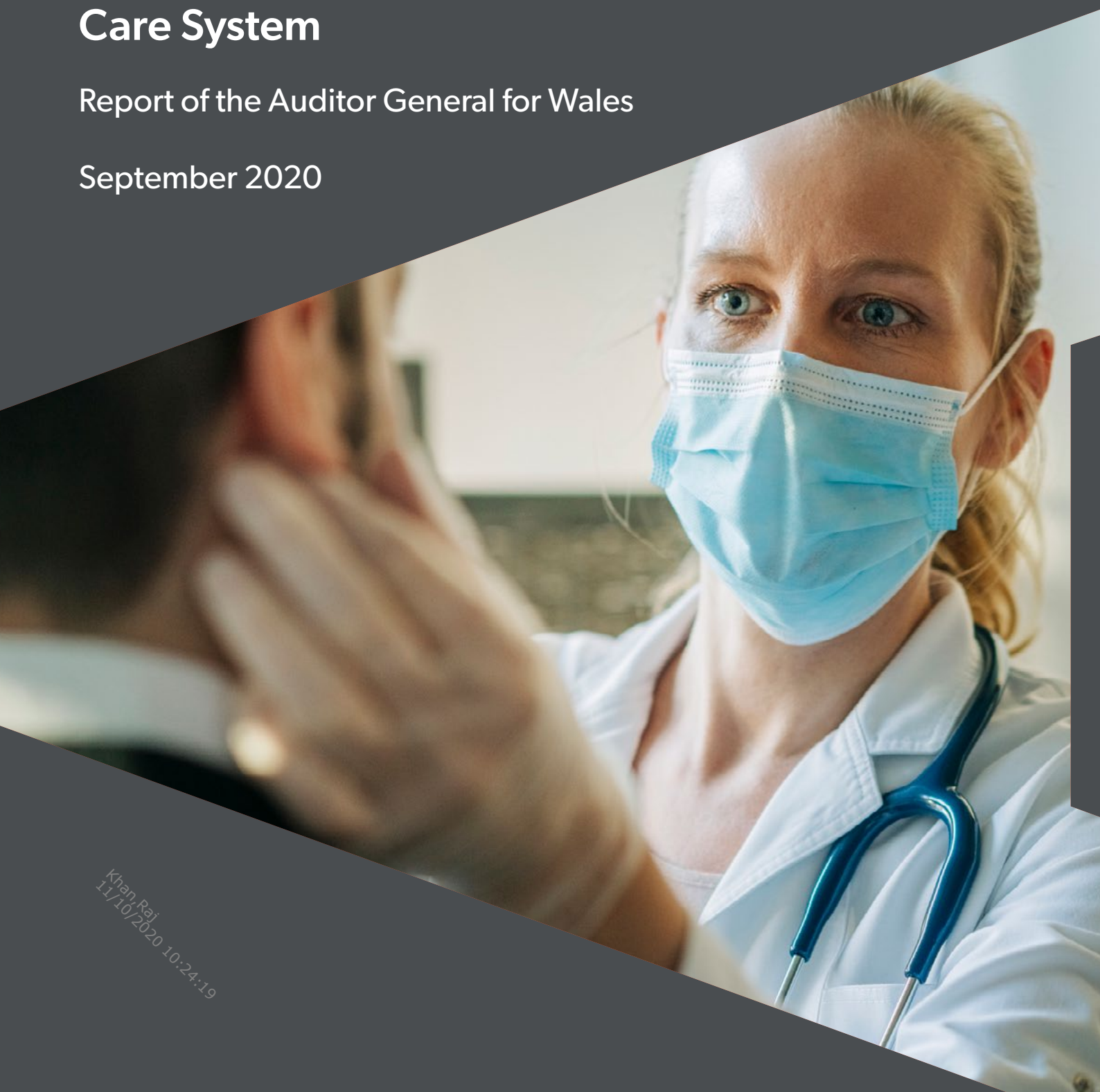
10 Opportunities for Resetting and Restarting the NHS Planned Care System

Report of the Auditor General for Wales

September 2020



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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

Contents

Summary report

1 On Friday 13 March 2020, the Welsh Government announced that it would be halting all non-urgent planned care treatment in hospitals. This came ahead of similar announcements for England, Scotland and Northern Ireland. Stopping non-urgent activity meant the NHS could free up capacity – beds, staff and equipment – to respond to the impending wave of COVID-19 cases. At the time, there were deep concerns that the UK was on a similar path to Italy, where the healthcare system was starting to become overwhelmed.

2 The NHS has continued to treat the most urgent patients. But hundreds of thousands of people in Wales are now 'parked' on waiting lists (**Box 1**). Between the end of January and May 2020 the total number of patients on a waiting list fell slightly from around 462,000 to 453,000. In part this fall was because, during the peak of the lockdown, there were far fewer people referred for a first outpatient appointment by their GP or other health professional. However, the numbers of patients waiting for long periods grew substantially. In May, around 148,000 had been waiting more than six months (up from 77,000 in January). Of those long waiting patients, 79,000 were still waiting for their first outpatient appointment (up from 33,000 in January).

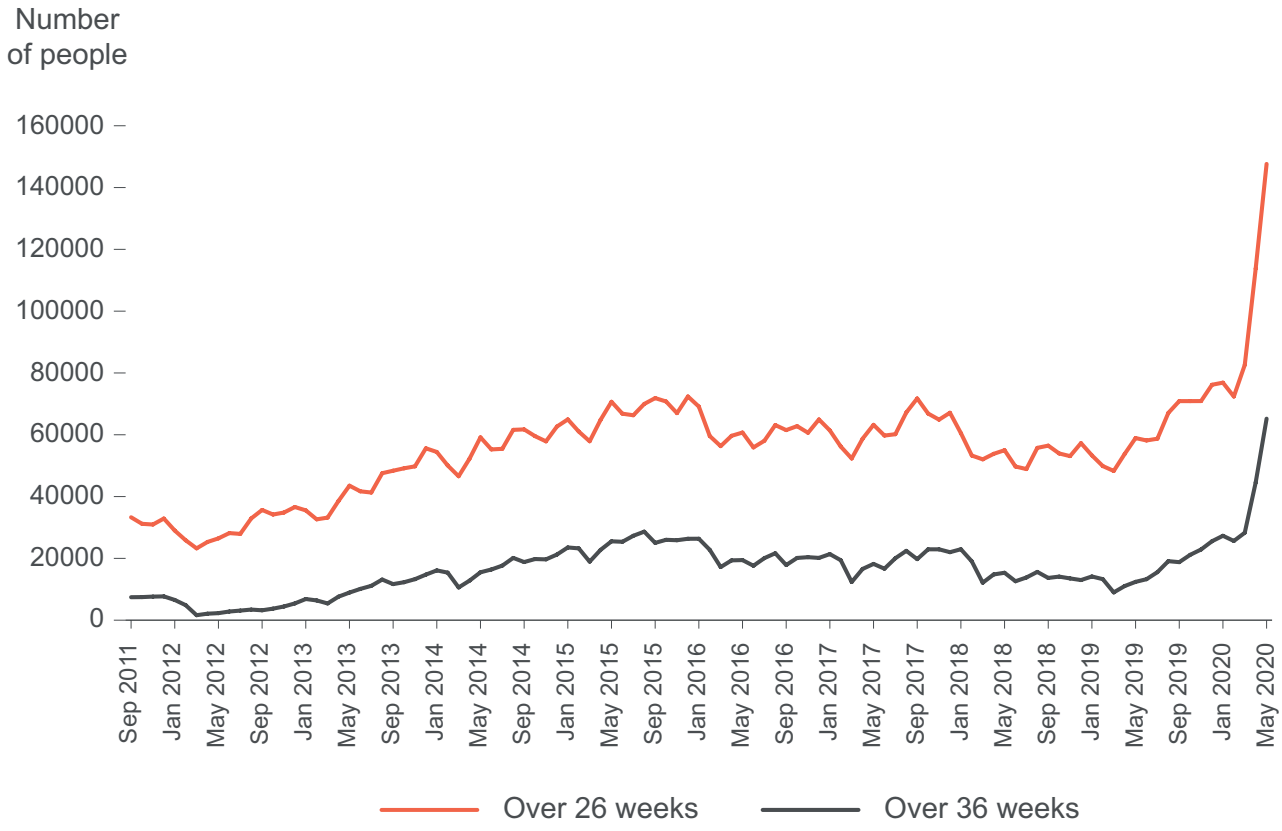
Box 1 – Waiting lists and waiting times

While NHS Wales is a complex system, waiting lists are essentially just queues. The NHS has various visible and less visible queues. The waiting list for planned care is one which is not visible, existing largely on computer systems with the patients doing the bulk of the waiting in their homes. The queue for cancer treatment is similar. The queue for emergency treatment is more visible, with patients waiting in waiting rooms, cubicles, sometimes in ambulances and on trolleys.

The Welsh Government has set targets for how long people in each of these queues should wait. The challenge for the NHS is to balance and prioritise within and between these queues because often they are competing for the same capacity: consultants, doctors, nurses, beds, appointment slots and operating theatres. Before COVID-19, the NHS was not meeting the waiting times targets for planned, cancer or emergency care.

3 At the time the UK went into lockdown, we were concluding our work to follow up progress against our 2015 reports on waiting times for elective care and orthopaedic services. Across both studies we had found the same story: many patients still face long waiting times (**figure 1**). Some progress has been made in specific areas but we have not seen the sorts of whole system change that is needed to make the planned care system sustainable.

Figure 1 – patients waiting over 26 weeks and 36 weeks as at May 2020



Source: Figures to January 2020 are from StatsWales, figures from February to May are from Welsh Government data

Note: figures for February to May have not been subject to the usual verification processes

4 Against the backdrop of COVID-19 we have reframed the findings and key messages from both reviews to inform the emerging plans for restarting planned care and the wider discussions on what a post COVID-19 NHS needs to look like. In this report we present ten key opportunities – five longer-term opportunities to reset the system and five immediate opportunities to restart the system (**figure 2**).

5 Taking these opportunities will help create sustainable changes to the system of NHS planned care in way that aligns well with the five ways of working set out in the Well-being of Future Generations Act, namely focusing on the long-term, collaboration, integration, prevention and involvement. We do not pretend that this will be easy but it is perhaps a once in a generation opportunity to strategically reshape a fundamental element of the NHS.

Figure 2 – Our 10 Key Opportunities for the NHS as it restarts planned care

Five opportunities to reset the system

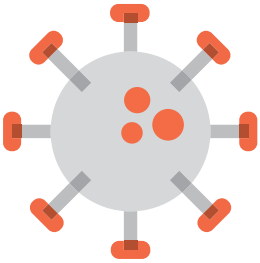
Take brave decisions about the target and accountability regime to align the planned care system around '**what matters**'

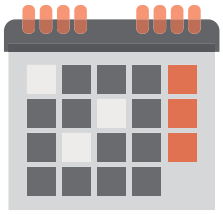
Strengthen **collective leadership** of planned care, learning lessons from COVID-19 and before

Consolidate and expand recent service changes in ways that involve patients

Undertake a **full and frank** review of capacity and the sustainability of the planned care system

Develop performance measures for planned care that align to outcomes and what matters to patients, families and communities





Five opportunities for restarting the system

Continue to **develop systems for prioritising patients** most in need of treatment

Engage with the public and patients about the options for treatment and the challenges, in line with principles of co-production

Carefully increase activity while sustaining the **focus on safety** and retaining flexibility to respond quickly to COVID-19

Engage clinicians and data scientists to rigorously analyse the backlog waiting lists with a view to reducing the risk of over-treatment

Promote prevention, self-care and behaviour change to **reduce respiratory illnesses** in particular and protect NHS capacity over the autumn/ winter months

Five opportunities to reset the system

01

Take brave decisions about the target and accountability regime to align the planned care system around 'what matters'

1.1 The national strategy for the NHS – A Healthier Wales – sets out the ambition for services to be focused on 'what matters' to patients. While waiting times matter to patients, we don't think it is the whole story.

1.2 For many years, the NHS has focused a great deal of managerial and clinical effort on meeting numerical waiting times targets at the end of March each year. We have come across multiple examples where the drive to meet targets potentially distorts clinical decision making and prioritisation. We think the focus on targets encourages short-term thinking and inhibits NHS bodies from developing realistic plans.

1.3 We heard some positive views about the work to revise the targets for eye care, where there has been a shift away from a one-size fits all target towards agreeing waits that are clinically relevant for each individual. We think there is opportunity to learn from that experience as part of a wider re-think of the approach to performance and accountability in the NHS, so that it aligns with ensuring that services focus on 'what matters' and quality and safety.

Strengthen collective leadership of planned care, learning lessons from COVID-19 and before

1.4 There is always a challenge in the NHS to balance national direction with local innovation in response to local needs and circumstances. Responding to our 2015 reports, the Welsh Government said that an initiative called the Planned Care Programme was going to bring together leaders from across the NHS to provide a national direction for planned care. However, our follow-up work has led us to conclude that the Planned Care Programme has had limited traction. A senior health board executive told us that 'the Programme has dropped little pebbles into lots of ponds but hasn't changed the whole system'.

1.5 In the coming months, the Welsh Government will be turning its attention to the plans for a new NHS Executive which will bring together national leadership and accountability. The Welsh Government will also be developing a new plan for clinical services across Wales. We think these are positive opportunities to reset the approach to strategic leadership.

1.6 We don't claim to have all the answers on what leadership should look like. But we think NHS leaders need to take this opportunity of reset to have a rigorous and evidence-based review of what has worked, what hasn't and why. This should take in learning from the response to COVID-19, where there has been a new approach to leadership, as well as learning from previous and current national programmes. What should be avoided is an automatic default to previous ways of working, as this is unlikely to provide the collective impetus to make the system changes which are needed.

Consolidate and expand recent service changes in ways that involve patients

1.7 Had the pandemic not occurred, our follow-up work would have commented on the slow pace at which the system had addressed issues we identified back in 2015. However, the rapid innovation and transformation that has come about as a result of COVID-19 has shown what can be done, albeit in an environment that is less cost constrained. The challenge now is to consolidate and build on the service change that has happened, including:

a building on the rapid expansion of digital services which provide a foundation for a broader transformation of the traditional outpatient model, while being mindful of the digital divide and make sure that services remain accessible for all patients; and

b building on the cultural change that has seen staff willing to blur and step completely out of traditional professional boundaries to support new and more efficient and effective ways of team working that enable staff to make best use of their expertise and skills.

1.8 In many cases, services have been changed at pace and under pressure. We recognise that it is difficult to fully engage with patients and co-produce the new ways of working. But as these new ways of working become embedded, there is an opportunity to engage with patients both to explain what they can expect and to understand their views and experiences in order to refine and improve.

1.9 Whilst, pre-COVID, change had been slow, it had been happening. In orthopaedics, CMAT[1]s have shown you can meet demand and patient needs outside of the hospital and potentially at lower cost, though there is scope to reduce some overlap in roles. Positively, our 2019 follow-up also shows there has been improved efficiency in many areas, like length of stay, although there are still opportunities to keep getting more efficient and productive.

Undertake a full and frank review of capacity and the sustainability of the planned care system

1.10 COVID-19 has shed a light on the stretched NHS capacity including beds, staffing and estate. Stopping all non-urgent planned care for such a long period to manage priority COVID-19 demand was extraordinary. But it was not entirely novel. Health boards have done it in a planned way to manage winter pressures in emergency care and in an unplanned way by cancelling operations at short notice. For years, planned care has been the safety valve when the pressure in the system gets too much.

1.11 In 2015, we concluded that supply was not matching demand for planned care and we think this still holds true. Before COVID-19, the NHS relied on paying clinicians a premium rate to carry out work at the weekends to improve waiting times. This short-term approach left the NHS exposed when the UK Government made changes to pension tax rules[2] and clinicians were no longer prepared to take on the extra work. As a result, waiting times were already on a sharply deteriorating trajectory during 2019-20: well before COVID-19 hit.

1 Clinical Musculoskeletal Assessment Treatment Service (CMAT) were developed to provide a community-based service for the assessment and treatment of musculoskeletal related pain and conditions

2 In 2019-20, new rules covering tax paid on pensions came into force. These had the effect of potentially leaving clinicians facing large tax bills if they carried out additional work. In December 2019, the Welsh Government mirrored a temporary solution to the issue, implemented in England, whereby the NHS would pay for the tax liabilities. The Welsh Government's concerns are set out in a letter from the First Minister to the Permanent Secretary, directing her to implement the same approach as England.

1.12 There are opportunities for the NHS to make better use of existing resources. As highlighted here and in our previous work, these opportunities lie in changing the system and services, making better use of technology, as well as making incremental efficiency improvements. Our 2015 work estimated some of the financial and capacity gains possible from more efficient and effective ways of working[3].

1.13 But alongside the focus on change and transformation, there also needs to be an open and frank discussion about the longer-term funding of the NHS. This should be based on a robust understanding of what it really costs to remove the backlog of patients and provide sufficient core capacity to meet the healthcare needs of the population in Wales.

Develop performance measures for planned care that align to outcomes and what matters to patients, families and communities

1.14 Our earlier point about rethinking the targets does not mean we are saying the NHS should stop measuring waiting times. The length of waits is an important indicator of quality, capacity and flow in the system. Our concern is the excessive performance management focus on a single measure. There are still some things to refine in terms of understanding end-to-end waiting times, like how to count waits for services like CMATS and community services.

1.15 We think that clinical risk and priority needs to feature more prominently in performance measures. In 2015, we said that the Welsh Government should publish waiting times data broken down by 'urgent' and 'routine' patients, but it didn't accept that aspect of our recommendation. There is a lot of work going on now to get a better understanding of the clinical risk on waiting lists. We still think there is an opportunity to revisit the spirit of that original recommendation to reflect the current importance of giving boards and the Welsh Government a clear view of how long urgent patients have been waiting.

3 For example, our 2015 report on waiting times for elective care estimated that reducing variation across all procedures could free up capacity equivalent to 32,000 procedures and 47,000 bed days, A 50% reduction in procedures known to be of limited clinical effectiveness could release capacity for 16,800 procedures, 22,000 bed days. The value of this capacity would be in the order of £26 million (in 2014-15 money). Figure 2 of the report sets out further capacity and efficiency opportunities.

1.16 There is also a big opportunity to focus more on outcomes and what matters to patients. There is already work underway to develop patient reported outcome measures to better understand clinical outcomes and support decisions making. But there are opportunities to speed up and expand the work. There are also opportunities to better understand patient satisfaction and engagement, especially around how involved they feel in decisions, how informed they are about processes and what to expect.

1.17 We also think there are opportunities to learn lessons from social care on their work around measuring personal outcomes. What matters to patients for example from a knee operation is not necessarily the clinical outcomes like healing of the bone and tissue. It is about the ability to walk to the post office, play football with a grandchild or get back dancing. If ‘what matters’ is actually what matters, then there is a need for a very different approach to what gets measured and some technical challenges to overcome in order to achieve that.

Five opportunities for restarting the system

02

Continue to develop systems for prioritising patients most in need of treatment

2.18 Given the size of the current planned care backlog and the constraints facing the NHS, prioritising patients based on clinical need is a sensible way to 'ration' the scarce healthcare resources in order to minimise harm. However, that inevitably means very long waits for those not considered a priority.

2.19 Traditionally, the NHS splits patients into 'urgent' and 'routine'. In the current circumstances that is not sensitive enough to distinguish between those who need to be seen within days and those within weeks or a few months. The NHS is now distinguishing between different types of urgent patients, but over time will also need to distinguish patients more generally.

2.20 In 2015, the Public Policy Institute for Wales (now Wales Centre for Public Policy) carried out an international review of approaches to prioritising elective care, highlighting some of the risks around points-based approaches to prioritisation. We think the NHS in Wales should look to international experience, including the live experiences of those slightly ahead of the UK on the pandemic curve, as it further refines its approach to prioritisation.

2.21 There is a lot of hard work involved in changing the underpinning systems to ordering by clinical priority. Booking systems and many other detailed aspects of planned care services have been based on prioritising people by how long they have waited. Also, the 'rules' of the game, such as what happens when patients cancel or don't attend are all part of a system focused on putting people in a time-based order. These will need to be updated. There is an opportunity to learn the detailed lessons from the implementation of the new eye care measures[4].

4 In June 2019, the Welsh Government announced a new approach to eye-care appointments, which involved prioritising patients' waiting times on the basis of their clinical need. Further detail can be found in the Health Minister's statement.

Engage with the public and patients about the options for treatment and the challenges, in line with principles of co-production

2.22 We think that there is an opportunity for the Welsh Government and the NHS to engage positively with patients as a result of the changes the NHS is having to make. The three areas we suggest the Welsh Government and NHS prioritise are:

a **Informing** the public about the scale of the issues facing planned care in the coming months and years. Being clear that some people will potentially wait a very long time for their routine operations.

b **Engaging** patients in decision making with clinicians to review the options and alternatives to surgery. In many cases, given a choice, patients would in any case prefer the least interventionist options. In some cases, this may require clinicians to think differently about what is best for the patient.

c **Being responsive** by keeping in touch with patients who may not be an urgent priority now and ensuring there is a system in place to re-classify them if their condition deteriorates significantly.

Carefully increase activity while sustaining the focus on safety and retaining flexibility to respond quickly to COVID-19

2.23 In restarting planned care, the NHS here is in the same position as many other developed countries in balancing risks. A multi-country analysis published in the Lancet sets out concerns about the risks of non-urgent surgery during the pandemic, which is ongoing. But at the same time, there are potential harms from not carrying out surgery and making patients wait for very long periods.

2.24 The NHS will need to be realistic in balancing the pressures to increase activity and use more capacity against the need to manage infection control and to respond to any local outbreaks. Capacity needs to be carefully managed. Our 2015 work raised concerns about the consequences of high bed occupancy with cancelled operations, patients being in beds usually used for other specialities and a general sense of a system that was highly pressured and reactive, where the focus is on finding beds. We think that during this period of recovery, potentially before a second wave in winter, the NHS should be thinking about what it needs to do to avoid returning to that sort of environment.

2.25 There is also the question of what to do with the surge capacity the NHS created to respond to COVID-19. Some of that was created by re-purposing operating theatres and wards, which would be needed to significantly increase planned care. With the possibility of a second wave in winter, decommissioning the surge capacity to accommodate more planned care needs to be carefully thought through and done in ways that can be reversed swiftly if required.

Engage clinicians and data scientists to rigorously analyse the backlog waiting lists with a view to reducing the risk of over-treatment

2.26 We think that there is an opportunity to engage clinicians and data scientists in analysing the waiting list, focusing in particular on reducing the amount of unwarranted variation and risk of over-treatment and harm. There are two main opportunities here:

a **procedures that are not normally undertaken**: where there is scope to develop a Wales wide list of which procedures have low clinical effectiveness and to do some analytical work looking at which patients are currently on a list for those procedures;

b **reducing variation across common activity**: where there is scope to compare waiting lists within health boards and across Wales to identify variation in rates of intervention for common procedures, which could indicate signs of over-treatment

2.27 Both pieces of analysis should be used to inform and, if necessary, challenge clinical decision making and ensure the conversation between clinicians and patients is centred around what matters and what is right for the patient.

Promote prevention, self-care and behaviour change to reduce respiratory illnesses in particular and protect NHS capacity over the autumn/ winter months

2.28 Each year, the NHS faces big challenges during the winter. Although this pressure is mostly felt in unscheduled care, it has knock-on consequences for planned care where operations are suspended or cancelled. In large part, these extra winter pressures are driven by flu and other respiratory conditions.

2.29 As a result of coronavirus, there has been a significant change in public behaviour in ways that could help reduce the spread of flu and other seasonal respiratory illnesses. We think there is an opportunity to invest in promoting strong public health measures and messaging to encourage continued hygiene measures social distancing and having clear plans to safely ramp up flu vaccination rates. We also think there is scope to expand the idea of self-isolation and self-care when you have early signs of any viral infections, not only suspected COVID. Such behaviours could help reduce the spread of flu and help protect NHS capacity during the difficult winter months.

Appendices

1 Audit methods

1 Audit methods

We have based the messages in this report on work we undertook to follow-up our 2015 reviews of waiting times for NHS elective care and orthopaedics services. The work was largely carried out over a 14 month period ending January 2020. Following the outbreak of COVID, we adjusted our reporting plans to take into account the impact of the pandemic on NHS planned care, and emergency recovery planning, nationally and locally. We have used discussions with Welsh Government officials and members of the Department for Health and Social Care's Quality Delivery Board to help test and shape our messages.

Further information on our audit methods is set out below.

Waiting Times for Elective Care Follow-up

- Self-assessment: we asked the Welsh Government to complete a self-assessment of progress against a range of areas related to our 2015 recommendations.
- Interviews with Welsh Government officials with responsibility for planned care within the Welsh Government.
- Interviews with a sample of health board executives with responsibility for planned care, in particular to gather their views on progress with the national planned care programme.
- We reviewed a range of documents, including Welsh Government correspondence with the Public Accounts Committee in relation to NHS waiting times, Welsh Government published plans, including the national strategy for the NHS A Healthier Wales. We also reviewed a range of internal documents that the Welsh Government provided as part of its self-assessment.
- Data analysis: we reviewed published data on the length of time people wait for treatment, as well as published data on activity and efficiency measures.

Orthopaedic services follow-up

Our work examined progress in each health board as well as national developments in respect of orthopaedic services. Collectively this involved:

- analysis of publicly available data sets and additional data from health boards;
- observations at relevant national meetings such as the Welsh Orthopaedics Board and Planned Care Programme Board;
- interviews with Welsh Government officials and relevant staff within health boards, typically the executive lead for orthopaedic services, clinical director and general manager for orthopaedic services, and the orthopaedic triage lead;
- a review a range of national and local documents, plans and reports.
- surveys of all health boards to capture qualitative information on orthopaedic services;
- A 'pathway walkthrough' at each health board to understand the process and issues faced on a day-to-day basis both by staff and patients; and
- focus groups with a range of staff involved in the orthopaedic pathway.

Reports setting out the key findings from our local orthopaedic work will be shared with individual health boards during autumn 2020, alongside a national summary of the key messages from this work.

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Archwilio Cymru
Audit Wales

The National Fraud Initiative in Wales 2018-20

Report of the Auditor General for Wales

This is an interactive pdf

To navigate through the document please use the buttons on the left side of the page and the links marked with underlined text

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Since we last reported on the NFI in Wales in October 2018, outcomes valued at £8 million have been recorded. The cumulative outcomes from the NFI in Wales since 1996 are now £42.9 million. Across the UK, the cumulative total of NFI outcomes are now £1.93 billion.

NFI outcomes in Wales have increased by £2.7 million to £8 million in the 2018-20 exercise. This increase was due to local authorities becoming more proactive in cancelling ineligible claims for Council Tax Single Persons Discount.

Data sharing enables matches to be made between bodies and across national borders. Data submitted by Welsh bodies for the 2018-2020 NFI exercise helped other organisations in other parts of the UK to identify 94 cases of fraud and error with outcomes of £125,000.

Whilst the majority of Welsh NFI participants display a strong commitment to counter fraud and the NFI, as reported in my recent report on counter-fraud arrangements across Wales, some bodies do not demonstrate a commitment to address fraud and do not ensure that sufficient, skilled staff resource is in place to investigate matches, prevent frauds and correct errors.

The COVID-19 pandemic has brought significant challenges across the public sector as bodies seek to deliver services for individuals, communities and businesses in an extremely difficult time. Since the start of the pandemic, the risk of fraud has increased as organisations become stretched and controls and governance are changing.

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Recommendations

- All participants in the NFI exercise should ensure that they maximise the benefits of their participation. They should consider whether it is possible to work more efficiently on the NFI matches by reviewing the guidance section within the NFI secure web application.
- Audit committees, or equivalent, and officers leading the NFI should review the NFI self-appraisal checklist. This will ensure they are fully informed of their organisation's planning and progress in the 2020-22 NFI exercise.
- Where local auditors have identified specific areas where improvements could be made, the public bodies should act on these as soon as possible.
- All participants should be aware of emerging fraud risks e.g. due to COVID-19, and take appropriate preventative and detective action.

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National Fraud Initiative Outcomes

The National Fraud Initiative (NFI) is a counter-fraud exercise across the UK public sector which aims to prevent and detect fraud. The NFI uses data sharing and matching to help confirm that services are provided to the correct people.

An NFI outcome describes the overall amounts for fraud, overpayments and error that are detected by the NFI exercise and an estimate of future losses that it prevents.

The NFI recorded outcomes of £8.0 million in 2018-20.

NFI outcomes cumulatively in the UK since 2006

£1.93 billion

NFI outcomes cumulatively in Wales since 2006

£42.9 million

NFI outcomes across UK from the 2018-20 exercise

£244.7 million

NFI outcomes in Wales from the 2018-20 exercise

£8 million

The background to the NFI is contained in **Appendix 1**

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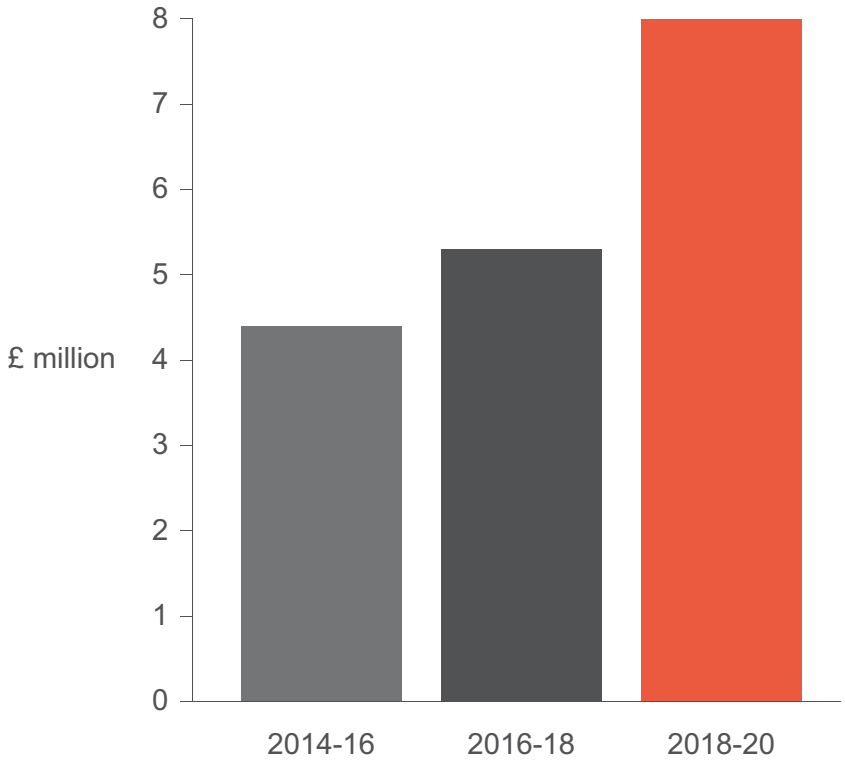
Trends in outcomes

Outcomes in Wales have increased by £2.7 million to £8 million in the 2018-20 exercise. This was despite the fact that immigration data was not included in the 2018-20 exercise due to restrictions placed on it by the Home Office following the review into the treatment of the Windrush generation. The increase in outcomes is due to several Welsh local authorities becoming more proactive in reviewing matches between Council Tax Single Persons Discount and the electoral register.

Having fewer matches provides some assurance there do not appear to be significant problems in the areas covered by the exercise. However, participants still benefit from the deterrent effect the NFI creates.

Outcomes in Wales increased to £8.0m in the 2018-20 exercise



Due to a formula error in the NFI computer system, pensions outcomes in the 2016-18 exercise were overstated by £0.1 million. The 2016-18 outcome figure has been adjusted accordingly in the above chart.

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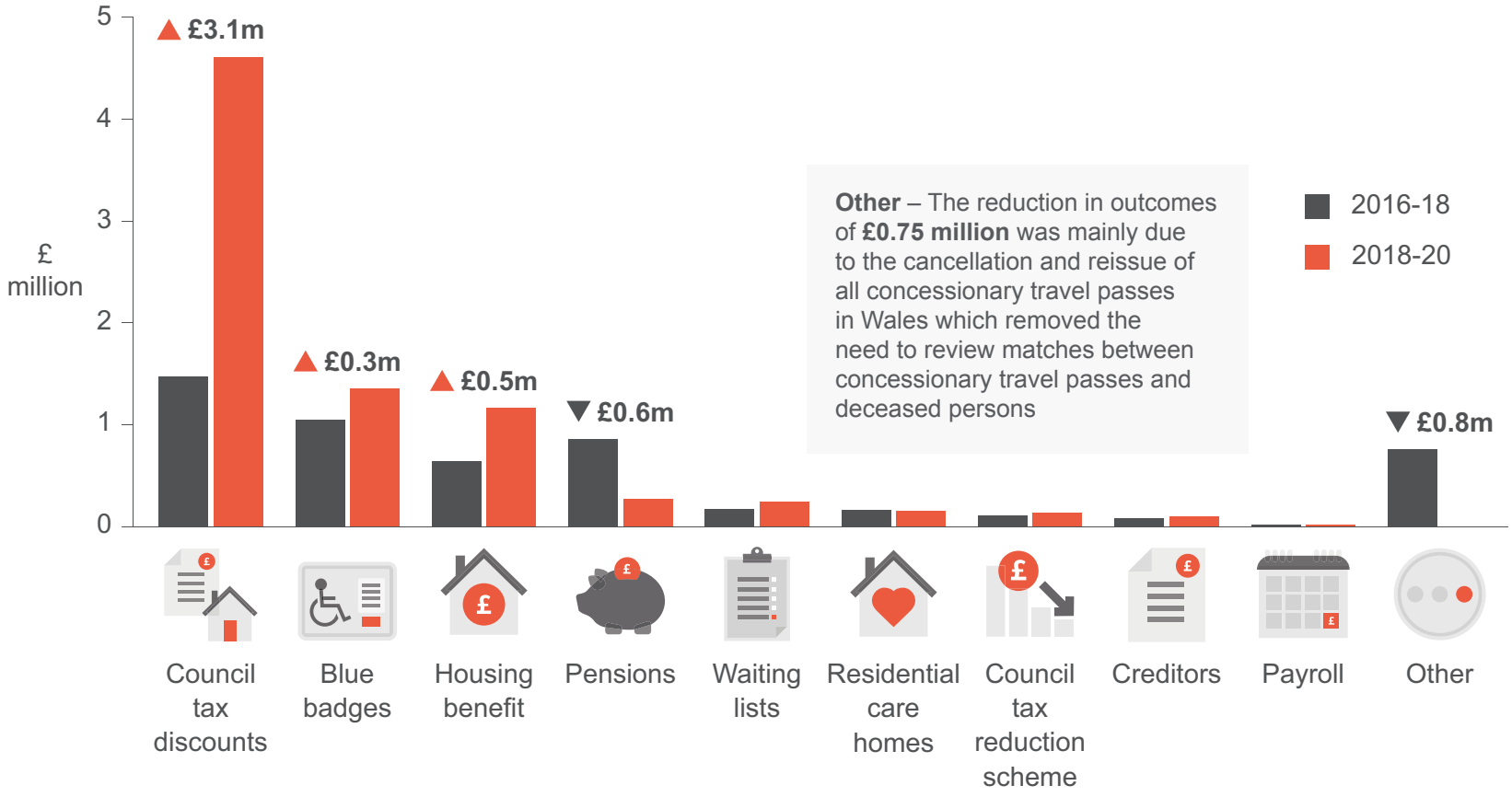
How the latest outcomes compare to the last exercise

NFI outcomes in Wales have **increased** by **£2.7 million** to **£8.0 million** in the 2018-20 exercise.



Other – The reduction in outcomes of **£0.75 million** was mainly due to the cancellation and reissue of all concessionary travel passes in Wales which removed the need to review matches between concessionary travel passes and deceased persons

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Seven areas generated almost 98% of outcomes

The areas which generated the most outcomes from the current exercise are as follows:

Category	£	Cases
Council tax discount	£4.6m	3939
Blue badges	£1.4m	2354
Housing benefit	£1.2m	179
Pensions	£0.3m	10
Waiting lists	£0.2m	74
Residential care homes	£0.2m	11
Council tax reduction scheme	£0.1m	11

When overpayments are identified, public bodies can take appropriate action to recover the money. As at 31 March 2020, 83% of overpayments had been recovered or were in the process of being recovered.

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Council tax discounts

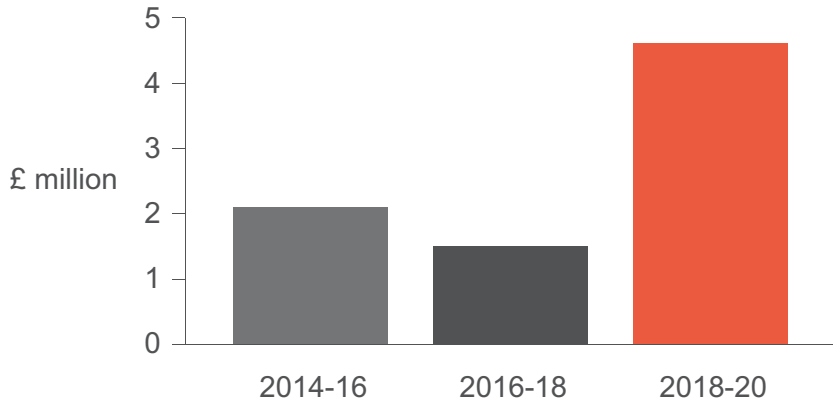
People living on their own, or with no countable adults in the same household, are eligible for a 25 per cent single person discount (SPD) on their annual council tax bill.

Council tax SPD data is matched to electoral register data to help find where people who are receiving the discount, but are not the only countable adult at their residence.

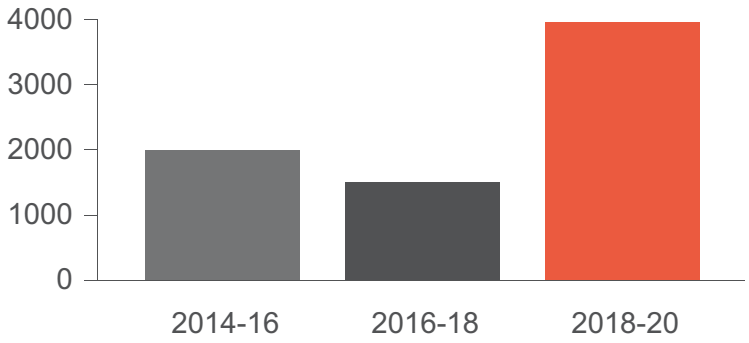
The 2018-20 NFI exercise found incorrectly awarded council tax discount totalling £4.6 million across Welsh councils. This is an average outcome of £1,003 for each case (£998 per case in the 2016-18 NFI). Review of the NFI matched led to the cancellation of 3,939 SPD claims.

The increase in outcomes is mainly due to local authorities becoming more proactive in investigating the matches.

Outcomes of **£4.6 million** in 2018-20



4,588 cases in 2018-20



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Case Study: Council tax single persons discounts

Vale of Glamorgan Council

The Council has a proactive and comprehensive approach to reviewing NFI Council Tax discount matches. All matches are reviewed at the earliest opportunity. New matches are checked against NFI matches from previous exercises to eliminate cases dealt with before the new matches were released. All remaining matches are then reviewed against the Council's internal systems to try and establish current the household status of the claimant. Where no mitigating household circumstances are identified on the Council's systems, letters are sent to claimants asking them to provide evidence of entitlement. As a result of this action in NFI 2018-20 the Council has so far cancelled 175 claims and identified recoverable overpayments of £112,523. The Council is currently investigating a further 400 cases.

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Pensions

The NFI provides councils that administer pensions an efficient and effective way of checking that they are only paying people who are alive.

The exercise found 10 instances where pensions had remained in payment after pensioners had died.

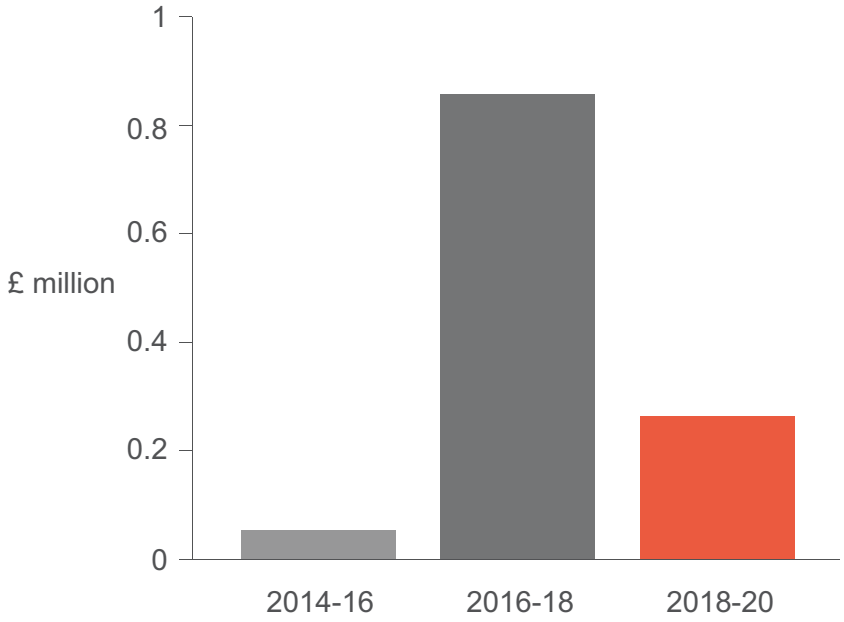
In total, pensions' outcomes for the 2018-20 NFI are £0.26 million. This equates to an average outcome of £26,000 per case.

This is a reduction of £0.59 million from the 2016-18 NFI exercise.

Pension outcomes have fallen due to the 'tell us once' reporting process having become more embedded over the last two years.

Pensions outcomes across the UK have fallen by 59 per cent from £136.9 million in 2016-18 to £55.5 million in 2018-20.

Outcomes of **£0.26 million** in 2018-20



Due to a formula error in the NFI computer system, pensions outcomes in the 2016-18 exercise were overstated by £0.1 million. The 2016-18 outcome figure has been adjusted accordingly in the above chart.

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Case Study: Pensions

Cardiff Council

The Council proactively reviewed matches between pensions in payment and deceased persons. One match indicated that a pension scheme member had passed away during November 2016. Examination of Council records established that the recipient had moved away from the Council area before their death. The investigator confirmed the date of death of the pension scheme member and that £8,504 had been paid into the scheme member's bank account since the date of death.
The investigator identified an individual who had Power of Attorney.
The Council carried out home visits and sent letters to the individual who had Power of Attorney to establish the circumstances that resulted in the overpayment. The individual did not respond. The investigator contacted the late pension member's bank, and established that the pension payments had not been withdrawn from the scheme member's account.
The Council is in the process of recovering the overpayment.

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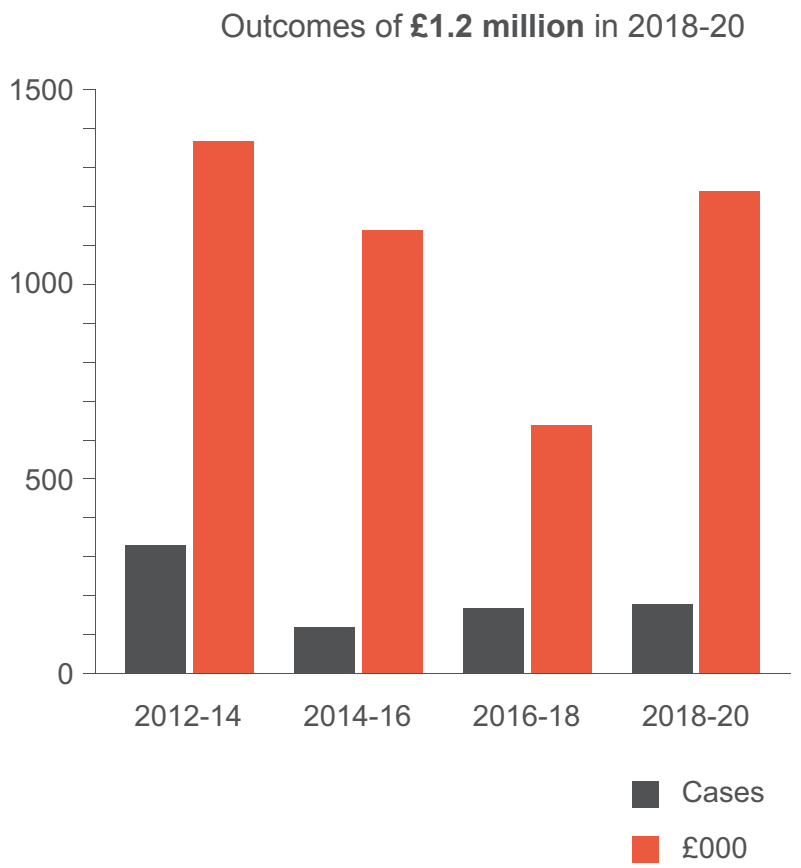
Housing benefits

The NFI provides councils and the Department for Work and Pensions (DWP) with the opportunity to identify a wide range of benefit frauds and errors.

Housing benefit data is matched to student loans, payroll, pensions, housing benefits, housing tenants, licences, deceased person and Amberhill data to help identify ineligible claims.

The value and number of housing benefit cases recorded with overpayments has risen from £0.6 million (169 cases) in the 2016-18 NFI to £1.2 million (179 cases) in the 2018-20 NFI.

Although the number of benefit cases has only increased slightly, the average value of overpayments in each case has increased from £3,781 in the 2016-18 NFI exercise to £6,496 in 2018-20.



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Case Study: Housing benefits

Carmarthenshire County Council

Carmarthenshire County Council recognises the importance of NFI in protecting the public purse against fraud risks and uses NFI to assist in the detection and prevention of fraud. The 2018-20 exercise identified 138 Housing Benefits to student loan matches. The Council initially considered only checking matches marked as high risk matches, but based on positive results in previous years felt it beneficial to extend the checking process beyond the high risk cases. Review of the matches led to 12 fraud investigations, where it was established that the benefit claimants had failed to declare that they were in receipt of student finance/ loans These cases generated overpayments of benefits in excess of £34,000. The Council has recovered the overpayments, or is in the process of recovery through deductions from ongoing benefit payments.

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Blue badges

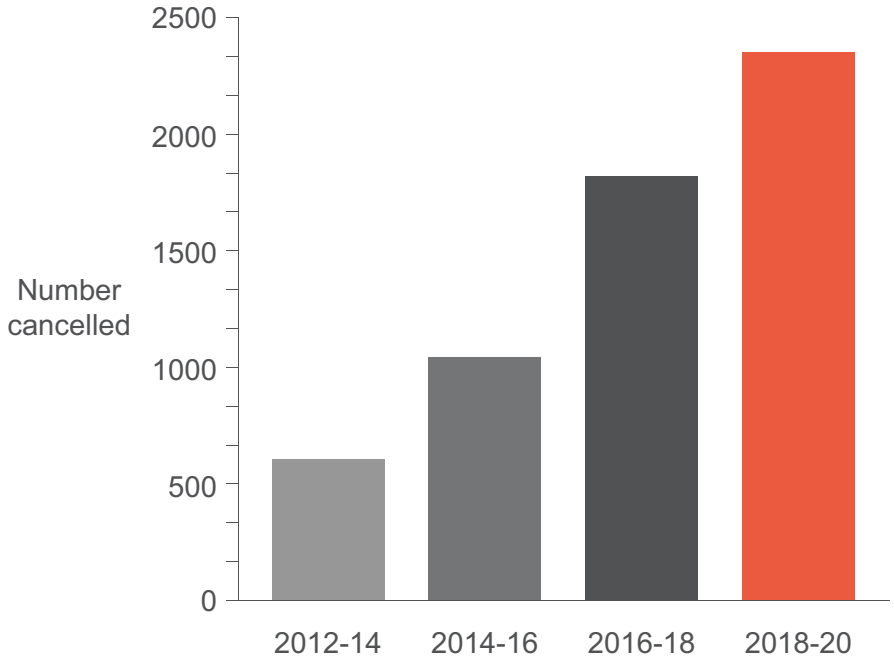
The blue badge parking scheme allows people with mobility problems to park for free at on-street parking meters, in 'pay and display' bays, in designated blue badge spaces, and on single or double yellow lines in certain circumstances.

Blue badge data is matched to deceased persons and Amberhill data.

Badges are sometimes used or renewed improperly by people after the badge holder has died. It is an offence for an unauthorised person to use a blue badge.

NFI 2018-20 resulted in the cancellation of 2,354 blue badges in Wales. The number of badges cancelled has increased in each NFI exercise since NFI 2012-14

2,354 outcomes in NFI 2018-20



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Housing waiting lists

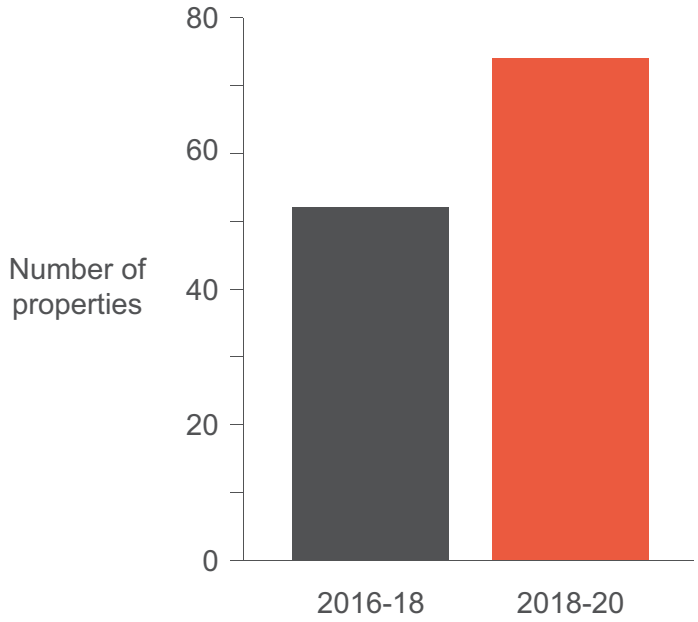
The aim of the NFI using housing waiting list data is to identify possible cases of waiting list fraud. This happens when an individual has registered on the waiting list but there are possible undisclosed changes in circumstances or false information has been provided. This was a new data set for the 2016-18 NFI exercise.

Housing waiting list data is matched to waiting list, housing benefit, housing tenants, deceased persons and Amberhill data.

Councils identified 74 cases where applicants were removed from waiting lists.

The estimated value of these cases is £0.24 million based on a calculation of the annual estimated cost of housing a family in temporary accommodation and the likelihood a waiting list applicant would be provided a property.

Outcomes of **£0.24 million** in 2018-20



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Creditors

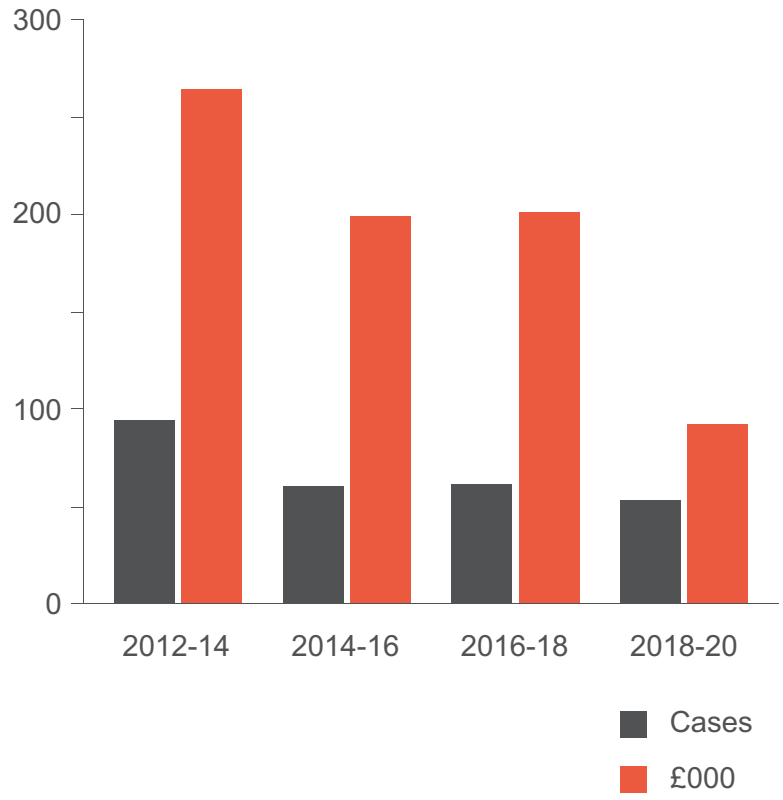
The NFI provides an efficient way to check for duplicate payments and that payments are only made to appropriate creditors.

Creditor data is matched to creditor and payroll data.

NFI 2018-20 has resulted in 53 creditor outcomes of £0.1 million compared to 61 outcomes worth £0.2 million in 2016-18. Recovery action is taking place for 100% of these overpayments.

Creditor outcomes have reduced over NFI exercises as participating bodies have improved their internal system controls.

Outcomes of **£0.1 million** in 2018-20



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Payments to residential care homes

The NFI identifies cases where a care home resident has died, but the local authority may not have been notified and so continue to make payments.

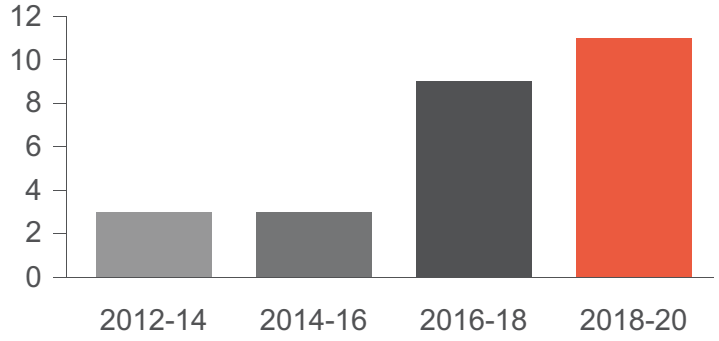
Residential care home data is matched to deceased persons and Amberhill data.

Councils have identified 11 cases of overpayments valued at £0.16 million to care providers for people who have died.

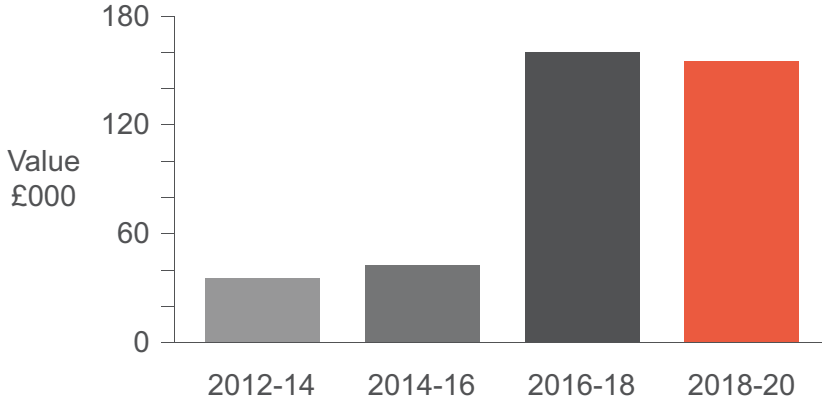
The average value of each case was £14,545.

93% of the overpayments have or are being recovered.

Number of cases of payments to private residential care homes for deceased residents



Outcomes of **£0.16 million** in 2018-20



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Council tax reduction

Council tax reduction helps those on low incomes to pay their council tax bills.

The NFI provides councils with the opportunity to identify a range of council tax reduction frauds and errors.

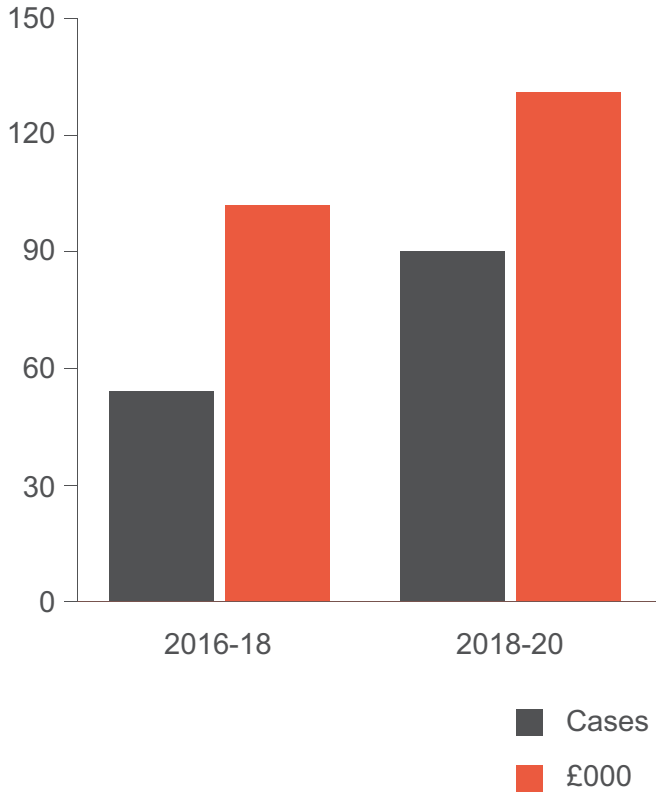
Council tax reduction data is matched to council tax reduction, payroll, pensions payroll, housing benefits, housing tenants, licences, deceased persons and Amberhill data.

The 2016-18 NFI was the first time council tax reduction data sets were included within the NFI.

Outcomes of £0.13 million were identified in the 2018-20 NFI and claims for council tax reduction were amended or cancelled in 90 cases.

The average value of each case was £1,457 compared to £1,887 in NFI 2016-18 suggesting that fraud and error is being identified earlier.

Outcomes of **£0.13 million** in 2018-20



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Fraud risks associated with COVID-19

The COVID-19 pandemic has brought significant challenges across the public sector as bodies seek to continue to deliver services for individuals, communities and businesses in an extremely difficult time. This includes additional fraud risks that will be important for public bodies to identify and manage.

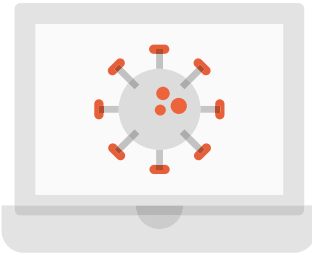
Good governance and sound controls are essential in such crisis situations.

The risks include, but are not limited to:

- Many public sector bodies have been working together in order to try to address these risks through data matching and sharing information. Additional assurance activity is also planned by many public sector bodies once the COVID-19 crisis is over.
- The Auditor General has been working with the Cabinet Office in order to promote the use of data matching as a means of preventing COVID-19 related fraud.
- Facilities to allow councils to carry out additional checks on bank accounts and company status in relation to business support grants have been rolled out to Welsh NFI participants.

government stimulus packages to support individuals and businesses being provided quickly with a lower level of scrutiny and due diligence than has previously been in place for similar schemes

an increase in phishing emails and scams trying to tempt staff working under pressure to click on links which allow fraudsters access to public sector systems



an increase in cyber-crime as more public sector staff connect remotely

public sector staff working under extreme pressure

public sector staff working remotely

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Matches benefiting other public bodies

One key benefit of a UK wide data matching exercise is that it enables matches to be made between bodies and across national borders. Data provided by Welsh participants for the 2018-20 NFI exercise helped other public bodies outside Wales identify outcomes worth almost £125,000.

Sector of source data	£	number of outcomes
Local authorities	99,552	76
NHS	24,538	17
Fire	898	1
Total	**124,989**	**94**

Most of these outcomes relate to housing benefits, housing waiting list and council tax reductions where, for example, payroll data from a health board may allow a council to identify a housing benefit overpayment.

For those public bodies taking part in the NFI which may not always identify significant outcomes from their own matches, it is important to appreciate that other bodies and sectors may do so.

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How bodies work with the NFI

The success of NFI is dependent on the proactivity and effectiveness of participant bodies in investigating the data matches.

Most participating Welsh public bodies managed their roles in the 2018-20 NFI exercise well.

However, some bodies could be far more pro-active in their approach to the NFI. In particular some local authorities reviewed very few of the matches they received, and as a consequence did not do sufficient work to address potential frauds. This was due to a failure to allocate adequate skilled counter-fraud resource to investigate the NFI matches.

We recommend that all bodies use our checklist to self-appraise their involvement in the NFI before and during the 2020-22 NFI exercise.

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Future developments

- The COVID-19 pandemic and the resulting emergency support packages put in place have led to a greater risk of fraud. The Auditor General has been working with the Cabinet Office to identify, develop and promote data matching facilities to help address some of this increased fraud risk. Work will continue in this area into the 2020-22 NFI exercise.
- The Auditor General has mandated that Welsh local authorities submit data on COVID-19 business support grants to NFI 2020-22 for data-matching to address fraud in this area.
- The 2020-22 NFI is now underway. Data sets have been reviewed following a period of consultation and NFI participants are starting to submit data for matching.
- The Auditor General continues to work with the Cabinet Office in developing new ways to prevent and detect fraud.
- The Auditor General continues to work with the Welsh Government in promoting and enhancing participation in the NFI across Wales.

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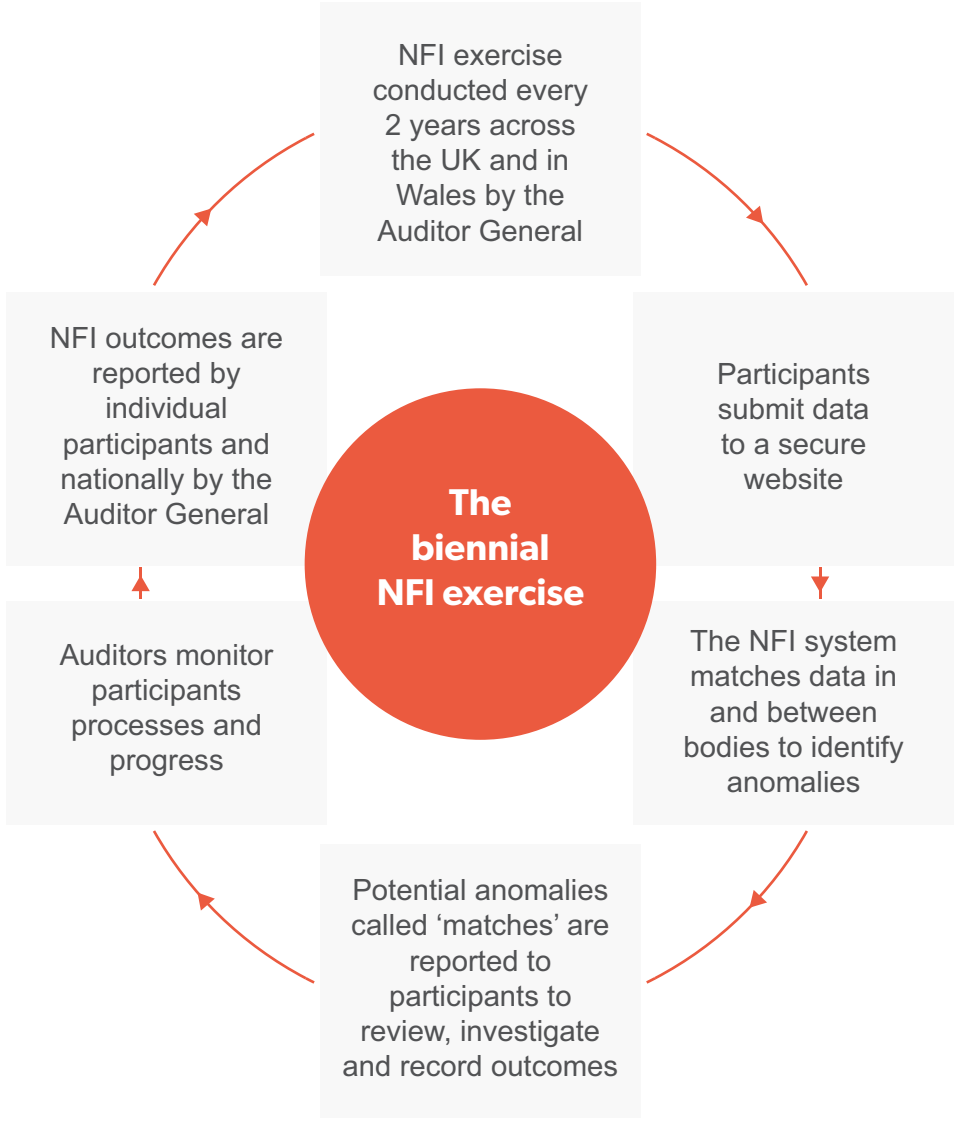
Appendix 1 – Background to the NFI

The NFI is a counter-fraud exercise across the UK public sector which aims to prevent and detect fraud. The Auditor General, Cabinet Office, Audit Scotland and the Northern Ireland Audit Office lead the exercise in Wales, England, Scotland and Northern Ireland respectively. The NFI takes place biennially and enables public bodies to use computer data matching techniques to detect fraud and error.

The main purpose of the NFI is to ensure funds and services are provided to the correct people, but NFI can also identify individuals entitled to additional services or payments e.g. housing benefit matches may identify customers entitled to council tax discount or reduction.

We carry out the NFI process under powers in the Public Audit (Wales) Act 2004. It is important for all parties involved that this exercise is properly controlled and data handled in accordance with the law. The Auditor General's Code of Data Matching Practice summarises the key legislation and controls governing the NFI data matching exercise is available from the Audit Wales website.



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The Auditor General is independent of the Senedd and government. He examines and certifies the accounts of the Welsh Government and its sponsored and related public bodies, including NHS bodies. He also has the power to report to the Senedd on the economy, efficiency and effectiveness with which those organisations have used, and may improve the use of, their resources in discharging their functions.

The Auditor General also audits local government bodies in Wales, conducts local government value for money studies and inspects for compliance with the requirements of the Local Government (Wales) Measure 2009.

The Auditor General undertakes the National Fraud Initiative in Wales under Part 3A of the Public Audit (Wales) Act 2004 which empowers him to conduct data matching exercises for the purpose of assisting in the prevention and detection of fraud in or with respect to Wales and to publish the results of any such exercise.

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

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Archwilio Cymru
Audit Wales

Welsh Community Care Information System

Report of the Auditor General for Wales

October 2020

This report has been prepared for presentation to the Senedd under the Government of Wales Act 1998 and the Public Audit (Wales) Act 2004.

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

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1 The Welsh Community Care Information System (WCCIS) is intended to enable health and social care staff to deliver more efficient and effective services using a single system and a shared electronic record. WCCIS is being developed for use across a wide range of adult and children's services, moving from a position of multiple systems at different stages of development or paper records. The Welsh Government has always intended that all 22 local authorities and seven health boards should implement WCCIS through a contract signed in March 2015.

2 The programme of work to implement and roll out WCCIS and realise its benefits is complex and ambitious. It requires various organisations to collaborate at a national, regional and local level, working within different accountability frameworks. Together they need to agree priorities and manage risks and inter-dependencies as part of wider policy development across the health and social care system. We have examined the latest position. **Appendix 1** describes our audit approach and methods.

Implementation and roll-out of WCCIS are taking much longer and proving more costly than expected. Despite efforts to accelerate the process, the prospects for full take-up and benefits realisation remain uncertain. Some important issues around the functionality of the system, data standards and benefits reporting are still to be fully resolved.

3 The Welsh Government recognises that an IT system alone will not deliver the changes to health and social care it wants to see. However, WCCIS is the key digital enabler. Through the WCCIS contract, local authorities and health boards can agree 'deployment orders' with the supplier without needing their own procurement process. The contracting framework has needed to evolve since 2015 to encourage delivery by the supplier and take-up by organisations.

4 There was an initial estimation that all local authorities and health boards could be using the system by the end of 2018, although the timescales were not binding. It was anticipated that the detailed plans would be completed in negotiation with the supplier and participating organisations.

5 As at 31 August 2020, 19 organisations were using WCCIS or had signed deployment orders, with four in active negotiation and six yet to commit. Of the 19 organisations, 13 local authorities and two health boards had gone live. However, 'live' can mean different things. Differences in how organisations are choosing to deploy WCCIS currently limit opportunities for integrated working and raise other value for money issues.

6 Key aspects of the expected functionality have been significantly delayed. This includes certain enhancements to the original contractual requirements. The current estimate is that the remaining updates will be delivered on a phased basis through to the end of 2021. Areas where work is still needed include Welsh-language requirements, mobile functionality and interfaces with other NHS Wales systems. The National Programme Team has also needed to address concerns about system performance.

7 Implementing and rolling out the system is proving more costly than expected and with additional investment needed to support related service transformation. To date, just over £30 million has been spent or committed to March 2022 by the Welsh Government and NHS Wales Informatics Service (NWIS). Further capital costs are possible, although these may fall to deploying organisations.

8 We have been unable to arrive at a reliable overall estimate of local implementation costs met from organisations' own budgets, although it is apparent that these run into several millions of pounds. Once organisations have gone live, they also pay ongoing service charges, although in most cases WCCIS has replaced predecessor systems and their associated costs. The National Programme Team has emphasised that accountability for detailed local costs, risk and benefits rests with the local organisations.

9 Through the national programme management arrangements, action has been taken at various points to review and try to accelerate delivery. However, some key issues have taken a long time to resolve or have still not been fully resolved. Recent changes to programme governance structures are intended to support a more co-ordinated national approach, including acceleration of national data standards which are key to realising some of the benefits of WCCIS. The work on data standards is at different stages across different service areas. We understand that the use of WCCIS to support the COVID-19 response has highlighted the importance of this work and showed that this is possible given enough focus.

10 Responsibility for implementing WCCIS is widespread and includes organisations that are not party to the contract. The Welsh Government can require health boards to use the system. It has not yet chosen to do so and is currently relying on accelerating take-up through additional funding. The Welsh Government has provided some financial support to local authorities but does not have similar powers to require them to use the system.

11 The arrangements for reporting the benefits from WCCIS roll-out have been the subject of discussion and review from the outset. Work is still ongoing to develop a suitable reporting framework.

The potential benefits of a shared electronic record across health and social care are clear to see; even more so given some of the challenges presented by the COVID-19 pandemic. However, the Welsh Government's ambitious vision for WCCIS is still a long way from being realised. It now needs to work with the various organisations involved to take stock of expectations for the remainder of the contract term and the resources and wider commitment needed to support progress.

Adrian Crompton
Auditor General for Wales

Key facts

Roll-out to 31 August 2020

	Health boards	Local authorities
Live	2	13
Deployment order signed – not yet live	2	2
No deployment order signed	3	7

Click here to access our interactive data tool which provides further detail on the roll-out position across all 29 organisations.

Central support costs to March 2022: actual/committed

£30.16 million

£8.41 million
capital costs for software development, licences, hardware and network infrastructure

£8.62 million
national programme management support

£13.13 million
support for health boards and local authorities for implementation and roll-out and related service transformation

[Excludes local implementation costs and service charges met from organisations' own budgets and wider opportunity costs associated with the overall governance arrangements for WCCIS implementation and roll-out.]

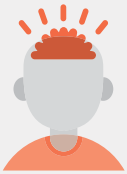
Potential service area coverage (with examples)

Social care services for adults, children and families

- Safeguarding and adult protection
- Fostering and adoption

Social care financial services

- Direct payments
- Financial assessments
- Foster care payments



Child and Adolescent Mental Health Services (CAMHS)

- Early intervention and prevention
- Learning disability service

Child community services

- School nursing
- Flying Start and Families First health visiting

Adult and older mental health

- Psychology
- Prescribed medication support
- Acquired brain injuries

Community (other)

- District nursing
- Physiotherapy
- Adult weight management

4 Recommendations

While there are important issues still to be resolved – including on outstanding functionality, data standards and benefits reporting – we are not making specific recommendations in these areas. They are all the subject of ongoing work through the national programme management arrangements. However, the recommendations that we have made are relevant from an overall programme delivery perspective. Also, some of the broader recommendations in our January 2018 report on informatics systems in NHS Wales remain relevant to WCCIS implementation.

Recommendations

R1 We recommend that, before committing any further central funding, the Welsh Government works with the WCCIS National Programme Team, health boards, local authorities and the supplier to:

- produce an updated business case that takes account of local, regional and national costs and sets out expectations for further roll-out of the system, its use over the remainder of the contract term, the development of national data standards and planning for any successor arrangements;
- ensure the organisations involved have the necessary capacity to support implementation and are giving enough priority to the programme against a clearly agreed plan; and
- pull together a clear national picture on feedback from front-line users about the performance and general functionality of the system.

Recommendations

R2 We recommend that the Welsh Government works with the National Programme Team to consider:

- how the WCCIS contract might have been strengthened to support and incentivise delivery and manage risk; and
- how relevant lessons can be applied to any successor contracting arrangements and wider public procurement.

Strategy and contracting

01

Contracting for the use of WCCIS across Wales is a key part of the Welsh Government's plans for integrated health and social care

WCCIS is the key digital enabler to support the Welsh Government's plans for integrated health and social care

1.1 For the Welsh Government, a common electronic health and social care record is key to its ambition of integrated and person-centred health and social care services. In **A Healthier Wales**[1], the Welsh Government committed to accelerate roll-out across local authorities and health boards.

1.2 Recently, the Welsh Government has sought to clarify what the 'Once for Wales' approach for digital systems that it set out in 2015[2] means in practice. It has confirmed that this approach allows for some all-Wales 'national systems' and for different 'interoperable' systems using the same standards. Reinforced by the experience of responding to the COVID-19 pandemic, the Welsh Government still considers that a national approach to information sharing between health and social care is an appropriate model to enable the co-ordination of care within the community.

1.3 The Welsh Government recognises that an IT system alone will not deliver the changes to health and social care it wants to see. Among other things, the Transformation Fund[3] and the Integrated Care Fund[4] are aimed at supporting integrated working across health and social care.

1 Welsh Government, **A Healthier Wales: our Plan for Health and Social Care**, June 2018.

2 Welsh Government, **Informed Health and Care – A Digital Health and Social Care Strategy for Wales**, December 2015.

3 Running between 2018-2021, the Transformation Fund is targeted to priority projects and new models of health and social care, with the aim of speeding up their development and demonstrating their value.

4 See Auditor General for Wales, **Integrated Care Fund**, July 2019 for further information.

Under a 'Master Services Agreement', local authorities and health boards can agree 'deployment orders' with the supplier – CareWorks – without needing their own procurement process

1.4 The WCCIS contract was awarded to the supplier, CareWorks, in December 2014 and signed in March 2015. CareWorks were predominantly experienced in providing social care software solutions. The company had previously provided social care systems for a consortium of eight local authorities in Wales.

1.5 Bridgend County Borough Council led the procurement because, at that time, it needed to replace its social care information system and had previously acted as lead authority in a consortium of eight local authorities. A 'Joint Procurement Board' with wider local government and NHS Wales representation supported the procurement process.

1.6 CareWorks intended initially to use two sub-contractors. One of the sub-contractors would help develop the required health board functionality. Between contract award and contract signing, CareWorks' offer changed and no longer involved that sub-contractor – Advanced[5]. We have been unable to confirm whether those responsible for the contracting process considered the impact of this change on CareWorks' ability to deliver the required health functionality, some of which remains outstanding. Advanced told us that it withdrew as it felt that the system requirements could not be delivered within the timeframe and cost envelope proposed at the time. In late 2019, Advanced acquired CareWorks resulting in changes to CareWorks' management arrangements for WCCIS.

1.7 The contractual model operates as a 'call off contract', including a 'Master Services Agreement' (MSA) and separate 'deployment orders' (**Box 1**). Including opportunities for extension, the contract runs to March 2027. The National Programme Team believes that there are grounds to extend individual deployment orders beyond 12 years, so that early adopters can continue to use WCCIS until 2030. This would help to align end dates and facilitate future collaborative procurement.

1.8 CareWorks offered an overall financial discount amounting to 11.5% of the pricing in its original bid if the costs for licences and ICT infrastructure were paid up-front rather than as organisations implemented the system. This option was preferred, with the Welsh Government funding the up-front costs.

5 The other subcontractor remained involved to provide data storage and infrastructure support.

1.9 Nevertheless, the contractual framework exposes the Welsh Government to some value-for-money risks. The return the Welsh Government gets on its investment in software development, hardware and licences depends on the pace of roll-out and the use organisations make of the available functionality. Bridgend County Borough Council was the only organisation required to sign a deployment order. The call-off nature of the contractual framework also exposed CareWorks to certain financial risks.

Box 1: The contractual framework for WCCIS (as agreed originally)

Master Services Agreement (MSA)

- Bridgend County Borough Council entered into the MSA with CareWorks
- The MSA sets out the overarching terms and conditions under which local organisations implement WCCIS
- For example, it sets out the 'Statement of Requirements' (SoR), CareWorks' technical solution to the SoR, governance arrangements, dispute resolution mechanisms, change control processes, service levels and service charges

Deployment orders

1 x for the central hardware, all-Wales licences and 'sunk development costs'[6] incurred by CareWorks, with these costs being met by the Welsh Government

[Up to] 29 x agreed between CareWorks and individual local authorities and health boards[7] – including common elements but able to be tailored to meet local requirements

Original contract timescales

- Minimum of eight years, from March 2015, for the MSA
- Option to extend the MSA for four years, until March 2027 (on a 1+1+1+1 basis)
- Local deployment orders may run beyond March 2027 but must end by March 2030
- Local deployment orders worked on an 8+1+1+1+1 year basis initially, but have since been amended

6 Before entering into the contract, at its own risk CareWorks enhanced its existing CareDirector product to meet some of the requirements, at a cost of £2.2 million.

7 While the focus has been local authority and health board settings, the contractual framework allows for Velindre NHS Trust and the Welsh Ambulance Services NHS Trust to agree deployment orders. The National Programme Team has engaged with both organisations to help them understand the potential benefits of implementing WCCIS.

The contracting framework has needed to evolve to encourage delivery by CareWorks, take-up by organisations and to correct some organisations' service charges

1.10 Under the contract the full functionality was expected to have been delivered before the end of 2015. The contract did not provide for any 'liquidated damages'[8] should CareWorks not deliver the full functionality on time, or additional payments should it meet contractual deadlines. However, the fixed-term nature of the contract provides some incentive for CareWorks, given that its revenue is based on take-up. There are also provisions in individual deployment orders for 'delay payments' in certain circumstances.

1.11 The financial model in the MSA set out the service charges each organisation was expected to pay CareWorks over the initial eight-year term of their deployment order. The total service charges amounted to just over £29 million across the 22 local authorities and seven health boards. However, the actual costs would increase over time to reflect inflation. If organisations choose to extend their deployment orders, the financial model provides for a reduced rate[9].

1.12 The service charges took account of the comparative size of each organisation and the cost to CareWorks of providing support for local implementation. The charges were fixed, regardless of how widely organisations might choose to deploy the system across their services or how much of the expected functionality was available when they signed deployment orders.

1.13 The service charges also included contributions towards £0.50 million for outstanding software development to deliver the statement of requirements functionality. These costs were additional to the development costs already paid by the Welsh Government. However, the Welsh Government has now agreed to fund these software development costs apart from £0.02 million already paid by deploying organisations up to September 2019. The service charges have been adjusted accordingly. The Welsh Government is also funding some additional development for enhanced functionality beyond the statement of requirements.

8 A liquidated damages clause is a common way of dealing with a possible breach under a commercial contract. The sum that must be paid must be fixed in advance (a reasonable estimation of the particular loss) and written into the contract.

9 One-year extension = 10% discount; two-year extension = 15%; three-year extension = 25%; four-year extension = 35%.

1.14 In November 2019, the National Programme Team and Careworks agreed a contract variation to support CareWorks to maintain development capability and accelerate the remaining software development. These changes mean that CareWorks will now receive some payments earlier than anticipated when it delivers outstanding functionality to an agreed set of payment milestones.

1.15 Other contractual changes have affected the way the deployment orders and service charges are working in practice across different organisations. Initially, the contract term was effective from the date a deployment order was signed. This was the case solely for Bridgend County Borough Council, who were the first deploying organisation. However, there was a concern this would discourage other organisations from signing orders because they were keen to avoid the contract running down before the system was ready. Meanwhile CareWorks was having to carry out preparatory work with no firm commitment from organisations.

1.16 Following a renegotiation during the first year of the MSA, the contract only becomes effective when the contracting organisation is satisfied the system has been operating in a stable manner for 30 days – 'stable operations'. The assumption was that it would take around six months after signing deployment orders to reach stable operations[10]. Therefore, the overall contract length was reduced from eight years to 7.5 years. Organisations were still liable for the full eight years' worth of service charges identified in the MSA but paid over a 7.5 year period instead.

1.17 An error in the financial model in the MSA, discovered after the contract term had been changed to 7.5 years, meant the service charges for seven organisations[11] did not cover the full term, falling short by up to three months' worth of payments. CareWorks offered the choice of continuing with a shorter contract term or making up the difference over the full contract term. Each of the seven organisations opted for a shorter initial contract term. The National Programme Team has explained that this option was deemed more cost effective should a contract extension be sought after the initial contract term given the discounted rates for the extensions (**paragraph 1.11**).

10 In practice, implementation work to reach stable operations has generally taken longer than six months.

11 Isle of Anglesey County Council, Vale of Glamorgan Council, Powys County Council, Powys Teaching Health Board, Merthyr Tydfil County Borough Council, Gwynedd Council, Ceredigion County Council.

1.18 All local authorities that have deployed the system to date are liable for service charges at the rates set out originally in the MSA. However, in June 2017 the WCCIS Leadership Board agreed a revised financial model for the five health boards that had not already signed deployment orders[12]. The revised model was based on a phased implementation[13] rather than a 'big-bang' approach. CareWorks had also agreed to an overall reduction in service charges under this model due to changes in planned implementation timescales and not all the expected functionality for health boards being available.

1.19 Organisations signing deployment orders can commission additional functionality beyond that provided for in the original contract. For example, Newport City Council commissioned an interface to its corporate finance system. The Council met the development costs, but the same functionality is now available to other organisations. Any other organisation taking up this functionality would not have to pay development costs but would pay additional service charges.

12 Powys Teaching Health Board and Betsi Cadwaladr University Health Board had already signed deployment orders by this point.

13 Once stable operations have been reached for the first phase of implementation, any subsequent phases must be completed within 24 months. The health board would be liable for service charges if any longer delay was due to local decisions.

Roll-out and costs

02

Implementing and rolling out WCCIS is taking much longer and proving more costly than expected, with the prospects for full take-up still uncertain

Roll-out has been much slower than initially expected, with some organisations still to commit and different choices being made about how much use to make of the system

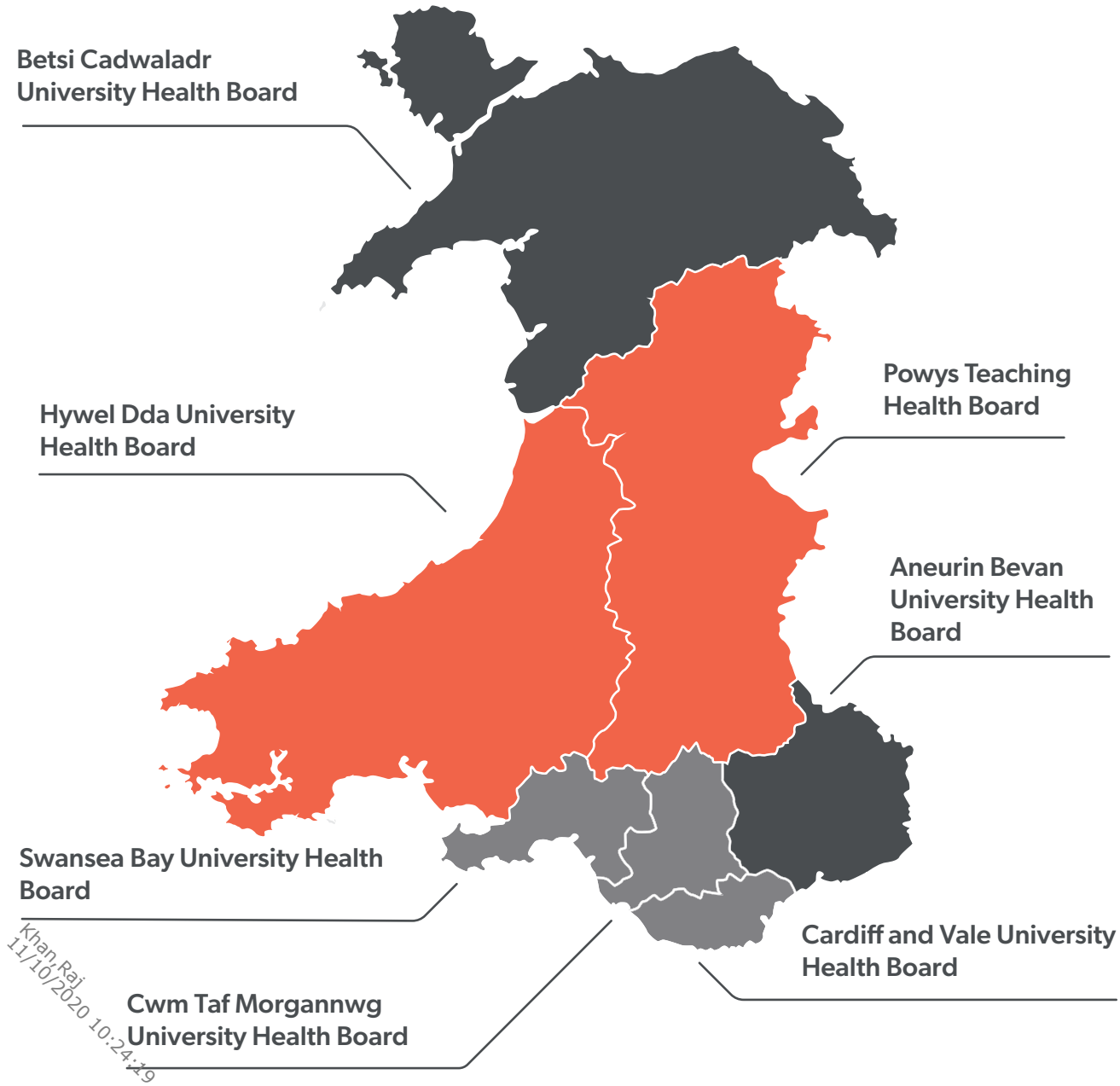
As at 31 August 2020, 19 organisations were using WCCIS or had signed deployment orders, with four in active negotiation and six yet to commit

2.1 The initial March 2015 full business case estimated that successful implementation for the whole of Wales could take up to four years to achieve. Estimated dates, that were also reflected in the contractual documents, suggested that all 29 organisations could be using the system by December 2018. Of these, 11 organisations were identified for potential go-live in 2015-16 and nine in 2016-17. These timescales were not binding. It was anticipated that the detailed development and implementation plans would be completed in negotiation with the supplier and participating organisations.

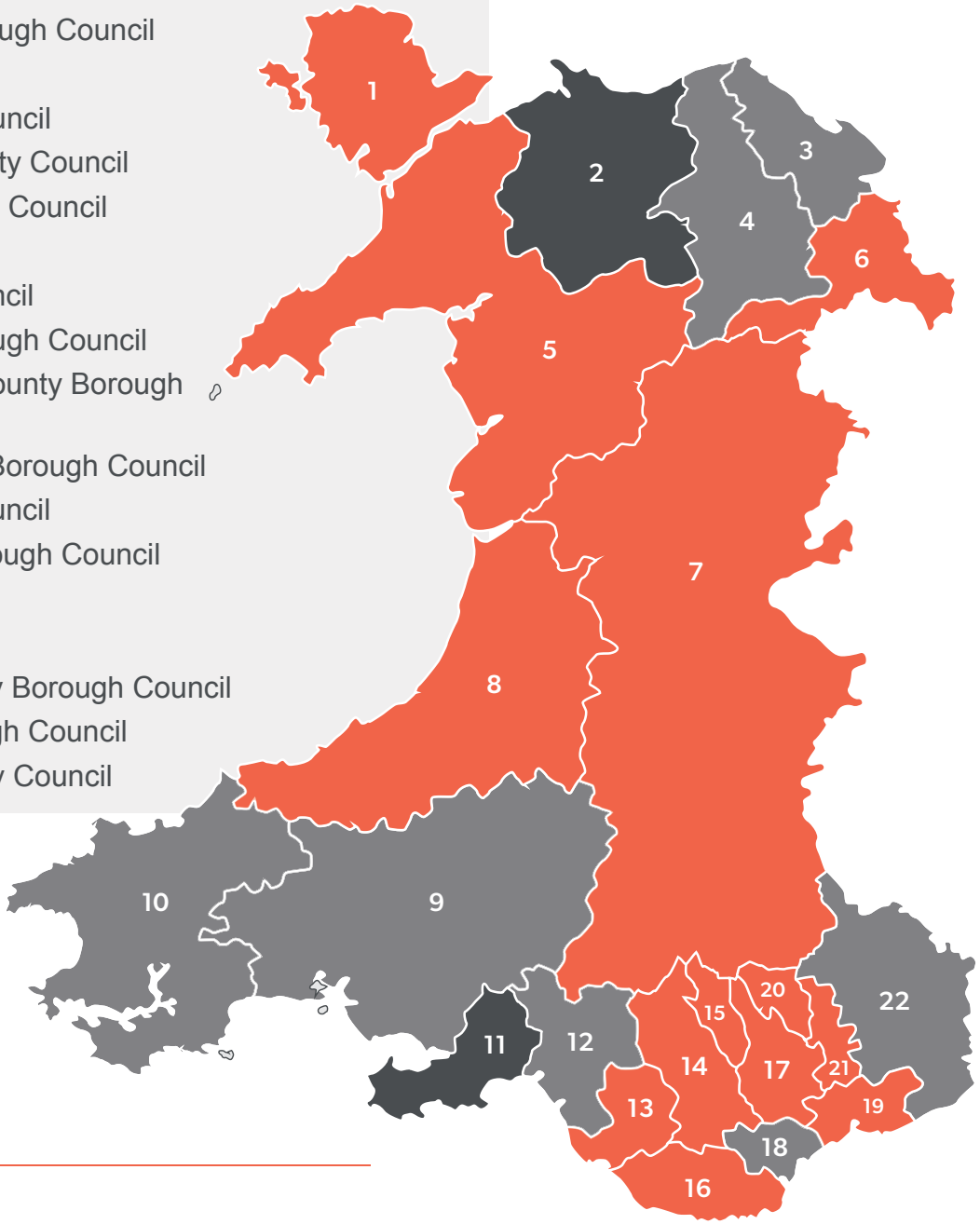
2.2 As at 31 August 2020, 13 local authorities and two health boards – Hywel Dda University Health Board and Powys Teaching Health Board – had gone live and were using WCCIS in some way (**Figure 1**). The business case recommended that WCCIS should be rolled-out on a regional basis and configured to support regional ways of working, reflecting wider policy developments. This approach to roll-out has not happened in practice.

Figure 1: Implementation status of local authorities and health boards as at 31 August 2020

- Live
- Deployment order signed but not yet live
- No deployment order signed



1 Isle of Anglesey County Council
2 Conwy County Borough Council
3 Flintshire County Council
4 Denbighshire County Council
5 Gwynedd Council
6 Wrexham County Borough Council
7 Powys County Council
8 Ceredigion County Council
9 Carmarthenshire County Council
10 Pembrokeshire County Council
11 Swansea Council
12 Neath Port Talbot Council
13 Bridgend County Borough Council
14 Rhondda Cynon Taf County Borough Council
15 Merthyr Tydfil County Borough Council
16 Vale of Glamorgan Council
17 Caerphilly County Borough Council
18 Cardiff Council
19 Newport City Council
20 Blaenau Gwent County Borough Council
21 Torfaen County Borough Council
22 Monmouthshire County Council



- Live
- Deployment order signed but not yet live
- No deployment order signed

Click here to access our interactive data tool which provides further detail on the roll-out position across all 29 organisations.

Source: National Programme Team

2.3 Two more local authorities have signed deployment orders. Of the remaining seven local authorities, three are in active dialogue with the supplier and four are not currently pursuing WCCIS take-up.

2.4 Of the remaining five health boards, two have signed deployment orders. Aneurin Bevan University Health Board signed a deployment order in March 2018 with the intention of full implementation by January 2021. The first phase of implementation in mental health services was scheduled for June 2019. In February 2019, CareWorks advised the health board that it would not be able to meet this date. Currently, the timescale for the health board implementing any aspect of WCCIS remains uncertain. In April 2020, the health board wrote to CareWorks with a claim for 'delay payments' under the contract terms. The health board continues to be engaged with the supplier to work through the issues to help inform a correction plan.

2.5 After signing a deployment order in March 2016, Betsi Cadwaladr University Health Board had an initial go-live date of April 2017 for a phased implementation commencing with mental health services. The date was not met, and the health board then discussed with CareWorks an initial small-scale implementation in its community nursing and mental health teams. The health board has informed us that it will be reviewing the potential for the WCCIS implementation, along with other priority programmes, as it returns to business as usual post COVID-19.

2.6 Swansea Bay University Health Board is in dialogue with CareWorks to work towards a deployment order. Two other health boards are not currently working towards signing a deployment order. Cardiff and Vale University Health Board's view is that even when all the agreed functionality is available, the current version of WCCIS would not meet its requirements, offering less and proving significantly more costly compared to its existing arrangements. Cwm Taf Morgannwg University Health Board is not in active dialogue with CareWorks but intends to implement WCCIS in mental health services first, once the relevant functionality is available.

2.7 Even with the benefit of hindsight, the estimated implementation timescales set out in the full business case appear to us to have been unrealistic. The timescales do not appear to have taken full account of the work required to implement the system and manage the necessary business change processes, whether at a national or local level.

2.8 CareWorks' capacity to support implementation has also been a concern through much of the period to date. As noted in **paragraph 1.6**, CareWorks intended originally to work with a subcontractor to help develop the required health board functionality. In addition, the original contractual framework did little to encourage organisations to support implementation or to incentivise delivery by CareWorks (**paragraph 1.10)**.

2.9 For most of the organisations (11 of 15) that have gone live, go-live dates agreed in deployment orders were missed. For local authorities, the average delay was four months with a range between one month and 26 months. For the two health boards, the delays were one month and five months.

Differences in how organisations are choosing to deploy WCCIS currently limit opportunities for integrated working and raise other value for money issues

2.10 'Live' can mean different things as organisations can choose which elements of the available functionality they use and how widely they deploy the system. For health boards, the variability has arisen as they have tailored deployment orders to meet their individual needs:

a Powys Teaching Health Board's deployment order is based on the organisation going live with all the available health functionality. Currently, it is using most of the available functionality. As at August 2020, the health board had 1,083 users of the system.

b Hywel Dda University Health Board's deployment order covers just the community nursing element of the system. As at August 2020, its 113 users were using the system to deliver community nursing services in Ceredigion[14]. The health board is looking to extend coverage for community services in Pembrokeshire and Carmarthenshire and at how it might use WCCIS in certain therapies services.

c As noted in **paragraph 2.4,** Aneurin Bevan University Health Board has agreed a phased approach to implementing WCCIS.

14 Ceredigion County Council is the only one of the three local authorities in the Hywel Dda region to have signed a deployment order. The Council went live with the system in August 2016.

2.11 All local authority deployment orders allow for coverage across a wide range of adult and children's social care services. For some services, such as disabled and frail older people and safeguarding children, all 13 live local authorities are using WCCIS in some way, but still with differences in the detail of their deployment. There is more of a pick and mix approach in other areas. Only one live local authority is using functionality around special education needs, with the same true for adoption. The National Programme Team's view is that there was always going to be some variation to reflect local needs and that this flexibility has encouraged take-up, with the opportunity to make more use of the system as a deployment order progresses.

2.12 The full business case did not articulate any specific expectations about how much use organisations would make of the system across different services. However, the current picture means that even where the system is live, it is not yet being used to its full potential. This, in turn, raises questions about the overall value for money of the expenditure to date. Some organisations' service charge costs are slightly lower than the costs they were incurring using previous systems. Nevertheless, the contractual framework means that all are essentially paying service charges for functionality that they are not currently using, albeit to different degrees.

2.13 The overall deployment picture and the different approaches to implementation mean that it is currently difficult to realise some of the information sharing and integrated working benefits that the system was expected to support. As part of wider work to identify data and information requirements around COVID-19 for community-based services, WCCIS has been used to help identify vulnerable persons to assist with the delivery of care packages. WCCIS is also being used to support rehabilitation care in the community for people who are recovering from coronavirus. The use of WCCIS to support the COVID-19 response has highlighted the need to address issues around national data standards. It has also shown that this is possible given enough focus.

Key aspects of the expected functionality have been significantly delayed and the National Programme Team has also needed to address concerns about system performance

2.14 As noted in **paragraph 1.10**, some early WCCIS documentation suggests that CareWorks was initially expected to have delivered all agreed functionality by October 2015. As at August 2020, key aspects of the originally agreed functionality were still to be fully delivered, notably the mobile application, the interfaces needed to enable WCCIS to integrate effectively with other NHS Wales IT systems and Welsh-language requirements (**Box 2**). In some of these areas the original contractual requirements have been added to and work is still needed to deliver these 'enhancements'.

Box 2: Key areas where functionality is still to be fully delivered, as at August 2020

Integration – The contract requires CareWorks to develop interfaces between WCCIS and several other NHS Wales systems/services, for example, to access diagnostic results, send to and receive information from GPs or receive hospital to community referrals. Developing these interfaces requires collaboration between the NHS Wales Informatics Service, CareWorks and health boards. Some of the required interfaces were identified in the original Statement of Requirements, while others were agreed in 2019 as enhancements to the 2015 contract.

Of the 16 interfaces now agreed, two are currently live and a further seven interfaces are ready to go into testing. The remaining seven are now scheduled for phased delivery through to the end of 2021.

Mobile application – Under the original contract requirements, WCCIS must be capable of working on a mobile platform via wireless and 3/4G so that it can be accessed by NHS and local authority staff working in the community. A version of the mobile application based on the original requirements is now scheduled to be piloted before the end of 2020. The pilot has been delayed in part due to the impact of COVID-19 and the capacity of local organisations to support this work. Enhanced functionality has also been agreed and is due to go into testing shortly, for example to include appointments management.

Welsh language –CareWorks must deliver a system compliant with the Welsh Language Act 1993 and Welsh Language (Wales) Measure 2011 which together govern the use of the Welsh language in the delivery of public services. Some key aspects of the functionality expected to meet Welsh-language requirements set out in the original contract are not yet available. For example, the system does not currently provide for structured data collection in Welsh.

2.15 It has been clear to the National Programme Team since implementation in Bridgend County Borough Council in 2016, that the system lacked some of the contractually agreed functionality. A November 2017 Gateway review found that the National Programme Team and CareWorks had different views about whether the issues identified were part of, or enhancements to, the original contractual requirements. In mid-2018, the National Programme Team began work to identify a definitive list of the functionality that remained outstanding.

2.16 By March 2019, CareWorks and the National Programme Team had identified that 157 of the 1,500 items set out in the Statement of Requirements had not been delivered. In addition, CareWorks' service desk was not operating as required, the system was not supporting performance reporting as expected, and updates to fix longstanding problems that live organisations were experiencing were failing testing[15]. Under the Master Services Agreement, the National Programme Team issued CareWorks with a contractual non-conformance notice and sought to remedy the situation.

2.17 After a further six months of dialogue, in November 2019 the National Programme Team and CareWorks agreed a timeline, or roadmap, for delivering the outstanding and enhanced functionality over four updates through to September 2020. Accelerated payments tied to delivery milestones and funded by the Welsh Government were also agreed (**paragraph 1.14**).

2.18 Partly as a result of the COVID-19 pandemic, the go-live date of the first of four planned updates to the system was delayed until mid-July. This impacted on the timetable for later updates, which include key aspects such as the enhanced mobile functionality. However, the continuing impact of the pandemic put the plan to complete all four updates by January 2021 at significant risk of delay. The current estimate is that the updates will be delivered on a phased basis through to the end of 2021.

2.19 In addition, arrangements have needed to be confirmed for longer-term operational support for the system platform. It has been known since 2018 that WCCIS is based on a version of a Microsoft platform that will not be supported after July 2021. The National Programme Team has since been discussing with CareWorks how to resolve the issue.

15 For example, some areas of the system cannot be audited, and an individual might have multiple active records running on the system. One of the original aims of WCCIS was to improve patient safety by having a single record. While the different records can be accessed, this currently involves workarounds.

2.20 Under the 'do minimum' option, WCCIS moves to an updated platform that is supported by Microsoft and with CareWorks required to meet the associated costs under the contract terms. Recently, another option emerged of moving to a newer version of the system hosted on the Cloud[16]. In July 2020, the National Programme Team considered the two options. For a variety of reasons, the National Programme Team considered that it was not now practical to move to the Cloud-based version within the required timescales.

2.21 Before the end of 2020-21, the National Programme Team expects to complete a detailed appraisal of the costs, benefits and risks of moving to the Cloud-based version of WCCIS. It intends to consider this in the context of longer-term decisions around the possible extension, or otherwise, of the contractual period and wider Welsh Government digital strategy.

2.22 There have been some significant performance issues with the system over the past year. These have included some complete outages among nine 'severity level 1' incidents[17] and with additional strain on the system during the COVID-19 response. We have heard from the front-line about the impact of system-performance issues on the ability of staff to do their job effectively. Concerns due to system performance issues, including risks to staff and service users, have also been raised in some local reporting by Care Inspectorate Wales and Healthcare Inspectorate Wales.

2.23 The National Programme Team has agreed a performance improvement plan with CareWorks, which has included the installation of additional technical capacity, coupled with recent software improvements. The National Programme Team reports this has resulted in significantly improved performance with ongoing monitoring of the situation.

16 Currently, WCCIS is centrally hosted on physical hardware in the NWIS data centre.

17 Severity level 1 incidents are the most serious type of system performance issue and defined as causing significant business impact and preventing a normal service being provided.

Implementing and rolling out WCCIS is proving more costly than expected and with additional investment needed to support related service transformation

Overall, just over £30 million has been spent or committed to March 2022 by the Welsh Government and NHS Wales Informatics Service (NWIS)

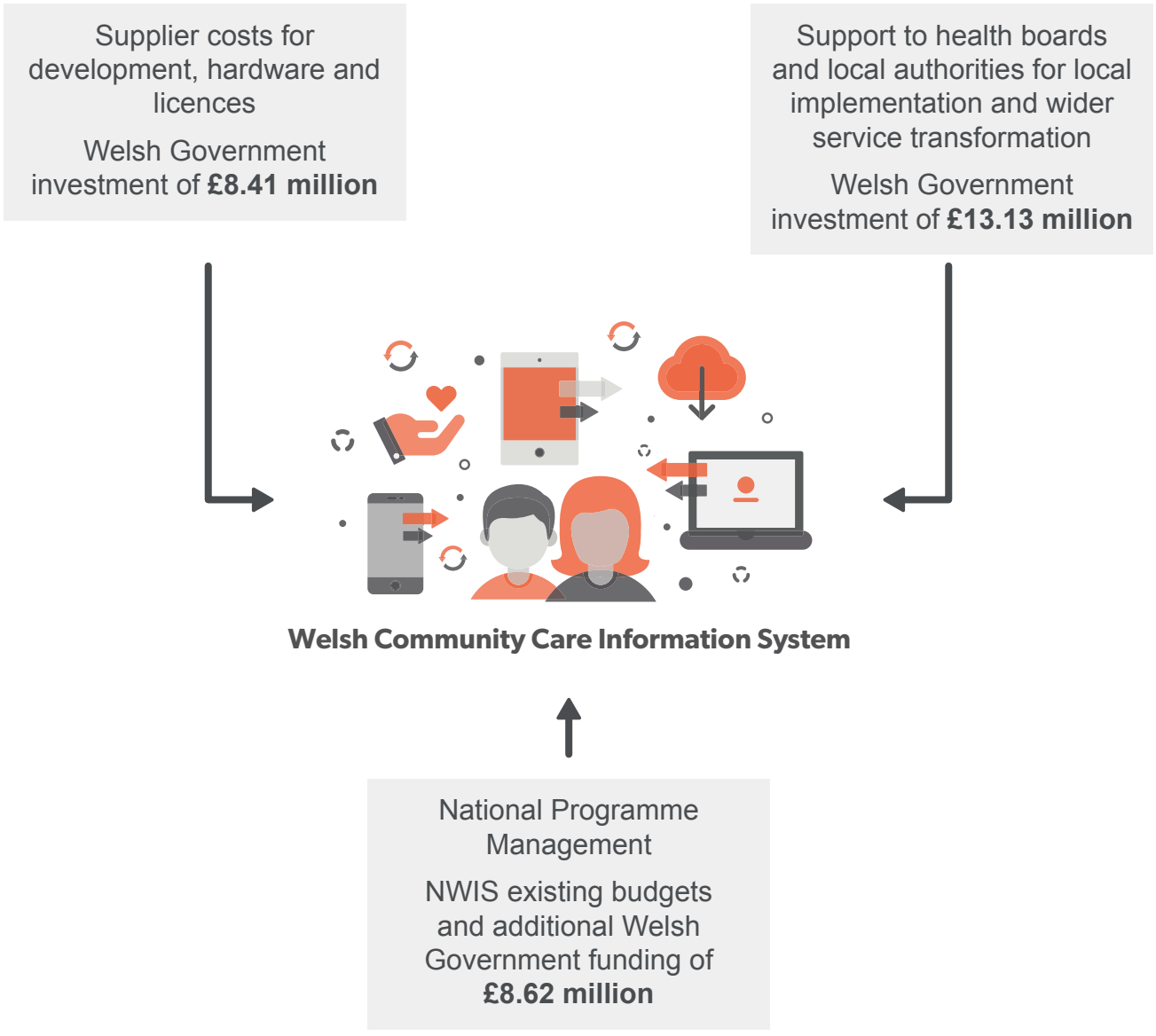
2.24 Where possible, we set out to compare the estimated costs of developing and rolling-out WCCIS with initial estimates in the full business case. Overall, central costs can be broken down into three main areas: Welsh Government capital investment; Welsh Government and NHS Wales Informatics Service (NWIS) spending on national programme support; and Welsh Government funding to support local organisations' costs. Exactly how this local funding is being spent across different activities is not clear. However, the National Programme Team has emphasised to us that its purpose extends beyond the scope of the initial business case.

2.25 We recognise that some of the central expenditure to support local WCCIS implementation would otherwise have been incurred to develop or replace other systems on an organisation-by-organisation basis. Also, some of that expenditure is supporting wider service transformation relating to the implementation of WCCIS or contributing to ongoing service charges. The business case accounted separately for ongoing service charges, which it assumed would be met in full by local organisations.

2.26 **Figure 2** provides a high-level overview of the £30.16 million known to have been spent by the Welsh Government and NWIS supporting WCCIS implementation and roll-out to date or committed through to the end of March 2022. While we are unable to provide a complete like-for-like comparison, the full business case allowed for central Welsh Government costs and NWIS programme support of £16.75 million up to the end of March 2022 and £20.18 million over a full 13-year term.

2.27 **Paragraphs 2.28 to 2.52** in the remainder of this part of our report provide further details about Welsh Government and NWIS expenditure and about additional expenditure by local organisations. In addition to the costs identified, there are opportunity costs associated with staff time that is being committed by various organisations to the overall governance arrangements for WCCIS implementation and roll-out.

Figure 2: Welsh Government and NWIS spend on WCCIS implementation and roll-out and related service transformation, to March 2022 (actual and committed)



Source: National Programme Team and Audit Wales analysis

Welsh Government capital funding of £8.4 million is currently within full business case estimates but with further capital costs possible that may fall to deploying organisations

2.28 The full business case identified a £9.89 million Welsh Government capital funding requirement (**Figure 3**), almost all of which was profiled in the period to the end of March 2021. Local authorities and health boards were expected to identify any local capital funding requirements as part of their local planning. As at December 2019, the Welsh Government had approved £8.41 million of capital grant funding up to March 2022. Should a future decision be made to move to the newer Cloud-based version of the system (**paragraphs 2.20 to 2.21**), additional funding will be required under its own business case.

Figure 3: Welsh Government capital grant funding for WCCIS implementation, up to March 2022 (£ millions)

	Full business case estimate to March 2027	Total grant funding (actual and committed to March 2022)
All-Wales licences	3.94	3.28
Software development	3.60	3.00
Central hardware[1]	2.26	2.10
Network infrastructure[2]	0.09	0.03
Total	**9.89**	**8.41**

Notes

1 Business case estimate included an estimated £0.94 million for a hardware refresh in 2020-21.

2 The National Programme Team has told us that, while it was originally allocated £0.09 million for network infrastructure, it will not draw down more than the £0.03 million already spent. The remaining £0.06 million has been subsumed within the commitment shown for central hardware.

Source: WCCIS full business case and National Programme Team reports

2.29 In March 2015, the Welsh Government approved an initial £6.58 million of capital funding for licences, software development and central hardware costs. This figure excluded provision for a planned refresh of the central hardware. It also excluded network infrastructure costs of £0.09 million which were covered by the Welsh Government in a separate approval. Meanwhile, the negotiated cost of the licences required was lower than expected in the business case and some additional software development was built initially into the service charges for local organisations (**paragraph 1.13**).

2.30 In December 2019, the Welsh Government approved additional capital grant funding of £1.80 million from its Digital Priorities Investment Fund[18]. This included a further £1 million provision for the planned central hardware refresh and £0.80 million for software development. The software development funding covers most of the costs that were initially built into local service charges and some additional enhancements that were not within the original scope of the business case and contract[19].

2.31 The £0.80 million figure agreed for software development was an estimate. The latest figure following commercial negotiation is £1.12 million. Deploying organisations will need to decide on the affordability and value for money of the remaining enhancements not covered by the Welsh Government funding.

2.32 In addition, the National Programme Team is currently negotiating with the supplier to finalise costs to refresh the central hardware during 2020-21. The National Programme Team is anticipating this cost may exceed the £1 million covered by the Welsh Government funding. Organisations that have signed deployment orders are liable to pay a share of any additional costs.

18 Announced in September 2019, the £50 million Digital Priorities Investment Fund is focused on transforming digital services for patients, the public and professionals, investment in data and intelligent information, modernising devices and moving to Cloud services, and cyber-security and resilience.

19 Organisations paying service charges had already contributed £0.02 million to the software development costs, and around £0.30 million of the committed Welsh Government funding is for software enhancements that were not included in the original contract.

At £8.6 million, expected national programme support costs to the end of March 2022 are around £1.7 million higher than estimated in the full business case for the same period

2.33 The full business case estimated a £10.28 million requirement for national programme support over a 13-year period to the end of 2026-27 (**Figure 4**). Within that, it estimated a £6.89 million requirement to the end of March 2022 made up of:

- £1.77 million to cover existing NWIS staff who were supporting WCCIS implementation; and
- £5.12 million for additional dedicated National Programme Team support.

Figure 4: Actual or planned expenditure on National Programme Team support to March 2022 (£ millions)

	Full business case estimate to March 2022	Full business case estimate to March 2027	Actual/committed expenditure to March 2022
NWIS (existing budgets)	1.77	2.17	3.32
Welsh Government funding (additional)	5.12	8.11	5.30
Total	**6.89**	**10.28**	**8.62**

Note: The full business case also included estimated costs associated with NWIS 'hosting' the ICT hardware for WCCIS. This was estimated at £0.59 million over 13 years. Deploying organisations had contributed £0.06 million to the end of 2019-20 with NWIS also reporting that it had absorbed costs of at least £0.05 million. We have not accounted for these costs in our overall analysis.

Source: WCCIS full business case and National Programme Team reports

2.34 Until March 2019, support costs were largely covered by a combination of NWIS's existing budgets and £1.5 million of Welsh Government funding from the Integrated Care Fund. In June 2019, responding to a request from the Welsh Government, the Senior Responsible Owners for the WCCIS programme provided an estimate of the overall costs incurred and the additional National Programme Team resources required through to March 2022 to help increase the pace of implementation in health boards and complete roll-out.

2.35 The Welsh Government agreed to provide an additional £3.80 million of support through the Digital Priorities Investment Fund. The funding is increasing capacity and capability in several areas. Among other things, these include a national service desk, system testing, training to ensure patient safety, standardisation of system content and work to develop interfaces with other NHS systems (**paragraph 2.14**).

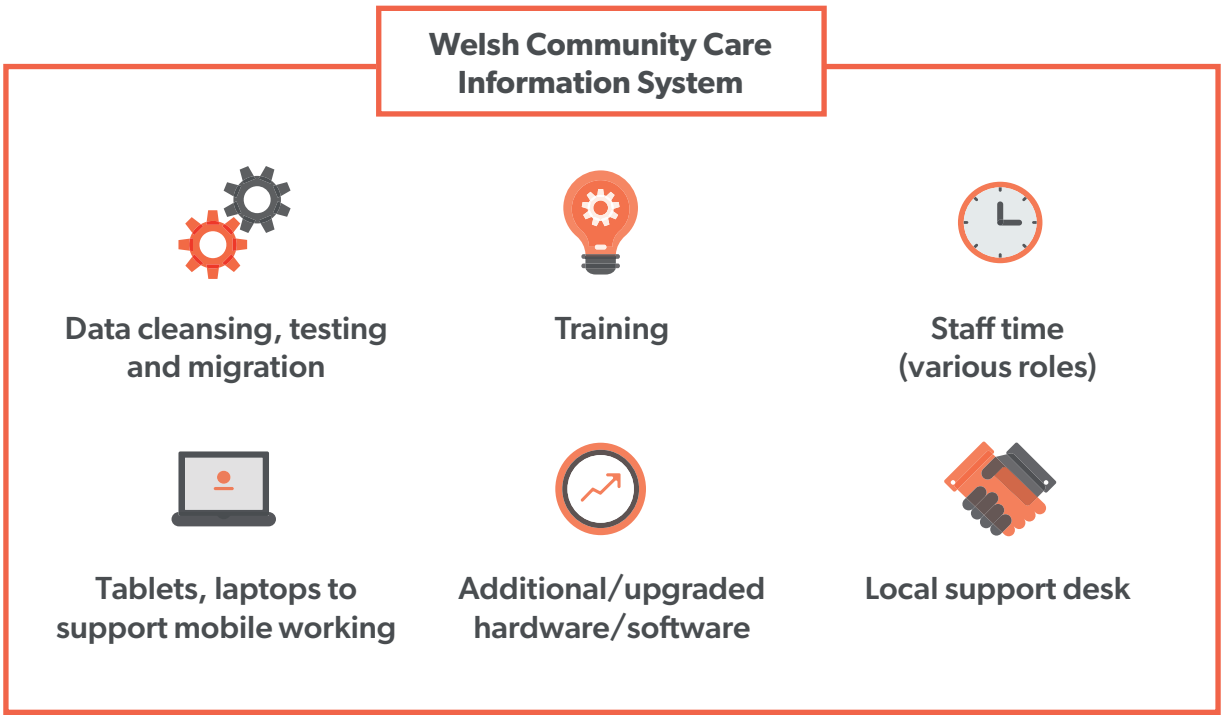
2.36 During the latter stages of our work, the National Programme Team changed its estimate of the amount of NWIS resources that had already been spent or were thought to be needed to support national programme management over the full 13 years of the programme. Its original estimate of £9.48 million, which informed the bid for additional Welsh Government funding on top of this figure, has reduced to £6.64 million. The National Programme Team advised us that the forward looking element of its original estimate was speculative and some over-estimation of past spend had occurred when preparing the original figures.

2.37 Together with the Welsh Government's funding, the £8.62 million cost of national programme support now estimated through to the end of March 2022 compares with the full business case estimate of £6.89 million. The National Programme Team has advised us that part of the reason for the increase is that the business case did not account for wage inflation for NWIS posts. The National Programme Team is still working through the support requirements and funding arrangements beyond March 2022.

The Welsh Government has so far committed just over £13 million to support local implementation and roll-out and related service transformation

2.38 The full business case acknowledged that organisations would incur additional local costs when implementing WCCIS. **Figure 5** describes some of the costs that might be incurred.

Figure 5: Examples of costs to support local implementation of WCCIS



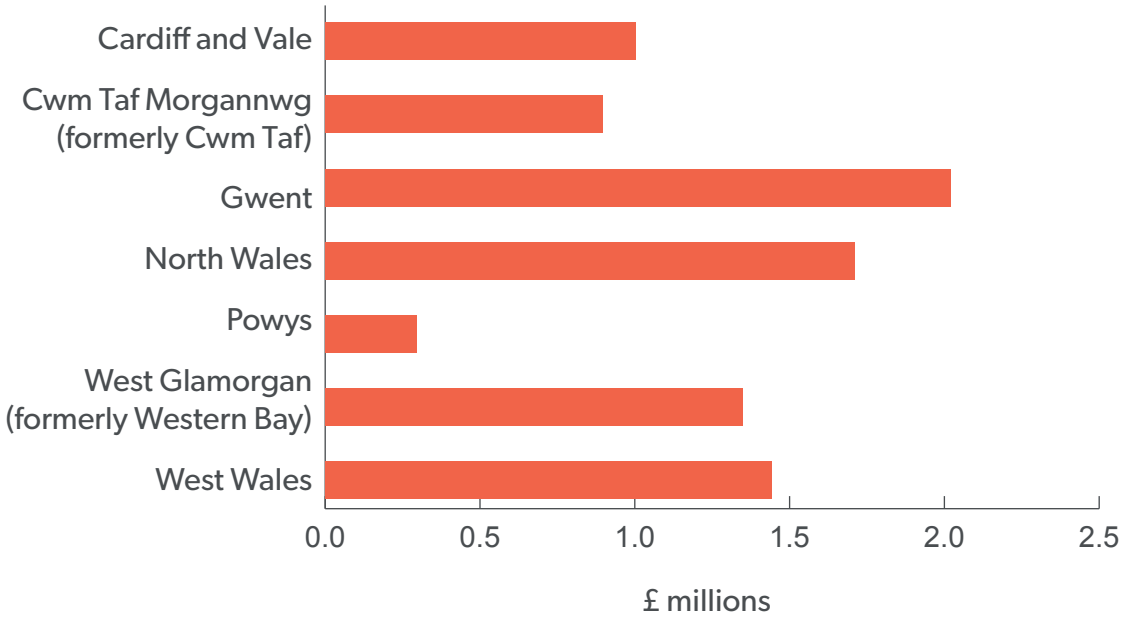
Source: Audit Wales

2.39 The full business case estimated that these costs would total £2.58 million and assumed that organisations would find these resources from their existing budgets. While there are additional costs being met from local budgets, by the end of 2021-22, local authorities and health boards will have received Welsh Government funding of £13.13 million to support implementation and roll-out. As noted in **paragraph 2.24**, the National Programme Team has emphasised to us that the activity that this funding supports extends beyond the scope of the original business case, including wider service transformation work related to WCCIS.

2.40 Much of this funding has come from the Integrated Care Fund (**Figure 6**). This funding is distributed through Regional Partnership Boards (RPBs)[20] and will continue through to the end of 2020-21. Overall, the Integrated Care Fund support will total £8.72 million.

20 RPBs consist of health boards, local authorities and the third sector. They work together to improve the wellbeing of the population and how health and care services are delivered.

Figure 6: Regional distribution of the Integrated Care Fund to support WCCIS implementation and related service transformation, April 2016 to March 2021



Notes: Cwm Taf Morgannwg Regional Partnership Board was previously the Cwm Taf Regional Partnership Board. It incorporated the Bridgend County Borough Council area on 1 April 2019 which had previously been part of the Western Bay Regional Partnership Board. The Western Bay Regional Partnership Board is now called the West Glamorgan Regional Partnership Board.

Source: Welsh Government

2.41 Initially, RPBs received a formula-based allocation. The National Programme Team considers that around £4.50 million of this funding between 2016-17 and 2018-19 was used predominantly to support planning work around local WCCIS implementation.

2.42 Since the start of 2019-20, funds have been allocated on a 'proposal' basis and with more of a focus on related service transformation. Some regions requested an increase on their previous allocations. This created a £0.21 million Integrated Care Fund shortfall for the two years 2019-2021. The difference was met by the Welsh Government Transformation Fund in 2019-20 and is being met from Welsh Government central reserves in 2020-21.

2.43 In 2018-19, the Welsh Government provided £0.05 million to Conwy County Borough Council on top of the Integrated Care Fund allocation distributed through the North Wales Regional Partnership Board. This came from a separate Welsh Government social services budget and covered additional training, staffing, software and technical support. The Council signed a deployment order in April 2019 and is currently in the implementation phase.

2.44 The full business case also identified that local authorities and health boards might have existing revenue budgets for IT systems that WCCIS would be replacing. However, some local authorities had developed 'in house' systems rather than contracting with external providers.

2.45 The National Programme Team requested a further £0.20 million from the Welsh Government between 2019-20 and 2021-22 to support Neath Port Talbot Council to implement WCCIS and £0.30 million to support Monmouthshire County Council[21]. Despite the funding request being agreed by the Welsh Government, Neath Port Talbot Council decided not to commission WCCIS and did not take the funding offered by the Welsh Government. There was a request for this funding to be released to support WCCIS implementation across the wider West Glamorgan region, but the Welsh Government turned this down. Monmouthshire County Council has not yet signed a deployment order and is still in dialogue with CareWorks. There is currently no agreed go-live date.

2.46 The Welsh Government is also providing £4.06 million from the Digital Priorities Investment Fund direct to health boards to accelerate implementation between 2019-20 and 2021-22[22]. This funding will address:

- financial challenges in some health boards where community health services are largely still operating paper-based systems and there are no revenue budgets for IT systems; and
- embedding of new ways of working for health professionals.

21 The National Programme Team also requested additional funding between 2019-20 and 2021-22 to support Flintshire County Council (£0.04 million) and Conwy County Borough Council (£0.46 million). The Welsh Government turned down this bid as the councils were already paying for existing systems.

22 This is funding to local bodies, in additional to the National Programme Team support from the same fund (**paragraph 2.35**).

We have been unable to arrive at a reliable overall estimate of local implementation costs met from organisations' own budgets, although it is apparent that these run into several millions of pounds

2.47 The National Programme Team has not collated information about overall local implementation costs, including contributions from local budgets. There has not been any specific guidance about how these costs, and any savings compared with previous systems or by not having to go through separate procurement processes, should be considered as part of local business case development. The National Programme Team has noted that it has provided ad hoc advice and supported knowledge sharing about local business case development. It has also emphasised that accountability for detailed local costs, risk and benefits rests with the local organisations.

2.48 We asked local authorities and health boards that have gone live or signed deployment orders if they could provide figures on local implementation costs met from their own budgets. Some were unable to do so.

2.49 Even where figures were reported, organisations had used different approaches or were unable to distinguish WCCIS specific costs from wider project work. It was difficult therefore to identify a valid overall estimate. However, examples included Betsi Cadwaladr and Aneurin Bevan university health boards which reported quite different figures of £0.41 million and £3.16 million up to the end of March 2020[23]. As noted in **paragraphs 2.4 to 2.5**, neither of the two health boards has yet gone live despite signing deployment orders.

2.50 Some organisations that are yet to sign deployment orders also provided forward-looking estimates. Cardiff and Vale University Health Board for example had estimated that implementation would cost £3.9 million, including work to develop functionality equivalent to its current arrangements. Ongoing maintenance costs would also be significantly more expensive.

2.51 To the end of June 2020, those organisations that have progressed with implementation to the point of paying service charges had paid a total of £2.56 million to CareWorks. The overall extent to which this is new expenditure compared with the cost of previous systems is not clear. However, some organisations are realising modest savings compared with the cost of previous systems (**paragraph 2.12)**. The roll-out position means that CareWorks' income from service charges has been substantially lower than expected at the outset.

23 The figures provided by Betsi Cadwaladr University Health Board include costs of staff directly employed to support implementation but exclude the value of staff time for others who still assisted. Similarly, Aneurin Bevan University Health Board has noted that its estimate does not account in full for all the staff time that has been committed.

2.52 There are other ongoing costs for organisations that have gone live, but that may also have been incurred previously supporting predecessor systems. The full business case included a £6.64 million estimate for financial resources required to fund ongoing local WCCIS support costs over a 13-year period.

Programme management

03

While action has been taken at various points to review and try to accelerate programme delivery, some key issues have taken a long time to resolve or have still not been fully resolved

The programme was slow to respond to issues identified by a November 2017 Gateway Review, including delays filling two important National Programme Team roles

3.1 As noted in **paragraph 2.7**, in our view some of the early estimations around the pace of roll-out were simply unrealistic. However, in a programme of this nature it is also inevitable that there will be a need to respond to issues as they arise and to keep delivery arrangements under review.

3.2 In November 2017, the programme's Senior Responsible Owners commissioned a 'Gateway Review' that looked at the prospects for successful delivery. For the purpose of the review, successful delivery was narrowly defined as delivering the technical platform within the available Welsh Government capital funding and its use as a stable live system by an [unspecified] critical mass of local authorities and health boards.

3.3 The review gave the programme an 'amber' rating. The review found that there were some significant issues facing the programme but that these issues were being addressed and, at the time, appeared resolvable.

3.4 Parts 1 and 2 of this report have already described various actions taken before and since the Gateway Review, including contractual changes and decisions around additional funding and implementation support. Nevertheless, many of the issues that have been identified during the life of the programme have taken a long time to resolve or have still not been fully resolved.

3.5 The National Programme Team considers that eight of the Gateway Review's nine recommendations are now complete, although most actions in response extended beyond the anticipated deadline of late spring 2018. Because it took about a year for the Welsh Government to agree funding, there were delays filling two new posts to support implementation. The Gateway Review found that programme staff were over-stretched and identified a 'significant weakness' in communication between the National Programme Team and other organisations. In December 2018, a new Programme Director took up post to oversee the governance and activity of the programme. From June 2019, a Communications Lead began working on a consultancy basis.

3.6 Work is ongoing to develop a Benefits Framework (**paragraph 3.18**) and despite the National Programme Team viewing the original recommendation as complete, further work is needed on the roadmap for the outstanding functionality (**paragraph 2.18**). Establishing revised governance arrangements has also taken longer than expected.

Recent changes to programme governance structures are intended to support a more co-ordinated national approach, including acceleration of national data standards which are key to realising some of the benefits of WCCIS

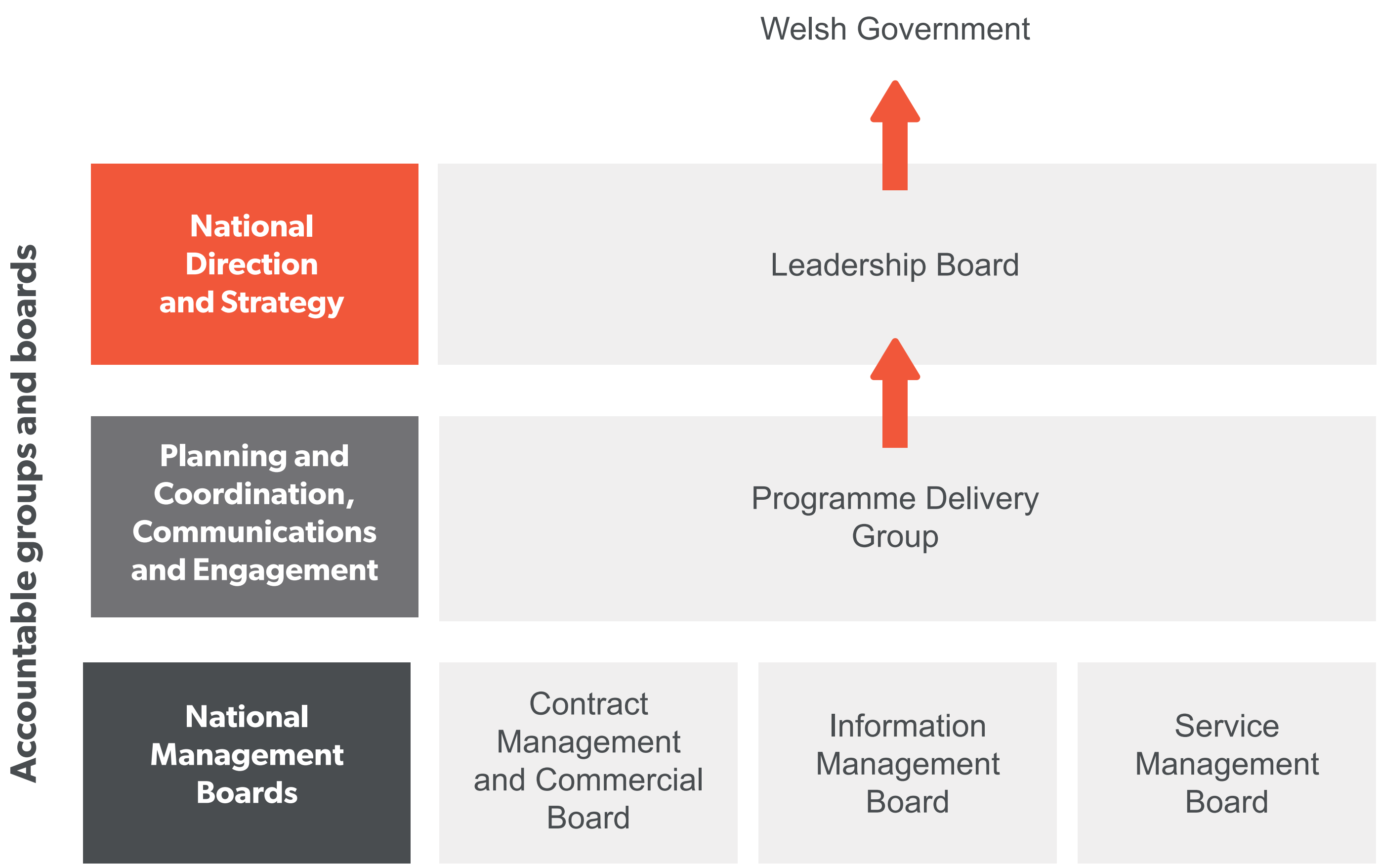
3.7 Following revisions to decision-making and escalation structures in May 2019, in September 2019, the WCCIS Leadership Board refreshed its Terms of Reference to try to clarify where it exercises decision-making authority. Under the current Terms of Reference, the Leadership Board has 'overall responsibility for ensuring the delivery of the digital capability to support service transformation and supporting and encouraging its implementation across Wales'.

3.8 Responsibility for implementing WCCIS is widespread and includes the health boards and local authorities as well as the Regional Partnership Boards. The Welsh Government can require health boards to use the system but has not yet chosen to do so. It is currently relying on accelerating take-up through the additional funding that it is providing (**paragraph 2.46**). Although it has also provided some financial support to local authorities, the Welsh Government does not have similar powers to require them to use the system.

3.9 In providing additional funding from the Digital Priorities Investment Fund, the Welsh Government made clear that it expected the National Programme Team to do several things by February 2020, including to develop a detailed delivery plan and timetable. None of the deadlines were met. In March 2020, the Welsh Government told the National Programme Team that continued funding is contingent on the required actions being undertaken or alternative arrangements being agreed. The required actions have since been discharged.

3.10 **Figure 7** sets out the current high-level programme governance arrangements as agreed from January 2020. In addition to the new National Programme Team roles described above, these structures have evolved over the life of the programme, with new groups set up recently to try to address some of the remaining areas of concern. The governance arrangements now include a revised Programme Delivery Group with regional representation to oversee and co-ordinate activities that require or would benefit from a national and strategic approach. At the time of our fieldwork it was too early to judge the impact of these revised arrangements, although the National Programme Team considers that they have proved invaluable through the COVID-19 response.

Figure 7: High-level governance structure for the WCCIS Programme, from January 2020



Note: **Appendix 2** provides further details about roles and responsibilities and other parts of the governance structures, including three further 'national assurance and advisory groups'.

Source: National Programme Team

3.11 A key aim is to accelerate national data standards as the basis for a national reporting framework in children's services, mental health, community nursing, social care and therapies[24]. Practitioners use electronic forms to assess the needs of patients. Individual organisations have developed their own forms, based on the information they want to report on and their own data definitions. The additional Welsh Government funding confirmed in December 2019 means that the National Programme Team is now able to support clinical informaticians to work in four of these five areas. However:

a work across the five areas is at different stages of development. Achieving consensus about the content of national forms is not straightforward, particularly as it requires a degree of consensus about working practices. For example, it took about three years to develop a standardised all-Wales nutrition risk assessment for use in adult in-patient settings. The Welsh Government has had an ambition to develop a core dataset for mental health since 2012[25]. This is now scheduled for delivery by the end of 2022.

b for any forms developed to be national, organisations not using WCCIS would also have to agree to use the forms, either as paper-based forms or changing their existing IT systems.

c it is not clear how the use of these forms could be mandated for use by local authorities.

3.12 A new Information Management Board will support the development of the national data standards and will also aim to address the long-standing issues around Welsh-language requirements and the development of an integrated record (**paragraphs 2.15 to 2.17**). An Integrated Record Group will link in with the Board, with its terms of reference to be agreed in September 2020.

Work is still ongoing to develop a framework for reporting on the benefits realised from WCCIS implementation

3.13 The potential benefits of WCCIS implementation can be immediate – for example implementation is seeing some community-based health records move onto an electronic system – and longer term, supporting wider service transformation. In articulating some of the potential benefits (**Figure 8**), the full business case set out the need for a 'benefits strategy', with roles clearly assigned. It made clear that responsibility for collecting evidence about benefits rested with local organisations. The suggested focus for the Leadership Board, set out in its terms of reference, was on collating that evidence and promoting the main messages.

24 Therapies include services such as podiatry, physiotherapy, occupational therapy, dietetics, speech and language therapy and art therapy.

25 Welsh Government, **Together for Mental Health Delivery Plan**, October 2012.

Figure 8: Potential benefits of WCCIS implementation

Source: Audit Wales based on WCCIS full business case

3.14 The arrangements for reporting the benefits from WCCIS implementation have been the subject of discussion and review from the outset (**Figure 9**). Despite some early developments, the November 2017 Gateway Review still called for a benefits realisation plan. It also highlighted the need to distinguish between the direct immediate business benefits from the technology itself and those from wider business change. The review recommended giving priority to collecting evidence of wider business change being achieved by roll-out of the system. Work is still ongoing to develop a suitable reporting framework.

Figure 9: Timeline of benefits reporting framework developments

3.15 Until March 2019, Regional Partnership Boards were not required to report on the specific outcomes being achieved with the funding they received for WCCIS implementation from the Integrated Care Fund (**paragraphs 2.40 to 2.42**). From April 2019, funding has been allocated on a 'proposal' basis with a focus on benefits realisation, although the reporting arrangements do not align with the intended outcomes outlined in the full business case for WCCIS implementation.

3.16 During our work, we asked local authorities and health boards for any evidence of local or regional benefits realisation. We received limited feedback. The National Programme Team shared with us evidence compiled by Bridgend County Borough Council which reflected on lessons learnt. In summer 2019, Powys Teaching Health Board surveyed its users although the response rate was low and the feedback mixed. Powys County Council has recently surveyed users' perceptions of the performance of the system, in its adults and children's social services departments. At the time of writing, we had not seen the full set of survey results.

3.17 We were not provided with any evidence at this stage that WCCIS is being used to progress wider service transformation benefits. Mainly, this is because the system has not yet been rolled out more fully. As noted in **paragraph 2.10**, even where the system has been implemented, there are differences in the way it is being used. Some of the issues around functionality (**paragraph 2.14)** and standardisation (**paragraph 2.35**) are also acting as barriers to integrated working.

3.18 In January 2020, the National Programme Team came together with regional representatives to discuss work to date on approaches to benefits management and reporting. Initiatives in this area were reported by the National Programme Team to be very variable between regions and local organisations.

3.19 The National Programme Team is now seeking to work effectively with regional WCCIS groups to develop a benefits framework that can support and inform local and regional developments and provide more detailed and structured national reporting. The national WCCIS Business Change Group is seen as a key forum to support this work. A task and finish group will be responsible for developing a national benefits framework that links effectively with, and supports, local and regional approaches.

3.20 The Welsh Government's recent approval of grant support from the Digital Priorities and Investment Fund comes with specific evaluation requirements. The Welsh Government is expecting the National Programme Team to produce a comprehensive annual report on the progress of the programme, starting with the period to the end of March 2020. That first report had been due by the end of April 2020, but completion has been delayed by the impact of COVID-19.

Appendices

1 Audit approach and methods

Audit approach

We examined whether key partners have put in place the appropriate arrangements to implement WCCIS and deliver its anticipated benefits.

We focussed on whether the functional requirements and intended benefits are being delivered within anticipated costs and timescales. We also considered the contractual model and the way in which the development and implementation of the system is being funded. We have not looked in detail at the arrangements that individual organisations have put in place to support local implementation or at the regional programmes of work that are intended to support wider service transformation related to WCCIS.

We confirmed the scope of our work to the Welsh Government and the WCCIS Leadership Board in October 2019 and gathered and reviewed most of our evidence between November 2019 and February 2020.

We provided feedback about our emerging findings to the Welsh Government and WCCIS Leadership Board members in February 2020.

In advance of publication, we invited comments on our draft report, or relevant extracts, from the Welsh Government, the WCCIS Leadership Board, the WCCIS supplier – CareWorks, and other named organisations. Our report reflects the position of the programme and the evidence available to us as at the end of August 2020.

Audit methods

Document review

We reviewed a wide range of WCCIS-related documents including contractual documents, business cases, papers supporting the National Programme governance arrangements, Ministerial briefings and a 2017 Gateway Review report.

For wider context, we also considered relevant issues covered in other reports relating to information systems in NHS Wales, including:

- Auditor General for Wales, **Informatics systems in NHS Wales**, January 2018
- National Assembly for Wales Public Accounts Committee, **Informatics systems in NHS Wales**, October 2018
- Channel 3 Consulting (for the Welsh Government), **Digital Architecture Review – Final Report**, March 2019
- Local Partnerships, **Welsh Government Review: Future Structure and Governance for Health Informatics in Wales**, March 2019

Interviews

We interviewed officers from across the Welsh Government, NHS Wales and local government and met with the NHS Assistant Directors of Informatics group. We had discussions with the chairs of WCCIS regional partnership groups and with regional co-ordinators, where regional structures exist.

We also met with CareWorks, the contracted supplier for WCCIS, and with its new parent company Advanced.

Analysing costs and benefits

We analysed several different sources of data to get an overall picture of expenditure on WCCIS implementation.

We also collected information from the 22 local authorities and seven health boards about expenditure on WCCIS and arrangements for measuring and reporting on the benefits of the system.

Visits

We visited Powys Teaching Health Board and Bridgend County Borough Council to meet with staff who use WCCIS.

2 Implementing WCCIS: roles and responsibilities

Figure 10 provides an overview of some of the key roles and responsibilities of those leading and managing the programme. **Figure 11** summarises the current governance arrangement for the WCCIS programme at a national level. Aspects of both the roles and responsibilities and the governance arrangements have evolved over time to address some of the challenges that have been faced.

The National Programme Team has emphasised to us that the role of the WCCIS National Programme is to ensure delivery of digital capability that can support local and regional service transformation and to support and encourage its implementation.

While it has an overall co-ordinating role, the National Programme does not have direct authority or accountability for all aspects of the complex landscape and the mix of stakeholders. Regional Partnership Boards have a role to align and support local organisations' take-up of the system as part of the wider aims of regional transformation strategy and plans. Local organisations have their own individual lines of accountability for their investment in local implementation.

In addition to the high-level structures described here, a range of other groups have been established at a national and a regional level to support WCCIS implementation and benefits realisation. These include a Business Change Group that reports to the Programme Delivery Group and oversees the work of a task and finish group established in February 2020 to develop a national benefits framework.

The core membership of the WCCIS Leadership Board includes the SROs, Director of NWIS, the WCCIS Programme Director and an Association of Directors of Social Services (ADSS) Cymru representative. The full board also includes Welsh Government policy leads, chairs of the three national boards, the WCCIS Communication and Engagement Lead and a senior representative of CareWorks, as required. Membership of other groups varies, but they draw in a wide range of representatives for specific organisations/sectors and professional groups.

Figure 10: Key roles and responsibilities in the WCCIS programme

Role	Responsibilities
Senior Responsible Owners (SROs)	Joint chairs of the Leadership Board. One is the Chief Executive of Powys Teaching Health Board and the other is Director of Social Services for Caerphilly County Borough Council. The role of the SROs is to ensure that work is governed effectively and delivers the programme objectives.
WCCIS Programme Director	Accountable to the SROs and chairs the Programme Delivery Group. Has a lead role in building and maintaining stakeholder relationships, engaging with Regional Partnership Boards, regional WCCIS boards, and other groups as required.
WCCIS Programme Manager	Day to day co-ordination, management and reporting on the programme.
WCCIS Communications and Engagement Lead	Responsible for national communication and engagement strategy and planning.
NWIS support	NWIS hosts the dedicated national programme, including the WCCIS Programme Director and Communications and Engagement Lead. NWIS staff provide additional operational support to the programme and NWIS manages the data centres that house the CareWorks hardware.

Figure 11: Key governance groups in the WCCIS programme

National direction and strategy	Leadership Board	Oversees the alignment of WCCIS with Welsh Government health and social care policy and strategy. Directly accountable to the Welsh Government via the joint SROs.
Planning and co-ordination, communications and engagement	Programme Delivery Group	National planning and co-ordination. Accountable to the Leadership Board. Responsible for co-ordinating the work of the three national boards across the seven regions.
National Management Boards	Contract Management and Commercial Board	Responsible for delivery of the contractual requirements. Provides commercial expertise and guidance to other groups.
	Information Management Board	Works with other national initiatives to develop and assure national information and data standards, and reporting requirements, across community health and social care services.
	Service Management Board	Ensuring WCCIS is operated in line with the Master Services Agreement and All-Wales Deployment Order.
National assurance and advisory groups	Practice/ Business Assurance Panel	Advisory group on integrated health and social care services. Provides assurance that programme plans and activities are consistently benefits led.
	Information Governance Advisory Panel	Providing advice, guidance and ensuring appropriate and timely consultation as required.
	Change Advisory Group	Approving, declining or deferring any request for change across all organisations using WCCIS.

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Report Title:	**Declarations of Interest, Gifts, Hospitality & Sponsorship**								
Meeting:	**Audit & Assurance Committee**						**Meeting Date:**	**17th November 2020**	
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**	**X**	
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Risk and Regulation Officer**								

Background and current situation:

As previously agreed by the Audit & Assurance Committee an update on Declarations of Interest, Gifts, Hospitality and Sponsorship would be provided to each Audit Committee for information. This report provides an up to date position from the new financial year of April 2020.

As the Health Board has begun to return to business as usual the Risk and Regulation Team have been able to re-commence its Standards of Behaviour communication plan.

Standards of Behaviour messages have been shared via Global Emails and CEO connects in September and October and the communication plan at Appendix 1 has been adopted by the Risk and Regulation team since September's meeting.

The Audit Committee will be interested to note that plans are underway to establish a Corporate Governance social media page to increase the team's communication reach and ability to communicate with staff members who do not have regular access to their emails.

The Risk and Regulation team have also met with colleagues from Betsi Cadwaladr University Health Board to review and test the Standards of Behaviour Software they have developed utilizing Welsh Government funding. Following that meeting an agreement in principle has been reached with Betsi Cadwaladr for the software to be shared with the Health Board for a nominal fee commencing April 2021. The use of this software will modernise how the Risk and Regulation Team record and report on Declarations of Interest, Gifts, Hospitality and Sponsorship with the intention that a more comprehensive register of interests is collated and maintained year on year.

Executive Director Opinion /Key Issues to bring to the attention of the Board/ Committee:

Following September's meeting when 8 Declarations had been submitted a further 101 Declarations have been received and included on the Health Board's Declarations of Interest register from 1 April 2020. These have been RAG rated as follows:

- Twenty Six (26) Declarations of Interest declared; one of which presented as a potential conflict with the others presenting as no cause for concern. The entry presenting as a potential conflict would only arise in procurement scenarios and would be picked up by the Health Board's internal procurement systems in the event that a potential conflict could be perceived.

- Seventy Two (72) Declarations of Interest with 'No Interest' declared which present no cause for concern
- Three (3) Declarations of Gifts which present no cause for concern.

Level of Conflict Key:

Level	Description
HIGH	High Conflict which needs managing
MEDIUM	Potential Conflict - Line Manager should be made aware and expectation that declaration is updated should conflict arise
LOW	No cause for concern

To date 109 Declarations have been received for the year 2020/21. Whilst it is accepted that this number will need to improve, assurance should be taken from the significant increase in returns since September's Committee meeting and the predicted increases expected over the coming months following the implementation of the Risk and Regulation Team's Communications Plan.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc:)

The management of the Standards of Behaviour Policy by the Corporate Governance Team should provide the Audit and Assurance Committee with assurance that adequate systems are in place for the ongoing monitoring of conflicts of interest and the declaration of gifts and hospitality.

Further assurance should be taken from the Corporate Governance Team's ongoing work with the Health Board's Countefraud Department for the investigation of specific cases and also following recent developments that will allow Declarations to be lodged and recorded through soon to be acquired specialist software which will allow a more efficient and all encompassing approach to be taken to the recording of declarations.

Recommendation:

The Audit & Assurance Committee is asked to:

- **NOTE** the ongoing work being undertaken within Standards of Behaviour.
- **NOTE** the update in relation to the Declarations of Interest, Gifts, Hospitality & Sponsorship Register.

Shaping our Future Wellbeing Strategic Objectives

This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	X
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care	X

			sectors, making best use of our people and technology	
4.	Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X
5.	Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	X	Long term	X	Integration		Collaboration		Involvement	X

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Appendix 1 – Communications Plan

September 2020 Reminder issued in CEO connects. ESR advert published advertising the ability to submit DoI returns via ESR and reminding all staff members Band 8A and above of the requirement for them to submit a return.	CEO Connects communication circulated on 30/09/2020
October 2020 Global Email circulated and posters distributed across Health Board sites. Circulation of posters to main sites and outlying areas to ensure that those areas without access to emails are aware of the requirement to submit returns.	Email circulated 08/10/2020
November 2020 Email reminder to all Band 8A employees and above to submit their Declaration of Interest. Governance Team Social Media page to be established to capture additional declarations and target staff members without regular access to work emails.	Update on 8A responses to be shared at following Audit and Assurance Committee (January 2021)
December 2020 Global email and CEO connects updated to be circulated specifically reminding staff of our Gifts and Hospitality policies.	
January 2021 A Global Declaration of Interest global email and CEO Connects update will be circulated. The content and tone of this will be dependent on the present position of the returns we have.	
February 2021 Covid Restrictions Dependent – A Declaration of Gifts and Hospitality update will be shared linked to the 6 nations.	
March 2021 Final DoI request of 2020/21 to be circulated for year end. Updated DOI's to be requested from all Executives and IM's for end of year reports.	
April 2021 New annual plan to be agreed.	

High Conflict which needs Managing
Potential Conflict - Line Manager should be aware and expectation that declrations is updated should conflict arise
No cause for concern

Level of Conflict	Name	Position held in UHB	Directorate / Speciality	Band	Clinical Board / Corporate Dept	Date Form Returned	Interests to Declare (Yes/No)	Third Party Declaration eg Spouse/Partner (Yes/No)	a) Directorships, including Non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies	b) Ownership or part-ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the UHB	c) A personal or departmental interest in any part of the pharmaceuticalhealthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	d) Sponsorship or funding from a known NHS supplier or associated company/subsidiary	e) A position of authority in a charity or voluntary body in the field of health and social care	f) Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests	g) Employment/self employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice
	Anna Burgess	Pharmacist Team Leader	Pharmacy	8b	CD&T	29/09/2020	Yes	No	N/A	N/A	The Neonatal and Paediatric Pharmacists Group (NPPG) have corporate partners (pharmaceutical companies) who pay the organisation for benefits such as access to professionals for advisory meetings. I attend these as an NPPG executive committee member. Conference attendance fee for the EuPFi conference 2020 paid for by Proveca Ltd.	Annual attendance at Neonatal and Paediatric Pharmacists Group (NPPG) Conference - this is an event sponsored by multiple pharmaceutical companies.	Member of the Neonatal and Paediatric Pharmacists Group (NPPG) executive committee and their Information Officer.	N/A	Presented healthcare professional educational sessions on excipients in medicines for children at events sponsored by Desitin Pharma Ltd and Proveca Ltd.
	Adam Joshua Cann	Trainee Clinical Psychologist	Clinical Psychology		CD&T	29/09/2020	Yes		N/A	N/A	N/A	N/A	N/A	N/A	Self employment as CBT therapist working with Efficacy Ltd
	Ian Williams	Paediatric Clinical Nurse Specialist	Children's Centre, St David's Hospital		Children & Women	08/10/2020	Yes	No	N/A	N/A	N/A	N/A	N/A	N/A	Tutoring with the Open University - Nursing
	Lynda Jenkins	Nursing Informatics Lead	Corporate Nursing		Corporate Nursing	09/10/2020	Yes	No	N/A	N/A	N/A	N/A	N/A	I undertake hospital inspections in other health boards/ private health care in Wales on invitation from health inspectorate Wales. These are infrequent.	N/A
	Alex Speakman	PN Pharmacist	Pharmacy		CD&T	09/10/2020	Yes	No	N/A	N/A	N/A	Offer of sponsorship to ESPEN nutrition conference from B.Braun, travel and conference fees, this was declined.	N/A	N/A	N/A
	Sarah Congreve	Vale Assistant Locality Manager	Vale Locality Office		PCIC	09/10/2020	No	Yes	N/A	N/A	N/A	N/A	N/A	Partner is the Business Manager of West Quay Medical Centre, Barry.	N/A
	Claire Main	Interim General Manager of Criticare Care and Major Trauma	Critical Care and Major Trauma		Specialist Services	09/10/2020	Yes	No	N/A	N/A	N/A	N/A	N/A	Executive member of Association of Nephrology Nurses UK representing nursing on various UK renal projects	N/A
	Tanya Burton	Myeloma Clinical Nurse Specialist	Haematology		Specialist Services	12/10/2020	Yes	No	N/A	N/A	We use some of the pharma drugs in our health boar	N/A	N/A	N/A	Janssen/Takeda/Celgene Sanofi
	Julie Highfield	Consultant Clinical Psychologist /Associate Director	Critical Care		Specialist Services	12/10/2020	Yes	Yes	N/A	N/A	N/A	N/A	National Director of Wellbeing Intensive Care Society	N/A	Occasional private practice
	Kim Atkinson	Strategic Lead Occupational Therapist	Therapies / Occupational Therapy		CD&T	12/10/2020	Yes	No	N/A	N/A	N/A	N/A	Vice Chair of Royal College of Ocuppational Therapists	N/A	N/A
	Michael Pruski	Healthcare Scienctist (Evaluation)	Medical Physics and Clinical Engineering	6	CD&T	12/10/2020	Yes	No	N/A	N/A	N/A	N/A	Council Member of the catholic Medical Association Club	N/A	N/A
	Natalie Robertson	Principal Physiotherapist in Mental Health	Physiotherapy		CD&T	13/10/2020	Yes	Yes	N/A	N/A	Husband is Director of Operations for CD&T - Matthew Temby	N/A	N/A	N/A	N/A
	Laura Gwyther	CART Clinical Nurse Specialist	Haematology		Specialist Services	13/10/2020	Yes	No	N/A	N/A	N/A	N/A	N/A	N/A	I have been asked along side all the other CART nurses across the UK to participate in a paid advisory board discussion hosted by Celgene. I would like to partake in the discussion to get more understanding of the new product and hear about other nurses experiences of CART so far. It is being held on 19th October 2020 from 1pm until 5pm. This is a one off participation as far as my knowledge serves.
	Jessica Hodges	Physiotherapist	Frailty	5		13/10/2020	Yes	No	N/A	N/A	N/A	N/A	N/A	N/A	Private Work as a Physiotherapist for Cardiff City Ladies Football Club.
	Laura Price	Assistant Psychologist	Neuroscience		Specialist Services	13/10/2020	Yes		N/A	N/A	N/A	N/A	N/A	N/A	Private healthcare work within ithe community
	Richard Whiston	Consultant Vascular Surgeon	General Surgery		Surgery	14/10/2020	Yes	No	N/A	N/A	N/A	N/A	Trustee of Haven Homecare	N/A	N/A
	Jill Lubienski	Family Therapist	SHED	8a	Mental Health	14/10/2020	Yes	No	N/A	N/A	N/A	N/A	N/A	N/A	I have a private psychotherapy practice based at my home in Cardiff. I do not see clients privately where they could be seen in the SHED team. I am also a self employed Associate for Partnership Projects UK (www.partnershipprojectsuk.co.uk) providing NVR parenting therapy, and training to practitioners and therapists but again this work does not cross over with my SHED employment.
	Debbie Roberts	Health Visitor	Flying Start	7	Children & Women	15/10/2020	Yes	No	N/A	N/A	N/A	N/A	N/A	Volunteer with Breastfeeding Network and Volunteer on the National Breastfeeding helpln	N/A
	Nicola-Xan Hutchinson	Consultant in Acute Respiratory Medicine	Medicine/Respiratory		Medicine	15/10/2020	Yes	No	N/A	N/A	N/A	Sponsorship for European Respiraotry Conference attendence fees by Boehringer Ingelheim	N/A	N/A	N/A
	Andy Lodwick	Lead Clinician Psychological Therapy Hub	Psychology		Mental Health	19/10/2020	Yes	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Private Physiotherapy Practice
	Catherine Twamley	Senior Nurse	Surgery	8a	Surgery	26/10/2020	No	Yes	Husband is construction director for Barratt David Wilson homes	N/A	N/A	N/A	N/A	N/A	N/A
	Ieuan Davies	Consultant Paediatric Gastroenterologist	Child Health		Children & Women	26/10/2020	Yes	Yes	N/A	N/A	Wife has done consultancy work for which she has been paid wthint he last 7 years with Janssen, Taeda and Jazz	N/A	Chair of NICE NG1 (2015), Previous Chair of the BSPGHAN Endoscopy Working Group and member of JAG (2012-2015). I have been a NICE expert adviser since 2016 and teach on their new Chair induction programme twice each year. Health Advisory Council of Coeliac UK since spring 2020 and Senedd Cross party Group on Coleiac Disease since spring of 2020.	I raise money for and contribute to events (as a speaker) held by CICRA and Crohn's and Colitis UK. I am part of IBD Wales.	N/A
Low	Ceris Devereux	Public Health Dietitian	Nutrition and Dietetics		Community Dietetics	10.09.20	Yes		N/A	N/A	I have done work advising Quorn foods around diet for monetary payment. I have also worked with the BDA in cooperation with alpro providing dietetic advice for monetary payment for E-learning.	N/A	N/A	N/A	I have undertaken some activities as part of my private practice.
Medium	Matthew Boyd-Anderson	Physiotherapy Technical Instructor	Therapies	0	CD&T	19.05.2020	Yes	No	N/A	N/A	N/A	N/A	N/A	N/A	Support Worker - Prospero Health and Social Care - Casual Flexi Hours
Medium	Stuart Walker	Executive Medical Director	Executive	Executive	Executive	30.09.20	Yes	Yes	Sister - Gilead employee, Father ILC CEO (both healthcare companies we may have relationships with)		see above re. sister/father - Gilead and ILC are pharma companies	N/A	N/A	N/A	N/A

Report Title:	**Legislative and Regulatory Tracker Report**								
Meeting:	Audit and Assurance Committee						**Meeting Date:**	17th November 2020	
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**		
Lead Executive:	Director of Corporate Governance								
Report Author (Title):	Head of Risk and Regulation								

Background and current situation:

In January 2019 the organisation received a report on Legislative and Regulatory Compliance which provided a 'limited' assurance rating and made seven recommendations. These recommendations were all accepted by the Director of Corporate Governance. Four of the ratings were classed as high priority and three were rated as medium priority.

Good progress has been made in September and October on the development of the Legislative and Regulatory Tracker but there is still some work to be done to ensure that the tracker is fit for purpose in providing assurance to the Audit Committee and the Board.

Executive Director Opinion /Key Issues to bring to the attention of the Board/ Committee:

Since September's meeting a new Risk and Regulation Officer has joined the Risk and Regulation team which has allowed more time to be devoted to the preparation and management of the Regulatory and Legislative Compliance Tracker. The additional support has allowed greater communication to be made with executive leads and accountable individuals and whilst this has not resulted in any significant changes to the Tracker for this meeting, it is predicted that noticeable improvements to the content of the Tracker and management of recommendations contained therein will be reported in the new year.

This in turn will provide further assurance to the Audit and Assurance Committee and the Board and ensure that any outstanding actions from the Internal Audit on this piece of work are implemented.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc:)

The tracker now provides the following details:

- All Regulatory Bodies which inspect Cardiff and Vale UHB are listed and include the bodies detailed at Appendix 1;
- The Regulatory Standard which is being inspected is listed;
- The Lead Executive in each case is detailed;
- The Assurance Committee where any inspection reports will be presented along with any action plans as a result of inspection is detailed;

- The accountable individual is detailed and where there is a gap this will be the lead Executive;
- Where we have been informed what the inspection cycle is we have detailed it, where we have not been informed or simply do not know we have put 'ad hoc'.
- The last inspection date is detailed and also detailed is where Cardiff and Vale have not been inspected in the last 10 years;
- Where we know the inspection date it is detailed. Where we know the inspection cycle and the last time it was inspected we have put in a predicted date so we do not completely lose sight of it. Where the cycle time is ad hoc we have stated that no inspection has been notified and when we are notified via the central inbox, which has been set up, this will be added to the tracker. Hence we have called this column 'expected date of inspection'. Where there is an * it means an inspection was expected but never took place;
- Where we know the outcome of the inspection we have included it. Where there were no issues picked up we have put this column to 'action complete' this links to the final column which is a binary complete or not complete. The reason for this is that it will link to the dials in due course.

The tracker will continue to be updated throughout the organisation and reported to the Audit Committee on a bi-monthly basis as well as being reported to Management Executive and HSMB meetings.

A further 9 inspections have been reported since September's Committee meeting, including inspections that had taken place prior to the Committee but had not previously been reported. Inspections undertaken by the Community Health Council, which have not previously been included in the Regulatory and Legislative Tracker have also been added. The additional inspections are as follows:

1) An inspection was undertaken by the Cardiff and Vale of Glamorgan Food Hygiene Ratings at Llanfair Unit 01/11/2018.

   Outcome – The inspection recorded a Food Hygiene Rating of 4.

2) An Inspection was undertaken by the Community Health Council at St Barrucs Ward on 03/02/2020.

   Outcome – a recommendation was made to explore opportunities for volunteer groups to visit regularly and spend more time with patients there. Possibly befriending groups to visit.

3) An Inspection was undertaken by the Community Health Council at Daffodil Ward UHL, on 03/02/2020.

   Outcome – Details of the recommendations and actions are awaited.

4) An Inspection was undertaken by the Community Health Council at Ward B6 Trauma Unit

UHW on the 25/02/2020.

Outcome – recommendations were made to:

- Consider improving the non-HCSW staffing levels (incentives for retention of staff) across the Ward's multidisciplinary teams, including a deputy to assist the Nurse Manager, and the possible impact of the MTC on this area regarding polytrauma patients. Explore opportunities for volunteer groups to visit regularly & spend more time with patients there. Possibly befriending groups to visit;
- Liaise with Estates to repair the bathroom/toilet problems and upgrade the interim reception desk;
- Place 'Putting Things Right' Information Notices in the Day Room.

5) An Inspection was undertaken by the Community Health Council at Ward C7 UHW on 26/02/2020.

Outcome – recommendations were made to:

- Update the notice boards on the Ward;
- Install a suggestion box so patients, relatives, carers and visitors can leave comments or suggestions;
- Place hand washing notices at all sink areas.

6) An Inspection was undertaken by Healthcare Inspectorate Wales of the Youth Services within the Children and Women's Health Board.

Outcome – A total of 37 recommendations were made for WG, UHB and independent service users to consider.

7) An Inspection was undertaken by Healthcare Inspectorate Wales at Ward E4 UHL on the 7th October 2020.

Outcome – An improvement plan was submitted to the Health Board on the 16th October 2020.

8) An Inspection of Specialist Services was undertaken by Healthcare Inspectorate Wales of the 30th September 2020.

Outcome – An improvement plan was submitted to the Health Board on the 12th October 2020.

9) An Inspection of Morgannwg Ward, Barry Hospital was undertaken by Healthcare Inspectorate Wales of the 22nd September 2020.

Outcome – To be confirmed.

Detailed below are inspections which were due to take place during the next quarter. As these would in many instances involve individuals coming onto site we do not believe that these inspections will take place.

1. The Cardiff and Vale of Glamorgan Food Hygiene Rtaings are scheduled to undertake an inspection of Ward Based Catering at Rookwood Hopsital and Brecknock House on the 02/12/20.

2. Fire and Rescue Services are scheduled to undertake inspections of Rhydlafar and Landsdowne Wards (St David's Hospital) and Sam Davies Ward Barry on the 01/01/2020.

3. Healthcare Inspectorate Wales are scheduled to undertake Quality checks at the following locations on the following dates:

   - Radyr Medical Centre - confirmation and information request 10/11/20 - Quality check date – 24/11/20
   - Porthceri Surgery - confirmation and information request 17/11/20 - Quality check date – 01/12/20
   - MAU, UHL - Confirmation and information request – 23/11/20 - Quality check date – 07/12/20
   - Teenage Cancer Trust, UHW - Confirmation and information request 23/12/20 - Quality check date 06/01/21
   - Noah's Ark, UHW - Confirmation and information request – 05/01/21 - Quality check date 19/01/21

4. The Medicines and Healthcare products Regulatory Agency are scheduled to inspect Pharmacy SMPU on 18/02/2021.

5. The office for Nuclear Regulation is scheduled to inspect Medical Physics on the 17/11/2020.

6. UKAS are scheduled to undertake inspections at Biochemistry between the 7th and 11th December 2020.

Recommendation:

For Members of the Audit Committee to:

(a) Note the inspections which have taken place since the last meeting of the Audit Committee in September 2020 and their respective outcomes.

(b) To note the continuing development of the Legislative and Regulatory Compliance Tracker.

Shaping our Future Wellbeing Strategic Objectives

This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report			
1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	x
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing	x	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	x	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	x

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	x	Long term	x	Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	~~Yes / No~~ / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Appendix 1 – Regulatory Bodies

- All Wales Quality Pharmacist;
- British Standard's Institute;
- Cardiff and Vale of Glamorgan Food Hygiene Ratings;
- Community Health Council;
- Fire and Rescue Services;
- Health Education and Improvement Wales;
- Health Inspectorate Wales;
- Health and Safety Executive;
- Human Tissue Authority;
- Information Commissioners Office;
- Joint Education Accreditation Committee
- Medicines and Health Products Regulatory Agency;
- Natural Resources Wales;
- Office for Nuclear Regulation;
- Quality in Primary Immunodeficiency Services;
- United Kingdom Accreditation Service;
- Welsh Water;
- West Midlands Quality Review Service.

Clinical Board	Directorate	Regulatory body/inspector	Service area	Regulation/Standards	Lead Executive	Assurance Committee	Accountable individual	Inspection Cycle Time	Last Inspection Date	Next Inspection Date	Recommendation Narrative / Inspection outcome	Inspection Closure Due by	Management Response	Please Confirm if completed (c), partially completed (pc), no action taken (na)
ALL WALES QUALITY ASSURANCE PHARMACIST														
CD&T	Pharmacy	Regional Quality Assurance Specialist	Pharmacy SMPU	Quality Assurance of Aseptic Preparation Services	Stuart Walker	QSE Committee	Darrel Baker	183	27/01/2020	27/07/2020	166 actions	31/12/2020		pc
CD&T	Pharmacy	Regional Quality Assurance Specialist	Pharmacy UHL	Quality Assurance of Aseptic Preparation Services	Stuart Walker	QSE Committee	Darrel Baker	365	06/08/2020	06/08/2021	91 actions	tbc	We have received the report but we are currently working on an action plan so we don't have a set closure date for the plan currently. Action plan is to be finalised by beginning of November, so will have the date for this then.	pc
CD&T	Pharmacy			Falsifying Medicines Directive	Stuart Walker	QSE Committee	Darrell Baker	n/a	n/a	n/a	no inspection data as yet			na
BRITISH STANDARDS INSTITUTE														
	Planning	British Standards Institute	Capital, Estates & Facilities	ISO - 14001 Environmental management system and accreditation	Abigail Harris	Health and Safety	Jon McGarrigle	185 (Twice Yearly)	01/07/2019	01/01/2020	Minor non conformances which will be addressed by next audit			
CARDIFF AND VALE OF GLAMORGAN FOOD HYGIENE RATINGS														
Estates	Facilities	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Teddy Bear Nursery	Food Safety Act 1990 (the Act),	Abigail Harris	Health and Safety	Kelly Lovell, Ruth Hutchinson		22/05/2020		Food rating 4		Due to COVID-19 an intelligence gathering exercise was undertaken. No matters of public health concern was identified.	
Estates	Facilities	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Barry Hospital Kitchens	Food Safety Act 1990 (the Act),	Abigail Harris	Health and Safety	Lesley James, Linda Watts, John Smith	Annual	10/03/2020	10/03/2020	Food rating 5		All recommendations actioned with the exception of the taps in St Barrucs unit 1 and 2 which are in progress. Inspection overdue.	pc
Estates	Facilities	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Teddy Bear Nursery	Food Safety Act 1990 (the Act),	Abigail Harris	Health and Safety	Kelly Lovell, Ruth Hutchinson		20/02/2020		Food rating 5			
Estates	Facilities	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Ward Based Catering, Brecknock House	Food Safety Act 1990 (the Act),	Abigail Harris	Health and Safety	Keith Prosser		02/12/2019	Planned for 02/12/20 but due to Covid-19 awaiting confirmation from EHO	Food rating 4	02/12/2020	Currently awaiting confirmation from Food Safety & Port Health (Cardiff), Shared Regulatory Services, of when inspections will re-commence	
Estates	Facilities	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Bwyd Blasus	Food Safety Act 1990 (the Act),	Abigail Harris	Health and Safety	Ranjith Akkaladevi		28/11/2019		Food rating 4			
Estates	Facilities	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Aroma Express, Brecknock House	Food Safety Act 1990 (the Act),	Abigail Harris	Health and Safety	Stepfanie Burgess		28/11/2019		Food rating 3			
Estates	Facilities	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Rookwood Hospital	Food Safety Act 1990 (the Act),	Abigail Harris	Health and Safety	Andrew Wood		25/11/2019	Planned for 02/12/20 but due to Covid-19 awaiting confirmation from EHO	Food rating 5	25/11/2020	Currently awaiting confirmation from Food Safety & Port Health (Cardiff), Shared Regulatory Services, of when inspections will re-commence	
Estates	Facilities	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Teddy Bear Nursery	Food Safety Act 1990 (the Act),	Abigail Harris	Health and Safety			04/09/2019		Food rating 4			
Estates	Facilities	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Llandough Hospital	Food Safety Act 1990 (the Act),	Abigail Harris	Health and Safety	Linda Watts, John Smith		19/09/2019	19/09/2020	Food rating 5		All recommendations actioned. Inspection overdue.	c
Estates	Facilities	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Hafan y Coed	Food Safety Act 1990 (the Act),	Abigail Harris	Health and Safety	Linda Watts, John Smith		19/09/2019	19/09/2020	Food rating 5		All recommendations actioned. Inspection overdue.	c
Estates	Facilities	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Llanfair Unit		Abigail Harris	Health and Safety	Linda Watts, John Smith		01/11/2018	01/04/2020	Food Rating 4		All recommendations actioned. Inspection overdue.	c
COMMUNITY HEALTH COUNCIL														
Mental Health	St Barrucs Ward,	Community Health Council			Abigail Harris	Audit and Assurance			3.02.20		1. Explore opportunities for volunteer groups to visit regularly & spend more time with patients there. Possibly befriending groups to visit.		The Young Onset Dementia team have started to improve their links with Ty Hapus charity and the Alzheimer's Society. Due to the Covid 19 pandemic the Health Board are limiting visiting to control the risk of infection spread. We are exploring opportunities to enhance our patient experience particularly from volunteers who can help with technology (Skype / Zoom calls to relatives as an example). We have contacted Mental Health Matters to discuss the options around this support and are hoping to improve this area in the next few weeks. To increase digital support to relatives by the end of August 2020. Unable to fully implement this recommendation due the limitations as a result of the Covid 19 pandemic. Unable to implement the recommendation to increase visiting of volunteers on the ward until Welsh Government advice changes.	c
Mental Health	Daffodil Unit, UHL	Community Health Council			Abigail Harris	Audit and Assurance			3.02.20					c

Surgery	Ward B6, Trauma Unit, UHW	Community Health Council			Abigail Harris	Audit and Assurance			25.02.20		1. Consider improving the non-HCSW staffing levels (incentives for retention of staff) across the Ward's multidisciplinary teams, including a deputy to assist the Nurse Manager, and the possible impact of the MTC on this area regarding polytrauma patients.		Ward B6 has changed its function since the Covid pandemic and is currently a Medical ward. The ward team will shortly be moving to University Hospital Llandough (UHL) to care for Trauma patients in the UHL footprint. 2 full time deputy sisters have been appointed to support the Ward Sister since Feb 2020. With planned move to UHL staffing levels will be improved. The Trauma and Orthopaedic Directorate works hard to retain staff, practice development nurse will be working clinical shifts alongside staff on the ward to offer support and guidance not only to newly registered but those wishing to progress. The impact of MTC is less likely to impact B6 with move to UHL	c
Surgery	Ward B6, Trauma Unit, UHW	Community Health Council			Abigail Harris	Audit and Assurance			25.02.20		2. Liaise with Estates to repair the bathroom/toilet problems and upgrade the interim reception desk.		The refurbishment of the ward including the bathroom/toilets was due to be undertaken in 2019/20 but it was agreed to prioritise C7 with B6 being programmed for 20/21. Unfortunately, due to the Covid situation the refurbishment programme has been put on hold for this financial year but it is hoped that this can be re-commenced in 21/22 and B6 would be the priority. In the interim Estate will visit the area to determine if any interim works can be undertaken to improve the facility.	c
Surgery	Ward B6, Trauma Unit, UHW	Community Health Council			Abigail Harris	Audit and Assurance			25.02.20		3. Place a 'Putting Things Right' Information Notices in the Day Room.		Sister Hodges has obtained a Putting Things Right poster and place in the day room. Subsequently with the planned move to UHL, she will ensure that this is included in patient areas in UHL also.	c
Medicine	Ward C7, UHW	Community Health Council			Abigail Harris	Audit and Assurance			26.02.20		1. Update the notice boards on the Ward	To be completed by Friday 31st July 2020	The visit undertaken by the CHC representatives occurred following the reopening of C7 North on 22nd January, 2020 to make C7 a full 38 bedded ward. Following the interim ward manager arrival in post on the 5th January a maintenance request was placed to have notice boards hung which was completed in the month of January. Following this, action content was prepared ready to display.	c
Medicine	Ward C7, UHW	Community Health Council			Abigail Harris	Audit and Assurance			26.02.20		2. Install a suggestion box so patients, relatives, carers and visitors can leave comments or suggestions.	To be completed by Friday 31st July 2020	Discussed by the ward manager and team as an additional source of feedback to the '2 minutes of your time' and National feedback surveys that the ward participates in.	c
Medicine	Ward C7, UHW	Community Health Council			Abigail Harris	Audit and Assurance			26.02.20		3. Place hand washing notices at all sink areas	To be completed by Friday 31st July 2020	Additional, hand washing notices ordered following CHC visit, which arrived the day of the ward move to A5.	c
FIRE AND RESCUE SERVICES														
Clinical Gerontology	Capital and Asset Management	Fire and Rescue Services	Rhydlafar Ward, St David's Hospital	Health and Safety at Work Act 1974	Abigail Harris	Health and Safety	Director of Strategic Planning	365	21/01/2020	01/01/2021	Complied with the requirements of the Regulatory Reform Safety Order 2005	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been completed.		c
Clinical Gerontology	Capital and Asset Management	Fire and Rescue Services	Lansdowne Ward, St David's Hospital	Health and Safety at Work Act 1974	Abigail Harris	Health and Safety	Director of Strategic Planning	365	21/01/2020	01/01/2021	Failed to comply with requirements of safety order. Schedule of works required included: 1 x management 1 x estates	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been completed.		pc
Clinical Gerontology	Capital and Asset Management	Fire and Rescue Services	Sam Davies Ward, Barry Hospital	Health and Safety at Work Act 1974	Abigail Harris	Health and Safety	Director of Strategic Planning	365	27/01/2020	01/01/2021	Failed to comply with requirements of safety order. Schedule of works required included: 2 x estates	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been completed.		pc
Estates	Capital and Asset Management	Fire and Rescue Services	Multistorey Car Park, Llandough	Health and Safety at Work Act 1974	Martin Driscoll	Health and Safety			16/03/2020		the standard of fire safety appeared to comply with the requirements of the Regulatory Reform (Fire Safety) Order 2005.			c
Surgery	Capital and Asset Management	Fire and Rescue Services	Orthopaedic Centre, Llandough	Health and Safety at Work Act 1974	Martin Driscoll	Health and Safety			18/02/2020		the standard of fire safety appeared to comply with the requirements of the Regulatory Reform (Fire Safety) Order 2005.			c
Medicine	Capital and Asset Management	Fire and Rescue Services	Ward A6	Health and Safety at Work Act 1974	Martin Driscoll	Health and Safety			19/02/2020		Duty of Works: Article 8: The provision in respect of fire resisting doors is not Adequate The standard of fire separation is not adequate Article 13: Fire fighting and fire detection: The fire detection is not adequate for the type and use of the premises. Aritcle 17: Maintenance - Fire resisting doors are not adequately maintained			pc
Specialist Services	Capital and Asset Management	Fire and Rescue Services	Rookwood Hospital, Artificial Limb Centre	Health and Safety at Work Act 1974	Martin Driscoll	Health and Safety			10/02/2020		Duty of Works: Article 8: The provision in respect of fire resisting doors is not Adequate The standard of fire separation is not adequate Article 13: Fire fighting and fire detection: The fire detection is not adequate for the type and use of the premises.			pc
Mental Health	Capital and Asset Management	Fire and Rescue Services	Vale Mental Health Services, Barry Hospital	Health and Safety at Work Act 1974	Martin Driscoll	Health and Safety			27/01/2020		Duty of Works: Article 8: The provision in respect of fire resisting doors is not Adequate The standard of fire separation is not adequate Article 13: Fire fighting and fire detection: The fire detection is not adequate for the type and use of the premises.			pc
Mental Health	Capital and Asset Management	Fire and Rescue Services	Vale Community Offices, Barry Hospital	Health and Safety at Work Act 1974	Martin Driscoll	Health and Safety			27/01/2020		Duty of Works: Article 8: The provision in respect of fire resisting doors is not Adequate The standard of fire separation is not adequate Article 13: Fire fighting and fire detection: The fire detection is not adequate for the type and use of the premises.			c
HEALTH EDUCATION AND IMPROVEMENT WALES														

HEALTH INSPECTORATE WALES														
PCIC	Radyr Medical Centre, Cardiff Porthceri Surgery, Barry MAU, UHL TCT, UHW Noah's Arc, UHW	HIW	GP Practice	HIW	Ruth Walker	QSE	Directors of Nursing for PCIC, Medicine and C&W				Quality checks to take place on the following dates: Radyr Medical Centre - confirmation and information request 10.11.20 - Quality check date - 24.11.20 Porthceri Surgery - confirmation and information request 17.11.20 - Quality check date - 01.12.20 MAU, UHL - Confirmation and information request - 23.11.20 - Quality check date - 07.12.20 Teenage Cancer Trust, UHW - Confirmation and information request 23.12.20 - Quality check date 06.01.21 Noah's Ark, UHW - Confirmation and information request - 05.01.21 - Quality check date 19.01.21			
Children & Women		HIW	Youth	HIW	Ruth Walker	QSE	Director of Nursing, C&W				HIW made 37 recommendation for WG, UHBs and indepdent service users to consider and act on. Template was returned to HIW by 09.10.20.	**Was reported to QSE in Sept 2019.**		
Medicine	Medicine	HIW	E4, UHL	HIW	Ruth Walker	QSE	Director of Nursing Medicine				Tier 1 remote inspection took place on 7th October 2020. Contact details to be confirmed by 23.09.20. 21/9/20 Nominated contact details sent - Julia Somferford 30/9/20 evidence sent 7/10/20 virtual interview 16/10/20 Letter from HIW - improvement plan response required 28.10.20 - evidence of completion to be submitted by 07.01.21.	Will be reported to Dec 2020 QSE Committee		
Specialist	Neuroscience	HIW		HIW	Ruth Walker	QSE	Director of Nursing Specialist Services		30-Sep-20		Tier 1 remote inspection took place on the 30th of September 2020. Documented evidence submitted by the 25th of September. **21/9/20 Nominated contact detailse sent** - Linda Jones 25/9/20 Evidence sent 30/9/20 Virtual Interview 12/10/20 Letter from HIW - response required by 21/10/20 Improvemnt plan submitted - awaiting confirmation from HIW	Will be reported to Dec 2020 QSE Committee		
Medicine	Clinical Gerontology	HIW	Morgannwg Ward, Barry Hospital	HIW	Ruth Walker	QSE	Director of Nursing, Medicine		22-Sep-20		Tier 1 remote inspection requested by HIW to take place 22nd September 2020. Documentary evidence to be submitted by 16th September 2020. **Self assessment and documentary evidence uploaded to HIW 16/09/20. 01/10/20 Factual Accuracy comments requested by 12/10/20** 19.10.20 - Letter from HIW confirming the Quality Check Report has now been finalised and published.	Will be reported to Dec 2020 QSE Committee		
Children & Women	Maternity	HIW	Maternity Services	HIW	Ruth Walker	QSE	Head of Midwifery				HIW are undertaking a national review of maternity services across Wales (Phase 2).	Details of community maternity sites sent to HIW 17.07.20 and self assessement sent 24.07.20.	07.08.20 - further clarification letter received from HIW.	
Medicine	Unscheduled Care	HIW	EU and AU, UHW	HIW	Ruth Walker	QSE	Director of Nursing, Medicine		10-11th March 2020		HIW have suggested that the UHB is required to provide HIW with details of the action it will take to ensure a system is in place to ensure all patients have a patient identification band to ensure staff can correctly identify patients and provide the right care. Six patients in the lounge area of the AU were not wearing wristbands; two patients were in receipt of intravenous medication.	Improvement plan to be returned by **19th March 2020.** Improvement Plan sent to CEO office to send to HIW on 18.03.20. Updated improvement plan sent to HIW 02.07.20. Assurance received 09.07.20.	**Reported at September 2020 QSE**	

Medicine			Sam Davies ward, Barry hopsital	HIW	Ruth Walker	QSE	Director of Nursing, Medicine		28-29th January 2020		HIW found overall that the ward provided a very good environment to support the care and treatment of the patients. The ward was well equipped, with a range of activities available to patients. The number of initiatives on the ward to improve patient outcomes is commended. Staff on the ward were committed to delivering a very good standard of patient care. There was very good management and leadership seen within the ward and staff felt supported by management. Patients reported a positive experience on the ward and were treated with dignity and respect. HIW recommended the service could improve discharge planning to avoid delayed transfers of care and provide a training matrix for staff.	Improvement plan to be returned by **24th March 2020** Improvement plan sent ot HIW 26.03.20. Letter received dated 27.03.20 advising inspection report has now been finalised and sent for publication and that sufficient assurance provided.	**To be reported at August 2020 QSE**	
Mental health			Hafan Y Coed - Elm and Maple Wards	HIW	Ruth Walker	QSE	Director of Nursing, Mental Health		10-12 February 2020		Immediate assurance letter issued 13/02/2020 with a deadline for response 20th February which was not met due to a delay in the CEOs office. Extension requested. 04.03.20 - Immediate Assurance acceptance received from HIW. Inspection next steps letter issued 13/03/20 to 1. Review the inspection report; 2. Complete the improvement plan; 3. Send HIW our feedback. Deadline is 24.03.20.	**24.03.20** Improvement plan sent to 26.03.20. Final report published **21.07.20**	**Reported at September 2020 QSE**	
Mental health	Community Mental health	HIW	Cardiff North West Gabalfa Clinic CMHT	HIW	Ruth Walker	QSE	Director of Nursing, Mental Health		Due on 17th & 18th March 2020- postponed due to Covid		Pre inspection infromation to be submitted by March 9th. 29.01.20 HIW informed of two liaison members of staff to work with HIW team. **Inspection was cancelled due to Covid 19**			
PCIC	GP Practice	HIW	Llanishen Court Surgery	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		10/12/2019		HIW found that there were limited processes in place to support the safe recruitment and training of staff. They also found in the records of a sample of members of staff, there was no evidence that DBS checks had been undertaken.	Immediate improvement plan to be returned by 19.12.19	**To be reported at April 2020 QSE Committee**	
Children & Women	Obs & Gynae	HIW	Maternity Unit, UHW	HIW	Ruth Walker	QSE	Director of Nursing, C&W		18,19&20/11.2019		Checks of equipment used in a patient emergency were insufficient. This is because checks were inconsistent and not all were recorded as being carried out appropriately in relation to neo-natal resuscitaires (daily checks), emergency resuscitation equipment (daily checks), difficult airway equipment (weekly checks). Also found was out-of-date equipment, including one airway and blood sample bottles, on one emergency trolley. Storage arrangements for the emergency resuscitation equipment, inlcuding a defibrilator was stored in a cluttered room with prevented ease of access in an emergency. Door to a treatment room on the Delivery ward was unlocked. The room contained stock, including epidural trolley and intravenous fluids. Immediate assurance plan submitted 28.11.19. **03.12.19 Assurance letter received.** 17.01.20 - draft report to Suzanne Hardacre to prepare response for RW by 28.01.20.	**Immediate assurance plan accepted 3/12/2019 Improvement plan submitted 30/1/20. Further assurance required in response to the improvement plan by February 19th. Not met due to a delay in the CEO office. Revised improvement plan sent 25th February**	**To be reported at February 2020 QSE Committee**	
PCIC	GP Practice	HIW	Meddygfa Canna Surgery, Cardiff	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		31/10/2019		06.11.19 - HIW have written to Mr Williams at the practice to provide them with 1) a copy of their action plan in relation to the schedule of work required, as set out in their letter dated 04.11.19, 2) a full update once the schedule of work has been completed, 3) confirmation that they have informed C&VUHB of this inspection, and the findings and actions set to the practice by the South Wales Fire & Rescue Service. 07.11.19 - Draft response sent to Ruth Walker for amendments and comments. The practice are in the process of taking the actions required. 13.11.19 - Response sent.			
PCIC	Dental	HIW (Non-compliance notice)	Newport Road Dental Clinic	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		02/10/2019					
Specialist	Rehabilitation	HIW (Unannounced)	Rookwood Hospital	HIW	Ruth Walker	QSE	Director of Nursing, Specialist		02/10/2019		14.11.19 - Letter received from HIW for response with action plan by 29.11.19. Action plan submitted 29/11/2019. Response sent 29.11.19. Will be reported in February 2020 QSE Committee.	Final report to be published 3/01/20. To be reported in February 2020 QSE committee		
Medicine	Stroke Rehabilitation	HIW (Unannounced)	Stroke Rehabilitation Centre, UHL	HIW	Ruth Walker	QSE	Director of Nursing, Medicine		17 & 18/09/2019		Immediate assurance was required in relation to appropriate checks on resuscitation trolleys. Action plan completed. Improvement plan submitted 1/11/2019 and accepted by HIW. Immediate assurance action plan submitted 26/09/19		Reported to December 2019 QSE commitee	
PCIC	Dental	HIW (Announced visit)	BUPA Dental Care, Canton	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		02/09/2019		Non-compliance notice issued regarding incorrect and hazardous storage of healthcare waste and innaccurate dental records. Improvement plan required by 11th September 2019.			

PCIC	Dental	HIW (Announced visit)	Family Dental Care (Cowbridge road west)	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		19/08/2019		Areas identified for improvement - Maintenance improvements in some clinical areas, radiology audits must demonstration whether image quality conforms to minimum standards, ensure verbal medical history checks undertaken with patients are recorded in patient records. Regulatory breaches regarding training (Dental Nurse had not undertaken the required number of hours (5) of verifiable training in radiology and radiation protection during their previous 5 year CPD cycle as recommended by the GDC, expired emergency drugs being sorted in draw next to in-date drugs which could potentially get mixed up in an emergency situation.		Final report published 20/11/2019	
PCIC	Dental	HIW (Announced inspection)	St Mellons Dental Practice (Restore Dental Group)	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		13/08/2019		There were no immediate assurance issues. Overall HIW found that systems were in place to capture patient feedback, comments and complaints. Patients who completed a HIW questionnaire rated the service provided at the practice as excellent or very good.Staff reported being happy in their roles and understood their responsibilities. Systems were in place to ensure staff were supported and had the necessary training to deliver their roles efficiently.The environment provided clinical facilities that were well-equipped,maintained and visibly clean and tidy. HIW recommended the service could improvethe following-aAn environmental risk assessment needs to be completed and any actions identified within the risk assessments need to evidence when they are completed. Medical histories need to be reviewed to ensure all patients complete one at every course of treatment, they are signed by the patient and countersigned by the dentist		Final report published 14/11/2019	
PCIC	GP Practice	HIW (GP Announced visit)	Waterfront Medical Centre	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		Inspection due on March 23rd 2020					
PCIC	Dental	HIW	Cathays Dental Practice	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		05/08/2019		Non-compliance notice - storage of healthcare waste. Immediate improvement plan provided 8/8/2019.		Final report published 7/11/2019	
PCIC	Dental	HIW	High Street Dental Practice, Cowbridge	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		23/07/2019		Non-compliance notice - The service must ensure healthcare waste is being stored appropriately and securely within the dental practice in line with best practice guidelines. HIW found evidence that the practice was not fully compliant with current regulations, standards and best practice guidelines		Final report published 24/10/2019	
PCIC	GP Practice	HIW	Birchgrove Surgery	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		10/07/2019		Area of concern - Findings during the HIW inspection - they considered the pre-employment records of two non-clinical members of staff and there was no evidence that the relevant Disclosure and Barring Service (DBS) checks had been carried out. The Practice Manager confirmed that the DBS checks were not routinely undertaken for any non-clinical members of staff such as Practice management, administrative and reception staff. Improvement required. The Practice must implement a process to ensure that: Pre-employment checks for all staff include the need for a DBS check appropriate to their roles and all current members of staff have a DBS check undertaken urgently, appropriate to their roles. A record must be kept within the Practice.		Final report published 11/10/2019	
PCIC	Dental	HIW (Announced visit)	Penarth Dental Healthcare	Penarth Dental Healthcare	Ruth Walker	QSE	Director of Nursing, PCIC		01/07/2019		HIW found evidence that the practice was not fully compliant with the regulations and other relevant legislation and guidance. HIW recommended improvements be made in the following; Provide more information to patients on how children and adults can best maintain good oral hygiene; the Fire Safety Officer must undertake training by a fire safety expert, make adjustments to the infection prevention and control procedures in place at the practice, provide a baby nappy bin and ensure the waste is disposed of appropriately, staff to receive training on the safeguarding of children and vulnerable adults, unused dental supplies need to be stored in a more secure cupboard, make adjustments to the arrangements for safe storage and use of the emergency drugs and emergency equipment available at the practice. HIW identified regulatory breaches during this inspection – whilst this has not resulted in the issue of a non compliance notice, there is an expectation that the registered person takes meaningful action to address these matters, as a		Final report published 2/10/2019	

PCIC	Dental	HIW (Announced visit)	Llanederyn Dental Practice	Private Dentistry Regulations/All Healthcare Standards	Ruth Walker	QSE	Director of Nursing, PCIC		23/05/2019		HIW found some evidence that they were not fully compliant with Private Dentistry Regulations and all Health and Care Standards. The practice has been recently bought by its current owners and through discussions with them it was clear that they are keen to develop and improve the practice. There were a number of policies and procedures in place, but they were not dated, not version controlled, did not contain a review date and in the majority of instances did not include a staff signature demonstrating that the policies and procedures had been read and understood. HIW recomended that the practice need to ensure that all staff are appropriately trained with evidence of this training held on file. HIW recommended a number of improvements should be made including the review of policies and procedures which should be communicated to staff; training to be given to all staff as required and evidence maintained of this training on a training matrix; introduction of a programme of clinical and quality audits; provision of more information to patients in the reception area; completion of patient clinical records as required by clinical guidelines and the provision of more robust management of the practice going forward. Whislt this has not resulted in the issue of a non compliance notice, HIW expectation is that meaninful action is		Final report published 26/08/2019	
PCIC	Dental	HIW (Announced visit)	Tynewydd Dental Care	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		13/05/2019		HIW found some evidence that the practice was not fully compliant with Private Dentistry Regulations and all Health and Care Standards and a non compliance issue was issued. Copy of immediate assurance letter dated 24.05.19 received.		Final report published 14/08/2019	
PCIC	Dental	HIW	Park Place Dental	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		01/05/2019		HIW recommend improvements could be made regarding advising patients of the results of their feedback and any changes. Review the management of emergency drugs and ancillary equipment.		Final report published 2/8/2019	
PCIC		HIW (Clinical Review)	Her Majesty's Prison, Cardiff	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		01/05/2019		It was recommended that immediate steps are taken to review, monitor and improve the standards of note keeping in the medical records at HMP Cardiff. Formal Protocols should be devised for chronic disease management of all major chronic diseases as would be the case in community GP monitoring. Formal protocols should be devised for action to be taken after a period of nonattendance for dispensing of medications. A period of non-attendance should be obvious to the staff dispensing medication as they mark the medication charts accordingly. The protocol should include but need not be restricted to : ? Action to be taken to determine the cause of the non-attendance ? Note should be made of whether the non-attendance is a free choice made by a patient with full capacity or whether there is some hindrance affecting their ability to attend ? If there is any hindrance, as was the situation in this case, the nature of this hindrance should be documented ? Any action that needs to take place to overcome the hindrance should be documented. ? The situation should be reviewed after a reasonable length of time to ensure that the hindrance had been overcome. ? In the case of patients who choose not to attend,			
PCIC	Dental	HIW (Announced visit)	Cathedral Dental Clinic	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		26/03/2019		Due to the CCTV cameras located within the practice, including the surgeries HIW have asked for CCTV signage to be clear and prominent to all patients and visitors attending the practice. Policies and procedures need to be updated to reflect current CCTV guidelines. The patient records HIWreviewed were detailed, but they identified some areas where improvement is required.		Final report published 27/06/2019	
Medicine	Emergency Care	HIW (Unannounced)	Emergency Unit/Assessment Unit	HIW	Ruth Walker	QSE	Director of Nursing, Medicine		25/03/2019		28th March 2019 - immediate improvement plan required - letter; response 05-04-19; HIW response 11-04-19 - immediate assurance plan not accepted; 2nd UHB reponse 29th April 2019; HIW response accepting immediate assurance. Response sent 07.06.19. HIW assurance received 20.06.19.		Final report published 28/06/2019	

Mental Health		HIW (Unannounced)	Hafan Y Coed	HIW	Ruth Walker	QSE	Director of Nursing, Mental Health		19-21/03/2019		HIW found the Health Board did not always meet all standards required within the Health and Care Standards (2015), the Mental Health Act (1983), Mental Health (Wales) Measure (2010) and the Mental Capacity Act (2005). HIW recommended that the service could improve upon: Areas of Mental Health Act documentation require improvement Garden areas on all wards are in need of maintenance and the responsibility for this, needs to be confirmed Inconsistency of information displayed for patients and relatives across the wards Page 7 of 34 HIW report template version 2 Areas of good practice employed on some wards are not shared with others to maintain consistency Some patients are sleeping out1 from their designated ward due to additional demand and		Final report published 8/7/2019	
PCIC	Dental	HIW (Announced visit)	Danescourt Dental Practice	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		18/03/2019		The practice has conducted an internal audit and has addressed the gaps in fridge temperature readings by updating the record sheet used, and developed a process to handover responsibilities during staff absences. The Primary Care team has also audited fridge temperature logs and noted that temperatures were recorded on all working days.		Final report published 19/06/2019	
PCIC	Dental	HIW (Announced visit)	Alison Jones, Barry	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		17/12/2018		HIW identified areas for improvement with regards to arrangements for checking of emergency drugs and equipment, first aid equipment and dental materials.Improvements were required with regards to some fire safety arrangements.More detailed patient records were needed in some areas to evidence the care and treatment provided to patients.The practice needed to implement a number of policies and procedures, and some were also in need of updating. Regular appraisals for staff needed to be introduced.		Final report published 5/4/2019	
PCIC	Community	HIW	Mental Health Team, Western Vale	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		04/12/2018		Overall HIW/CIW found that service user feedback was generally positive.The environment was clean and tidy.Robust management of medicines processes were in place. There was provision of a support worker service that evidenced a positive and direct impact on service users. Application of Mental Health Act and Mental Health Measure (2010) and legal documentation was carried out well. Identification of a vision for the future of the service was supported by a passionate management team, and atrong integrated leadership model, supported at a senior management level. This is what HIW recommend the service could improve: Recruitment into key roles, such as psychiatrists and psychologists. Timeliness of transportation for services users to a place of safety and/or hospital. Organisation of outpatient and medication clinics. Completion of appropriate forms for service user capacity assessment by clinical staff. Clarity for staff regarding new processes and procedures following the merge of three teams.		Final report published 24/04/2019	
PCIC	Dental	HIW (Announced visit)	Penylan Dental Practice	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		28/11/2018		HIW recommended that the practice move its emergency drugs and equipment to a place that is more accessible. Improvements recommended included: the practice are to ensure that all staff have completed appropriate safeguarding training, a feminine hygiene bin is to be installed in the staff toilet, emergency drugs with their appropriate algorithms to be stored in separate and labelled containers/bags. There were no areas of non compliance identified at this inspection		Final report published 01/03/2019	
PCIC	GP Practice	HIW (Announced visit)	Pontprennau Medical Centre	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		05/11/2018		HIW found that the practice was not fully compliant with the Health and Care Standards in all areas of service provision. HIW did make a number of recommednations for improvements which included that they review and update written policies and procedures to ensure they all accurately reflect current arrangements at the practice, that they demonstrate that suitable staff recruitment checks have been conducted and ensure all staff have received up to date mandatory training and that records for this are kept within the practice. They further recommended that practice meetings should be formalised utilising agendas, and developing meeting minutes to aid communication throughout		Final report published 06/02/2019	
PCIC	Dental	HIW	Windsor Road Dental Care, Cardiff	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		29/10/2018		This will be managed directly with the primary care contractor by HIW. We will only see final response from the practice when it is published with the report. We will however ask for specific assurance on this particular inspection when PCIC report to QSE Committee in December 2018.			

HEALTH AND SAFETY EXECUTIVE														
CD&T	Radiology	HSE	Radiology	The Ionising Radiations Regulations 2017	Martin Driscoll	Health and Safety	Andrew Wood/Kathy Ikin	ad hoc	not inspected in the last 10 years	No future inspection date set	An Interventional Radiologist exceeded the annual dose limit to the lens of the eye. This is reportable to the Health and Safety Executive. The HSE visited on 29/10/19 following this notifcation. As a result of the visit, two improvement notices and one material breach were issued.	09/12/2019	HSE provided with narrative responses to each identified breach and the summary action plan. Revised radiation risk assessment for the vascular suite (and later rolled out across Radiolgy) Reduction to affected Radiologist clinical sessions, a change to the protective eyewear and further optimisation of clinical practice with respect to radiation protection and equipment to ensure that eye dose levels can remain within the 5 year statutory limit. The introduction of improved governance over Radiation Protection Supervisor practice will ensure a wider responsibility to recognise in a timely manner if the additional actions are insufficient to offer the required protection to staff. Request made to HSE to adopt the adjustment levels for reported doses as suggested within the report and permit observation of the IRR17 radiation dose limit of 100mSv over a period of 5 years for the Radiolgist to remain	c
CD&T	Medical Physics	HSE	Medical Physics	Control of Artificial Optical Radiation at Work Regulations 2010	Martin Driscoll	Health and Safety	Andrew Wood/Kathy Ikin	ad hoc	not inspected in the last 10 years	No future inspection date set	last inspections pre 2004, no inspeciton data currently available			na
CD&T	Medical Physics	HSE	Medical Physics	The Control of Electromagnetic Fields at Work Regulations 2016	Martin Driscoll	Health and Safety	Andrew Wood/Kathy Ikin	ad hoc	not inspected in the last 10 years	No future inspection date set	last inspections pre 2004, no inspeciton data currently available			na
HUMAN TISSUE AUTHORITY														
Specialist Services	N&T	HTA	South Wales Transplant and NORS programme	Human Tissue Act	Fiona Jenkins	QSE Committee	Rafael Chavez	730	01/10/2019 - self assessment compliance update	01/10/2021	Number of areas of good practice noted from inspection in 2016/17. Self assessment compliance update provided in September 2019 which demonstrated evidence and compliance with the updated questions	n/a		c
CD&T	Haematology	HTA	South Wales BMT Programme	Human Tissue Act	Fiona Jenkins	QSE Committee	Xiujie Zhao	730	22-23/01/2019	no date set	1 minor	06/09/2019	next inspection expected Jan/Feb 2021	c
CD&T	Haematology	HTA	Stem Cell processing Unit (HTA)	Human Tissue Act	Fiona Jenkins	QSE Committee	Alun Roderick/Sarah Phillips	730	22/01/2019	01/10/2021	1 major 4 minors	06/09/2019	next inspection expected Jan/Feb 2021	c
CD&T	Cellular Pathology	HTA	Mortuary (Cell Path - HTA)	Human Tissue Act	Fiona Jenkins	QSE Committee	Adam Christian/Scott Gable	730	22/11/2018	no date set	3 criticals, 14 majors, 9 minor	31/01/2019		c
INFORMATION COMMISSIONERS OFFICE														
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				To ensure that the IGET covers all necessary topics during meetings the organisation should introduce a set of formal ToRs		Following a review, IGET has been replaced by a new IG Group. The ToR are enclosed.	c
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				To ensure that policies remain fit for purpose and that staff have appropriate direction and information to avoid the risk of data protection breaches, the organisation should ensure that they are subject to timely routine review.		All D&HI policies to be reviewed and updated if necessary	pc
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				To ensure that staff are fully aware of the responsibilities regarding IG, the organisation should consider means by which assurance can be given that staff have read appropriate policies and therefore are aware of organisational requirements and their responsibilites		IG Manager to investigate the feasibility of implementing a process that provides this assurance	na
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				To ensure that staff receive the appropriate level of IG training for their role, regular training needs analysis should be undertaken in order to inform the IG training programme		There currently is a national piece of work looking at the different training requirements across NHS staff in Wales. This is being considered at the Information Governance Management Advisory Group (IGMAG)	na
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				In order to ensure that specialised roles with IG responsibility have received appropriate training to carry out their role effectively, a training needs analysis for these roles should be undertaken. To ensure that training requirements for staff with specialised DP roles are recognised and formalised, these should be included in all job descriptions of roles with IG responsibilities. This should ensure that staff can carry out their roles effectively		For the following staff, a TNA shall be undertaken separate to the piece of work referenced in A4: Caldicott Guardian, SIRO, Data Protection Officer, Information Asset Owners, Information Asset Administrators	na
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				The organisation should provide detailed information about how compliance with data protection policies and procedures is to be monitored to give assurance regarding observance.		The IG Policy will be reviewed and consideration given to potential data protection compliance monitoring.	na
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				To ensure that management have a complete picture of performance and compliance, and provide assurance that the organisation is complying with the relevant legislation, the reporting of KPIs relating to records management should be reinstated		The reporting of such measures, as outlined, may be more appropriately, and may already be, reported at a Medical Records Group. If this isn't the case, the IG Manager will work with the Medical Records management to ensure that these KPIs are reported.	na
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				The organisation should ensure that all areas have carried out comprehensive data mapping exercises to ensure that the there is a clear understanding and documentation of information processing.in line with the requirements of the organisation's IG policy and national legislation.		All IAR are currently being centrally collated. A review will be conducted to ensure that IAO are correctly capturing lawful basis etc...	na

IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				The organisation should ensure that it has a complete ROPA which includes all the information required by the legislation, so they are aware of all information held and the flows of information within the organisation, and have assurance that the record is an accurate and complete account of that processing.		Ensure that a ROPA is undertaken in line with Art 30 of the GDPR.	na
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				The organisation should ensure that there is an internal record which documents all processing activities in line with the legislation. This will provide assurance that all information processed is recorded as required by the appropriate legislation.		Ensure that a ROPA is undertaken in line with Art 30 of the GDPR.	na
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				The organisation should review the purposes of processing activities to ensure that they identify and document a lawful basis for general processing and an additional condition for processing criminal offence data, and therefore obtain assurance that they meet their obligations under the current legislation. The organisation should ensure that it documents the reasons for determining the lawful bases for each processing activity. Otherwise they risk failing to correctly identify the lawfull basis for processing and not meeting their obligations under the relevant legislation. The organisation should ensure that there are clear procedures in place to ensure that the t lawful basis is identified before starting any new processing of personal data or special category data. This will provide assurance that the organisation is relying on the correct lawful bases as required by the legislation.		Review Privacy Notice and IG Policy to ensure lawful basis for processing criminal data is clearly documented. 5.2.5.1 of the IG Policy (Data Protection Impact Assessment) states that 'All new projects or major new flows of information must consider information governance practices from the outset' and 'In order to identify information risks, a DPIA must be completed'. This is the point at which the lawful basis will be determined by theIG dept. The UHB's Privacy Notice does not document the lawful basis for each processing activity. We would be unable to document within the scope of the Privacy Notice the lawful basis for each of the UHB's numerous processing activities.	na
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				The organisation should document its lawful bases for processing special category data is correct based on the requirements of Article 9 of the GDPR and Schedule 1 of the DPA 2018 to provide assurance that it has appropriately considered how a determination was reached.		Ensure that our lawful basis for processing special category data is reviewed and documented	c
	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				The organisation should ensure that there is an APD in place to define which schedule 1 conditions are relied on, so that the organisation is in compliance with the legislation. In order to ensure compliance with the legislation, the organisation should further: Create an APD which considers what procedures are in place to ensure compliance with the Article 5 principles of GDPR. Ensure the APD considers how special category data will be treated for retention and erasure purposes Ensure the APD defines a responsible individual for the processing activity		APD to be implemented	c
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				In order to be sure that it is keeping to data protection legislation by providing accurate processing information, the organisation should ensure that only current and accurate privacy information containing all the information as required under Articles 13 & 14 of the GDPR is available on its website. To ensure that it is upholding the requirement for data subjects to be properly informed of ho their information is being processed, the organisation should ensure there is a clear link to the general privacy notice from the front page of its website.		UHB website to be reviewed and any old documentation removed. Access to privacy notice considered.	na
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				The organisation should ensure that there is a process in place to provide privacy information to individuals if personal data obtained from a source other than the individual it relates to. This should be recorded on privacy information to make sure that the organisation is fulfilling its obligations in regard to the data which it processes.		In the context of referrals into the UHB and out of the UHB, the patient is likely to already be aware of this dataflow. This represents an exemption under Article 14 (5)(a) of the GDPR. In all other cases, we believe that manually informing individuals of this information would represent a 'disproportionate effort' given that we are unable to determine what a referring organisation has made their patients aware of and the volume of referrals received by the UHB -- therefore being exempt under Art 14(5)(b).	na
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				The organisation should consider additional means in which privacy information can be promoted or made available to individuals, to ensure that it does not rely on passive communication which risks individuals not being made aware of how their data is processed. This would help ensure that the a organisation is not in breach of legislation.		Will raise at the national Information Governance Group to investigate how other UHBs/Trusts are achieving this requirement.	na

IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				To ensure that privacy information is available to all areas of the population the organisation must consider means of providing information to those who may not understand the standard notice. This would help ensure that the a organisation is not in breach of legislation, and all data subjects can understand the provided privacy information.		To consider alternative versions are available to ensure all data subjects can understand their rights and how their data is processed. The UHB was of the view that the current privacy notice satisfied this requirement but this will be reviewed.	na
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				In order to ensure that the privacy information is effective, the organisation should consider means to evaluate how effective it is by means of user testing or evaluation of complaints. This would provide the organisation with assurance that they were effectively providing privacy information as required by the legislation. A log of historical Privacy Notices should be maintained to allow a review of what privacy information was provided to data subjects on what date. This would provide the organisation with assurance that it has carried out effective reviews of privacy information.		A log of privacy notices should be kept and maintained. The IG dept will work with the Concerns to ensure that a mechanism is introduced to ensure any concerns received about the Privacy Notice are fed back to the IG dept and used to inform future publications of the Privacy Notice.	na
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				The organisation should ensure that all staff receive regular training and refresher training on fair processing policies and privacy information.		Will speak to NWIS regarding national e-learning module to understand whether training on fair processing can be incorporated. The IG dept will also add guidance to its internal webpage for staff engagin with patients.	pc
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				The organisation should ensure that it has documented what information needs to be given to the ICO in the event of a reportable data breach. This will provide assurance that breaches are being reported in accordance with the legislation.		Procedure detailing breach reporting procedure and what detail needs to be provided should be created	na
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				To ensure that the organisation notifies individuals appropriately where there their personal data has been breached, the organisation should ensure that there is a documented procedure to ensure that the following is included in all breach reporting: the DPO details, a description of the likely consequences of the breach and a description of the measures taken to deal with the breach (including mitigating any possible adverse effects). This will help the organisation keep to the legislation when informing individuals about a data breach.		Procedure detailing breach reporting procedure and what detail needs to be provided should be created	na
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				Retained data should be reviewed on regular basis to identify any opportunities for minimisation or pseudonymisation of data to provide assurance for the organisation that they process the least information possible in line with the legislation.		This should be achieved by regular review of IAR. Linked to A23.	na
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				To ensure that the IAO function is effective, the organisation should formalise the appropriate level of access which IAOs have to the SIRO and DPO, and ensure that designated IAO responsibility is included in job descriptions. This will provide assurance to the organisation that the IAOs are able to effectively carry out their role in the risk management process as required in legislation. When IAO responsibility has been included in job descriptions, the organisation should ensure that all staff are aware of this and what the responsibility entails. This will provide further assurance to the organisation that the IAOs will effectively carry out their role in the risk management process as required in legislation.		The IG dept suggests that the role of IAO is assigned to a designated level of management across the organisation (e.g. Directorate Manager/General Manager) and that this role is incorporated into Job descriptions.	na
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				The organisation should ensure that all staff with specific information risk roles receive regular training to provide assurance that they are able to carry out their roles effectively with regard to information risk.		TNA to be performed. National piece of work currently being undertaken.	na
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				To ensure that staff with specific risk management roles are fulfilling those roles effectively, the organisation should formalise means by which IAOs are routinely consulted on project and change management processes s and attend or are able to feed into IG meetings. This will provide assurance that they are carrying out their roles in relation to risk management effectively and thereby reduce the risk of a breach of legislation through information risk not being handled properly.		This is being considered by the IG group which will feed into Digital Management Board	na
JOINT EDUCATION ACCREDIATION COMMITTEE														
Specialist Services	Haematology	JACIE	South Wales BMT Programme	6th edition of JACIE standards	Stuart Walker	QSE Committee	Keith Wilson	1460	4-5/02/2019	01/02/2023	Minor deficiencies noted	01/10/2019	One of the JACIE recommendations is a new fit for purpose facility and the plans for academic avenue were shared with the inspection team. If a new facility isn't progressed then the programme will not be re-accredited - the service have submitted the required improvement plan - awaiting re-accreditiaon status	pc

MHRA														
CD&T	Lab Med	MHRA	Blood transfusion (BSQR)	Blood and Safety Quality Regulations	Fiona Jenkins	QSE Committee	Andrew Gorringe/Alun Roderick	365	4-5/03/2020	no date set	6 others and 1 comment	31/03/2021	Descalated from MHRA Inspection Action Group March 2020	c
CD&T	Pharmacy	MHRA	Pharmacy SMPU	Good manufacturing practice (GMP) and good distribution practice (GDP)	Stuart Walker	QSE Committee	Darrel Baker	365	18/02/2020	18/02/2021	1 major 10 others	31/03/2021		pc
CD&T	Pharmacy	MHRA	Pharmacy UHL	Good manufacturing practice (GMP) and good distribution practice (GDP)	Stuart Walker	QSE Committee	Darrel Baker	365	23/07/2019	23/07/2020	3 majors 2 others	31/03/2020	Descalated from MHRA Inspection Action Group 1st July 2020	pc
CD&T	Medical Physics	MHRA	Radiopharmacy	Good manufacturing practice (GMP) and good distribution practice (GDP)	Fiona Jenkins	QSE Committee	Andrew Wood/Kathy Ikin	730	23/07/2019	no date set	5 majors, 2 others	tbc with regulator	Descalated from MHRA Inspection Action Group 1st July 2020	c
CD&T	Medical Physics	MHRA	Medical Physics	Lasers, intense light source systems and LEDs – guidance for safe use in medical, surgical, dental and aesthetic practices 2015.	Fiona Jenkins	QSE Committee	Andrew Wood/Kathy Ikin	ad hoc	02/01/2011	no inspection notified	No inspection to date in this area	n/a		na
CD&T	Medical Physics	MHRA	Medical Physics	Safety Guidelines for Magnetic Resonance Imaging Equipment in Clinical Use 2015.	Fiona Jenkins	QSE Committee	Andrew Wood/Kathy Ikin	ad hoc	03/01/2011	no inspeciton notified	no inspection to date in this area	n/a		na
CD&T	Medical Physics	MHRA	Medical Physics	Managing Medical Devices 2015	Fiona Jenkins	QSE Committee	Andrew Wood/Kathy Ikin	ad hoc	05/01/2011	no inspeciton notified	no inspection to date in this area	n/a		na
NATURAL RESOURCES WALES														
CD&T	Radiology	NRW	Radiology UHL	Environmental Permitting (England and Wales) Regulations 2016 Permit HB3393NA (Sealed Source Cat 5)	Fiona Jenkins	QSE Committee	Andrew Gordon/ Lesley Harris	1461	12/02/2020	no date set	none	compliant n/a		c
CD&T	Radiology	NRW	Radiology UHL and Theatres (unable to seperate visit and report)	Environmental Permitting (England and Wales) Regulations 2016 Permit HB3393NC (Open Sources)	Fiona Jenkins	QSE Committee	Andrew Gordon/ Lesley Harris	730	12/02/2020	no date set	Radiology - 3 actions - completed 0 non compliance	13/03/2020		c
CD&T	Radiology	NRW	Radiology UHW, Medical Physics, Radiopharmacy, Pathology & InVitro Lab (unable to seperate visit and report)	Environmental Permitting (England and Wales) Regulations 2016 Permit ZB3793ND (Open Sources) Previously CD9399	Fiona Jenkins	QSE Committee	Andrew Gordon/ Lesley Harris	730	30/04/2019	no date set	Radiology - 1 action, completed 1 recommendation, completed	01/05/2019		c
CD&T	Radiology	NRW	Radiology UHW, Medical Physics, Radiopharmacy, Pathology & InVitro Lab (unable to seperate visit and report)	Environmental Permitting (England and Wales) Regulations 2016 Permit CD9437 (Sealed Sources CAT 5)	Fiona Jenkins	QSE Committee	Andrew Gordon/ Lesley Harris	1461	30/04/2019	no date set	Radiology - None	Compliant n/a		c
OFFICE FOR NUCLEAR REGULATION														
CD&T	Medical Physics	Office for Nuclear regulation	Medical Physics	The Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations 2009	Fiona Jenkins	QSE Committee	Andrew Wood/Kathy Ikin	185 (Twice Yearly)	17/03/2017	17/11/2020	4 non conformances, 3 recommendaitons	01/05/2017	Inspection scheduled 17th November 2020 Gap analysis/readiness assessment completed	c
QUALITY IN PRIMARY IMMUNODEFICIENCY SERVICES														
Specialist Services	Immunology	Quality in Primary Immunodeficiency Services (QPIDS)	Immunology	Quality in Primary Immunodeficiency Services Standards	Stuart Walker	QSE Committee	Stephen Jolles/Richard Cousins	365		01/10/2019				
Specialist Services	Immunology	Quality in Primary Immunodeficiency Services (QPIDS)	Immunology	Quality in Primary Immunodeficiency Services Standards	Stuart Walker	QSE Committee			01/10/2019		Accreditation deferred for 6 months		Investment secured from WHSSC to address staffing deficiences and the alternative space has been secured. Awaiting outcome of deferment.	c
RESEARCH AND DEVELOPMENT														
	Haematology	Research and Development			Stuart Walker	QSE Committee								
UKAS														
Exec	Institute of Medical Genetics	UKAS	Institute of Medical Genetics, UHW	ISO 15189	Fiona Jenkins	QSE Committee	Lisa Grffiths		29/05/2020	no date set	No findings/non-conformances were raised, so there is no improvement action report			
CD&T	Biochemistry	UKAS	Cellular Patholgy/ (Mortuary - UKAS)	ISO 15189	Fiona Jenkins	QSE Committee	Adam Christian Scott Gable Sally Jones	365	23-29/03/20	no date set	31 Mandatory findings 31 Evidence required 11 Action recommended	2/8/2020		c
Specialist Services	ALAS	SGS/UKAS	ALAS (CAV)	ISO 9001:2015	Fiona Jenkins	QSE Committee	Paul Rogers	185 (Twice Yearly)	15-17/01/2020	01/01/2020	2 x Major Corrective Actiions, 1 X Minor Corrective Action, Several Opportunities for Improvement	06/09/2019	Happy with progress from previous audit. The 2 opportunities for improvement are in progress and we will be able to demonstrate this at the next audit. RAG rating amber as will not receive confirmation of closure until next audit in Dec 2020.	pc
Surgical Services	Perioperative	SGS/UKAS	SSSU	ISO 13485:2016	Fiona Jenkins	QSE Committee	Clare Jacobs	365	01/01/2019	01/09/2019	3 minors	01/01/2020		
Surgical Services	Perioperative	SGS/UKAS	HSDU	ISO 13485:2017	Fiona Jenkins	QSE Committee	Mark Campbell	365	07/08/2019	01/08/2020	2 minors	07/08/2020		
CD&T	Haematology	SGS/UKAS	Haematology/Blood Transfusion (UKAS)	ISO 15189:2012	Fiona Jenkins	QSE Committee	Alun Roderick	n/a	06/11/2019	n/a	Accreditation extra visit: Action Mandatory x 2 Require Evidence to UKAS x 1 Action Recommended x 1	06/12/2019	Blood transfusion sits in CD&T CB not SpS CB	
Specialist Services	Medical Genetics	SGS/UKAS		ISO 15189:2012	Fiona Jenkins	QSE Committee	Peter Thompson		2 and 5/11/19		Action Mandatory x 14 Require Evidence to UKAS x 14 Action Recommended x 5	05/12/2019	Medical Genetics no longers sits in SpS CB. The service has transferred to the instiute of Medical Genetics	

CD&T	Haematology	UKAS	Phlebotomy (UKAS)	ISO 15189	Fiona Jenkins	QSE Committee	Andrew Gorringe/Alun Roderick	365	31/03/20 - 7/04/20	19/04/2021	included in Haematology findings above	05/05/2019		c
CD&T	Biochemistry	UKAS	Biochemistry (UKAS)	ISO 15189	Fiona Jenkins	QSE Committee	Carol Evans/Nigel Roberts	365	04/12/2019	07/12/2020 to 11/12/2020	25 findings	16/02/2020		c
CD&T	Biochemistry	UKAS	Specimen Reception (UKAS)	ISO 15189	Fiona Jenkins	QSE Committee	Carol Evans/Nigel Roberts	365	04/12/2019	07/12/2020 to 11/12/2020	2 findings and 1 reccomendation Included in findings of Biochemistry UKAS	16/02/2020		c
CD&T	Lab Med/Haematology	UKAS	Haematology/ Blood Transfusion laboratory	ISO 15189	Fiona Jenkins	QSE Committee	Alun Roderick Vicky Cummings Rachel Borrell	365	31/03/20 - 7/04/20	19/04/2021	4 mandatory findings 4 evidence required	18/05/2020		c
WELSH WATER														
Estates		Welsh Water			Abigail Harris	Health and Safety								
WSAC														
CD&T	Audiology	WSAC	audiology - adults	audiology quality standards	Fiona Jenkins	QSE Committee	Lorraine Lewis	1095	01/06/2019	01/06/2022	compliant with 8 of 9 standards and meeting 85% target	12/07/1905		
CD&T	Audiology	WSAC	Newborn hearing screeing wales	audiology quality standards	Fiona Jenkins	QSE Committee	Jackie Harding	730	01/06/2018	01/06/2020	80% target met in all standards and 85% overall target met	01/01/2019		
CD&T	Audiology	WSAC	audiology - paediatrics	audiology quality standards	Fiona Jenkins	QSE Committee	Jackie Harding/Rhian Hughes	730	01/06/2018	01/06/2020	80% target met in all standards and 85% overall target met	12/07/1905		
WEST MIDLANDS QRS														
Specialist Services & Children and Women	Haematology	West Midlands QRS	Red Cell Service (Clinical Haematology)	Published by Thalassaemia and Sickle Cell Society (2018)	Medical Director	QSE Committee	Jonathan Kell (Adult Lead), Indu Thacker (Paeds Lead, Clare Rowntree (Clinical Director)	1095	01/10/2019	01/10/2022	WHSSC commissioned service with investment in staff	01/12/2019	WHSSC ICP approved - Business case scheduled for approval at BCAG 21/10/2020.	c

Report Title:	**Internal Audit Recommendation Tracker Report**								
Meeting:	Audit Committee						**Meeting Date:**	17th November 2020	
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**		
Lead Executive:	Director of Corporate Governance								
Report Author (Title):	Head of Risk and Regulation								

Background and current situation:

The purpose of the report is to provide Members of the Audit Committee with assurance on the implementation of recommendations which have been made by Internal Audit by means of an Internal Audit recommendation tracking report.

The Internal Audit tracking report was first presented to the Audit Committee in September 2019 and approved by the Committee as an appropriate way forward to track the implementation of recommendations made by Internal Audit.

The tracker goes back 3 financial years and shows progress made against recommendations from 17/18, 18/19 and recommendations which have been made during 19/20.

Executive Director Opinion /Key Issues to bring to the attention of the Board/ Committee:

As can be seen from the attached summary tables the overall number of outstanding recommendations has reduced from 164 individual recommendations to 111 for the period September 2020 to November 2020.This is due to a large number of recommendations having been completed during this period with no additional recommendations being added during this period.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc:)

A review of all outstanding recommendations has been undertaken since the last meeting of the Audit Committee where the Internal Audit tracker was presented (September 2020). Each Executive Lead has been sent the recommendations made by Internal Audit which fall into their remits of work.

The table below shows the number of Internal Audits which have been undertaken over the last three years and for the financial year 2019/20 and their overall assurance ratings.

	Substantial Assurance	Reasonable	Limited Assurance	Rating N/A	Total

		Assurance			
Internal Audits 17/18	7	25	5	-	37
Internal Audits 18/19	10	26	7	-	43
Internal Audits 19/20	10	25	2	2	39

Attached at Appendix 1 are summary tables which provide an update on the September 2020 position.

ASSURANCE is provided by the fact that a tracker is in place. This assurance will continue to improve over time with the implementation of quarterly follow ups with the Executive Leads.

Recommendation:

The Audit Committee Members are asked to:

(a) Note the tracking report which is now in place for tracking audit recommendations made by Internal Audit.
(b) Note that progress will be seen over coming months in the number of recommendations which are completed/closed.

Shaping our Future Wellbeing Strategic Objectives
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

1.	Reduce health inequalities	x	6.	Have a planned care system where demand and capacity are in balance	x
2.	Deliver outcomes that matter to people	x	7.	Be a great place to work and learn	x
3.	All take responsibility for improving our health and wellbeing	x	8.	Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4.	Offer services that deliver the population health our citizens are entitled to expect	x	9.	Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5.	Have an unplanned (emergency) care system that provides the right care, in the right place, first time	x	10.	Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	x

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant, click here for more information

Prevention	x	Long term		Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	~~Yes / No~~ / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

INTERNAL AUDIT REPORT RECOMMENDATIONS FOR 2017/18 (November 2020 Update)

	Update November 2020				Update November 2020				Update November 2020			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Complete												
Overdue under 3 months												
Overdue over 6 months under 12 months												
Overdue more than 12 months	2		2		9	1	8		4	1	2	1
Superseded												
Total	**2**		**2**		**9**	**1**	**8**		**4**	**1**	**2**	**1**

Total number of recommendations outstanding as on 30th October 2020 for financial year 2017/18 is **15** compared to the position in September 20 when a total number of outstanding recommendations of **22** were noted.

INTERNAL AUDIT REPORT RECOMMENDATION FOR 2018/19 (November 2020 Update)

	Update November 2020				Update November 2020				Update November 2020			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Date not reached	4		2	2	9		4	4	1			1
Complete												
Overdue under 3 months												
Overdue by over 3 months under 6 months												
Overdue over 6 months under 12 months	1			1								
Overdue more than 12 months	5	2	1	2	4	1	1	2	2		1	1
Superseded												
Total	**10**	2	3	5	**12**	**1**	**5**	**6**	**3**		**1**	**2**

Total number of recommendations outstanding as on 30th October 2020 for financial year 2018/19 is 25 compared to the position in September 20 when a total number of outstanding recommendations of **39** were noted**.**

INTERNAL AUDIT REPORT RECOMMENDATIONS FOR 2019/20 (November 2020 Update)

	Update November 2020				Update November 2020				Update November 2020			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Date not reached									1			1
Complete												
Overdue under 3 months												
Overdue by over 3 months under 6 months	2			2	20	12	3	5	13	2	3	8
Overdue over 6 months under 12 months	5		4	1	17		6	11	6	1	1	4
Overdue more than 12 months	1		1		6		2	4				
Superseded												
Total	**8**		5	3	**43**	**12**	**11**	**20**	**20**	**3**	**4**	**13**

Total number of recommendations outstanding as on 30th October 2020 for financial year 2019/20 is **71** compared to the position in September 20 when a total number of outstanding recommendations of **77** were noted**.**

Audit	Final Report Issued on	Audit Title	Executive Lead for Report	Audit Rating	No. of Recs Made	Rec No.	Rec. Rating	Recommendation Narrative	Management Response	Executive Lead for Recommendation	Agreed Implementation Date	Please confirm if completed (c), partially completed (pc), no action taken (na)	Executive Update
IA 1718	01/02/2018	WLI Payments Follow-Up	Chief Operating Officer	Reasonable	2	R1/2	M	The UHB has produced a WLI Payments Policy /Procedure and this has been disseminated to Directorates, but has yet to be finalised and approved by the organisation. Additionally, there are no local Directorate procedures in place for the management of WLI payments as they will work to the UHB Payments Policy/Procedure (Finding 1 – Partially Actioned).	Not Provided	Chief Operating Officer	01/06/2018	pc	WLI Policy drafted but needs to be reviewed to ensure it aligns with the latest Welsh Consultant Contract.
IA 1718	01/02/2018	Residences	Director of Planning	Reasonable		R6/10	L	The UHB should document future plans for the provision and utilisation of residences.	The UHB is currently embarking on a significant master planning exercise for the UHB site and an estate rationalisation programme across the UHB. The provision of accommodation will be considered as part of this exercise. This process will likely take in excess of 12 to 18 months. Progress will be reported as part of the verall master planning exercise.	Director of Finance		na	All rental arrears are addressed with tennats and payments are agreed.
IA 1718	01/04/2018	Wellbeing of Future Generations Act	Director of Public Health	Reasonable		R4/5	M	The Health Board must ensure that its obligations in respect of the Act are appropriately communicated to all staff within the Health Board. We recommend that the Health Board develop a	The Chair of the Steering Group met with UHB Director Communications and the UHB Engagement Lead in March to discuss the approach to raising awareness within the UHB. Draft Communications Plan to be brought to the next Steering Group on 4 June.	Director of Public Health	01/06/2018	pc	The Director of Comms has confirmed 4.8.20 that the current comms plan is the formal plan, and will be subject to at least annual updates. This will be circulated to all WFG
IA 1718	01/11/2017	Nurse Revalidation	Executive Nurse Director	Reasonable		R2/3	M	The C&V UHB PADR form should be revised for Nursing Staff to include an appendix to ensure Nurse revalidation portfolio completion is discussed at each annual appraisal during the 3 year cycle.	The Senior Nurse for Nurse Education will work with the lead for PADR to create a section for revalidation for nurses within the pay progression document. Pay progression training continues, to assist nurses in the completion of documentation (through enhanced communication and coaching workshops).	Director of Nursing	01/03/2018	c	
IA 1718	01/11/2017	Nurse Revalidation	Executive Nurse Director	Reasonable		R3/3	L	Where nurses are using their line manager as their confirmer, the confirmers should be reminded of ESRs capability to make them aware that staff members in their hierarchy are approaching their nurse revalidation date.	An email via the Directors of Nursing will be issued to remind staff of ESR capability re revalidation/registration.	Director of Nursing	01/01/2018	c	system rules setup to overide early clocking in. If staff clocks in early and work overtime supervisers amend early clocking in.
IA 1718	01/04/2018	University Hospital of Wales Neo Natal Developm	Director of Planning	Reasonable		R6/7	L	The Capital Procedures Manual should be revised to include the requirement for a Project Director's Acceptance Certificate signed by the Chief Executive and Project Director.	Agreed	Director of Planning	31/05/2018	pc	A review of the capital management procedure is due to be undertaken by internal audit in this financial year and the management will be updated to incorporate this and any other changes identified
IA 1718	01/04/2018	University Hospital of Wales Neo Natal Developm	Director of Planning	Reasonable		R7/7	M	Requests for 'Single Tender Action' should be approved and reported to the Audit Committee in accordance with Standing Financial Instructions and the current UHB Scheme of Delegation. The Estates Department's Capital Projects Manual pro-forma, Single Tender Action	Agreed	Director of Planning	31/05/2018	pc	Ongoing
IA 1718	01/05/2018	Business Continuity Planning Follow-Up	Director of Planning	Reasonable	1	R1/1	H	The significant, high priority, issue that remains from the original review can be summarised as follows: The EPRR team have begun to accumulate BCPs from across the	Not Provided	Director of Planning		pc	This action will be included for all future reports as appropriate so is partially completed.
IA 1718	01/05/2018	Mortality Reviews	Executive Medical Director	Reasonable		R2/3	M	The Health Board must ensure that level 1 mortality reviews are completed for all inpatient deaths.	A review of the current paper trail will be undertaken and improved as necessary. Clinical Boards will be reminded of the need to complete the level one reviews at the time of death certification as acquiring the notes afterwards is often difficult due to the current process of managing case notes of deceased patients in medical records. A meeting will take place with the CD for Internal Medicine to review their processes as they have the most deaths in the UHB. The Medical Director will note the findings of the Internal Audit in the June HSMB Meeting to ensure the Clinical Boards are reminded of their responsibility to complete level one reviews.	Executive Medical Director	01/06/2018	pc	Approx 80% of inpatient deaths undergo level 1 review New process in development, superseeding this issue The MD is currently working with the AMD for patient safety and governance, and the patient safety team, to develop a new process for learning from death reviews. This will be aligned with the introduction of the National Medical Examiner process which is curently in development in Wales. The new delivery process has the same aspirations as outlined in this audit .
IA 1718	01/05/2018	Mortality Reviews	Executive Medical Director	Reasonable		R3/3	M	The Universal Mortality Review form question pertaining to the need to trigger a Level 2 review should be revised and re-written to improve clarity and remove ambiguity as to its application.	The wording on the form and subsequent IT development was so that any 'yes' answer would trigger a level 2 review. The double negative was a calculated risk. Given this feedback we will review and revise it.	Executive Medical Director	01/07/2018	pc	Approx 80% of inpatient deaths undergo level 1 review New process in development, superceding this issue The MD is currently working wit the AMD for quality and safety, and the quality and safety team, to develop a new process for learning from new death reviews. This will be aligned with the introduction of the new Medical Examiner process which is curently in development in Wales. That new process has the sam aspirations as outlined in this audit with a new delivery process. At the UHB level, a Mortality review group has been set up with representation from all the CB's.
IA 1718	01/06/2018	RTT Performance Reporting	Director of Transformation and Informatics	Reasonable	4	R1/4	M	The Health Board should ensure there is a formalised policy that encompasses the operational procedures for data collection, monitoring and reporting of RTT.	We accept that there is a need to review the appropriateness of our RTT policy, ensuring it is live and covers our developing processes for managing patients as well as any rule and definitional changes. At the present time WG are reviewing RTT measures and we have received requirements from WG that have material impact and conflict with existing guidance, primarily around ophthalmology measures, but there are also changes to diagnostics, sleep, cancer and cardiac.	Director of Transformation & Informatics	01/09/2018	pc	performance reporting is being reviewed with input from the COO's office
IA 1718	01/06/2018	RTT Performance Reporting	Director of Transformation and Informatics	Reasonable		R2/4	M	The Health Board should consider validating data of patients that are 'in target' due to the potential that these patients may have incorrectly applied suspensions and thus overall understating the amount of breaches.	We accept the point made in the context that data quality audits should extend to reported cancer waiting times – periodic audit of RTT pathways does already occur. Validation of all cancer pathways open and closed does occur at the weekly tracking meetings, and teams are reminded of the requirement to ensure that all management actions are accurately captured on the PMS system. A periodic audit, which will not be monthly, of data quality for cancer patients will be put in place as part of the new member of the cancer services team.	Director of Transformation & Informatics	01/11/2018	pc	
IA 1718	01/06/2018	RTT Performance Reporting	Director of Transformation and Informatics	Reasonable		R3/4	M	The Performance Report should include a note next to the SCP compliance figures to ensure the Board understands that these figures are not necessarily accurate and are not a true reflection of performance as data collection systems are currently not fit for purpose and data sets have not been defined.	Accepted	Director of Transformation & Informatics	01/05/2018	pc	the overall performance report is being reviewed for Qtr 4 2020/21
IA 1718	01/06/2018	RTT Performance Reporting	Director of Transformation and Informatics	Reasonable		R4/4	L	The Performance Report should include data on the related Cancer patient volumes in addition to percentage compliance as this will be a useful metric to aid the Board's understanding of scope (eg. Total number of USC/Non-USC and corresponding number of patients 'in target' and 'breached')	The reporting of volumes occurs infrequently. There is a balance to be had in the detail presented within the board report. The board have asked that they receive less granular information on the operational performance of the board and more detail on the strategic and tactical performance of the board. As such we will partially accept the recommendation and provide an infrequent update on volumes, unless of course it is a material factor in explaining performance	Director of Transformation & Informatics	01/06/2019	pc	the overall performance report is being reviewed for Qtr 4 2020/21

Audit	Final Report Issued on	Audit Title	Executive Lead for Report	Audit Rating	No. of Recs Made	Rec No.	Rec. Rating	Recommendation Narrative	Management Response	Executive Lead for Recommendation	Agreed Implementation Date	Please confirm if completed (c), partially completed (pc), no action taken (na)	Executive Update
IA 1718	01/08/2018	Costing Review	Director of Finance	Reasonable	6	R1/6	H	Management will look to increase the level of clinical engagement throughout the costing process.	The PCB platform provides the UHB with an effective dashboard for analysing costing data at a component level. Whilst the UHB can make greater use of the PCB tool, its utilisation is complex, requiring statistical, financial and service knowledge and the associated resource to support this level of analysis. Data and analysis outputs are used by the organisation to inform the transformation and CRP opportunities agenda and our IMTP. Evidence of this is available. The new osting system and efficiency framework provides the opportunity to re-engage with interested clinicians and efforts are ongoing to achieve this this through evised performance management processes. Finance delivery unit dashboard	Director of Finance	01/04/2018	pc	There is an increased level of engagement with regard to the benchmarking and costing data. Working groups have been established with the transformation team and clinical boards. These have currently been suspended due to COVID-19
IA 1819	12/02/2019	Performance Reporting Data Quality - Non RTT	Director of Public Health	Substantial		R2/3	L	The Performance Report working spreadsheet should be linked to data sources and SOPs in order to aid collation and ensure the on-going robustness of the process.	As identified above – not all the data is available to achieve this. The UHB is actively contributing, via membership of WG & NHS Wales committees to changing and improving data flows and making the required data available.	Director of Transformation & Informatics		pc	work in progress to ensure accurate reporting is in apce for Q4 2020/21
IA 1819	15/05/2019	Strategic Planning/IMTP	Director of Planning	Substantial	1	R1/1	M	Management should ensure that the plans for Clinical Boards are produced on a timely basis to enable the Clinical Boards to report on their projects in a consistent manner and allow them to monitor them appropriately.	A revised monitoring process for reporting clinical board progress on IMTPs will be in place for 2019/20. This will utilise the Shaping Our Future Wellbeing- Annual Plan (X-Matrix) methodology to provide clarity on performance and accountability arrangements. Progress against key IMTP priorities as captured in the annual plan document will be reported to Management Executives on a monthly basis as agreed at Management Executives on 09/05/19.	Director of Planning	01/07/2019	na	
IA 1819	30/08/2018	Dental CB – Theatre Sessions	Chief Operating Officer	Reasonable	3	R1/2	H	The Dental administration staff should ensure that Patient Dental files contain copies of all necessary documentation relating to the procedures undertaken.	Urgent meeting to be arranged with Clinical Lead and Peri-Operative Care Manager to define a process to manage documentation	Chief Operating Officer	01/09/2018	pc	This action is partially complete and will now be reaudited when green, amber zones are created in SSSU and main theatre - completion will be in September 2020
IA 1819	01/12/2018	Renal IT system	Chief Operating Officer	Reasonable		R4/10	M	The DR plan should be revised to include contact details of support organisations, user departments and management. The DR plan should be tested and subject to subsequent review.	Dialogue with the Vendor parties has already started regarding the failback process. Action is underway to test and resolve, and identify an appropriate timetable for follow-up to ensure regular review. The BCP will be revised with immediate attention	Chief Operating Officer	01/04/2019	c	The BCP and DR plan have been revised. A new plan will be devised and tested following implementation of a new IT infrastructure, expected by July 2020
IA 1819	15/02/2019	Kronos Time Recording System - Estates	Director of Planning	Reasonable	6	R1/6	H	Suitably qualified and experienced staff should be assigned specific responsibility for overseeing the pilot. This should include resolving all outstanding issues, developing management reports, monitoring and reporting progress of the pilot to an appropriate level of Estates Management and the final evaluation of the suitability of the system.	Suitably qualified and experienced staff should be assigned specific responsibility for overseeing the pilot. This should include resolving all outstanding issues, developing management reports, monitoring and reporting progress of the pilot to an appropriate level of Estates Management and the final evaluation of the suitability of the system.	Director of Finance	01/06/2019	pc	Interface requires testing to complete pilot
IA 1819	15/02/2019	Kronos Time Recording System - Estates	Director of Planning	Reasonable		R4/6	M	Where overtime has been worked this should be reflected in the start and finish times recorded in Kronos, and should be authorised on the timesheets. Management should investigate the feasibility of including a 'reason for overtime' or Notes field on timesheets with the system providers so that in future all overtime can be claimed and	The issue will be considered as part of the system review although all overtime is authorised and recorded therefore the risk is low. Kronos has been updated to include overtime reasons.	Director of Planning	01/06/2019	na	
IA 1819	15/02/2019	Kronos Time Recording System - Estates	Director of Planning	Reasonable		R5/6	M	Staff should be instructed to clock in no more than 27 minutes before the start of their shift. Where staff do clock in more than 27 minutes before the start of their shift, supervisors should amend the timesheet start time to the scheduled start time if the additional time is not to be paid as overtime. Supervisors should	Staff clock in on arrival on site but are not paid from this point, unless authorisation is given for overtime. Staff will be advised not to clock in as suggested and this will be monitored but the risk associated with this practice is considered low.	Director of Finance	01/03/2019	na	system rules setup to overide early clocking in. If staff clocks in early and work overtime supervisers amend early clocking in.
IA 1819	15/02/2019	CRI Safeguarding Works	Director of Planning	Reasonable	5	R1/5	M	Progression at risk should be fully documented, approved and recorded at the risk register (O).	Agreed. **ALL FUTURE PROJECTS**	Director of Planning	22/05/2020	na	Included on the project risk register
IA 1819	15/02/2019	CRI Safeguarding Works	Director of Planning	Reasonable		R4/5	L	4) Project benefits should be clearly identified and documented in the business case, including: ? Baseline value; ? Method of measurement; ? Target improvement; ? Timing of when the benefit would be achieved; and ? Lead responsibility for the benefit (D). (This recommendation being for implementation at future projects). Post project evaluations should be delivered in accordance with agreed Business Case requirements, or a revised approach should be appropriately approved (O).	Agreed. **ALL FUTURE PROJECTS**	Estates Manager	01/05/2019	na	
IA 1819	15/02/2019	CRI Safeguarding Works	Director of Planning	Reasonable		R5/5	L	5) The required approach to post project evaluation and benefits assessment should be agreed with the Welsh Government, in relation to the CRI afeguarding project and wider investment at the CRI site (O).	Agreed.	Estates Manager	01/04/2020	na	
IA 1819	11/04/2019	Commissioning	Director of Transformation and Informatics	Reasonable	3	R1/3	H	Strategic Commissioning Group Terms of Reference document should be revised and updated to state the quorate attendance level and its current membership. Additionally, its membership should include representation from the Clinical Boards to ensure a broad contribution and as such an improved strategic approach in full alignment with the Group's Terms of Reference.	The Strategic Commissioning Groups Terms of Reference, including membership was reviewed at a facilitated workshop on 20th Feb 2019. The first draft of a refreshed Terms of reference is scheduled for discussion at the May 2019 meeting of the Strategic Commissioning and Finance Group. Clinical Board representation will be fully considered.	Director of Transformation & Informatics	01/04/2019	na	
IA 1819	15/05/2019	Water Safety	Director of Planning	Reasonable		R2/7	M	The current position in respect of the backlog of remedial jobs, should be routinely reported to the Water Safety Group (O).	Agreed	Director of Finance	30/06/2019	pc	Ongoing discussions at scheduled meetings
IA 1819	15/05/2019	Water Safety	Director of Planning	Reasonable		R3/7	M	Training should be updated for all key staff with assigned water management responsibilities (O).	Agreed	Director of Finance	30/07/2019	na	
IA 1819	15/05/2019	Water Safety	Director of Planning	Reasonable		R4/7	M	a) An audit trail should be maintained where routine checks are not completed, in cases where risk-based decisions dictate alternative monitoring/testing schedules will be applied. b) Key person dependency should be reviewed and removed, where possible, to facilitate the timely identification and completion of	Agreed	Director of Finance	01/11/2019	pc	Statutory inspections ongoing, information being entered into MiCad, live database

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IA 1819	15/05/2019	Water Safety	Director of Planning	Reasonable		R5/7	H	a) For those clinical boards identified in this audit as being non-compliant with required flushing practices, the Chair of the WSG should request assurance from the clinical boards that practices have been improved.	Agreed	Director of Finance	01/11/2019	na	
IA 1819	15/05/2019	Water Safety	Director of Planning	Reasonable		R6/7	H	The risk assessment process, including preparation of appropriate prioritised action plans to address the identified risks, should be completed as soon as possible (D).	Agreed	Director of Finance	30/07/2019	na	
IA 1819	15/05/2019	Water Safety	Director of Planning	Reasonable		R7/7	M	Progress, including highlighting of any delays, should be regularly reported to the Water Safety Group (O).	Agreed	Director of Finance	31/10/2019	na	
IA 1819	15/05/2019	UHB Core Financial Systems	Director of Finance	Reasonable		R3/5	M	Management should inform responsible staff to promptly notify eEnablement of changes to the Purchasing Oracle hierarchy list. The required forms should be completed to process updates.	Recommendation Accepted. The UHB's current procedure will be updated to clarify the responsibility to review approvers at the Clinical Board level and within Corporate Finance. NWSSP have developed a new Oracle User Accress Form which is now in use. NWSSP have now provided a user guide for the new Oracle Access form and the Oracle Purchase Hierarchy Report. The UHB will incorporate the guides within its budgetary control procedure by the end of October.	Director of Finance	31/07/2019	pc	A list of actions were agreed with NWSSP Procurement eEnablement on the 21st June 2019. Actions included the establishment of a revised Oracle User Form which would include ESR position numbers which could be linked to Oracle responsibilities. **On the 15.06.2020 NWSSP confirmed that the user forms has been revised and are at the moment in the final stage of implementation**
IA 1819	15/05/2019	UHB Core Financial Systems	Director of Finance	Reasonable		R4/5	M	Management should ensure that a standard procedural guide is produced to support staff in the maintenance of the Oracle Purchasing hierarchy. The guide should also state an appropriate agreed period for the review of the hierarchy.	Recommendation accepted. The UHB's current procedure will be updated to clarify respective responsibilities at the Clinical Board level and within Corporate Finance. The minimum expectation is that purchasing hierarchies will be reviewed quarterly. NWSSP have now provided a user guide for the new Oracle Access form and the Oracle Purchase Hierarchy Report. The UHB will incorporate the guides within its budgetary control procedure by the end of October.	Chief Operating Officer	01/04/2020	pc	A list of actions were agreed with NWSSP Procurement eEnablement on the 21st June 2019. Actions included the establishment of a revised Oracle User Form which would include ESR position numbers which could be linked to Oracle responsibilities & an agreement to investigate whether Finance staff could be provided with read only access to hierarchies. The read only access to hierarchies was sucessfully tested and an amended ''CVT Finance Inquiry'' responsibility in Oracle PROD was applied with the
IA 1819	15/05/2019	UHB Core Financial Systems	Director of Finance	Reasonable		R5/5	M	Management should ensure that the required forms are completed, signed and forwarded to eEnablement for all additions to the Oracle Hierarchy. Management should also liaise with eEnablement to ensure there is an organised system for storing the Financial limit forms so they can be easily retrieved here an audit trail is required.	Recommendation accepted. The UHB's revised procedure will be updated to clarify respective responsibilities for establishing approvers and maintaining appropriate records for additions to the Oracle Hierarchy. NWSSP have now provided a user guide for the new Oracle Access form and the Oracle Purchase Hierarchy Report. The UHB will incorporate the guides within its budgetary control procedure by the end of October.	Chief Operating Officer	31/08/2019	pc	AA list of actions were agreed with NWSSP Procurement eEnablement on the 21st June 2019. Actions included the establishment of a revised Oracle User Form which would include ESR position numbers which could be linked to Oracle responsibilities & an agreement to investigate whether Finance staff could be provided with read only access to hierarchies. The read only access to hierarchies
IA 1819	17/05/2019	Specialist Services Clinical Board – Medical Finance Governance	Chief Operating Officer	Reasonable	2	R1/2	H	Management should carry out a comprehensive review of the current and future consultant staffing levels to ensure that the Critical Care service can be sustainably delivered in the future. This should include review of the current service model.		Chief Operating Officer	01/04/2019	na	Active recruitment taking place and plan to be fully recruited to existing capacity by Nov 2020 succession planning being identified and models of care being reviewed
IA 1819	18/01/2019	Legislative/Regulatory Complaince	Director of Corporate Governance	Reasonable		R5/7	H	The Senior Fire Safety Office should ensure that sufficient evidence is available to support the completion of actions before they are recorded as complete on the Tracking Report.	Agreed	Director of Corporate Governance	01/02/2019	pc	It should be recognised that the current all Wales FRA tool used by all Welsh Health Boards and managed by SSP does not evidence completion of actions making evidance of
IA 1819	18/01/2019	Legislative/Regulatory Complaince	Director of Corporate Governance	Limited		R6/7	H	The Senior Fire Safety Officer should ensure that there is appropriate attendance at the DFSM meetings from each of the Clinical Board Fire Safety Managers.	Agreed	Deputy CEO & Executive Director of Workforce and OD	30/06/2019	na	This action if for the Fire Safety Manager to be followed up by end of June
IA 1819	12/02/2019	Surgery Clinical Board – Medical Finance Governance	Chief Operating Officer	Limited	6	R1/6	H	The Directorate should ensure that consultants carry out all planned sessions wherever possible and appropriate reasons are recorded for the cancellation of clinics and theatres. Colorectal Consultants should ensure that they cover and backfill the other Consultants lists if they are unable to carry out the planned session.	• A new system to accurately record consultant activity in theatre is being developed with a clear desktop procedure. • Through job planning each consultants expected activity will be agreed in weeks and monitored accordingly by the Directorate • Expectation around backfill sessions will be agreed and signed by consultants and a system to monitor this will be managed by the Directorate team • Systems will be put in place by end of March 2019	Chief Operating Officer	30/03/2019	c	Theatre sessions reviewed on a weekly basis by the specialty manager for General Surgery. Improve annual leave data base has been developed for General Surgery which includes reason for absence. Joint job planning meeting is scheduled for the end of August, at which discussions will be held in relation to backfilling. The Directorate have seen improvements in terms of backfilling.
IA 1819	14/02/2019	Internal Medicine Directorate – Mandatory Training & PADRs Follow-Up	Chief Operating Officer	Limited		R2/6	H	Management should ensure that all members of staff within the directorate are fully compliant and up to date with their mandatory training. If staff members believe that ESR is not tracking when a module is completed, staff should print out the certificate available to provide proof and store it within their personal file.	Improved compliance for 85% of staff with completion of 100% mandatory and statutory training modules (44% improvement over 6 months). Staff to be allocated onto study leave planner and compliance monitored monthly via ESR and discussed with ward managers at 121s.	Director of Transformation & Informatics	01/07/2019	pc	Work has commenced to cleanse ESR which will mean that Ward Managers receive accurate monthly data from workforce. Ward Managers are held to account for the training compliance of their team and this is discussed monthly with the Senior Nurse Plan to be compliant by Sept 2020
IA 1920	16/08/2019	Carbon Reduction Commitment	Director of Planning	Substantial	1	R1/1	M	The UHB should ensure that the strategy is agreed as soon as possible so that the surplus allowances can be sold for the best achievable price.	The UHB will be agreeing the strategy regarding the course of action to be adopted for surplus allowances during August 2019.	Director of Planning	16/08/2019	na	The surplus CRC allowances were advertised to be sold via procurement however there were no bids therefore no sale was made.
IA 1920	23/09/2019	Legislative / Regulatory Compliance	Director of Corporate Governance	Reasonable		R5/7	M	The Senior Fire Safety Office should ensure that sufficient evidence is available to support the completion of actions before they are recorded as complete on the Tracking Report.	Agreed	Deputy CEO & Executive Director of Workforce and OD	01/02/2019	pc	It should be recognised that the current all Wales FRA tool used by all Welsh Health Boards and managed by SSP does not evidence completion of actions making evidance of closure a laborious resource intensive task. However CEF intend to develop an alternative electronic system to enable closure of actions to be carried out by the responsible person attributed to each action resulting in evidence that is both current and auditable.
IA 1920	23/09/2019	Legislative / Regulatory Compliance	Director of Corporate Governance	Reasonable		R6/7	M	The Senior Fire Safety Officer should ensure that there is appropriate attendance at the DFSM meetings from each of the Clinical Board Fire Safety Managers.	Agreed	Deputy CEO & Executive Director of Workforce and OD	01/05/2019	pc	This action if for the Fire Safety Manager to be followed up by end of June
IA 1920	12/12/2019	Consultant Job Planning Follow-up	Executive Medical Director	Limited	4	R1/6	H	Clinical Boards must ensure that all consultants complete a job plan or have their existing job plan reviewed on an annual basis.	1. Processes are in place to support the completion and reporting of job planning activity. There is monthly reporting of the annual job planning process via the Clinical Board Performance reviews. There has been recent improvement in a small number of Clinical Boards. Immediate steps will be taken by the Medical Director and the Director of Workforce to target those Clinical Boards with poor performance and those not significantly improving (5 out of 8) to request an improvement plan which will ask for reported improvement in annual job planning review rates over a period of three months. Clinical Board Directors should ensure that the Clinical Directors take responsibility for these being undertaken and have internal Clinical Board systems to monitor improvement.	Executive Medical Director		pc	24/08/2020: the e-JP system has been procured and contract start date is 31/08/2020. System build and training will take place throughout September and October. System will go live in October for directorates to put consultant Job Plans onto the system.
IA 1920	12/12/2019	Consultant Job Planning Follow-up	Executive Medical Director	Limited		R2/6	H	The UHB job planning guidance should require consultants to use the standard Job Plan template contained within the guidance unless they can provide a valid reason for not doing so. Job Planning documentation should be completed in full and should include full details of the activities to be undertaken in each session. Line managers should ensure that the number and split of sessions recorded in ESR agrees to and is supported by a fully completed job plan.	1. Clinical Board Directors and Clinical Directors should ensure that summary job plans data are submitted to the Medical Workforce Team on a regular basis so that updates can be made in the ESR system. This will be recognised by implementation of actions in Management Recommendation 1 in terms of outcomes. 2. Medical Workforce to update ESR system with summary job plan data – this has been already reviewed by the Medical Director and Director of Workforce recently and there is no back-log of data to currently input into the system (maximum wait two weeks). Clinical Directors/DM will be able to submit to ESR and their data will be entered in a timely way. The previous guidance issued	Executive Medical Director		pc	24/08/2020: the e-JP system has been procured and contract start date is 31/08/2020. System build and training will take place throughout September and October. System will go live in October for directorates to put consultant Job Plans onto the system.

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IA 1920	12/12/2019	Consultant Job Planning Follow-up	Executive Medical Director	Limited		R3/6	H	Clinical Board management must ensure that all consultants complete the outcome measures template contained within the UHB Job Planning guidance as part of the job planning process.	1. Review of job planning guidance with regard to job plan template and re-issue to Clinical Board Senior Teams for cascade to their Clinical Directorates. 2. The Medical Director and Workforce Director will present to the HSMB in June 2018 the outcome of the Internal Audit Report - outlining the actions to be taken and re-emphasise the information available to the Clinical Boards and Clinical Directorates.	Executive Medical Director		pc	24/08/2020: First draft of procedure sent out to BMA for comments and to all CBDs and CDs for comments.Awaiting comments, this procedure will then go out for 28days consultation prior to approval. Procedure includes the need to complete the outcome forms
IA 1920	12/12/2019	Consultant Job Planning Follow-up	Executive Medical Director	Limited		R4/6	H	In accordance with the guidance, Clinical Board management should ensure that individual, personalised schedules are completed for all consultants that are on Team or Annualised Hours Job Plans.	Review of job planning guidance with regard to job plan template and re-issue to Clinical Board Senior Teams for cascade to their Clinical Directorates. This will emphasise the need for all members of a team to complete individually the team job plan.	Executive Medical Director		pc	24/08/2020: First draft of procedure sent out to BMA for comments and to all CBDs and CDs for comments.Awaiting comments, this procedure will then go out for 28days consultation prior to approval. Procedure includes annualised job plans, with the annual job plan cycle aligned to the financial year. Please see procedure for details
IA 1920	12/12/2019	Consultant Job Planning Follow-up	Executive Medical Director	Limited		R5/6	L	The UHB should consider developing additional methods of communication and / or training for both line managers and consultants to improve the completion rate and quality of consultant job plans.	A planned schedule for training should be refreshed and communicated, including sources of information available to Clinical Directors. **Implemented.** Evidence was provided to confirm that a series of training sessions detailing the findings from the original audit was delivered by the Assistant Medical Director (Medical Workforce and Revalidation).	Executive Medical Director		na	24/08/2020: Training has been provided by the AMD for Workforce and implemented. In line with the implementation of the e-JP system, a revised training plan will be developed to update all CDs with how this will work with the new system.
	12/12/2019	Consultant Job Planning Follow-up	Executive Medical Director	Limited		R6/6	M	All completed job plans must be signed by the Consultant and the clinical manager responsible for agreeing them. The standard Job Plan documentation included in the UHB Job Planning guidance should be updated to incorporate the use of digital signatures.	1. The job plan review does not require an actual signature but there does need to be a record of the job plan being agreed by all parties and signed. 2. An electronic job planning system will be trialled in Cardio Thoracic should provide a seamless and electronic system solution in the future, pending evaluation of the pilot and consideration of costs. This will include the ability for electronic sign off.	Executive Medical Director		na	24/08/2020: the e-JP system has been procured and contract start date is 31/08/2020. System build and training will take place throughout September and October. System will go live in October for directorates to put consultant Job Plans onto the system. The system will make use of digital signatures. Within procedure and system, noted that no response will be taken as assumed acceptance of JP.
IA 1920	24/02/2020	Brexit Planning	Director of Planning	Reasonable	4	R1/4	H	The business continuity arrangements within Mental Health should be further reviewed, scrutinised, approved and embedded within the Clinical Board.	Draft business continuity plans completed and circulated within Mental Health, and shared with EPRR Team. The Clinical Board is holding a Business Continuity Exercise for mental health leads, facilitated by	Director of Finance		na	
IA 1920	24/02/2020	Brexit Planning	Director of Planning	Reasonable	4	R2/4	M	Management information surrounding areas of lower compliance should be distributed to the clinical/service boards and staff should be encouraged to complete the nationality section on ESR.	Work will continue to address the information gap by encouraging Clinical and Service Boards to encourage their staff to update their information. The Head of Workforce Governance will provide, if required, information on a Directorate or	Director of Finance		na	
IA 1920	24/02/2020	Brexit Planning	Director of Planning	Reasonable	4	R3/4	M	Staff should be reminded to the importance for attending meetings.	Group members are committed to attending meetings. However, existing work commitments, no-notice issues and winter pressures have all contributed to a slight reduction in the expected attendance. If/when the group reconvenes later in 2020, the membership will be reviewed.	Director of Finance		na	
IA 1920	24/02/2020	Brexit Planning	Director of Planning	Reasonable	4	R4/4	L	Going forward, if there is a requirements for daily reporting in the future; all required areas of the Health Board should complete the required forms.	UK/Welsh Government reporting focussed on the key areas of Medical Devices/Clinical Consumables, General Supplies and Workforce. As such – the key areas for concern were primarily Clinical Boards – hence the requirement for daily reporting. However, the recommendation is noted.	Director of Finance		na	
IA 1920	24/01/2020	Freedom of Information	Director of Transformation and Informatics	Reasonable	7	R7/7	L	FoI certification or additional FoI training should be available for team members whose role involves processing and answering FoI requests.	FOI lead in discussion with NWIS re national approach to training.	Director of Transformation & Informatics		pc	potential training opportunities discussed at local and national level;
IA 1920	21/02/2020	Medical Staff Study Leave	Director of Workforce and Organisational Development	Reasonable	6	R1/6	M	The UHB Study Leave Procedure for Medical & Dental Staff should be reviewed and revised. The policy should more clearly specify: - roles and responsibilities – of Directorates, Managers, Consultants; - funding and budget guidance.	UHB Study Leave procedure document will be reviewed and strengthened in the areas outlined in the report. This will require agreement with the Local Negotiating Committee (LNC) of the UHB.	Director of Workforce and Organisation Development	01/07/2020	pc	No change. To go to the LNC on 26th November.
IA 1920	21/02/2020	Medical Staff Study Leave	Director of Workforce and Organisational Development	Reasonable	6	R3/6	M	Directorate administrative arrangements should be reviewed and strengthened in line with the revised Health Board Procedure and as a part of producing local operational procedures, particularly the recording of clinical authorisation on Intrepid. Procedures should	Comprehensive Review of local processes Directorate by Directorate will take place to ensure consistency of process with UHB Procedures and guidance	Director of Workforce and Organisation Development	01/09/2020	pc	Email reminders sent out to HR leads to remind them of the deadline for responses (end of November).
IA 1920	21/02/2020	Medical Staff Study Leave	Director of Workforce and Organisational Development	Reasonable	6	R4/6	M	The following arrangements are reviewed and strengthened:- - budget setting, monitoring and reporting; - payment of honorary staff expenses; and - ability to access Trust funds to support study leave budgets.	Capped annual or triannual budget allocations are to be introduced after discussion with the LNC. Honorary Academic Consultants are contractually entitled to 0.6 of this annual or triannual allocation as per contract terms and conditions. Once capped allocation agreed consistent budget line allocation will be anticipated against which spend can be measured.	Director of Workforce and Organisation Development	01/09/2020	pc	No change. To go to the LNC on 26th November.
IA 1920	21/02/2020	Medical Staff Study Leave	Director of Workforce and Organisational Development	Reasonable	6	R5/6	M	Assess and review the use of Intrepid as a tool for managing activities other than junior doctors and formulate a plan going forward.	Intrepid approval system enables approver to view a 'team' leave view that facilitates approval only where cover for clinical services can be managed and Intrepid will not allow leave application unless cover has been agreed by a named colleague. The UHB is currently considering options for e rostering of Medical Staff etc within the Medical Productivity Project alongside e job planning.	Director of Workforce and Organisation Development	01/12/2020	pc	There has been an 'All Wales' E-Rostering discussion group set up. Hilary Sharp is on the panel and the date of the first meeting is TBC.
IA 1920	21/02/2020	Medical Staff Study Leave	Director of Workforce and Organisational Development	Reasonable	6	R6/6	M	Develop the Intrepid User Group to co-incide with the introduction of the updated Health Board Procedure and local operational procedures. Besides regularising practices, the group could be a forum to identify development opportunities and good practice. The ability of the system to generate 'team views' and reports should be considered as	Intrepid User Group will be refreshed with revised TOR and membership. Minutes of meetings and associated Action plans will be reviewed by the Medical Workforce Advisory Group	Director of Workforce and Organisation Development	01/07/2020	pc	The October MWAG meeting was cancelled and has been rescheduled. To be raised at the next MWAG meeting on 11.11.20.
IA 1920	24/02/2020	Control of Contractors	Director of Finance	Reasonable	11	R1/11	M	RAMS (where applicable) should be requested and retained prior to the contractor commencing the relevant activity on site (O)	Accepted. RAMS will now be incorporated within the database implemented in January 2020. It will be the Engineering Manager's responsibility to review the database on a weekly basis to ensure the required suite of RAMS is evident. A sample check of the database will be undertaken on a monthly basis by the Health & Safety and Asbestos Manager, to ensure compliance and reported to the Capital, Estates & Facilities Department Health & Safety Meeting. The first compliance check will be reported to the March	Director of Finance	01/03/2020	na	
IA 1920	24/02/2020	Control of Contractors	Director of Finance	Reasonable	11	R2/11	L	Management should undertake a data cleansing exercise of the Backtraq system (O)	Accepted. An initial review of the database, in consultation with the relevant officers within the Capital, Estates & Facilities department, will be undertaken to remove any contractors that have not been used in the past three years. The remaining contractors will then be reviewed accordingly.	Director of Finance	01/10/2020	na	
IA 1920	24/02/2020	Control of Contractors	Director of Finance	Reasonable	11	R3/11	M	Induction content should be reviewed and updated to reflect current practice (O)	Accepted. The presentation will be updated to reflect current practice. The audit-visual presentation will be audible version of the induction will be removed from use until any ambiguities in the narrative have been addressed. In the interim, physical presentations by UHB staff will be undertaken.	Director of Finance	01/03/2020	na	
IA 1920	24/02/2020	Control of Contractors	Director of Finance	Reasonable	11	R6/11	M	The functionality of the Backtraq system should be reviewed for the timeliness and detail of the management information provided. (D).	Accepted. Initial discussions have been held with the software provider re: potential enhancements to the existing system. However, it is accepted that a standalone system for sign in/out would be more effective.	Director of Finance	01/09/2020	na	

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IA 1920	24/02/2020	Control of Contractors	Director of Finance	Reasonable	11	R8/11	L	A Permit to Work procedure should be developed, ratified and communicated to all relevant officers (D)	Accepted. The procedure is currently out for consultation and will be presented to the Capital, Estates & Facilities department Health & Safety meeting for ratification at the March 2020	Director of Finance	01/03/2020	na	
IA 1920	24/02/2020	Control of Contractors	Director of Finance	Reasonable	11	R9/11	M	Management should collate the output of the contractor monitoring forms for reporting to an appropriate forum; for actions to be taken where required. (O)	Accepted. In the role of Framework Manager, the Head of Discretionary Capital & Compliance, will initially hold six-monthly review meetings with all contractors addressing the recommendation requirements; and subsequent frequency will be dependent on how often the contractor is used by the UHB. However, all will have an annual review meeting.	Director of Finance	01/09/2020	na	
IA 1920	24/02/2020	Control of Contractors	Director of Finance	Reasonable	11	R10/11	M	Formal post completion review meetings of contractor performance should be undertaken in accordance with HSE guidance (O)	Accepted, as per the response to recommendation 9.Accepted, as per the response to recommendation 9.	Director of Finance	01/09/2020	na	
IA 1920	24/02/2020	Control of Contractors	Director of Finance	Reasonable	11	R11/11	M	An annual audit of compliance with the policy should be completed and reported to an appropriate forum. (O)	Accepted. Discussions will be held with the Head of Health & Safety with a view to enhance the data that is reported to the Health & Safety Committee within the Annual Report.	Director of Finance	01/06/2020	na	
IA 1920	30/03/2020	Risk Management	Director of Corporate Governance	Reasonable	4	R1/4	M	We recommend that the risk management training framework is finalised and detailed training materials are developed for roll out across the health board.	A detailed plan will be developed but due to activities which Clinical Boards are dealing with in relation to COVID 19 the roll out of that programme will be delayed.	Director of Corporate Governance	07/2020 - 12/2020	pc	Contact has been made with Clinical Boards to establish risk leads and a training programme is scheduled to be rolled out during November. A new Risk and Regulation Officer commenced work in October 2020 and will be tasked with progressing the training regime from the date of appointment.
IA 1920	30/03/2020	Risk Management	Director of Corporate Governance	Reasonable	4	R2/4	M	We recommend that training initiatives include the distinction between risks and issues and that the latter are addressed through an alternative allied management oversight activity.	Agreed – this will be picked up through the detailed training programme referenced above.	Director of Corporate Governance	01/07/2020	na	To be addressed in training programme commencing November 2020
IA 1920	30/03/2020	Risk Management	Director of Corporate Governance	Reasonable	4	R3/4	M	We recommend that going forward the weaknesses observed in the recording of risk mitigating actions are addressed.	Agree this will initially be addressed through the training programme and then there will be a continuous review and support to ensure the weaknesses do not reoccur.	Director of Corporate Governance	01/07/2020	na	To be addressed in training programme commencing November 2020
IA 1920	30/03/2020	Risk Management	Director of Corporate Governance	Reasonable	4	R4/4	L	We recommend that going forward the weaknesses observed and recorded in the Board Assurance Framework reporting are addressed.	Agree	Director of Corporate Governance	01/07/2020	c	Adequate cross referencing between the BAF, Strategic objectives and CRR to be included in time for the September Board meeting.
IA 1920	18/05/2020	UHW Neonatal Development	Director of Planning	Substantial	2	R1/2	L	The UHB should ensure KPI / performance management submissions are completed as per Framework guidance (O).	Agreed. Management will ensure that the Project Manager provides reminders to the key officers at the UHB facilitate submission of the KPIs as per the Framework guidance.	Director of Planning	At Future Projects	pc	ongoing until the end of the prorject
IA 1920	18/05/2020	UHW Neonatal Development	Director of Planning	Substantial	2	R2/2	L	Assurances should be provided by the Cost Adviser that source documentation is reviewed routinely, not limited to final account, in confirming calculations of staff / labour costs attributed to the project (O).	Agreed. Management will write to the Cost Advisers setting out the requirements to provide assurances that source documentation has been appropriately reviewed prior to the sign off of the monthly certificates.	Director of Planning	At Future Projects	pc	ongoing until the end of the prorject
IA 1920	18/05/2020	Specialist Neuro & Spinal Rehabilitation and Older People's Services (Rookwood Relocation)	Director of Planning	Reasonable	3	R1/3	M	Management, in consultation with their advisers, should seek approval of plans for financing the shortfall in the 2020/21 financial year. Continued scrutiny will be applied of the reasonableness for further changes requested / required to the project. (O)	Agreed. Any changes to the project are routinely scrutinised by Project Board. The potential project overspend has been reported at every Capital Management Group so Executives are fully aware of the position. This will continue to be monitored as the project moves towards closure with the expectation that any shortfall will be met from the UHB's discretionary capital programme.	Director of Planning	ongoing to end of project	pc	ongoing to the end of the project. Changes to be agreed with project board and capital management group due to the UHB financial position
IA 1920	18/05/2020	Specialist Neuro & Spinal Rehabilitation and Older People's Services (Rookwood Relocation)	Director of Planning	Reasonable	3	R2/3	M	The risk register will be updated to extend consideration of mitigation actions for the ten open risk identified; and consideration will be given for new risks as they arise. (O)	Agreed. The Project Director will write to the Project Manager as custodian of the project risk register to ensure: a) It is completed appropriately; and b) It is considered at all progress meetings.	Director of Planning	01/05/2020	pc	ongoing. Risk register reviewed at regular project team and project board meetings
IA 1920	18/05/2020	Specialist Neuro & Spinal Rehabilitation and Older People's Services (Rookwood Relocation)	Director of Planning	Reasonable	3	R3/3	M	All payments should be made in accordance with the terms of the contract. (O)	Agreed. The Capital Planning leads will be reminded to process payments within seven days of receipt of the Project Manager's certification.	Director of Planning	01/05/2020	pc	Continuing monitoring of payments in accorance with the terms of the contract
IA 1819	14/02/2019	Internal Medicine Directorate – Mandatory Training & PADRs Follow-Up	Chief Operating Officer	Limited		R2/6	H			Chief Operating Officer	01/07/2019	c	Update August 2020 - Monthly IM Directorate Performance Review meetings are held on a monthly basis. There has been a challenge for the past four months with increased covid activity causing staff to be off sick and shielding. The Directorate plan has been developed by the Lead Nurses for the completion of all VBA and statutory and mandatory training to be completed by the end of the 2020 calendar year.
IA 1920	18/05/2020	Surgery CB - Enhanced Supervision	Chief Operating Officer	Reasonable	7	R1/7	M	Surgery Clinical Board should introduce an overarching procedure/guidance provided for Ward Managers that formalises the governance arrangements relating to the use, monitoring and reporting of enhanced supervision of patients.	The Surgery Clinical Board agreed with the above recommendation. The Surgery Clinical Board will (via a task and finish group) review the reporting of enhanced monitoring booklet and its suitability for use within Surgery Clinical Board. A supporting document/ guidance can be developed and produced to assist in use of the enhanced supervision document. This updated document will be agreed via the Surgery Nursing Board formal meeting structure	Chief Operating Officer	01/09/2020	c	Action due to be completed Sept 2020
IA 1920	18/05/2020	Surgery CB - Enhanced Supervision	Chief Operating Officer	Reasonable	7	R2/7	M	Specialling Risk Assessment Forms should be completed by Ward Managers and authorised by Senior Nurses for all patients that commence enhanced supervision so as to formally record and justify its use.	The enhanced supervision document will be reviewed by Surgery Clinical Board and updated to ensure that a risk assessment is included and that there is a section which documents and records agreement to commence enhanced supervision by the Senior/ Lead Nurse. This updated document will be agreed via the Surgery Nursing Board formal meeting structure	Chief Operating Officer	01/09/2020	c	Action due to be completed Sept 2020
IA 1920	18/05/2020	Surgery CB - Enhanced Supervision	Chief Operating Officer	Reasonable	7	R3/7	M	All patients that receive enhanced supervision should retain a fully completed Specialling Care Plan, medical review, 'Read about Me' - Life style Questionnaire, Falls Risk Indicator Assessment and DoLs Proforma (if applicable). Specialling Risk Assessments must be retained on the patient's notes and regularly reviewed and scored to justify ongoing use of enhanced supervision.	After updating the Enhanced supervision document Surgery Clinical Board will re audit the use of the document and how the document is used alongside 'Read about Me' - Life style Questionnaire, Falls Risk Indicator Assessment and DoLs Proforma (if applicable). The results will be reported to Surgery Clinical Nursing Board Formal meeting.	Chief Operating Officer	01/11/2020	c	Action due to be completed Sept 2020
IA 1920	18/05/2020	Surgery CB - Enhanced Supervision	Chief Operating Officer	Reasonable	7	R4/7	M	Behaviour Monitoring Charts must be completed for 7 days, evidencing the hourly review of the level of enhanced monitoring and a formal written assessment of need for continuation of enhanced monitoring carried out by a registered nurse on a daily basis. Care	A guidance document will be developed to support the Enhanced supervision document by Surgery Clinical Board which will help support what the requirement is for recording engagement by all members of the MDT.	Chief Operating Officer	01/09/2020	c	Action due to be completed Sept 2020
IA 1920	18/05/2020	Surgery CB - Enhanced Supervision	Chief Operating Officer	Reasonable	7	R5/7	M	Hourly reviews during the period of enhanced supervision, and formal written assessments should be carried out by registered nurses on a daily basis to support justification to continue the supervision. Communication of risks to all members of the multi-disciplinary team	A guidance document will be developed to support the Enhanced supervision document by Surgery Clinical Board which will help support what the requirement is for recording engagement by all members of the MDT.	Chief Operating Officer	01/09/2020	c	Action due to be completed Sept 2020
IA 1920	18/05/2020	Surgery CB - Enhanced Supervision	Chief Operating Officer	Reasonable	7	R6/7	L	Enhanced Supervision Patient Record Booklet should be revised to include early indicator requirement 'triggers' which would aid the nurses' decision making process as to whether to commence enhanced supervision.	The enhanced supervision document will be reviewed by Surgery Clinical Board and updated to ensure that a risk assessment is included and that there is a section which documents and records agreement to commence enhanced supervision by the Senior/ Lead Nurse. This updated document will be agreed	Chief Operating Officer	01/09/2020	c	Action due to be completed Sept 2020
IA 1920	18/05/2020	Surgery CB - Enhanced Supervision	Chief Operating Officer	Reasonable	7	R7/7	L	Ward Managers should be provided with training relating to the use of theenhanced supervision facility on Clinical Workstation as it would provide 'real time' information and aid the active monitoring and management of patients undergoing observation	Awareness will be raised on the use of the icon on the Clinical Work station via professional nursing forums and by local communication routes	Chief Operating Officer	01/09/2020	pc	Action due to be completed Sept 2020
IA 1920	19/05/2020	Infection Prevention and Control	Executive Nurse Director	Reasonable	8	R1/8	M	All out of date Infection Prevention and Control policies and procedures should be reviewed and updated, and any bad links reinstated. The C & V Infection Prevention and Control intranet pages should be updated to reflect the list of current policies and	Infection Prevention and Control policies and procedure are reviewed, updated and ratified as required by the core IP&C team and the Infection Prevention and Control Group. Since a member of the IP&C team with administrative rights for the Intranet left the organisation in July 2018 we have been unable to get anyone	Executive Director of Nursing	01/09/2020	c	

Audit	Final Report Issued on	Audit Title	Executive Lead for Report	Audit Rating	No. of Recs Made	Rec No.	Rec. Rating	Recommendation Narrative	Management Response	Executive Lead for Recommendation	Agreed Implementation Date	Please confirm if completed (c), partially completed (pc), no action taken (na)	Executive Update
IA 1920	19/05/2020	Infection Prevention and Control	Executive Nurse Director	Reasonable	8	R2/8	M	The IPCG Terms of Reference and membership list should be reviewed, updated and formally approved by the Group. In particular, the Estates Department should be requested to ensure they provide a regular representative for the Group.	The TOR will be reviewed by the Infection Prevention and Control Group as a priority. This was on the agenda for February 2020 before it was impacted by COVID-19; there is a plan to re-agenda in 2020.	Executive Director of Nursing	01/06/2020	c	
IA 1920	19/05/2020	Infection Prevention and Control	Executive Nurse Director	Reasonable	8	R3/8	M	The IP & C Annual Programme should be updated to reflect the period it covers, and all references to it being a draft document should be removed. The IP & C	The Annual Programme for IP&C will be uploaded to the Intranet.	Executive Director of Nursing	01/09/2020	c	
IA 1920	19/05/2020	Infection Prevention and Control	Executive Nurse Director	Reasonable	8	R4/8	L	The minutes of each IPCG meeting should be presented to the Health Board Quality, Safety and Experience Committee for information and monitoring purposes. The IP & C Senior Nurse should prepare update reports for the Q, S & E Committee on a more regular basis. We would suggest half yearly	IPC reports to QSE bi-annually as part of the Health and Care Standards selfassessment and follow up report. Exception reports are brought as appropriate. Reporting mechanisms to QSE currently under review and future IP&C reporting will align with the output of that review.	Executive Director of Nursing	01/09/2020	c	
IA 1920	19/05/2020	Infection Prevention and Control	Executive Nurse Director	Reasonable	8	R5/8	M	The IP & C Team should consider how the number of IP & C audits undertaken can be increased. An annual programme of planned IP & C audits should be drawn up with targets set for the number of audits to	The IPC Team are now at full complement which will allow for more audits to be undertaken. This was a priority set for 2020 but has been impacted by COVID-19; we will be	Executive Director of Nursing	01/12/2020	c	
IA 1920	19/05/2020	Infection Prevention and Control	Executive Nurse Director	Reasonable	8	R6/8	M	Staff completing RCA investigations should be reminded that they should be undertaken jointly by Nursing and Medical staff.		Executive Director of Nursing		c	
IA 1920	19/05/2020	Infection Prevention and Control	Executive Nurse Director	Reasonable	8	R7/8	M	Management should put checks in place to ensure that the data recorded in the Incident Log matches the details recorded in the Outbreak Tables.	This will be reviewed routinely in the future	Executive Director of Nursing		c	
IA 1920	19/05/2020	Infection Prevention and Control	Executive Nurse Director	Reasonable	8	R8/8	M	lead nurse from the IP & C team should be assigned to each Clinical Board IP & C group and Q, S & E group. Where possible the designated lead nurse or arepresentative from the IP & C team should attend all Clinical Board IP & C and Q, S & E meetings.	There is an IP&C nurse assigned to each Clinical Board who attends the Clinical Board Q&S meetings where possible. In future if they cannot attend they will send a representative on their behalf.	Executive Director of Nursing	01/09/2020	c	
IA 1920	21/05/2020	Management of Health Board Policies and Procedures	Director of Corporate Governance	Reasonable	5	R1/5	H	The UHB should ensure policies are reviewed and updated within appropriate timescales.	A plan will be put in place to review all out of date policies and to contact document owners to update their policies. Due to activities which colleagues are dealing with in relation to COVID 19 the roll out of that plan will be delayed until Health Board staff have substantially returned to a business as usual position.	Director of Corporate Governance	01/12/2020	na	
IA 1920	21/05/2020	Management of Health Board Policies and Procedures	Director of Corporate Governance	Reasonable	5	R2/5	M	Review the 'register' for completeness. Assess if all policies, procedures and other written control documents available on the intranet and internet are current and then ensure they are all	A plan will be put in place to review the register for completeness and to consider that document alongside the written control documents available on the intranet and internet. It is assumed that not all documents available on the intranet and	Director of Corporate Governance	01/12/2020	na	
IA 1920	21/05/2020	Management of Health Board Policies and Procedures	Director of Corporate Governance	Reasonable	5	R3/5	M	1. Review the readability of documents to make ways to write clearer, especially those available through internet to wider audience. From register, 372 out of 393, recorded as published on internet.	Recommendations are noted and agreed. A plan will be put in place to action the recommendations and circulate appropriate messages to document owners to address the issues raised.	Director of Corporate Governance	01/12/2020	na	
IA 1920	21/05/2020	Management of Health Board Policies and Procedures	Director of Corporate Governance	Reasonable	5	R4/5	L	Review of record keeping process for when a request is made to create new written control document; from receipt of request to create, to issue of draft for consultation. Review of record keeping process for the consultation process; from request made, publishing and any feedback received.	Recommendations are noted and agreed. A plan will be put in place to action the recommendations and put in place appropriate processes.	Director of Corporate Governance	01/12/2020	na	
IA 1920	21/05/2020	Management of Health Board Policies and Procedures	Director of Corporate Governance	Reasonable	5	R5/5	L	Review of record keeping process for notifying stakeholders of new, amended and exiting policies.	Review of record keeping process for notifying stakeholders of new, amended and exiting policies.	Director of Corporate Governance	01/12/2020	na	
IA 1920	19/05/2020	Pre-employment Checks	Director of Workforce and Organisational Development	Reasonable	10	R1/10	H	Temporary Staffing Management should revise their current pre-employmentchecks procedures. The following highlighted areas should be considered for revision:				na	
IA 1920	19/05/2020	Pre-employment Checks	Director of Workforce and Organisational Development	Reasonable	10	R2/10	M	Health Board managers should be reminded that internal applicants cannot commence in post prior to pre-employment checks being fully completed. Managers should also be reminded to take notice of the weekly Trac update				na	
IA 1920	19/05/2020	Pre-employment Checks	Director of Workforce and Organisational Development	Reasonable	10	R3/10	M	Temporary Staffing Department management to familiarise themselves with the NHS Employment Checks Standards and implement appropriate procedural guidance, ensuring it satisfies all requirements/criteria of the Standards.				na	
IA 1920	19/05/2020	Pre-employment Checks	Director of Workforce and Organisational Development	Reasonable	10	R4/10	M	Management to review the process for Consultant reference checks to ensure it adheres to the relevant guidance.				na	
IA 1920	19/05/2020	Pre-employment Checks	Director of Workforce and Organisational Development	Reasonable	10	R5/10	L	Management to review the Employment Services SLA.				na	
IA 1920	19/05/2020	Pre-employment Checks	Director of Workforce and Organisational Development	Reasonable	10	R6/10	L	Management to review Internal and External Recruitment Process Flowcharts and determine if their content is relevant.				na	
IA 1920	19/05/2020	Pre-employment Checks	Director of Workforce and Organisational Development	Reasonable	10	R7/10	L	Management to review the apparent contradicting information found in the NHS Reference Standard and the NWSSP Reference Guidance and determine which is more relevant. Management should consider updating the guidance if necessary.				na	
IA 1920	19/05/2020	Pre-employment Checks	Director of Workforce and Organisational Development	Reasonable	10	R8/10	L	NWSSP Recruitment and Health Board recruiting managers to be reminded of the importance of considering validity of references when undertaking and approving pre-employment checks.				na	
IA 1920	19/05/2020	Pre-employment Checks	Director of Workforce and Organisational Development	Reasonable	10	R9/10	L	Management should review all supporting policies/procedures listed in the CVU Recruitment Policy. Management should review and consider updating the Secondment Policy to include the requirement for pre-employment checks to be completed before an employee can commence in a secondment post. Management should review the Recruitment of Locum Doctors and Dentists Policy, ensuring all terminology is relevant.				na	
IA 1920	19/05/2020	Pre-employment Checks	Director of Workforce and Organisational Development	Reasonable	10	R10/10	L	Temporary Staffing Department management to review the standard letter sent with the conditional offer and ensure it complies with the Identification Check NHS Standard.				na	
IA 1920	TBC	Strategic Planning - IMTP	Director of Planning	Reasonable	4	R1/4	M	Management should ensure that the business case procedural document (flowchart) is up to date and reflects the current system in place regarding the processing of projects/ schemes from the point of		Director of Planning		na	
IA 1920	TBC	Strategic Planning - IMTP	Director of Planning	Reasonable	4	R2/4	M	Management should ensure that all key staff required to sign the business case complete and evidence sign off at the required stage.		Director of Planning		na	
IA 1920	TBC	Strategic Planning - IMTP	Director of Planning	Reasonable	4	R3/4	M	Management should ensure that the due process and documentation required to document decisions of business cases are adhered to.		Director of Planning		na	
IA 1920	TBC	Strategic Planning - IMTP	Director of Planning	Reasonable	4	R4/4	L	Management should ensure the ToR are reviewed and updated as required.		Director of Planning		na	

Report Title:	**Audit Wales Recommendation Tracking Report and Regulatory Tracker Report**								
Meeting:	Audit Committee						**Meeting Date:**	17th November 2020	
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**		
Lead Executive:	Director of Corporate Governance								
Report Author (Title):	Head of Risk and Regulation								

Background and current situation:

The purpose of the report is to provide Members of the Audit Committee with assurance on the implementation of recommendations which have been made by Audit Wales by means of an external audit recommendation tracking report.

Executive Director Opinion /Key Issues to bring to the attention of the Board/ Committee:

24 External Audit Recommendations were brought forward from September's Audit Committee. Following that Committee meeting a further 4 recommendations have been added to the tracker which relate to Test, Trace and Protect (1) and the Audit of Accounts Report Addendum – Recommendations (3).

The External Audit tracker demonstrates that 6 further recommendations have completed since September, however, there are also 14 (of 28) recommendations that are partially complete. 8 actions of 28 have had no recorded action taken since September's Committee meeting.

9 actions of the 28 are over 1 year old (of which 1 has completed) and 15 of 28 are over 6 months old (of which 1 has completed). 4 actions of the 28 are less than three months old.

A new Risk and Regulation Officer joined the Corporate Governance team on the 26th October 2020 and it is hoped that additional support will be available to Executive and Operational Leads to ensure that actions are progressed and completed in a timelier manner moving forward.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc:)

A review of all outstanding recommendations has been undertaken since September 2020 and this will now continue and will be reported at each Audit Committee moving forward to provide a regular update in movement of recommendations.

The Appendix 1 shows a summary status of each of the recommendations made for external audits undertaken in **17/18, 18/19 and 19/20** as at 30th October 2020.

This report and appendices will also be discussed at Management Executive and HSMB so that the leadership team of the organization has an overview of progress made against External Audit Recommendations.

Recommendation:

The Audit Committee Members are asked to:

(a) Note the progress which has been made in relation to the completion of Audit Wales recommendations.

(b) To note the continuing development of the Audit Wales Recommendation Tracker.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	x
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing	x	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	x	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	x

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	x	Long term		Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	~~Yes / No~~ / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

External Audit (WAO) Recommendations 2017/18 – 2019/20 (November 2020)

External Audit	Complete	No action	Partially complete	< 3 mths	> 3 mths	+6 mths	+ 1 year	Grand Total
Structured Assessment 2018	1	-	5	-	-	6	-	6
Clinical Coding Follow Up	1	-	2	-	-	-	3	3
Discharge Planning	-	-	1	-	-	-	1	1
Review of Medical Equipment	2	-	-	-	-	-	2	2
Audit of Financial Statements	-	-	2	-	-	-	2	2
Structured Assessment 2019	-	1	-	-	-	-	1	1
Implementation of the Wellbeing of Future Generations Act	2	3	4	-	-	9	-	9
Test, Trace and Protect	-	1	-	1	-	-	-	1
Audit of Accounts Report Addendum - Recommendations	-	3	-	3	-	-	-	3
Total	**6**	**8**	**14**	**4**	**-**	**15**	**9**	**28**

From the above table it can be seen that since the last report to Committee in September 2020 6 of 28 outstanding WAO recommendations from September 2020 have been completed. It can also be seen that there are a further 8 of 28 recommendations where there has been no action a further and 14 of 28 where the recommendation is partially completed. 9 actions of 28 are over 1 year old and 15 of 28 are over 6 months old

Audit Log Ref No.	Financial Year Fieldwork Undertaken	Final Report Issued on	Audit Title	Executive Lead for Report	No. of Recs Made	Rec No.	Recommendation Narrative	Management Response	Executive Lead for Recommendation	Operational Lead for Recommendation	Agreed Implementation Date	Committee Implementation Monitored by	Updated Implementation Date	Please confirm if completed (c), partially completed (pc), no action taken (na)
WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	11	R1/11	The Health Board should complete our 2017 structured assessment recommendations by the end of 2019.	Agreed and these will be monitored to ensure this happens through Management Executives and reported to Audit Committee	Director of Corporate Governance	Head of Corporate Governance	Dec-19	Audit and Assurance Committee		c
WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	11	R1g/11	R7 [2017] The Health Board needs to ensure that the level of information reported to the Resource and Delivery Committee on its performance is sufficient to enable the Committee to scrutinise effectively. This should include: • ensuring that the Committee receives more detailed performance information than that received by the Board. Consideration should be made to including a summary of the Clinical and Service Board dashboards used in the monthly executive performance management reviews; • expanding the range of performance metrics to include a broader range of key performance indicators relating to workforce. Consideration should be made to revisiting the previous workforce KPIs reported to the previous People, Planning and Performance Committee.	Overall this recommendation has been partly addressed. • The S&D Committee continues to receive a high-level performance dashboard, which is less detailed than the performance report received by the Board. • Since September 2018, the S&D Committee receives six-monthly updates against the workforce plans, including key workforce metrics.	Director of Transformation and Informatics		Dec-19	Audit and Assurance Committee	Dec-19	pc
WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	11	R3b/11	b. Review and update the Standing Orders and Standing Financial Instructions, ensuring these documents are reviewed and approved on an annual basis;	Agreed and timetabled to be undertaken on an annual basis going forward	Director of Corporate Governance	Head of Corporate Governance	Mar-19	Audit and Assurance Committee	Dec-19	pc
WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	11	R3d/11	d. Ensure the governance team manage policy renewals and devise a process to keep policy reviews up to date;	Agreed	Director of Corporate Governance	Head of Corporate Governance	Oct-19	Audit and Assurance Committee	Dec-19	pc
WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	11	R4/11	The Health Board should update its performance management framework to reflect the organisational changes that have taken place since 2013.	We accept that the performance management framework should be reviewed to ensure it fully supports the organisational business.	Director of Transformation and Informatics	Director of Digital and Health Intelligence	Sep-19	Audit and Assurance Committee	Dec-19	pc
WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	11	R11/11	The Health Board should routinely update IT Disaster Recovery plans after key changes to IT infrastructure and networks and at scheduled intervals and test plans to ensure they are effective	The CAV IT Disaster Recovery plan is reviewed annually at a minimum and in response to specific circumstances. Testing is undertaken (both Check list and Technical) and multiple system restores are performed successfully annually. Additional infrastructure and software have been put in place to improve this process. A schedule of testing is being developed as part of the technical roadmap work.	Director of Transformation and Informatics	Director of Digital and Health Intelligence	Mar-19	Audit and Assurance Committee	Dec-19	pc
WAO 14	2018-19	Jun-18	Review of Medical Equipment: Update on Progress	Director of Therapies & Health Science	8	R3/8	R3 Review medical equipment risk management throughout the organisation, ensuring alignment between the corporate and operational approach.	Ensure CBs capture medical equipment risks as part of their risk management processes. These will be monitored via MEG, and escalated through relevant strategic committees, eg Strategy and Resources/Capital Management/QSE/Management Executive as required.	Director of Therapies & Health Science	Deputy Director of Therapies & Health Science	Apr-19	Strategy and Delivery		c
WAO 14	2018-19	Jun-18	Review of Medical Equipment: Update on Progress	Director of Therapies & Health Science	8	R7/8	R7 Ensure all relevant service areas collaborate, consult and engage on medical equipment issues. It should give particular attention to the arrangements in place for maintenance and replacement of beds and hoists.	Monitor attendance and engagement of CB MSDOs and other members at MEG, escalate non-attendance or lack of engagement. Monitor progress of action plan developed by Health and Safety Advisor following the Arjo Proact 2017 survey Health and Safety Committee 18/005 minute (25 January 2018). Maintain hoists within the Clinical Engineering Department at the end of external supplier contract. Ensure Clinical Engineering is represented at the Bed Management Group	Director of Therapies & Health Science	Deputy Director of Therapies & Health Science	Dec-18	Strategy and Delivery		c
WAO 16	2017-18	Dec-17	Discharge Planning	Chief Operating Officer	4	R4a	Explore developing an e-learning course for discharge planning which ward staff may find more accessible.	Work is ongoing with LED colleagues to develop a discharge planning focused e-learning resource.	Chief Operating Officer	Head of Integrated Care	Dec-18	Strategy and Delivery		pc
WAO 17	2019-20	Jun-19	Clinical Coding Follow-up From 2014 not yet completed	Director of Transformation and Informatics		R1	**Clinical Coding Resources:** Strengthen the management of the clinical coding team to ensure that good quality clinical coding data is produced. This should include: c) ensuring that there is capacity to allow band 4 coders to undertake mentoring and checking of coding of band 3 staff in line with job descriptions; d) revisiting the allocation of specialities across staff to ensure that there is sufficient flexibility within the existing capacity to cover periods of absence and succession planning is in place for staff who are due to retire in the next five to ten years; g) increasing levels of engagement between the different teams within the Health Board, to provide opportunities to raise issues, develop peer support arrangements and share knowledge; h) updating the clinical coding policy to reflect the current operational management arrangements; and k) increasing the range of validation and audit processes, including the consideration of the appointment of an accredited clinical coding auditor.	The UHB faces on-going challenges on the use of its resources in light of increasing demand for services and inflation surpassing investment. As a consequence the UHB made a difficult decision to reduce non direct clinical expenditure by 12.6% in 2018/19. However recognising the value of coding, there was a marginal increase in expenditure on the staff who do the coding when factoring in pay awards and increments, but this required an ongoing reduction in supervisory expenditure. The UHB faces on-going challenges on the use of its resources in light of increasing demand for services and inflation surpassing investment. As a consequence the UHB made a difficult decision to reduce non direct clinical expenditure by 12.6% in 2018/19. However recognising the value of coding, there was a marginal increase in expenditure on the staff who do the coding when factoring in pay awards and increments, but this required an ongoing reduction in supervisory expenditure. c)We do allow capacity in order to allow Band 4s to mentor/check Band 3 work. The approach is consistent with our induction programme which has been in place since 2017. d)We continuously revisit coding speciality allocation. Periods of absence are covered to a sufficient degree and we are content with our succession planning. We don't believe that speciality rotation is compatible with our specialised casemix. Accuracy and completeness are above standard using this model. g)The benefit of staff at both sites meeting as one has yet to be determined. Formal regular team meetings were ended after a lack of engagement. The option remains open if staff wish to meet and we will revisit this option again. h) This will be reviewed by September 19. k) Unless affected by the present review which will lead to the restructuring of the Digital team, the intention is that a new Band 5 (Assistant coding manager) appointment will have an element of their time for audit.	David Thomas	James Webb		Digital Health Information		pc

WAO 17	2019-20	Jun-19	Clinical Coding Follow-up From 2014 not yet completed	Director of Transformation and Informatics		R2	**Medical Records:** R2 Improve the arrangements surrounding medical records, to ensure that accurate and timely clinical coding can take place. This should include: a) reinforcing the Royal College of Physician (RCP) standards across the Health Board and developing a programme of audits which monitors compliance with the RCP standards; b) improving compliance with the medical records tracker tool within the Health Board Patient Administration system (PAS); c) putting steps in place to ensure that notes that require coding are clearly identified at ward level and that clinical coding staff have early access to medical records, particularly at UHW; e) reducing the level of temporary medical records in circulation; f) considering the roll out of the digitalisation of health records to the Teenage Cancer Unit to allow easier access to clinical information for clinical coders; and g) revisiting the availability of training on the importance of good quality medical records to all staff.	a)Head of Clinical Coding to raise concerns with Patient Safety / Clinical Audit. b) The UHB is developing mobile tracking technology which would support an audit programme designed to determine levels of tracking compliance across departments. c) The coding staff will continue to work with the ward staff to ensure necessary notes are available in a timely manner. With regards the second, Central Health Records will prioritise medical records required for clinical coding within their 'Click and Collect' service (as and when centralised filing libraries becomes fully restricted . e) Central filing libraries will become fully restricted ensuring enhanced stock management (access will be limited to trained staff only). The actions associated with R2 b) will also ensure medical records are located more timely. Furthermore, the UHB's increased use of local and national digital systems will reduce the need for temporary medical records to be created. f) Necessary coding staff have access to an IT system within the unit that provides all relevant clinical data for day admissions. g) Head of Coding to discuss with Medical Directors to establish the most appropriate platform	David Thomas	James Webb		Digital Health Information		pc
WAO 17	2019-20	Jun-19	Clinical Coding Follow-up From 2014 not yet completed	Director of Transformation and Informatics		R3	Board Engagement: Build on the good level of awareness of clinical coding at Board to ensure members are fully informed of the Health Board's clinical coding performance. This should include: c) raising the awareness amongst Board members of the wider business uses of clinically coded data.	c) It is the intention to expose more pathway level outcomes, system improvement and clinical and cost effectiveness data to the board in line with our strategy.	David Thomas	James Webb		Digital Health Information		c
WAO 18	2019-20	Jul-19	Audit of Financial Statements Report Addendum - Recommendations	Director of Finance	9	R1	**1: the 'retire and return' arrangements require strengthening** The Health Board should strengthen its current guidance so that it clearly sets out all the key elements of the DoH guidance. The revised guidance should include all the DoH's employer-checks, which the Health Board should always apply and clearly evidence when assessing a business case for an employee to retire and return. The Health Board should ensure that its updated guidance is shared with all Clinical Boards and Departmental Heads.	The Health Board is currently reviewing the Retire and Return Procedure in partnership with Trade Unions. The purpose of this review is to reduce inconsistencies in the way that it is applied across the UHB by reducing the level of manager's discretion involved and ensuring that applications can only be rejected for robust business reasons. Reference will be made to the DoH guidance and checklist as appropriate. Reference will also be made to the other flexible retirement options to raise awareness of the flexibilities available.			Feb-20	Audit and Assurance		pc
WAO 18	2019-20	Jul-19	Audit of Financial Statements Report Addendum - Recommendations	Director of Finance	9	R4	**4: the Phase 2 and Phase 3 continuing healthcare claims require concluding** The Health Board should establish the reason for the ongoing delay with each of the remaining Phase 2 and Phase 3 claims and it should seek to conclude them promptly	Phase 2 – awaiting grant of probate for one claim. Face to face meetings required for both claims Phase 3 –Work during the first quarter of 2019-20 has left 61 cases open; 6 are planned for reimbursement imminently, 25 have been reviewed but are not yet ready for reimbursement due to requiring further meetings, negotiation, panels etc.,30 are not yet reviewed, Good progress continues to be made as agreed within the available resource which includes additional staff employed, with the intent to continue to conclude cases promptly			Mar-20	Audit and Assurance		pc
WAO 19	2019-20	Nov-19	Structured Assessment	Chief Executive Officer	2	R2	**Performance Management Framework** R2 We found that performance monitoring at an operational level is sound, but some information received by the Board and its committees need to be improved. When the Health Board restarts its performance framework review it should be extended to include: • Monitoring IMTP delivery on a quarterly basis and reporting the wholescale position to the Strategy and Delivery Committee and Board. We have previously suggested presenting the committee with a summarised version of the IMTP progress reports available at clinical board performance reviews. • Ensuring that the Strategy and Delivery Committee receives, the same or more, detailed performance information than that received by the Board.	Agree to recommendation. The flash report which is used for Performance Reviews will be sent to Strategy and Delivery of a quarterly basis. December 2019 we will start from the beginning of the New Year and send to the S&D Committee in January 2020 Agree to the recommendation. The performance information is currently under review alongside other performance information to the Committees to ensure a consistent approach and that assurance can then be appropriately provided to the Board from each Committee.	Director of Planning Director of Digital and Health Intelligence	Director of Planning Director of Digital and Health Intelligence	Jan-20	Audit and Assurance Committee		No longer applicable - in relation to Director of Planning item
WAO 20	2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Public Health	10	R1	**Long-term** Further enhance the profile of primary care by building upon the successes of existing promotional campaigns.	We will continue to build on the Primary Choice campaign to promote Primary Care.		Director of Operations, PCIC	Ongoing	Strategy and Delivery		na
WAO 20	2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Public Health	10	R2	2 Develop a campaign to educate the public about what types of services will be available at each of the centres and hubs.	We have an active engagement programme for each of the Wellbeing Hubs and Health and Wellbeing Centres, we will continue to evolve our engagement working with local organisations, public health colleagues and community groups to promote the services in each centre.	Director Planning		Dec-21	Strategy and Delivery		pc
WAO 20	2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Public Health	10	R3	3 Use examples of successfully moving services from secondary to community and primary care to promote and sustain a shift in resources from other services that could be provided closer to home.	Supporting services to move to community delivery is a core element of the Health Board's Integrated Medium Term plan. Through this process we are celebrating and promoting examples of good practice.	Director Planning		Ongoing	Strategy and Delivery		c
WAO 20	2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Public Health	10	R4	4 Develop a model to monitor and review the impact and benefits of the centres and hubs. Use a blended approach that includes outcome measures, data, exemplar projects and patient stories to show not only cost effectiveness but also the positive impact on patient experience.	The Regional Partnership Board is developing an Outcomes Framework which will provide a tool to support the evaluation of the impact of Health and Wellbeing Centres and Wellbeing Hubs.	Director Planning		Jul-20	Strategy and Delivery		c
WAO 20	2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Public Health	10	R5	**Prevention** 5 Undertake needs assessments on an ongoing basis and continually review services to ensure that centres and hubs remain current and fit for purpose.	Primary Care Clusters are required to produce plans to meet the needs of their populations, this will include considerations of Wellbeing Hub services once established. These plans will take into account evidence from wider needs assessments including future updates to the population assessment required under the Social Services and Wellbeing Act and the Wellbeing Assessment required under the WFG Act		Director of Operations, PCIC	Annually	Strategy and Delivery		na
WAO 20	2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Planning	10	R6	6 Develop a clear plan to agree finances prior to centre and hub services commencing to prevent duplication of resources.	This will form part of the operating model of the Wellbeing Hubs.	Director of Planning		Nov-21	Strategy and Delivery		na
WAO 20	2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Public Health	10	R7	**Integration** 7 Undertake a community services mapping exercise for each of the localities to identify services it could signpost patients to if they fall outside of the services delivered by centres and hubs.	We will be undertaking this mapping on a locality and cluster basis in partnership with existing tools and services such as Dewis Cymru.	Director of Planning		Oct-21	Strategy and Delivery		pc

WAO 20	2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Public Health	10	R8	**Collaboration** 8 Develop some overarching principles for the centres and hubs operating model which allow for some local variation based on community need.	We will establish an overarching operating model for the Health and Wellbeing Centre and Wellbeing Hubs focussed on operating as single assets and supporting community ownership.	Director of Planning		Oct-21	Strategy and Delivery		pc
WAO 20	2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Public Health	10	R9	**Involvement** 9 Explore the best vehicles to engage marginalised citizens both in terms of planning future centres and hubs and in ensuring they are accessible to all when in operation. For example, by finding community leaders to help roll out key messages and engage with these groups on an ongoing basis.	We will ensure this forms part of the engagement plan for each project.	Director of Planning		Oct-21	Strategy and Delivery		pc

Report Title:	Report of the Losses and Special Payments Panel								
Meeting:	Audit and Assurance Committee						**Meeting Date:**	17th Nov 2020	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**X**	**For Information**	
Lead Executive:	Executive Director of Finance								
Report Author (Title):	Head of Financial Accounting and Services								

Background and current situation:

As defined in the Standing Financial Instructions, the Audit and Assurance Committee is required to approve the write off of all losses and special payments within the delegated limits determined by the Welsh Government. To assist the Audit and Assurance Committee with this task, the UHB has established a Losses and Special Payments Panel, under the chairmanship of the Director of Finance (delegated to The Deputy Director of Finance). This panel meets twice yearly and is tasked with considering the circumstances around all such cases and making appropriate recommendations to the Committee.

The work of the panel supports the UHB's sustainability and ensures that we make the best use of the resources that we have.

The Losses and Special Payments Panel last met on 23rd October 2020 to consider the 6 month period 1st April 2020 to 30th September 2020. This report informs the Audit and Assurance Committee of the items considered at this meeting and the recommendations made for formal Audit and Assurance Committee approval. The minutes of the last meeting of the Losses and Special Payments Panel are attached as Appendix 1. These minutes give more detail about the issues discussed at the meeting, including those items that have been recommended to the Audit Committee for approval.

Executive Director Opinion /Key Issues to bring to the attention of the Board/ Committee:

These losses and special payments need to be considered and approved by the Audit and Assurance Committee.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc. :)

The following losses have been identified for write off:

- Clinical Negligence claims of £8.661m and Personal Injury claims of £0.027m for the period 1st April 2020 to 30th September 2020;
- Bad Debt write-offs of £3,391 for the period 1st April 2020 to 30th September 2020;
- Permanent Injury losses of £77,408 for the period 1st April 2020 to 30th September 2020;
- Small Claims losses of £13,870 for the period 1st April 2020 to 30th September 2020;

- Employment Tribunals settled of £162,397 for the period 1st April 2020 to 30th September 2020;
- Treforest Flood loss of £2.019m.

Recommendation:

The Audit and Assurance Committee is asked to:

- **APPROVE** the write offs outlined in the Assessment Section of this report.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	x	Long term	x	Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Not Applicable

MINUTES OF THE MEETING OF THE LOSSES AND SPECIAL PAYMENTS PANEL HELD ON 23rd OCTOBER 2020

PRESENT: Mr C Lewis – Interim Director of Finance (Chair)
Mr A Crook – Head of Workforce Governance
Mrs H Lawrence – Head of Financial Accounting & Services
Mr S Monk – Losses & Taxation Accountant
Mrs S Wicks – Claims Manager
Mr A Williams – Head of Financial Services

APOLOGIES: Mr R Cockayne – Security Manager
Mr C Greenstock – Counter Fraud Manager

1. Minutes of Last Meeting

The minutes of the last meeting were reviewed for accuracy and the group endorsed the minutes as an accurate record. There were no matters arising which were not covered elsewhere on the agenda.

2. Clinical Negligence and Personal Injury Losses

Mr Monk presented the financial report on Clinical Negligence and Personal Injury Income & Expenditure (I&E) losses for the 6 month period ending 30th September 2020 and the finalised claims for write off for the period 1st April 2020 to 30th September 2020.

The I&E effect for the period was described as shown below: for comparison, the figures for the same period in 2019/2020 were also shown.

SUMMARY OF LOSSES

	2019/2020 £'000	2019/2020 £'000
Clinical Negligence	21,488	26,233
Personal Injury	106	238
Total Loss	21,594	26,471
Less WRP Receipts Due	-21,063	-25,598
Total Net Cost to the UHB	531	873

With respect to Clinical Negligence claims, Mr Monk advised that the gross I&E charge for all recorded claims was £21.488m. Mr Monk also advised that the number of new claims received by the UHB was broadly in line with previous years. There were 14 existing claims valued at £11.511m where Legal & Risk Services had reassessed the probability of success to be certain to settle from Possible to settle. There was also a movement in the value of existing cases of £10.180m. Mrs Wicks advised that claims were now valued higher due to a number of factors, including life expectancy and long term cost of care.

The impact of all recorded Personal Injury claims had been a gross I&E charge of £0.106m. Mr Monk advised that the UHB has seen a reduction in new claims primarily due to the resource that the UHB had put into the investigation of claims which had also served to drive down defence and claimant costs.

Mr Monk reminded the group that the Welsh Risk Pool reimbursed the UHB for all costs of a claim subject to an excess of £25k. Therefore the net cost to I&E during the period was £0.531m which was significantly lower than the corresponding period in 2019/2020. This can be attributed to the lower number of claims where the probability of loss has changed compared to 2019/2020.

Recommendation

The Panel recommended that the Audit and Assurance Committee note that following expected reimbursement from the WRP, the net expenditure incurred by the UHB on these Clinical Negligence and Personal Injury claims was £0.531m for the period 1st April 2020 to 30th September 2020.

Finalised Clinical Negligence (including Redress) Claims

Mr Monk advised the Panel that during the six month period ending 30th September 2020, there were 27 claims (where liability had been conceded and settlements paid) which had concluded at a total settlement cost of £8.661m (which are treated as a loss). The UHB also incurred £0.227m in legal fees re these cases and was successful in recovering £8.350m from the Welsh Risk Pool for these claims, resulting in a net cost to the UHB of £0.538m.

Finalised Personal Injury Claims

During the six month period ending 30th September 2020, 5 claims where liability had been conceded and settlements paid have concluded at a total settlement cost of £0.027m (which are treated as a loss). The UHB had also

incurred £0.002m in defence fees, resulting in a total cost to the UHB of £0.029m.

Mr Monk reminded the group that expenditure on defence fees on Clinical Negligence and Personal Injury cases was not treated as a loss and also that it should be remembered that the loss is accrued over the lifetime of a claim which can span many years.

Recommendation

The Panel recommended that the Audit and Assurance Committee approve the write off of 27 Clinical Negligence claims totalling £8.661m and 5 Personal Injury claims totalling £0.027m for the period 1st April 2020 to 30th September 2020.

3. Bad Debt Write Offs

Mr Williams presented a report on proposed invoice write-offs for the period 1st April 2020 to 30th September 2020.

These were as follows:

Category of Debt	Value	Number
Accommodation	297	1
Payroll	1,579	6
Private Patients	0	0
O/Seas Patients	184	2
Misc	1,331	15
Total	**3,391**	**24**

The number of write offs actioned in the first 6 months of this financial year is low compared to previous years. This is due partly in a delay in actioning some write offs until after the end of September so they will not be reported until the next meeting and partly due to a reduction in the number of debts being referred to CCI Credit Management due to the revised working practices during the COVID-19 pandemic.

As in previous years the overpayment of salary for those employees who have terminated continue to prove difficult to collect with all debts being referred to CCI Legal Services if we have been unable to collect.

Included in the Miscellaneous category are 3 invoices totalling £1k relating to WEQAS, these debts were referred to CCI Legal Services but they were unable to collect.

No debt with a value of over £500 has been written off during this period.

The table below provides a comparison of the totals for previous years:

	2015/16		2016/17		2017/18		2018/19		2019/20		2020/21	
	Value	No	Value	No	Value	No	Value	No	Value	No	Value	No
Accommodation	8	1	1,049	8	0	0	2,668	6	1,222	1	297	1
Dental	130	10	81	6	203	15	401	16	164	10	0	0
Medical Records	360	22	650	35	1,070	47	672	42	70	4	0	0
Payroll	2,004	7	20,025	53	12,639	26	11,262	31	21,733	67	1,579	6
Private Patients	4,578	32	24,325	28	23,764	63	2,887	27	16,048	27	0	0
O/Seas Patients	53,011	48	16,475	10	58,632	40	74,450	26	76,415	20	184	2
IVF Wales	0	0	31,026	24	0	0	0	0	0	0	0	0
Misc	17,787	50	78,685	61	35,847	54	48,194	524	18,265	89	1,331	15
	77,877	**170**	**172,315**	**225**	**132,155**	**245**	**140,534**	**672**	**133,916**	**218**	**3,391**	**24**

Recommendation

The Panel recommended that the Audit and Assurance Committee approve the write off of 24 bad debts totalling £3,391 for the period 1st April 2020 to 30th September 2020.

4. Permanent Injury Losses

Mr Monk presented a report on permanent injury costs for the period 1st April 2020 to 30th September 2020. He explained that permanent injury allowances were approved by the NHS Pensions Agency and the long term costs were picked up by the UHB. The costs must be treated as losses and should be noted by the Panel. The UHB made payments on a quarterly basis to the Pensions Agency based on bills received from them.

One case had been closed during the period as a result of the death of the beneficiary. This had led to an income & expenditure benefit of £6,128 as the relevant provision had been released. In addition there were a total of 25 cases ongoing, which in expenditure terms had resulted in a net benefit over the six month period to the UHB of £47. There were payments made in the same period of £112,493.

Mr Monk stated that as the one case had concluded then the total payments made in respect of it would now be recognised as a loss. The total payments incurred over the life of the case were £77,408.92.

Recommendation

The panel recommended that the Audit and Assurance Committee note the Income and Expenditure benefit of £47 for the period 1st April 2020 to 30th September 2020 and to write off the 1 case closed totalling £77,408.

5. Small Claims

Mr Monk presented a report on the small claims made during the period 1st April 2020 to 30th September 2020. During the period 24 claims had been settled at a total cost of £13,870.69. Mr Monk stated that the corresponding figure for the previous 6 month period in 2019/2020 was £15,878.25.

Recommendation

The Panel recommended that the Audit and Assurance Committee approve the write off of 24 small claims totalling £13,870 for the period 1st April 2020 to 30th September 2020.

6. Employment Tribunal Costs

Mr Crook presented a report outlining the claims and costs for the period 1st April 2020 to 30th September 2020. Mr Crook stated that during the period, Cardiff and Vale University Health Board had been involved with 10 Employment Tribunal claims. 6 of these cases were still live as of 30th September 2020. 4 cases had settled during the period at a cost of £162,397.12.

Recommendation

The Panel recommended that the Audit and Assurance Committee approve the write off of 4 Employment Tribunal cases of £162,397 for the period 1st April 2020 to 30th September 2020.

7. Security Losses

Mr Monk advised the Panel that Mr Cockayne was not able to attend the meeting but would submit a full year report at the next meeting in May 2021.

8. Counter Fraud

Mr Greenstock was unable to attend the meeting but had presented a report for the period 1st April 2020 to 30th September 2020. The report stated that there were 15 ongoing cases under investigation with a potential loss of £75,000. There had been no cases closed during the period that had resulted in a loss, therefore there were no cases to be approved for write off.

9. Any Other Business

Mr Lewis presented a report on the flood damage incurred at a number of Cardiff & Vale (C&V) properties within the Treforest Industrial Estate, Pontypridd. Flood water from the river Taff had burst its banks in the early hours of Sunday 16th February 2020 following torrential rain from Storm Dennis. The water level reached a height of 63cm throughout the properties, causing extensive damage to the fabric of the buildings, offices and clinic rooms. Additionally, there was damage and contamination of equipment and stock. The properties included the storage, workshop, office and laboratory facility for the Artificial Limb and Appliance Service, IT Department, Designed to Smile Community Dental Service and Genetics Laboratory.

The total loss was £2.019m.

The loss is above C&V's delegated limit of £50,000 for write-off of such incidents. Therefore approval for the loss was requested from Welsh Government and was given on the 20th July 2020.

The Welsh Risk Pool (WRP) provide indemnity for loss or damage to Welsh NHS property and equipment. In compliance with the procedures for this cover, C&V has submitted a claim to the WRP for reimbursement of the costs of this loss subject to an excess of £50,000. Claims are presented to the WRP Advisory Committee for approval. C&V are awaiting the outcome of the claim that has been submitted.

Recommendation

The Panel noted the contents of the report and recommended that the Audit and Assurance Committee write off the loss of £2.019m.

Mr Crook advised that there were no Voluntary Early Release (VERS) payments made during the period. Mr Monk also advised that there were no Ex Gratia losses incurred during the period 1st April 2020 to 30th September 2020.

The next meeting of the panel would be in May 2021.

Report Title:	**Proposed Changes to Governance Arrangements**									
Meeting:	Audit and Assurance Committee						**Meeting Date:**	17.11.20		
Status:	**For Discussion**	**x**	**For Assurance**	**X**	**For Approval**		**For Information**			
Lead Executive:	**Director of Corporate Governance**									
Report Author (Title):	**Director of Corporate Governance**									

Background and current situation:

There has been a need to review our Governance arrangements in light of learning from the first wave of COVID-19 and also as numbers are now increasing and progressing to a second wave. We have also now received the final reports and recommendations of all three audits on Governance which were undertaken as follows:

- Due Dilligence Review of the Principality Stadium – KPMG
- Structured Assessment – Audit Wales
- Governance Review – Internal Audit

There is a further Governance Review taking place on the Lakeside Wing which is being undertaken by Welsh Government and this review is commencing 2nd November. Any further recommendations made from this review will also be considered when known.

The KPMG Review is presented to the Private session of this Audit Committee (along with responses to recommendations and observations) and the Audit Wales Structured Assessment and the Internal Audit Review of Governance is presented to this Public Session of the Committee.

Executive Director Opinion/Key Issues to bring to the attention of the Board/Committee:

The Proposed Amendments to Governance Arrangements (Appendix 1) include the development of a New COVID-19 Report (Appendix 2), changes to the Terms of Reference (Appendix 3) of the COVID-19 Board Governance Group and a further Governance Structure (Appendix 4). These arrangements also reflect the recommendations made by Audit Wales but will also ensure robust and improved governance arrangements are in place during the second wave of the pandemic.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc.):

Implementation of these revised governance arrangements will further stregthen what was previously in place and will ensure a more transparent approach with the involvement of the whole cadre of Independent Members.

In addition to the above and in order to apply additional Board member scrutiny and to assist with their individual development, all Independent Members should attend the Board

Governance Group as often as possible. This will provide additional assurance to the full Board and minimise any possible criticism when the minutes are presented in public.

It will however be important to ensure that there is no duplication in these reporting arrangements at the various Committtees and the Board Governance Group.

Recommendation:

The Audit Committee is asked to recommend that the Board:

(a) Approve the proposed amendments to governance arrangements (Appendix 1);
(b) Approve the changes to the Board Governance Group Terms of Reference (Appendix 2) which extends the Membership to include all Independent Members;
(c) Approve the COVID-19 Report Template (Appendix 3) covering the key areas of Quality and Safety, Workforce, Governance, Operational Framework, Governance and Public Health;
(d) Approve that the first 90 minutes of future Board Development sessions are in public demonstrating that the Board is meeting in public every month;
(e) Approve the revised Governance Structure ensuring appropriate reporting to the Committees of the Board during the second wave (Appendix 4).

Shaping our Future Wellbeing Strategic Objectives
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

1.	Reduce health inequalities	x	6.	Have a planned care system where demand and capacity are in balance	x
2.	Deliver outcomes that matter to people	x	7.	Be a great place to work and learn	x
3.	All take responsibility for improving our health and wellbeing	x	8.	Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4.	Offer services that deliver the population health our citizens are entitled to expect	x	9.	Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5.	Have an unplanned (emergency) care system that provides the right care, in the right place, first time	x	10.	Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	x

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant, click here for more information

Prevention	x	Long term		Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Not Applicable

Proposed Amendments to Governance Arrangements October 2020

In light of the surge of Covid infection rates across Cardiff & Vale region, we will need to further consider, once again, reviewing and strengthening our governance arrangements to ensure that appropriate assurance is being provided on the work of the Board in the Covid and non-Covid arenas.

I am mindful of the contents of the recent draft Structured Assessment report provided by Audit Wales where several helpful suggestions have been put forward that will allow us to provide additional scrutiny opportunities to take place in the public domain. The following will apply with effect from 1st December 2020.

Board/Committee	**Additional Pandemic Requirements**
Board meetings held in public	New Covid report (Appendix 2) covering the impact of Covid on key areas including: • Quality of service and Patient safety (Lead Exec of QPS Committee) • Workforce including staff wellbeing and safety (Lead Exec of S&D Committee) • Governance arrangements (Director of Corporate Governance) • Operational framework and update (CEO and COO) • Public health update (Exec Director of Public Health) Where any of these key areas form part of a separate report on the same agenda and they pick up Covid specific impact, there will be no need to duplicate in this report. A simple cross reference will be sufficient. No other amendments proposed at this time
Board Development meetings	The first 90 minutes of this meeting will be held in public. Agenda items for the public part of the meeting will be primarily directed towards Covid related updates, issues, concerns and probably incorporate the new style report as outlined above to make it effectively a monthly update.
Covid Board Governance Group	Core membership to be expanded to include CEO, Vice Chair, Chair of Audit Committee, IM Finance (if not Audit Committee Chair), IM Legal, IM Capital and Estates, Director of Corporate Governance and UHB Chair. Additional executives will be invited by the CEO when appropriate. The core membership is geared towards delivery against the main focus of the Covid Board Governance Group which is to provide speedy turnaround of Chairs Actions when required. An open and standing invitation to be extended to all Independent Board members to attend this meeting if they are available and wish to do so. Terms of Reference to be amended and scrutinised by the Audit Committee prior to Board approval.
Audit Committee	Additional paper to be considered at each committee to outline the impact of Covid on governance arrangements, assurance framework, and committee frameworks and assure the Board on public scrutiny levels across the UHB. Also review of WG Guidelines and compliance against them.

Quality, Safety and Experience Committee	Additional paper to be considered at each committee to outline the impact of Covid on patient safety identifying any key areas of concern e.g. IP&C, PPE, clinical staffing levels etc.
Strategy & Delivery	Workforce paper to specifically cover impact of Covid on capacity, staff numbers, well-being and safety
IMs	Series of 121s planned for this month followed by team meeting afterwards to discuss how IMs are “maximised”

COVID 19 – Update Report covering key activities in relation to • Quality and Safety • Workforce • Governance • Operations • Public Health	Month: November 2020
Quality and Safety	Executive Nurse Director/Executive Medical Director
Workforce	Deputy CEO and Executive Director of Workforce and OD

Governance	Director of Corporate Governance
Operations including Operational Framework	Chief Operating Officer

Public Health	Executive Director of Public Health

COVID 19 Board Governance Group – Terms of Reference

1. Introduction

This Group has been set up to enable the Board to approve decisions between Board Meetings specifically decisions arising as a result of and relating to COVID 19.

2. Constitution and Purpose

Within current Standing Orders the Chair may take decisions or action on urgent matters which would normally be made at a Board Meeting. This meeting has been developed as a Chair's action group which has the same authority as the Chair has when signing off Chairs actions. The only difference is the way the Chairs actions are being executed in that those involved are meeting virtually.

The Chair and the Chief Executive supported by the Director of Corporate Governance as appropriate may deal with an action or decision on behalf of the Board after consulting with two Independent Members. Such decision should be formally recorded and reported to the next meeting of the Board for consideration and ratification. To ensure that all Independent Member are aware of all decisions being made which require Chair's action the membership of the group includes all Independent Members.

3. Delegated Powers

The Board Governance Group can make decisions on behalf of the Board in line with normal process set out for Chair's action within Standing Orders.

Attached at the appendix are decisions which will be presented to the Group from the COVID 19 Strategic Group.

The Group also has authority to make decisions on other urgent matters which would normally go to the Board if that matter cannot wait until the next Board Meeting.

4. Membership

Members

Chair of the Board
Vice Chair (Chair of Strategy and Delivery Committee)
~~Chair of Audit Committee~~
Independent Member – Finance (Chair of Audit Committee)
Independent Member- Estates (Chair of Finance Committee)
Independent Member – Local Authority (Chair of Quality, Safety and Experience Committee)
Independent Member – ICT (Chair of Digital Health Intelligence Committee)
Independent Member – Trade Union

Updated 28.10.20NJF

Independent Member – Third Sector (Interim Chair of Mental Health and Capacity Legislation Committee)
Independent Member – Communities (Chair of Health and Safety and Chair of Charitable Funds Committee)
Independent Member – Universities

Chief Executive

In attendance

Director of Corporate Governance
Other Executive Directors who the Chief Executive decides should attend to present on specific issues

Member Appointments

The membership of this Group shall be determined by the Chair of the Board.

Secretariat

The Secretary to the Group will be determined by the Director of Corporate Governance.

Support to Group Members

The Director of Corporate Governance, on behalf of the Group Chair, shall:

- Arrange the provision of advice and support to Group Members on any aspect related to the conduct of their role

5. Group Meetings

Quorum

At least three Independent Members plus the Chief Executive Officer or his Deputy must be present to ensure the quorum of the Committee. The Independent Members should include ~~either~~ the Chair~~, or~~ the Vice ~~Chair~~ Chair, the Chair of Audit Committee or the Chair of the Finance Committee of the Board.

Frequency of Meetings

Meetings shall be held on a weekly basis. This will be reviewed on a regular basis.

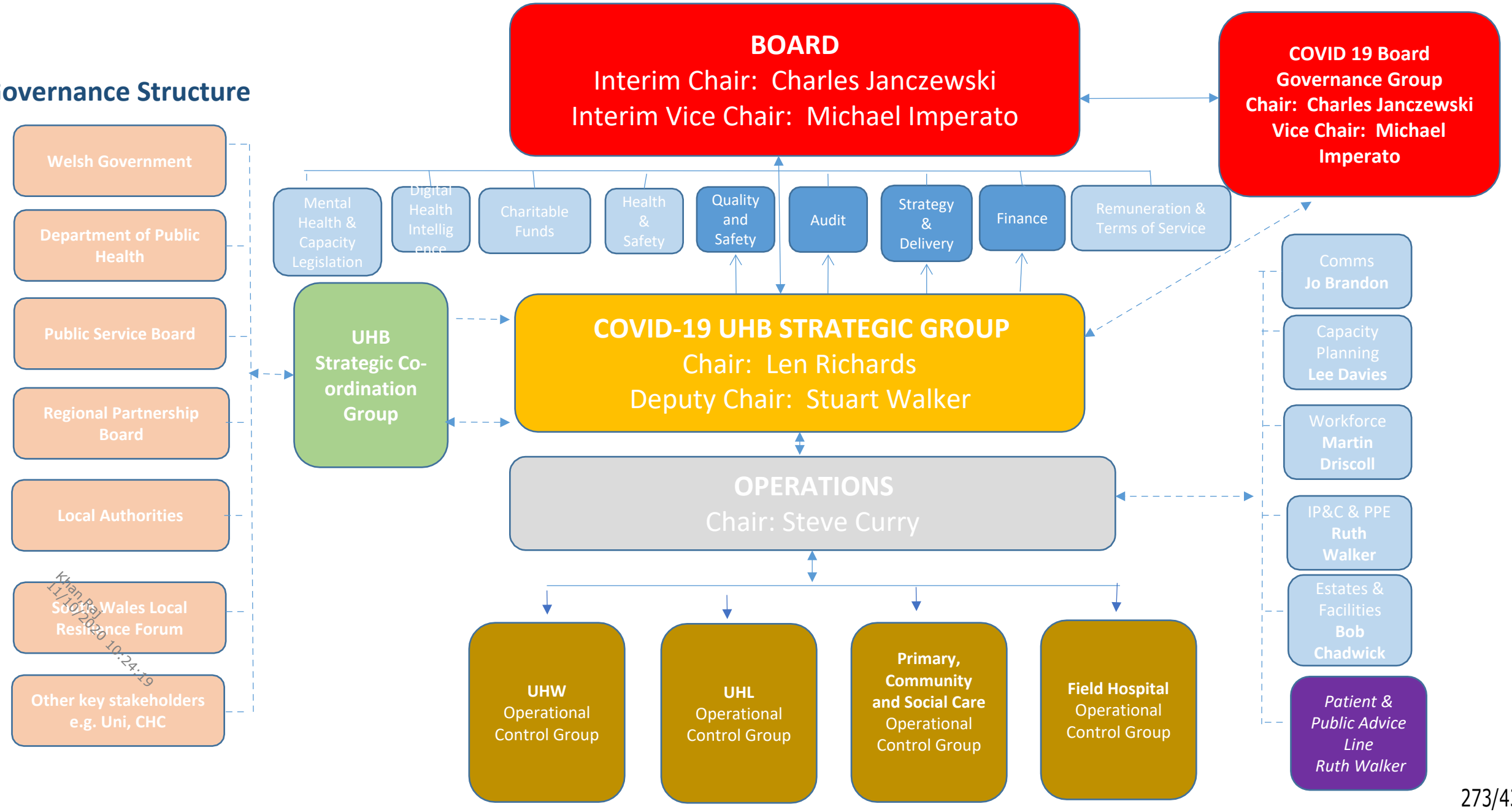
6. Reporting and Assurance Arrangements

The Group Chair shall:

- Report to each Board meeting on the Groups decisions and other activities via the Chair's report
- Ensure the minutes of each meeting of the Group are presented to the Board meeting and circulated to Independent Members as soon as possible after each meeting.
- Ensure appropriate escalation arrangements are in place to alert the Board and Welsh Government of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

UHB GOVERNANCE AND DELIVERY ARRANGEMENTS FOR THE MANAGEMENT OF COVID – 19

Governance Structure



Pre–Employment Checks

Final Internal Audit Report

Cardiff and Vale University Health Board

2019/20

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

Review reference:	C&V-1920-40
Report status:	Final Internal Audit Report
Fieldwork commencement:	4th February 2020
Fieldwork completion:	13th March 2020
Draft report issued:	19th March 2020
Management response received:	NWSSP – 26th August 2020 CVUHB – Not received
Final report issued:	3rd November 2020
Auditor/s:	Morgan Bowen, Ian Virgill
Executive sign off:	Martin Driscoll (Executive Director of Workforce, CVU)
Distribution:	Lianne Morse (Head of Operational HR, CVU) Carys Fox (Dir of Nursing, Strategic Nursing Workforce) Sandra Coles (Senior Nurse, Temporary Staffing Dept, CVU) Kelly Skene (Head of Recruitment, NWSSP) Sian Bryant (Recruitment Business Partner, NWSSP) Nadia Bates (Recruitment, NWSSP)
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

ACKNOWLEDGEMENT
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - Please note:

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

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Cardiff and Vale University Health Board, no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

The review of the Pre-Employment Checks (PEC's) was completed in line with the 2019/20 Internal Audit plan for Cardiff and Vale University Health Board.

The relevant lead Executive Director for this review is the Executive Director of Workforce.

All NHS candidates must undergo and comply with NHS Wales Pre-Employment Checks as part of their on-boarding process. The Pre-Employment Checks process should form part of robust recruitment practices to ascertain a person's fitness and suitability for the role they have been conditionally offered, verifying they meet all preconditions of employment.

The Pre-Employment Checks process should comply with the NHS Employment Check Standards and all relevant regulatory requirements.

The Standards apply to all successful applicants including internal and external employees, and bank staff.

The Pre-Employment Checks for prospective Cardiff and Vale employees are carried out by the NHS Wales Shared Services Partnership (NWSSP) Recruitment Service, with the exception of medical and bank staff whose pre-employment checks are carried out by the Health Board itself. However, the Health Board retains responsibility for ensuring that staff do not commence employment without satisfactory completion of the checks.

Locum Doctors' pre-employment checks are not completed in-line with the six NHS Standards. Consequently, this area was not reviewed as part of this audit.

2. Scope and Objectives

The objective of the audit was to evaluate and determine the adequacy of the systems and controls in place for the management of Pre-Employment Checks, in order to provide assurance to the Health Board Audit Committee that Pre-Employment Checks are completed in a correct and timely manner.

The main areas that the review sought to provide assurance on are:

<u>Pre-Employment Checks</u>

- The Health Board and the NWSSP Recruitment Service has appropriate and up to date guidance in place for the completion of Pre-Employment Checks; and
- The six NHS Employment Checks Standards are fulfilled to verify an individual meets the preconditions for the role prior to commencing employment;

Timescales of Pre-Employment Checks

- Target timescales set in the Internal Fast Track Process are being met;
- Target timescales set for external applicants are being met; and
- Delays in the Pre-Employment Check Process are communicated effectively and common issues are identified and addressed appropriately.

3. Associated Risks

The potential risks considered in this review are as follows:

- Patient safety may be compromised if Pre-Employment Checks are not completed correctly;
- Target timescales are not met resulting in delays to the recruitment process and possible financial implications to the Health Board; and
- Non-compliance with the NHS employment Checks Standards.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the Pre–Employment Checks process is **Reasonable Assurance**.

RATING	INDICATOR	DEFINITION
Reasonable assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.

Overall, the controls in place to manage the risks associated with the systems and processes tested within the review are of a reasonable standard. However, we have identified a number of weaknesses in the areas reviewed.

We identified a number of issues concerning the Health Board and NWSSP's procedural guidance and process flow charts. Testing of pre-employment checks found some overall non-compliance with the six NHS Standards. We identified some weaknesses in communication between the Health Board and NWSSP concerning internal appointments.

The testing undertaken identified that pre-employment checks for both internal and external candidates are not always completed within the target timescales. It is however noted that the reasons for the delays generally relate to external issues that are outside the control of both NWSSP Recruitment and the Health Board.

One high priority issue was identified in this review concerning pre-employment checks undertaken for bank staff.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Health Board & NWSSP Guidance			✓	
2	Completion of PECs prior to commencement			✓	
3	Timescales for Internal Fast Track Process			✓	
4	Timescales for External Candidates			✓	
5	Communication of Delays			✓	

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted six issues that are classified as weaknesses in the system control/design for Pre–Employment Checks.

Operation of System/Controls

The findings from the review have highlighted four issues that are classified as weaknesses in the operation of the designed system/control for Pre–Employment Checks.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Pre-Employment Checks

Objective 1: The Health Board and the NWSSP Recruitment Service have appropriate and up to date guidance in place for the completion of Pre-Employment Checks

We note the following areas of good practice:

- NWSSP has up to date procedural guidance relating to the completion of Pre-Employment Checks and how to navigate the Trac system; and
- The Health Board has up to date procedural guidance for the recruitment of Medical Staff.

We identified the following significant findings:

- We found the Temporary Staffing Department do not have procedural guidance for bank staff recruitment.

Objective 2: The six NHS Employment Checks Standards are fulfilled to verify an individual meets the preconditions for the role prior to commencing employment

We note the following areas of good practice:

- All identification and supporting documentation is checked, signed and dated by the NWSSP recruitment team during the face to face pre-employment checks meeting to verify it's validity before being photocopied/scanned and uploaded to the central Trac system;
- Trac has a 'communications' section which logs all communications over the course of the pre-employment checks process, providing a comprehensive audit trail;
- All healthcare practitioners registrations/nursing PINs are checked online by NWSSP and Medical Work Force to verify their validity; and

- Before the unconditional letter is sent out, an ECO ('employment check O.K.') check is completed by NWSSP to ensure all PEC's have been completed accordingly.

We identified the following significant findings:

- We highlighted several non-compliances with the NHS Checks Standards whilst undertaking testing on temporary staffing recruitment which included: invalid documentation accepted as proof of identification and right to work in the UK, documentation not signed and dated as proof of validity by the individual undertaking the check and references did not cover a sufficient period of consecutive employment.

Timescale of PECs

Objective 3: Target timescales set in the Internal Fast Track Process are being met

We note the following areas of good practice:

- An E-bulk online electronic service is used for DBS referrals which speeds up the process when submitting multiple referrals;
- The Home Office 'Right to Work' online portal is used, where appropriate, to speed up the process in determining whether a non-UK individual has the right to work in the UK;
- Referees are sent four automatic reminder emails via Trac. NWSSP will manually chase outstanding references following this, where necessary. The Trac system sends automatic emails to managers when references require approval; and
- A file review is completed by NWSSP 5 days after the conditional offer letter is sent out. Progress is then checked on a daily basis.

We noted the following issue under this objective:

- Four of ten on-boarding times tested did not meet the target timescale; however, delays were due to issues outside of NWSSP control such as: delays with DBS applications and Occupational Health clearance and applicants awaiting exam results/professional registrations. Consequently no recommendation has been made for this objective.

Objective 4: Target timescales set for external applicants are being met

We note the following areas of good practice:

- Please see areas of good practice detailed in Objective 3 'Target timescales set for Internal Fast Track applicants are being met'

We noted the following issue under this objective:

- Seven of ten on-boarding times tested did not meet target timescale; however, delays were due to issues outside of NWSSP control such as: delays with DBS applications and Occupational Health clearance, postal verification being utilised as opposed to the face to face PEC meeting and invalid documentation being provided by the applicant. Consequently no recommendation has been made for this objective

Objective 5: Delays in the Pre-Employment Check Process are communicated effectively and common issues are identified and addressed appropriately

We note the following areas of good practice

- NWSSP send monthly 'Managers Updates - Outstanding Actions' reports to the Health Board notifying recruiting managers of any delays in the pre-employment checks process. Managers are expected to take relevant action to speed up any pre-employment checks relating to their applications;
- Recruiting managers are sent automatic weekly reports via Trac to update them of any open applications or vacancies; and
- On-boarding statistics for non-medical Health Board recruitment show an annual average compliance with the 27 day on-boarding target.

We identified the following findings:

- Pre-Employment Checks are not always completed prior to an internal candidate commencing employment. There appears to be a lack of communication between the Health Board and NWSSP regarding the completion of PECs and the confirmation of start dates.

7. Summary of Recommendations

The audit findings and recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**1**	**3**	**6**	**10**

Finding 1 - Procedures in place for bank recruitment pre-employment checks require review (Operating effectiveness)	Risk
We highlighted numerous non-compliances with the NHS Employment Checks Standards whilst undertaking testing on temporary staffing recruitment pre-employment checks. The non-compliances highlighted are as follows: • We found that Identification, Right to Work and Qualification documentation are not signed and dated as evidence of validity by the individual undertaking the pre-employment checks; • We found that downloaded bank statements had been accepted as valid proof of address; • We found that a downloaded E-P60 had been accepted as proof of right to work in the UK; • We found that references did not cover a consecutive two year period of employment/education prior to the applicant commencing post; • We found that dates detailed on references differed to the corresponding dates detailed on Trac; and • We found that Qualification Certificates/Proof of Registration are not uploaded to Trac.	Patient safety may be compromised if pre-employment checks are not undertaken appropriately

Recommendation	Priority level
Temporary Staffing Management should revise their current pre-employment checks procedures. The following highlighted areas should be considered for revision: • All original Identification, Right to Work and Qualification documents should be brought to enrolment and photocopied by the Temporary Staffing Department. All copies should be signed and dated and then uploaded to Trac as evidence of proof of validity by the individual undertaking the checks. Online/downloaded documentation should not be accepted as proof of identification or right to work in the UK • References should cover the consecutive two year period of employment/education prior to the commencement of post. Reference dates should correctly correspond to the dates detailed on Trac; • Original Qualification Certificates/Proof of Registration (i.e. screenshot of nursing PIN) should be uploaded to Trac to evidence the individual meets the criteria of the role conditionally offered; and • Management should inquire if 'Qualification Check' can be added to the Temporary Staffing Trac list of required pre-employment checks.	**High**
Management Response	**Responsible Officer/ Deadline**

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Finding 2 - Internal applicants commencing post before PECs are completed (Operating effectiveness)	Risk
We tested the 10 individuals who had been on the December 2019 escalation report the longest. We found that 2 individuals were still listed on December 2019's report despite having start dates of February 2019 and October 2019, respectively. NWSSP confirmed that pre-employment checks had not been completed for either individual until January 2020. NWSSP were unable to confirm why these individuals had been able to commence employment without their PECs being completed. We contacted the recruiting managers to query these appointments and found that one individual had commenced and ended their secondment before their PECs were completed (no formal reason could be given for this). Similarly, the other individual had also started their secondment before PECs were completed due to their manager believing the checks had been fully undertaken.	Patient safety may be compromised if Pre-Employment Checks are not completed appropriately.
Recommendation	**Priority level**
Health Board managers should be reminded that internal applicants cannot commence in post prior to pre-employment checks being fully completed. Managers should also be reminded to take notice of the weekly Trac update emails and the monthly escalation reports sent to them and regularly check on the progress of their applicants' pre-employment checks and take action as required to speed up the process. Managers should be encouraged to use Trac to keep up to date with progress of applications. The 'Managers Tips to Reduce Time to Hire' guidance should be circulated throughout the Health Board via email.	**Medium**

Management Response	Responsible Officer/ Deadline

Finding 3 - Procedural guidance required for bank recruitment (Control design)	Risk
We found the Temporary Staffing Department do not currently have any procedural guidance documents in place for bank staff recruitment.	Patient safety may be compromised if pre-employment checks are not completed appropriately.
Recommendation	**Priority level**
Temporary Staffing Department management to familiarise themselves with the NHS Employment Checks Standards and implement appropriate procedural guidance, ensuring it satisfies all requirements/criteria of the Standards.	**Medium**
Management Response	**Responsible Officer/ Deadline**

Finding 4 - Reference Checks for Consultants (Operating effectiveness)	Risk
During the course of the audit we tested five consultants' references. As per the Medics Recruitment guidance, a minimum of 3 references should be sought for consultants before the post can be confirmed. The 'Medical/Dental Workforce Department - Recruitment and Selection Guidance for Hospital Doctors and Dentists' reads; *'For Consultant appointments, a minimum of three references are sought - at least one of which must be from the current or most recent employer. All instances where the applicant has been employed by more than one employer in the last three years, references are sought from at least two employers within that period including one from the current or most recent employer. Additionally for Consultant posts, if the applicant's current or most recent employment has been in a substantive Consultant post or in a Locum Consultant post for a period exceeding 12 months then a fourth reference is sought from the relevant Medical Director.'* We found only two references were obtained for 4 of the 5 consultants prior to the post being confirmed.	Patient safety may be compromised if Pre-Employment Checks are not completed appropriately.
Recommendation	**Priority level**
Management to review the process for Consultant reference checks to ensure it adheres to the relevant guidance.	**Medium**
Management Response	**Responsible Officer/ Deadline**

Finding 5 - SLA to be reviewed (Control design)	Risk
The NWSPP SLA highlights the on-boarding process. It specifies the responsibilities of NWSPP and the Health Board during the PEC process. The current SLA covers the period 2017-18. We found no evidence to suggest this has been reviewed since its completion in November 2017.	Patient safety may be compromised if Pre-Employment Checks guidance is not correct and up to date.
Recommendation	**Priority level**
Management to review the Employment Services SLA.	**Low**
Management Response	**Responsible Officer/ Deadline**

Finding 6 - Recruitment Process Flowcharts to be reviewed (Control design)	Risk
We found there are Fast Track and External flowcharts that specify target timescales for the on boarding of non-medical staff. We found the Internal Fast Track Process flowchart does not identify a completion or review date so we were unable to ascertain when this was last reviewed. Testing showed that several fast track processes could not be utilised due to limitations in NWSSP document accessibility and DBS checks lasting a limited period. These limitations often result in fast track recruitment exceeding the 5-14 day target. The External Recruitment flowchart detailed a completion date of November 2016. We found there was no evidence of this flowchart being reviewed since its completion.	Patient safety may be compromised if Pre-Employment Checks guidance is not correct and up to date.
Recommendation	**Priority level**
Management to review Internal and External Recruitment Process Flowcharts and determine if their content is relevant.	**Low**
Management Response	**Responsible Officer/ Deadline**
All process documents are reviewed regularly, however we have omitted to date the documents to record this. Going forward we will ensure all documentation is dated with review dates and regular reviews of documentation are diarised and placed on Recruitment Managers agenda.	Head of Recruitment, Employment Services Complete

Finding 7 - Reference guidance to be reviewed (Control design)	Risk
When examining procedural guidance relating to reference checks we noticed some contradicting information between the NHS Standard and Shared Services Reference Guidance. The NHS Employment History and Reference Checks Standard details the following, '*For new appointments from outside of the NHS, employers should seek the necessary references to validate a period of* ***three consecutive years*** *of* ***continuous employment*** *or training immediately prior to the application being made*', whist the Shared Services Reference Guidance details, '*Recruitment will request two written references covering the* ***last two years*** *of employment and/or education history... Where an appointee has been with the same employer for over two years one reference is sufficient. Should an applicant have more than two employers within the last two years references should cover a sufficient period of time i.e. 12-18 months, a pragmatic approach should be taken to the number of references requested i.e. not exceed three references'.*	Patient safety may be compromised if Pre-Employment Checks guidance is not correct and up to date.
Recommendation	**Priority level**
Management to review the apparent contradicting information found in the NHS Reference Standard and the NWSSP Reference Guidance and determine which is more relevant. Management should consider updating the guidance if necessary.	**Low**

Management Response	Responsible Officer/ Deadline
This was part of a business improvement techniques project undertaken with HBs in 2014. The outcome of the project to was to reduce the number of references required and the time period. In Nov 2014 it was agreed by Assistant Directors of Workforce that in Wales we would reduce the number of references required as the most recent references add the most value to the recruitment process. On occasion 5 references would be requested by following NHS Employers guidance, where there was often a delay in obtaining this number and they didn't add value. The aim was to maintain safe recruitment, but also to reduce the time to hire.	Head of Recruitment, Employment Services Complete

Finding 8 - Reference Checks for Non-Medical Staff (Operating effectiveness)	Risk
When undertaking the non-medical staff testing we highlighted the following issue pertaining to one individual's reference checks: Two references were obtained for one employee covering a total period of June 18 - Jan 2020. Reference 1 was detailed as covering period June 2018 - January 2020 on the application form however the reference itself detailed covering period June 2019 - December 2019. Following a failed reference attempt of obtaining a second reference, NWSSP requested a third referee's details. The applicant's sister, a supervisor at a restaurant, submitted this reference (which covered period June 2018 - January 2020). At no point did the applicant detail this restaurant as a place of work on their application form. We feel this may be a potential validity issue.	Patient safety may be compromised if Pre-Employment Checks are not completed correctly. Non-compliance with the NHS employment Checks Standards.

Recommendation	Priority level
NWSSP Recruitment and Health Board recruiting managers to be reminded of the importance of considering validity of references when undertaking and approving pre-employment checks.	**Low**
Management Response	**Responsible Officer/ Deadline**
Where we cannot obtain full employment references, a character reference is sought.	Head of Recruitment, Employment Services Complete

Finding 9 - CVU Guidance to be reviewed/updated (Control design)	Risk
We reviewed the CVU policies/procedures listed in the CVU Recruitment Policy. We found that numerous policies/procedures are overdue review. We highlight the following potential issues: • Testing showed secondment recruitment breached the pre-employment checks standards. There is currently no information pertaining to pre-employment checks in the Secondment Policy. The policy has not been reviewed since March 2016. • We found the following detailed within the Recruitment of Locum Doctors and Dentist Policy, '*the CRB check procedure should be carried out'.* The Locum Recruitment Policy has not been reviewed since July 2015.	Patent safety may be compromised if pre-employment checks are not completed appropriately.

Recommendation	Priority level
Management should review all supporting policies/procedures listed in the CVU Recruitment Policy. Management should review and consider updating the Secondment Policy to include the requirement for pre-employment checks to be completed before an employee can commence in a secondment post. Management should review the Recruitment of Locum Doctors and Dentists Policy, ensuring all terminology is relevant.	**Low**
Management Response	**Responsible Officer/ Deadline**

Finding 10 - Letter sent to successful bank applicants requires updating (Control design)	Risk
We highlighted a concern regarding the standard letter sent out with the conditional offer of appointment of successful bank applicants; it informs the applicants of what identification documents they need to provide in order to satisfy the identity pre-employment check. The letter details the following, '*We require a total of 3 forms of ID consisting of utility bill, bank or Credit Card statement, Council Tax information or HMRC Tax details, no more than 3 months old, Passport or Driving Licence*'.	Patient safety may be compromised if pre-employment checks are not completed appropriately.

This requirement does not match that of the NHS ID Check Standard which specifies the following: *'Prospective employees will need to provide one of the following combinations: – Two forms of photographic personal identification from List 1, and one document confirming their current residing address from List 2. – One form of photographic personal identification from List 1, and two documents confirming their current residing address from List 2.'*	
Recommendation	**Priority level**
Temporary Staffing Department management to review the standard letter sent with the conditional offer and ensure it complies with the Identification Check NHS Standard.	**Low**
Management Response	**Responsible Officer/ Deadline**

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No assurance** - The Board can take **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

Surgery Clinical Board - Theatres Directorate

Sickness Absence Management

Final Internal Audit Report

2020/21

October 2020

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Auditors:	Ian Virgill, Stuart Bodman, Cara Vernon
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Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

ACKNOWLEDGEMENT
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - Please note:

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

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Cardiff and Vale University Health Board, no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

Our review of the sickness absence management processes operating within the Surgery Clinical Board was completed in line with the 2020/21 Internal Audit Plan for Cardiff and Vale University Health Board.

The Health Board relies on its workforce in order to provide a high quality service to its patients.

Effective procedures for the management of staff sickness absence are essential to:

- Support the health and wellbeing of employees in the workplace;
- Support employees to return to work following a period of sickness absence safely and as quickly as possible; and
- Support employees to sustain their attendance at work.

The relevant lead Executive Director for this review is the Chief Operating Officer.

2. Scope and Objectives

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Surgery Clinical Board for the management of sickness absence, in order to provide assurance to the Health Board's Audit Committee that risks material to the achievement of system objectives are managed appropriately.

The purpose of the review was to assess the processes for reporting, recording and managing sickness absence and compliance with the All Wales Managing Attendance at Work Policy.

The areas that the review sought to provide assurance on were:

- Local notification and recording of sickness absence on ESR.
- Timely and accurate completion of self-certification forms, return to work interviews and GP Fit Notes (where applicable);
- Documented monitoring and management of frequent short term sickness absence;
- Documented management of long term sickness absence;
- Reporting and escalation of sickness absence management compliance, absence rates and actions taken.

Detailed testing for the review was undertaken on a sample of staff groups within the Theatres Directorate, and these were determined following discussion with Clinical Board management and review of sickness absence rates.

The staff groups sampled for testing within the Theatres Directorate were:

- Recovery, UHW
- Trauma Theatres, UHW
- Children's Hospital for Wales (CHfW) Scrub
- Ortho 2, UHL
- Recovery, UHL
- Scrubs, UHL

3. Associated Risks

- Non-compliance with the All Wales Managing Attendance at Work Policy.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with established controls within Surgery Clinical Board – Theatres Directorate - Sickness Absence Management is **Reasonable assurance.**

Reasonable assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.

Overall the processes in place that underpin sickness management in accordance with the All Wales Managing Attendance at Work Policy are working effectively across the majority of the six sampled staff groups within the Theatres Directorate.

All sickness absence stated on Rosterpro reconciled to individual ESR accounts in all six areas and mechanisms for sickness absence monitoring

and reporting of sickness 'hot spots' are in place as a standing agenda item of the Surgery Clinical Board meetings.

For the majority of areas, the key findings relate to minor elements of non-compliance in respect of inconsistent completion or retention of Sickness Notification Forms, Self-Certification Forms, Return to Work Interview Forms and GP Fit Notes.

Whilst the majority of areas actively monitor, manage and document short term sickness absence, there are small incidences of non-recording of 'Short Term Review Prompts'.

Generally, long term sickness is being fully managed and required interviews are being undertaken, with evidence of Occupational Health liaison where required.

However, testing identified major shortfalls in compliance within the Trauma Theatres, UHW in respect of completion of sickness notification, key sickness documentation, short term sickness absence monitoring and long term sickness management. This included the use of social media as a means of ongoing communication for a long term sickness episode without any formal documentation of the required processes as stated in the All Wales Managing Attendance at Work Policy.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Notification and recording on ESR			✓	
2	Completion of required documentation			✓	
3	Frequent short term sickness absence			✓	
4	Management of long term sickness absence		✓		
5	Reporting and escalation of sickness absence			✓	

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted 1 issue that is classified as a weakness in the system control/design for Surgery Service Group – Theatres Directorate - Sickness Absence Management.

Operation of System/Controls

The findings from the review have highlighted 4 issues that are classified as weaknesses in the operation of the designed system/control for Surgery Service Group – Theatres Directorate - Sickness Absence Management.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: Local notification and recording of sickness absence on ESR.

The following areas of good practice were noted:

- The dates for all of the sampled sickness absence episodes, as stated on Rosterpro, reconciled to individual ESR accounts.

The following significant findings was noted:

- Sickness Notification Forms are not being consistently completed and retained within staff personal files.

Objective 2: Completion of required sickness absence documentation

The following areas of good practice were noted:

- CfHW Scrub and Ortho, UHL areas were fully compliant with their use of sickness absence documentation for all the sampled episodes.

The following significant findings were noted:

- Within the remaining sampled areas, self-Certification Forms, Return to Work Interview Forms and GP Fit Notes are not being consistently completed and retained within staff personal files for all sickness episodes.

Objective 3: Documented monitoring and management of frequent short term sickness absence.

The following areas of good practice were noted:

- The majority of areas sampled actively monitored, managed and documented short term sickness absence in accordance with the NHS Wales Managing Attendance at Work Policy requirements.

The following significant findings were noted:

- Inconsistent documentation of 'Short Term Review Prompts' within CHfW Scrub Team.
- Absence of any monitoring, documentation and management of 'Short Term Review Prompts' within Trauma Theatres, UHW.

Objective 4: Management of long term sickness absence

The following areas of good practice were noted:

- The majority of areas sampled fully manage and document contact maintained and interviews undertaken during episodes of long term sickness, in accordance with the NHS Wales Managing Attendance at Work Policy, with Occupation Health liaison where appropriate.

The following significant findings were noted:

- The absence of any documentary evidence to support the management of long term staff sickness absence within Trauma Theatres, UHW.
- Long term sickness management of a staff member within Trauma Theatres, UHW was undertaken verbally and via social media ('WhatsApp').

Objective 5: Reporting and escalation of sickness absence management compliance, absence rates and actions taken.

The following areas of good practice were noted:

- Sickness absence monitoring and reporting of sickness 'hot spots' are a standing agenda item of the Surgery Clinical Board meetings.

The following significant finding was noted:

- The absence of formal review of sickness absence activity within the Theatres Directorate and reporting to the Clinical Board.

7. Summary of Recommendations

The audit findings and recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**1**	**4**	**0**	**5**

Finding 1 - Management of long term sickness absence (Operating effectiveness)	Risk
Sampled staff personal files within all six sampled areas were tested to establish if the key facets of long term sickness absence management, such as monitoring and regular contact maintained throughout the absence period, were being complied with and were supported by documented Clinical Leader led interviews, in accordance with Section 4 of the NHS Wales Managing Attendance at Work Policy. Good practice is noted that five of the six areas tested were fully compliant with the requirements of the NHS Wales Managing Attendance at Work Policy. However, testing undertaken within the Trauma Theatres, UHW identified that there is no documentary evidence to support the management of long term sickness absence relating to the relevant two members of staff sampled. Anecdotal evidence was provided by the Clinical Leader that long term sickness management was undertaken verbally, however Occupational Health liaison cannot be evidenced for either of these staff. Additionally, there is no evidence that formal, documented long term sickness meetings were arranged or held over the durations of each absence. One staff member had their long term sickness monitoring/discussions conducted via social media ('WhatsApp') which was subsequently not recorded. This is not a communication tool recommended in line with the Sickness Absence Policy and is potentially a breach of IT Security infrastructure and GDPR guidance. The case was particularly sensitive and there was also no evidence that the Clinical Leader had referred to or sought any advice from Occupational Health, which is again not in line with the sickness absence policy.	Non-compliance of the All Wales Managing Attendance at Work Policy.

Recommendation	Priority level
Long term sickness within Trauma Theatres, UHW must be monitored, reviewed and documented appropriately and evidence retained on individual personal files in accordance with Section 4 of the NHS Wales Managing Attendance at Work Policy.	**High**
Management Response	**Responsible Officer/ Deadline**
Immediate action has been taken in relation to the Trauma Theatre long term sickness reviews. A review of all documentation is underway with a completion deadline of 9th October 2020 – to be led by Jayne Thain, Theatre Manager for the area. The relevant actions and review will be held within the trauma team to ensure that the policy is implemented in full moving forwards. Regular sickness review meetings to be implemented for this area to be led by Jayne Thain, Theatre Manager.	Ceri Chinn, Lead Nurse – 9th October 2020

Finding 2 - Sickness Notification Forms (Operating effectiveness)	Risk
A review was undertaken at each of the six areas sampled to ensure accurate completion on the first day of sickness and retention of Sickness Notification Forms which are then recorded on Rosterpro and ESR. All staff sickness episodes sampled in four of the six areas held fully completed Sickness Notification Forms and the dates stated were accurately recorded on both Rosterpro and individual ESR accounts. However, the following two areas did not consistently complete and retain these on individual staff personal files: <u>Trauma Theatres, UHW</u> • 4 of 5 staff sickness episodes sampled were not supported by a Sickness Notification Form and there is no evidence that these were completed on the first date of absence. <u>Theatres - Scrub UHL</u> • 2 of 5 staff sickness episodes sampled were not supported by a Sickness Notification Form and there is no evidence that these were completed on the first date of absence.	Non-compliance of the All Wales Managing Attendance at Work Policy.
Recommendation	**Priority level**
Sickness Notification Form must be completed by Clinical Leaders and retained on respective personal files.	**Medium**

Management Response	Responsible Officer/ Deadline
Required actions have been undertaken – reminder has been sent to Theatre Managers for dissemination to Clinical Leaders. A reminder session on sickness process will be held at the next Clinical Leader meeting.	Ceri Chinn, Lead Nurse – 9th October 2020

Finding 3 - Absence of required sickness documentation (Operating effectiveness)	Risk
A review was undertaken at each of the six areas sampled to ensure accurate completion and retention of Self Certification Forms, Return to Work Interview Forms and where applicable GP Fit Notes. Testing was also undertaken to reconcile the start and end dates stated on each of these documents to each other, and to Rosterpro and individual staff ESR accounts and as such was found to be accurate. However, the following areas did not consistently complete and retain Self Certification, Return to Work Interview Forms and GP Fit Notes as follows; <u>Theatres Recovery, UHW</u> • 1 of 10 sampled staff did not hold a Self-Certification Form for the episode. <u>Trauma Theatres, UHW</u> • No Self Certification Forms could be located for the 5 staff sickness episodes sampled; • Only 1 of 5 staff sampled held a completed Return to Work Form for the episode; and	Non-compliance of the All Wales Managing Attendance at Work Policy.

• A GP Fit Note for a week's duration of absence was missing from one of the sampled staff member's personal file. Ortho Team 2, UHL • Only 1 employee sampled was required to submit GP Fit Notes for the episode, but there was a period of 15 days where coverage was not made. Recovery, UHL • 2 of 9 staff sampled did not hold a Self-Certification Form on their personal files for the episode of sickness; and • 2 of 9 staff sampled did not hold a Return to Work Form on their personal files for the episode of sickness. Theatres – Scrub, UHL • 3 of 5 staff sampled did not hold a Self-Certification Form on their personal files for the episode of sickness; and • 3 of 5 staff sampled did not hold a Return to Work Form on their personal files for the episode of sickness.	
Recommendation	**Priority level**
All episodes of sickness absence must be supported by accurately completed Self Certification Forms, Return to Work Interview Forms and where applicable GP Fit Notes.	**Medium**

Management Response	Responsible Officer/ Deadline
Required actions have been undertaken – reminder has been sent to Theatre Managers for dissemination to Clinical Leaders. Jon Barada, Theatre Manager, will meet with the new interim clinical leaders in these areas (not in post during the period covered by the audit) to explain the findings of the report and ensure that the actions are picked up. A reminder session on sickness process will be held at the next Clinical Leader meeting.	Ceri Chinn, Lead Nurse – 9th October 2020

Finding 4 - Monitoring, management and documenting frequent short term sickness absence. (Operating effectiveness)	Risk
Sampled staff personal files within all six sampled areas were tested to establish if the key facets of short term sickness absence management such as the monitoring, Clinical Leader review and completion of relevant documentation supporting 'Short Term Review Prompts' was undertaken in accordance with Section 3 of the NHS Wales Managing Attendance at Work Policy. Testing identified that four of the six sampled areas are fully managing and documenting their staff in this respect, however two areas were not fully compliant as follows: <u>CHfW Scrub</u> • 2 of 5 sampled staff that required 'Short Term Review Prompts' were not supported by the appropriate interview documentation. <u>Trauma Theatres, UHW</u>	Non-compliance of the All Wales Managing Attendance at Work Policy.

• There is no documentary evidence to support that short term sickness absence was effectively monitored and documented in a timely manner and 'Short Term Review Prompts' are not being actioned and recorded in accordance with the requirements of the NHS Wales Managing Attendance at Work Policy.	
Recommendation	**Priority level**
All short term sickness must be monitored, reviewed, documented appropriately and retained on individual personal files in accordance with Section 3 of the NHS Wales Managing Attendance at Work Policy.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Required actions have been undertaken – reminder has been sent to Theatre Managers for dissemination to Clinical Leaders. A reminder session on sickness process will be held at the next Clinical Leader meeting. The relevant actions and review will be held within the trauma team to ensure that the policy is implemented in full moving forwards.	Ceri Chinn, Lead Nurse – 9th October 2020

Finding 5 - Absence of formal reporting of sickness absence activity from the Theatres Directorate to Clinical Board. (Control design)	Risk
Sickness absence monitoring and reporting forms part of Clinical Board meetings and sickness 'hot spots' are routinely discussed based upon ESR sickness reports. However, there is currently no formal monitoring of sickness absence activity within the Theatres Directorate and no reporting of such up to Clinical Board level.	Non-compliance of the All Wales Managing Attendance at Work Policy.
Recommendation	**Priority level**
A formal monitoring and reporting process should be implemented within the Theatres Directorate highlighting sickness absence activity which is then reported up to the Clinical Board.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The process of collecting theatre sickness rates was previously through monthly confirm and challenge meetings, and also Perioperative Care Performance Meetings. These will be reinstated in due course, following COVID changes. The plan for escalating rates through Clinical Board will be discussed with Clinical Board members to agree – current options include Lead Nurse Meeting or GM and Lead Nurses Meetings.	Ceri Chinn, Lead Nurse – 9th October 2020

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No assurance** - The Board can take **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

Regional Partnership Board

Final Internal Audit Report

Cardiff and Vale University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

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	Murray Gard – Principal Auditor
Executive sign off:	Abigail Harris – Executive Director of Planning
Distribution:	Cath Doman - Director of Health and Social Care Integration
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Committee:	Audit & Assurance Committee

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1. Introduction and Background

Our review of the Regional Partnership Board ('the RPB') was completed in line with the 2020/21 Internal Audit Plan for Cardiff & Vale University Health Board (the 'Health Board').

The Cardiff and Vale Regional Partnership Board provides the governance arrangements for overseeing the work of the Integrated Health & Social Care Partnership that has been established as part of the Social Services and Well Being Act Wales (2014) to:

- improve the well-being of the population; and
- improve how health and care services are delivered.

The above RPB is made up of the City of Cardiff Council, Vale of Glamorgan Council, Cardiff & Vale University Health Board, Welsh Ambulance Services NHS Trust, Third & Independent sectors and Carer representatives.

There are a total of Seven Regional Partnership Boards throughout Wales and all must:

- Produce a regional population assessment;
- Produce a regional area plan; and
- Provide a regional annual report demonstrate citizen engagement and co-production.

The Health Board receives revenue funding from Welsh Government as part of the Integrated Care Fund (ICF). The aim of the fund is to support initiatives, which prevent unnecessary hospital admission, inappropriate admission to residential care, and delayed discharges from hospital, and has to be used in partnership with other organisations. The ICF is intended to help the RPB develop and test new approaches and service delivery models that will support the underpinning principles of integration and prevention

ICF revenue funding for 2019-20 was built into the main Health Board allocation as a ring-fenced element. The Health Board will be given its resource limits at the beginning of the financial year and will call down monthly funding requests against these limits to fund their monthly commitments including the ICF.

The relevant lead for the review is the Executive Director of Planning.

2. Scope and Objectives

The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to the Regional Partnership Board. The review will seek to provide assurance to the Health Board's Audit Committee that risks material to the system's objectives are managed appropriately.

The areas that the review sought to provide assurance on were:

- Appropriate governance arrangements are in place that ensure the Health Board is exercising its duties to the RPB effectively;
- There are suitable financial controls in place to protect the Health Board and ensure there are clear lines of accountability between the parties involved; and
- Effective processes are in place to ensure regular monitoring and reporting of the RPB activities into the Health Board.

3. Associated Risks

The potential risks considered in the review were as follows:

- Outcomes of the RPBs activities, relevant to the Health Board are not met as a result of ineffective service planning;
- Service does not meet outcomes due to poor monitoring and governance arrangements; and
- Ineffective Financial accountability due to poor controls.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the Regional Partnership Board is **Reasonable Assurance**.

RATING	INDICATOR	DEFINITION
Reasonable assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.

We identified that overall the arrangements in place within the Health Board relating to the Regional Partnership Board are of a reasonable standard, with good practice noted across the majority of areas reviewed, including:

- Effective governance structures are in place for overseeing the work of the Integrated Health & Social Care Partnership.
- Appropriate financial management and monitoring arrangements are in place for the Integrated Care Fund.

The review highlighted no high priority findings. However we did identify a number of areas where the governance arrangements relating to the RPB, Strategic Leadership Group (SLG) and ICF Programme Board meetings require strengthening. We also identified a lack of formal reporting within the Health Board of the outcomes of the RPB's activities.

It is acknowledged that a review of the governance arrangements for the Regional Partnership Board is already underway and is due to be completed by the end of 20/21.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Appropriate governance arrangements are in place that ensure the Health Board is exercising its duties to the RPB effectively			✓	
2	There are suitable financial controls in place to protect the Health Board and ensure there are clear lines of accountability between the parties involved				✓
3	Effective processes are in place to ensure regular monitoring and reporting of the RPB activities into the Health Board			✓	

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted one issue that is classified as weakness in the system control for the Regional Partnership Board.

Operation of System/Controls

The findings from the review have highlighted three issues that are classified as weaknesses in the operation of the designed control for the Regional Partnership Board.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1 – Appropriate governance arrangements are in place that ensure the Health Board is exercising its duties to the RPB effectively.

The following areas of good practice were noted:

- The RPB has a Terms of Reference (TOR) in place that includes the purpose, delegated powers, membership and quorum requirements of the RPB;
- Development workshops for the RPB had been undertaken during 2019/20 to help develop the priorities of the Partnership's activities;
- Attendance by Health Board members at RPB meetings is in line with the quorate requirements of the TORs;
- The Strategic Leadership Group (SLG) also has a TORs in place;
- The Executive Director of Planning and Strategy has attended every meeting of the SLG during 2019/20; and
- The Integrated Care Fund has a written agreement in place that covers the 2019/20 revenue allocation. The Chief Executive and executive Director of finance from the Health Board have signed this document. This document sets out high-level governance arrangements including the ICF Programme Board, roles and responsibilities of the partners etc.

Three findings were noted for this objective:

- The RPB was due to meet four times per year on a formal basis, however, during 2019/20 there were only three formal meeting in June, October and February.

- The Frequency and attendance at SLG meetings was inconsistent from the Health Boards perspective and the TOR for the SLG requires review.
- We did not identify a control mechanism for the Integrated Care Fund Programme Board, which accounts for:
    - Required Health Board membership.
    - Frequency of meetings.
    - Quorum requirements.

Objective 2 - There are suitable financial controls in place to protect the Health Board and ensure there are clear lines of accountability between the parties involved.

The following areas of good practice were noted

- Individual projects that are funded through the ICF have their expenditure tracked on a scheme-by-scheme basis;
- Quarterly reporting on projects takes place that highlights for example year to date expenditure and measuring outcomes;
- Reconciliations from the ICF allocation to the reserve were found to be accurate; and
- We reviewed a sample of actual ICF transactions from the ledger and found them to be appropriate and authorised.

No findings were noted for this objective:

Objective 3 - Effective processes are in place to ensure regular monitoring and reporting of the RPB activities into the Health Board

The following areas of good practice were noted

- Quarterly reporting to Welsh Government was undertaken as per stipulated timescales;
- The Health Boards Chief Executive and Executive Director of Finance signed off the quarterly reports prior to submission; and
- Frequent reference and updates are made on the activities of the RPB within the committee structure of the Heath Board i.e. to the Strategy and Delivery Committee and the Board.

One findings was noted for this objective:

- We did not note any formal reporting to the UHB Board of the outcomes that have been made through the activities of the RPB.

7. Summary of Recommendations

The audit findings and recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**0**	**2**	**2**	**4**

Finding 1 - Frequency of RPB Meetings (Operating effectiveness)	Risk
The terms of reference for the Regional Partnership Board sates that "The Regional Partnership Board will meet four times per year on a formal basis". However, during the 2019/20 financial year there was only three formal meeting in June, October and February.	Service does not meet outcomes due to poor monitoring and governance arrangements.
Recommendation 1	**Priority level**
Management should ensure that the frequency of RPB meetings is in line with the approved terms of reference.	**Low**
Management Response	**Responsible Officer/ Deadline**
The meeting prior to the financial year 19/20 was held on 19.03.19. The meeting frequency is quarterly however occasionally this will fall outside of the financial year to accommodate availability of the members and also to align with Welsh Government reporting schedule. RPB meeting are scheduled annually and are in place for 20/21. No further action required. The inclusion of the 4th meeting within 19/20 was missed by a matter of days and it therefore did not impact materially on the governance.	Complete

Finding 2 - Strategic Leadership Group (Operating effectiveness)	Risk
We reviewed the governance arrangements for the Strategic Leadership Group during 2019/20 and noted the following: • There is a requirement to review the Terms of Reference on an annual basis, however, The TORs supplied to the auditor was dated 2018. In addition, within these Terms of reference, there is also no section surrounding the quorum requirements. • TORs states bi-monthly meetings should take place (6 per year), however, over our sample period of the 2019/20 financial year we only identified five sets of meetings taking place. We note that a meeting in April 2019 was due to take place but was cancelled on short notice; and • The TOR identified five key individuals from the health board that formed the core membership on the Strategic Leadership Group. The following attendance is noted: ○ Two individuals attended all the meeting; ○ One individual did not attend any of the meetings; ○ One individual attended on one meetings; and ○ The other individual attended three meetings.	Service does not meet outcomes due to poor monitoring and governance arrangements.
Recommendation 2	**Priority level**
Management should review the governance of the SLG to ensure appropriateness.	**Medium**

Management Response	Responsible Officer/ Deadline
1. The governance of the Regional Partnership Board arrangements is currently under review and three new partnership boards are due to be established. This will impact on the TOR and membership of the SLG to ensure that there is appropriate representation. This work will be completed by the end of 20/21. 2. Meeting frequency has now increased to monthly.	Cath Doman, Director of Health and Social Care Integration March 2021

Finding 3 - Integrated Care Fund Programme Board (Control design)	Risk
The Integrated Care Fund Programme Board has responsibility for the effective delivery of the overall Programme within available funding, including identifying opportunities for joint working, reducing duplication, identifying, and managing risks pertinent to the successful implementation of the Programme. However, there is no formal terms of reference for this Programme Board and as such; there is no control mechanism in place, which accounts, for example: • Membership details; • Frequency of meetings; and • Quorum requirements. We note that there were only two formal meetings during 2019/20 (July and December 2019). Minutes from the July meeting stated that there were to be additional meetings in October 2019 and January 2020 however, these did not take place.	Service does not meet outcomes due to poor monitoring and governance arrangements.
Recommendation 3	**Priority level**
Management should ensure that governance arrangements are enhanced for the Integrated Care Fund Programme Board.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Much of the business originally intended for the ICF programme board is dealt with via the SLG and directly with SROs. This Programme Board will be reviewed along with the overarching RPB governance during this financial year.	Meredith Gardiner, Programme Manager March 2021

Finding 4 - Reporting (Operating effectiveness)	Risk
We reviewed the monitoring and reporting of RPB activities into the Health Boards Strategy and Delivery Committee and the Board itself, we noted that: • There are regular references to the activities of the RPB; • The Executive Director of Planning provided a verbal update on the Integrated Care Fund; and • Updates had also been provided through the interim Chairs reports. The RPB produces an annual report but we could not verify that the Board had reviewed this report.	Service does not meet outcomes due to poor monitoring and governance arrangements.
Recommendation 4	**Priority level**
Management should consider formal reporting on outcomes from the RPBs activities into the Health Board, to allow for effective scrutiny.	**Low**
Management Response	**Responsible Officer/ Deadline**
CAVUHB is a partner in the Regional Partnership Board and does not hold a scrutiny role, however it is important that the Board is sighted on RPB business and can respond appropriately. Members of the CAVUHB Board are also members of the RPB, including the CEO, Chair, Exec Director of Strategy and Planning. A CAVUHB IM currently chairs the RPB. There are therefore existing strong controls and influence.	Abigail Harris, Executive Director of Planning 31.03.21

The Annual Report for 19/20 will be taken to Board to note in October 2020, in addition to ongoing verbal updates as currently provided by the Executive Director of Planning.	

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No assurance** - The Board can take **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

Cardiff and Vale University Health Board

Environmental Sustainability Report

Final Internal Audit Report

2020/21

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

Review reference:	CVU-2021-38
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Auditor/s:	Olubanke Ajayi Olaoye (Principal Auditor) Ken Hughes (Internal Audit Manager)
Executive sign off:	Chris Lewis, Acting Director of Finance
Distribution:	Geoff Walsh, Director of Capital, Estates & Facilities Jon McGarrigle, Trust Energy Advisor Fitzroy Hutchinson, Energy Manager
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

ACKNOWLEDGEMENT
NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Internal Audit Charter and the Annual Plan, approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Cardiff and Vale University Health Board, no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

The review of the Environmental Sustainability Report was completed in line with the Internal Audit Plan. The review sought to provide the Cardiff and Vale University Health Board (the 'Health Board') with assurance regarding the process for the production and approval of the Environmental Sustainability Report (the 'report').

The Government Financial Reporting Manual (the 'FReM') requires that entities falling within the scope of reporting under the Greening Government commitments, and which are not exempted by the *de minimis* limit, or other exemptions under Greening Government (or other successor policy), shall produce a sustainability report to be included within the Management Commentary in accordance with HM Treasury issued Sustainability Reporting in the Public Sector guidance.

It should be noted that due to the impact of Covid-19, the deadline for end of year reporting for all NHS bodies was extended by the Welsh Government to the 31st August 2020.

The relevant lead Executive for the assignment is the Executive Director of Finance.

2. Scope and Objectives

The overall objective of the review was to assess the adequacy of management arrangements for the production of the Sustainability Report within the Annual Report:

- Whether the form and content of the report complies with the requirements of guidance published by the Welsh Government.
- Whether the information published within the report provides an accurate and representative picture of the quality of services it provides and the improvements it has committed to undertake.

The audit focused upon the 2019/20 report, which will be published within the Annual Report. The scope of the audit review was limited to the following aspects:

- The Health Board has appropriate arrangements for the preparation, approval and publication of the report including ensuring compliance with relevant guidance.
- Testing a sample of selected indicators to ensure the underpinning data is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review.

This review drew on the findings of any relevant audit assignments undertaken within the reporting year to prevent any duplication.

3. Associated Risks

The potential risks considered in the review were as follows:

- Reputational risk from non-compliance with Welsh Government guidance and breach of key public disclosure reporting requirement and lack of transparency.
- Reputational risk that published information does not present a fair and balanced picture to stakeholders of the performance in the year.
- Data quality risk that published information is either incomplete or inaccurate due to information governance controls overall or system control over reported information for individual data elements.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with establishment controls within the Sustainability Reporting is **Reasonable assurance.**

RATING	INDICATOR	DEFINITION
Reasonable assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.

Our annual audit has confirmed that despite the disruption caused by Covid-19 restrictions, the 2019/20 Sustainability Development Report (SDR) was prepared in accordance with the guidance and revised deadlines published by the Welsh Government. The internal guidance document had also been updated and clearly sets out the process for compiling and generating the SDR.

However as recommended in last year's internal audit report, a timetable setting out deadlines for the submission of data and for the subsequent internal review, audit and approval of the SDR had not been drawn up prior to the commencement of the SDR compilation process.

In addition the revised approval and sign off arrangements require internal audit to be provided with evidence that the SDR has been retrospectively approved by the Environmental Management Steering Group / Health & Safety Group and signed off by the Director of Capital, Estates and Facilities. However to date no such evidence has been provided.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	The form and content of the report complies with the requirements of guidance published by the Welsh Government				✓
2	The information published within the report provides an accurate and representative picture of the quality of services it provides and the improvements it has committed to undertake				✓
3	The Health Board has appropriate arrangements for the preparation, approval and publication of the report including ensuring compliance with relevant guidance			✓	
4	The data underpinning the report is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review.				✓

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted no issue classified as weaknesses in the system control/design for Sustainability Reporting.

Operation of System/Controls

The findings from the review have highlighted 2 issues that are classified as weaknesses in the operation of the designed system/control for Sustainability Reporting.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: The form and content of the report complies with the requirements of guidance published by the Welsh Government:

The following areas of good practice were noted:

- Responsibilities for production of the Sustainability Report had been clearly assigned and documented;
- There was evidence that Welsh Government guidance was utilised in the development of the Sustainability Report;
- The Sustainability Report included the main sections and three mandatory tables as required by the guidance; and
- The Sustainability Report detailed the ongoing initiatives and programmes designed to improve sustainability within the UHB.

No findings were identified for this objective.

Objective 2: The information published within the report provides an accurate and representative picture of the quality of services it provides:

The following areas of good practice were identified:

- The UHB was accredited with the Environmental Management Standard ISO14001 covering all sites within the UHB's portfolio; and
- The report references key performance indicators and benchmarks where they exist to support the narrative.

No findings were identified for this objective.

Objective 3: The Health Board has appropriate arrangements for the preparation, approval and publication of the report including ensuring compliance with relevant guidance.

The following areas of good practice were identified:

- A task and finish group was convened prior to the commencement of the report compilation process; and
- The draft Sustainability Development Report was subject to review by Internal Audit prior to publication.

The following findings were identified for this objective:

- There was no timetable in place for the preparation of the 2019/20 Sustainability Development Report.
- Approval and sign-off of the final version of the Sustainability Development Report should take place retrospectively after the report has been published, but Internal Audit have not been provided with any evidence of this.

Objective 4: The data underpinning the report is robust and reliable, conforms to specified data quality standards and prescribed definitions and is subject to appropriate scrutiny and review.

The following areas of good practice were identified:

- There was sufficient supporting information provided that could be reconciled back to the data included in the report;
- A Cardio tool developed by the Stockholm Institute for use by the NHS Wales was used to covert energy consumption data into Greenhouse gas emissions;

No findings were identified for this objective.

7. Summary of Recommendations

The audit findings and recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	0	2	0	2

Finding 1 - Timetable (Operating effectiveness)	Risk
Compilation of the Sustainability Development Report (SDR) requires the collection of data from a variety of internal and external sources in accordance with guidance and publication deadlines set by the Welsh Government. As previously recommended by internal audit, the requirement to draw up a timetable annually setting out timescales for the report preparation, internal review, audit, approval and submission had been incorporated into the C&V internal procedural guidance document. However, whilst it is acknowledged that an initial meeting of the task and finish group was held in February 2020, there was no timetable drawn up prior to the commencement of the SDR compilation process.	Reputational risk from non-compliance with Welsh Government guidance and breach of key public disclosure reporting requirement and lack of transparency.
Recommendation 1	**Priority level**
Management should ensure a timetable is prepared annually and made available to all relevant staff prior to compiling the SDR. This should include the timeline for the first meeting of the task and finish group, data submission deadlines, the various stages of review and approval and submission to the Communications Team.	**Medium**
Management Response	**Responsible Officer/ Deadline**
A preliminary timetable will be prepared annually with liaison with NHS Wales Shared Services Partnership Audit and Assurance Services regarding the indicative completion dates for each activity.	Energy Manager/Head of Energy and Performance – March 2020

Finding 2 - Review and approval of the Sustainability report (Operating effectiveness)	Risk
The guidance procedure for producing the Sustainability Report requires the draft report to be independently checked for accuracy by a member of estates staff prior to submission for finalisation to the Environmental Management Steering Group / Health & Safety Group and sign off by the Director of Capital, Estates and Facilities. The final report should then be submitted to internal audit for review and the Communications Team for publication. However the process has evolved over time and accuracy checking of the draft sustainability report is now undertaken by internal audit prior to submission to the Communications Team. We were informed that the report is then retrospectively submitted to the Environmental Management Steering Group / Health & Safety Group for approval and the Director of Capital, Estates and Facilities for sign off, although no evidence of approval and sign-off has been provided to audit.	Reputational risk from non-compliance with Welsh Government guidance and breach of key public disclosure reporting requirement and lack of transparency.
Recommendation 2	**Priority level**
Evidence of the retrospective approval of the sustainability report by the Environmental Steering Group / Health & Safety Group and sign off by the Director of Capital Estates and Facilities should be provided to audit each year. The documented procedural guidance should be also updated to reflect the actual review and approval process currently in place.	**Medium**

Management Response	Responsible Officer/ Deadline
The evidence of the retrospective approval of the sustainability report by the Environmental Steering Group / Health & Safety Group and sign off by the Director of Capital Estates and Facilities is/will be provided to audit each year.	Energy Manager/Head of Energy and Performance November 2020

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No assurance** - The Board can take **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

Management of Serious Incidents

Final Internal Audit Report

Cardiff and Value University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Executive sign off:	Ruth Walker - Executive Director of Nursing
Distribution:	Carol Evans - Assistant Director Patient Safety and Quality Maria Roberts - Head of Patient Safety
Committee:	Audit Committee

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1. Introduction and Background

Our review of the management of Serious Incidents was completed in line with the 2020/21 Internal Audit Plan for Cardiff and Vale University Health Board (the 'Health Board').

Organisations and services should put in place systems and procedures to ensure that there is appropriate management and reporting of all Serious Incidents.

"Putting Things Rights – Guidance on dealing with concerns about the NHS from April 2011", defines a Serious Incident as *"an incident that occurred during NHS funded healthcare (including in the community), which resulted in one or more of the following:*

- *unexpected or avoidable death or severe harm of one or more patients, staff or members of the public;*
- *a never event - all never events are defined as serious incidents although not all never events necessarily result in severe harm or death (see Never Events Framework);*
- *a scenario that prevents, or threatens to prevent, an organisation's ability to continue to deliver healthcare services, including data loss, property damage or incidents in population programmes like screening and immunisation where harm potentially may extend to a large population;*
- *allegations, or incidents, of physical abuse and sexual assault or abuse;*
- *loss of confidence in the service, adverse media coverage or public concern about healthcare or an organisation".*

The Health Board is required to report all serious incidents to the Welsh Government within 24 hours of the incident taking place, where possible. Welsh Government will then grade the incident and provide a timescale within which the Health Board must submit a completed investigation.

The relevant lead for the review was the Executive Nurse Director.

2. Scope and Objectives

The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place within the Health Board for the management of serious incidents. The review sought to provide assurance to the Health Board's Audit Committee that risks material to the system's objectives are managed appropriately.

The areas that the review sought to provide assurance on were:

- Serious incidents are appropriately identified with staff having clear and accessible policies, procedures and guidance;
- Reporting of Serious Incidents complies with all external requirements (including Welsh Government);

- Serious Incidents are subject to appropriate investigation including any root cause analysis, and are closed in accordance with Welsh Government timescales; and
- Periodic reports on Serious Incidents are produced and communicated to Clinical Boards and appropriate Health Board Groups to ensure that lessons learned are shared across the organisation.

3. Associated Risks

The potential risks considered in the review are as follows:

- Serious Incidents are not effectively managed within the UHB;
- Lessons are not learnt and actions are not taken to prevent re-occurrence of incidents; and
- The Health Board fails to comply with reporting requirements.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with established controls relating to the management of Serious Incidents is Reasonable Assurance.

RATING	INDICATOR	DEFINITION
Reasonable assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.

We identified that overall the arrangements in place within the Health Board relating to the management of Serious Incidents are of a reasonable standard, with good practice noted across the majority of areas reviewed, including:

- Appropriate policies, procedures and other written documentation.

- The Datix system provides a platform for logging and tracking of serious incidents.
- Regular reporting was identified to both the Clinical Boards and Corporate Committees.

The review highlighted one high priority findings:

- We identified delays when completing and submitting the closure forms to Welsh Government.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Serious incidents are appropriately identified with staff having clear and accessible policies, procedures and guidance.				✓
2	Reporting of Serious Incidents complies with all external requirements (including Welsh Government).			✓	
3	Serious Incidents are subject to appropriate investigation including any root cause analysis, and closed in accordance with Welsh Government timescales.		✓		
4	Periodic reports on Serious Incidents are produced and communicated to Clinical Boards and appropriate Health Board Groups to ensure that lessons learned are shared across the organisation.			✓	

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted no issues classified as weaknesses in the system control for Concerns / Serious Incidents.

Operation of System/Controls

The findings from the review have highlighted six issues classified as weaknesses in the operation of the designed system for Concerns / Serious Incidents.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1 – Serious incidents are appropriately identified with staff having clear and accessible policies, procedures and guidance.

The following areas of good practice were noted:

- The Health Board has an "Incident, hazard and near miss reporting policy" that was approved by the Quality, Safety and Experience Committee in September 2018;
- Accompanying this policy is an "Incident, Hazard and Near Miss Reporting Procedure" that was also last approved in September 2018;
- Serious Incidents that occur throughout the Health Board are reported and managed via the incident reporting system (Datix). The user profiles within Datix ensure that access to the system and individual incidents is appropriately controlled;
- Datix also provides a unique identification number for each incident along with an audit trail of any additions or changes made. Datix will also prevent the reporter submitting the incident, unless all required fields are completed;
- A link to the Datix portal is located on the Front page of the Health Boards Intranet site so that staff members can access the system easily. There is a plethora of resources available, including; and
    - Contact details for incident managers & supervisors;
    - Quick guide help sheets; and
    - Incident manager's checklist etc.
- The patient Safety team also has separate intranet pages that have more detailed guidance documents, including:
    - Serious incident flowcharts;

- Processes for undertaking a root cause analysis;
- Root cause analysis report template;
- Improvement plan template; and
- Statement writing guidance.

No findings were noted for this objective.

Objective 2– Reporting of Serious Incidents complies with all external requirements (including Welsh Government)

The following areas of good practice were noted:

- There was clear linkage between the Patient Safety Team and the Clinical Boards when dealing with serious incidents;
- The SI1 form was completed and signed off prior to Welsh Government submission; and
- Incidents information was uploaded to the National Reporting and Learning System (NRLS) in a timely manner.

Two findings were noted for this objective.

- Welsh Government expects Serious Incidents to be reported to them via the Patient Safety Team within 24 hours of the incident occurring, where possible. We identified that only three out of our sample of 20 incidents achieved this; and
- We identified that three out of the seven Clinical Boards did not have an operational key contact for Quality & Safety; who can help co-ordinate responses for example to investigations of serious incident etc.

Objective 3 Serious Incidents are subject to appropriate investigation including any root cause analysis, and closed in accordance with Welsh Government timescales.

The following areas of good practice were noted:

- Where a root cause analysis or an investigation had been completed, the documents were comprehensive and signed off;
- The completed documents were all available within the incident reporting system (Datix); and
- We noted that there are arrangements in place for monitoring of the action plans, usually via the Clinical Boards Quality and Safety Meetings.

Three findings were noted for this objective

- We identified that only one incident from our sample of twenty achieved the timescales for submitting the closure forms to Welsh Government.

- We noted that not all outstanding actions had been completed at the time of fieldwork and further work is required to ensure these are completed and embedded within working practices.
- We identified that the Datix system was not always being used to its full potential.

Objective 4 - Periodic reports on Serious Incidents are produced and communicated to Clinical Boards and appropriate Health Board Groups to ensure that lessons learned are shared across the organisation.

The following areas of good practice were noted:

- We found that the patient safety team provides regular reports on serious incidents to the Clinical Boards that we reviewed;
- There is evidence of regular reporting to the Management Executive meetings and also a specific concerns meeting that takes place on a regular basis;
- Reporting on serious incidents was evidenced to the Health Board's Quality, Safety and Experience Committee in October 2019; and
- Reporting has also taken place to the Health Board meetings in November 2019 and March 2020.

One finding was noted for this objective:

- There was inconsistency in the information that was provided to individual Clinical Boards

7. Summary of Recommendations

The audit findings and recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**1**	**2**	**3**	**6**

Finding 1 - Serious Incident Closure Requirements (Operating effectiveness)	Risk
We reviewed a sample of 20 serious incidents from three Clinical Boards, to identify if the timescales for submitting the closure forms to Welsh Government were achieved. The closure forms can only be submitted once any investigation or root cause analysis has been completed. Our testing identified the following: • Only one incident achieved the closure target; • Four of the sampled incidents had not submitted the closure form at the time of audit fieldwork. We noted that all of these incidents had already exceeded their target date; • The total average delay from the date closure forms were due for submission to Welsh Government until they were actually submitted was 125 days. We acknowledge that actions are being taken to address the issues prior to submission of the closure forms to Welsh Government.	The Health Board fails to comply with reporting requirements.
Recommendation 1	**Priority level**
Management should ensure that appropriate processes are in place for concluding investigations/Root Cause Analysis and the submission of closure forms to the Welsh Government in a timely manner.	High

Management Response	Responsible Officer/ Deadline
The Patient safety team will work with Clinical Boards to improve the timeliness of the closure of serious incidents. In order to achieve this we will:	Assistant Director Patient Safety and Quality
Issue revised targets for monthly closure of incidents	December 2020
Train 100 additional staff in RCA and introduce a system of follow up whereby staff have to commit to undertaking RCAs x 2 within 12 months of completing training	By December 2021
Review process for the commissioning of RCA investigations	By end March 2021
Introduce monthly Serious Incident tracker meetings with Clinical Boards	By January 2021

Finding 2 - Initial Reporting to Welsh Government (Operating effectiveness)	Risk
We reviewed a sample of 20 serious incidents as per finding one, to identify if the timescales for reporting to welsh government were achieved. Welsh Government expects Serious Incidents to be reported to them via the Patient Safety Team within 24 hours of the incident occurring, where possible. Our testing identified the following; • Three incidents had delays from the incident date to entering onto the Datix system; with the longest being 6 days; • Average delays from the incident being reported to submission of SI1 form to Welsh Government was 13 days;	The Health Board fails to comply with reporting requirements.

• Therefore, the Average delay from incident occurring to incident being reported to Welsh Government was 13.5 days; and • From our review of the SI1, we did not identify explanations as to the reasons for delays in reporting to Welsh Government.	
Recommendation 2	**Priority level**
Management should remind staff surrounding the requirement for prompt reporting of Serious Incidents and submission of the SI1 form to Welsh Government.	Medium
Management Response	**Responsible Officer/ Deadline**
Staff will be reminded of the importance of timely reporting and escalation of serious incidents The UHB will work with Welsh Government and the Delivery Unit to update the current All Wales SI Framework. This will include negotiation of the requirement to report SIs within 24 hours. The Patient Safety team will introduce a quality assurance and monitoring process to track the timeliness of reporting and to ensure that the delays for reporting are clarified on the Datix system	Assistant Director Patient Safety and quality End October 2020 Review end January 2021. End March 2021

Finding 3- Monitoring of Actions (Operating effectiveness)	Risk
We reviewed the same sample of 20 serious incidents as previously considered in the other findings and reviewed the investigations/Root cause analysis for completeness and the monitoring of outstanding action. Of the incidents sampled, six incidents had actions that were outstanding when the closure forms were submitted to Welsh Government. We noted that there are arrangements in place for monitoring the actions via the Clinical Boards Quality and Safety Committees, however, at the time of fieldwork, not all outstanding actions had been completed and further work is required to ensure these are completed and embedded within working practices. E.G. One of the incidents is due to be discussed at the Clinical Boards Quality and Safety Committee meetings once they resumed following a break in the schedule due to COVID.	Lessons are not learnt and actions are not taken to prevent re-occurrence of incidents.
Recommendation 3	**Priority level**
Management should ensure that all outstanding actions are completed.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The Patient Safety team, working with the Clinical Boards, will review the way in which outstanding actions are monitored within Clinical Boards and also within	Assistant Director Patient Safety and Quality End December 2020

the corporate Patient Safety team The requirement for improved functionality in relation to the monitoring of action plans, will be fed in to development of the revised Once for Wales Concerns management System	By April 2021

Finding 4- Key Contacts (Operating effectiveness)	**Risk**
The patient safety team usually link with the Directors of Nursing in the Clinical Boards, or alternative where relevant, regarding the management of Serious Incidents. Some of the Clinical Boards/Directorates have Quality and Safety Leads who are also key contacts. Through conversations with Management, we note that three out of the seven Clinical Boards did not have an operational key contact for Quality & Safety at the time of audit fieldwork; who could help coordinate responses for example to the timely investigation of serious incidents etc.	The Health Board fails to comply with reporting requirements.
Recommendation 4	**Priority level**
Management should consider having key contacts for Quality and Safety issues with each Clinical Board.	Low
Management Response	**Responsible Officer/ Deadline**
A review of existing structures and resources available for the support of QSE activity across the organisation will take place as part of the development of the QSE Framework 2021-2026.	Assistant Director Patient Safety and Quality

Finding 5 - Completeness of Datix (Operating effectiveness)	Risk
We reviewed the completeness of the incident reporting system Datix and identified the following: Section 4.2 of Datix provides space for the completion of the instigation i.e. details of investigation officer, findings, recommendations etc. From our sample of 20 incidents, five instances were identified where this section had not been fully completed. Audit notes that the information can be found within the documents attached to the system. Within one of the incidents, the latest correspondence chasing for updates was on 9th September 2019. Noting the closure report has not yet been submitted to Welsh Government and our fieldwork was undertaken in august/September 2020, this requires updating so that an appropriate audit trail is maintained.	Lessons are not learnt and actions are not taken to prevent re-occurrence of incidents.
Recommendation 5	**Priority level**
Staff should be reminded to keep Datix as up to date as possible to ensure an effective audit trail.	Low
Management Response	**Responsible Officer/ Deadline**
All staff (in Clinical Boards and in the Corporate Patient Safety team) will be reminded of the need to keep Datix as up to date as possible	Assistant Director Patient Safety and Quality End November 2020

Finding 6 - Consistency of Reports (Operating effectiveness)	Risk
The patient safety team engage with the Clinical Boards and provide monitoring reports surrounding serious incidents. However, audit notes that there are inconsistencies with the information that is provided to individual Clinical Boards. Management commenced work to review this in 2019 but priorities such as the escalation of work to upgrade the Datix system as part of an all Wales project and the Covid -19 pandemic has slowed the review.	Serious Incidents are not effectively managed within the UHB.
Recommendation 6	**Priority level**
The review into the consistency of information supplied to Clinical Boards should be completed.	Low
Management Response	**Responsible Officer/ Deadline**
The consistency of information supplied to Clinical Boards will be reviewed and completed	Assistant Director Patient Safety and Quality End December 2020

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No assurance** - The Board can take **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

Governance Arrangements during the Covid-19 Pandemic

Advisory Review Final Report

2020/21

Cardiff and Vale University Health Board

Audit and Assurance Services

Private and Confidential

Contents

Review reference:	CUHB2021.47
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Auditors:	Ian Virgill, Head of Internal Audit Felicity Quance, Senior Audit Manager Martyn Lewis, IT Audit Manager
Executive sign off:	Nikki Foreman, Director of Corporate Governance Chris Lewis, Deputy Finance Director
Distribution:	Nikki Foreman, Director of Corporate Governance Chris Lewis, Deputy Finance Director Andrew Gough, Assistant Director of Finance
Committee:	Audit Committee

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NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

1. INTRODUCTION

The NHS in Wales continues to face unprecedented pressure in planning and providing services to meet the needs of those who are affected by Covid-19 and other essential services.

At the time of this report, the number of cases of Covid-19 in Wales is in decline and there is an opportunity for NHS Wales organisations ('organisations') to take stock following the initial peak of cases experienced between March and May 2020.

This rapid advisory review was requested by the Director of Finance to assess the adjusted financial and overall governance arrangements that were put in place to enable Cardiff and Vale University Health Board (the 'Health Board') to maintain appropriate governance whilst enabling its senior leadership team to respond to the rapidly developing emergency.

At the time that many of the adjustments to governance arrangements were being made, the Cardiff and Vale area was experiencing a relatively high number of cases within its population. It is against this backdrop that we have assessed the effectiveness of those arrangements and whether they complied with Welsh Government guidance. The key objective of the review is to provide independent, timely feedback to enable changes to be made to temporary governance arrangements if they are to be used in the future.

A key element of the Health Board's response was the establishment of the Dragon's Heart surge hospital within the Principality Stadium. The governance arrangements around the establishment and operation of the Dragon's Heart Hospital have been subject to separate review by KPMG and were therefore not included within the scope of this advisory review.

This rapid review was completed during late June and July and involved interviewing key members of the Health Board and reviewing associated documentation supplied, where available. We have undertaken further detailed discussions and walkthroughs of arrangements in place and actions undertaken to manage the pandemic within the Health Board. However, whilst we have assessed this information against Welsh Government and other guidance, we have not undertaken detailed operational testing of the arrangements in place. We worked closely with Audit Wales to avoid unnecessary duplication with their work, sharing information where relevant and undertaking a number of interviews together.

Further detail regarding the scope of the review, the guidance used as the basis of the assessment and the review work undertaken are included in the appendices to this report.

We would like to thank Executive Directors and Independent Members (IMs) for their time and contribution to this review.

2. EXECUTIVE SUMMARY

Main Observations

The Health Board's temporary governance arrangements operated effectively during the peak of the pandemic. The Health Board generally complied with the guidance and the principles issued by Welsh Government.

The Command Structure introduced by the Health Board operated efficiently and enabled the organisation to make decisions in an agile way so that it could effectively manage the delivery of its services during the pandemic. It is however noted that the decision to not formally operate under a Gold Command and Control structure may have impacted on the transparency of decision making and the opportunity for scrutiny and challenge by IMs and the wider community. There is an opportunity now for management to fully assess the appropriateness of the command structure and the transparency of decision making.

Board, Audit & Assurance Committee, Quality, Safety & Experience (QS&E) Committee and Finance Committee meetings continued during the peak and the business of those meetings was generally appropriate. There may however have been scope to further review the agendas of the committees to ensure appropriate focus on Covid-19 related issues whilst providing assurance on areas normally covered by other Committee meetings that were postponed. It is acknowledged that the April Audit and QS&E committee meetings were held just before Welsh Government guidance was issued. At the time of the next meetings of these committees, the Health Board had begun to return to business as usual

Regular briefing of IMs outside of the formal committee forums was undertaken. However, in the early stages of the pandemic, the process for engaging with the IMs could have been developed further.

'Virtual' meetings using Skype and latterly Microsoft Teams have developed over time, with initial teething troubles and connectivity problems nationally throughout the NHS. All planned meetings have gone ahead and the disciplines and etiquette involved is evolving.

Good financial governance was maintained during the pandemic with Covid-19 related expenditure being separately identified and reviewed.

The Health Board continues to adapt the temporary governance arrangements as the pandemic progresses and has commenced the process of moving from the emergency response phase to planning services going forward. This includes assessing opportunities to continue some of the new ways of organising and delivering services in order to realise a transformed health and care system focused on achieving the best outcomes.

Priority Considerations for the Future

We have not assigned priority ratings to considerations for the future, but we would highlight the following to be key areas of focus for the Health Board to take into account as it reviews its processes:

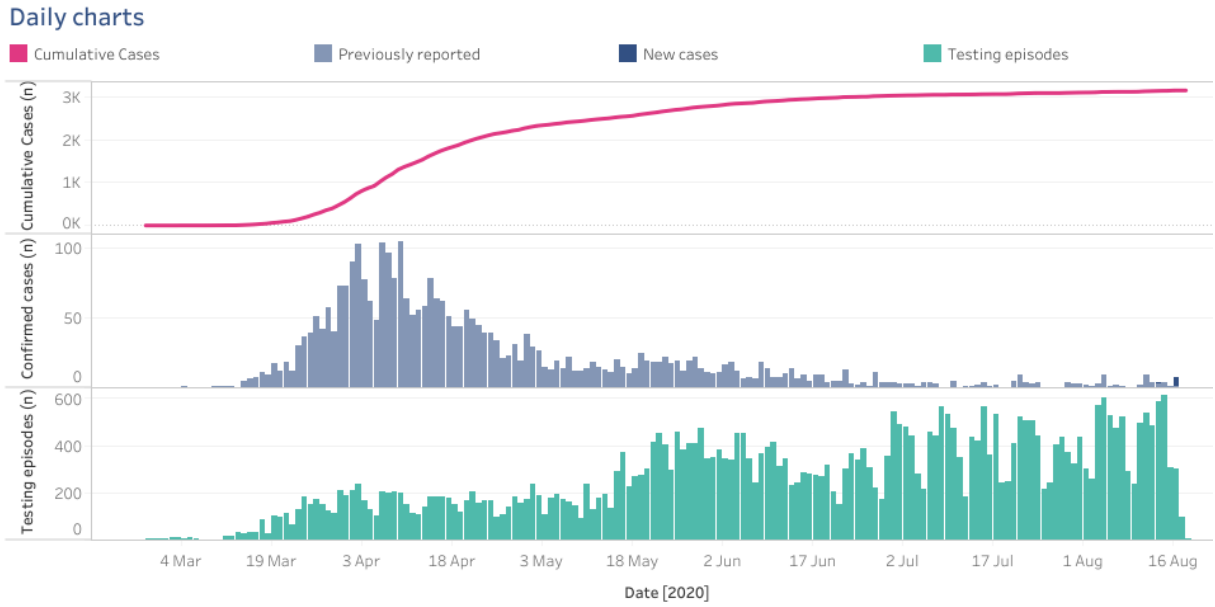
- Releasing the papers and minutes as soon as possible after Board and committee meetings;
- Review the agendas of the Audit & Assurance and other continuing committees to ensure that they provide appropriate scrutiny and assurance over key areas;
- Further develop guidance around what decisions should be recorded and the level of information required to be documented within the Decision Logs and when this should be escalated to the Board Governance Group (BGG) / Board;
- A protocol pack, setting out the steps to take immediately, through to ongoing requirements (e.g. records required, meeting groups, Decision Log requirements) should be established in preparation for future events;
- Ensure more robust arrangements are included for reporting and oversight of the BGG to ensure effective transparency and scrutiny;
- Review of the appropriateness of the decision to not invoke formal Gold Command and the effectiveness of the command structure introduced, in order to inform arrangements in the event of any second wave;
- A detailed Finance Department Business Continuity Plan should be produced, communicated and kept up to date;
- Strengthen the process for recording and evidencing authorisation of Covid-19 expenditure items; and
- Ensure that the approved Covid-19 donations bids process is effectively implemented, utilised and publicised across the Health Board.

3. BACKGROUND AND CONTEXT

Overview of the Impact of the Pandemic on the Health Board

In the period of a few weeks (23rd March to 16th April 2020) a rapid escalation of the pandemic impacted the Health Board. The graphs below illustrate the acceleration of the cases of Covid-19 within the Health Board's region.

Cardiff and Vale University Health Board Daily Reports



Source:https://public.tableau.com/profile/public.health.wales.health.protection#!/vizhome/RapidCOVID-19virology-Public/Headlinesummary

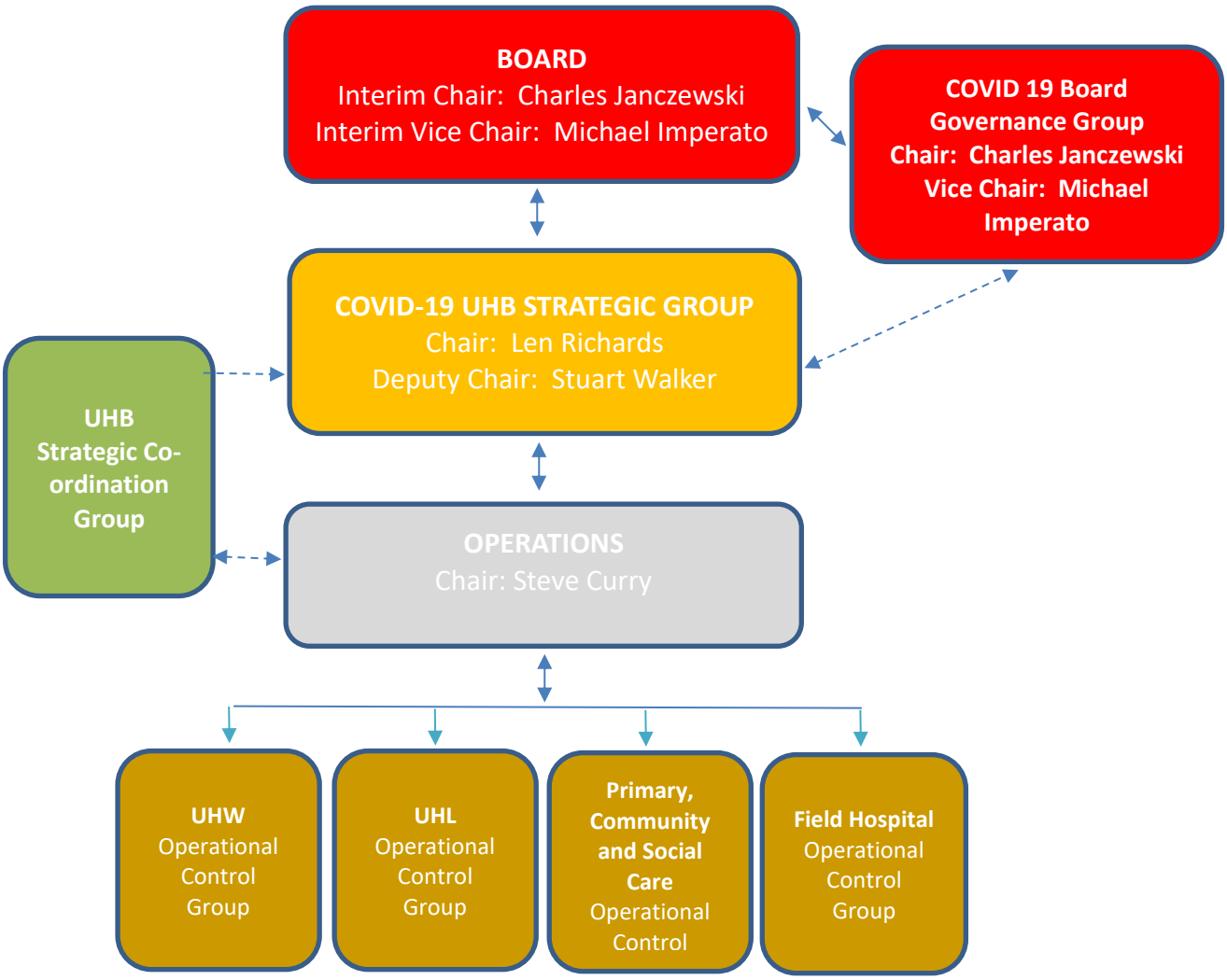
During the onset of the pandemic the Health Board areas experienced a higher level of cases than the average for the whole of Wales. This is illustrated by the weekly figures for the Health Board and All Wales total cases per 100,000 population detailed below.

CVUHB	16/03-22/03	23/03-29/03	30/03-05/04	06/04-12/04	13/04-19/04	20/04-26/04
Cardiff	20.4	56.7	111.5	116.1	84.2	58.1
Vale of Glamorgan	8.2	65.1	87.6	97.3	68.9	52.4
Wales Total	12.5	36.4	66.6	73.8	65	45.9

Source: https://public.tableau.com/profile/public.health.wales.health.protection#!/vizhome/RapidCOVID-19virology-Public/Headlinesummary

Command and Control Structure

The Health Board rapidly established the following temporary governance structure to progress actions / decisions during the outbreak:



Within each level of the temporary command structure, it is expected that the Governance Principles (the 'Principles') set out by the Welsh Government and detailed within Appendix One, are embedded.

The Health Board also moved away from a Clinical Board based operational structure to a site based structure consisting of the following four areas:

- University Hospital of Wales;
- University Hospital Llandough;
- Dragon's Heart Hospital; and
- Primary, Community and Social Care.

Adjusted Governance Arrangements

In addition to the Command and Control structure, the Health Board implemented a range of temporary measures to facilitate new ways of working including:

- streamlining of the Board and committee structure including the postponement of committees of the Board, excepting the Audit & Assurance, QS&E and Finance Committees;
- the introduction of virtual meetings with the available telephone and video conferencing facilities and changes to the public's access to meetings and records; and
- the implementation of authorisation limits within the Strategic and Operational groups for the approval of Covid-19 related expenditure and changes regarding the use of the BGG as a Chair's Action approval mechanism, to facilitate decision making between Board meetings.

The conclusions and considerations for the future in this report take into account the rapid onset of the pandemic at the beginning of its spread through Wales and the consequent impact on the Health Board and the Cardiff and Vale region. Considered in this context, the Health Board quickly established governance arrangements and continued to strengthen measures to manage the pandemic as more guidance became available.

4. DETAILED FINDINGS

This section sets out the detailed findings of the review, under the headings of Strategic Governance, Financial Governance and Other Areas of Governance.

Strategic Governance

1. Board and Committee Meetings
2. Decision Making Arrangements
3. Command Structure
4. Risk Management

Financial Governance

5. Annual Accounts and Reporting
6. Financial Systems and Processes
7. Covid-19 Expenditure (Revenue and Capital)
8. Workforce
9. Budgets and Savings

Other Governance Areas

10. Partnership Arrangements
11. Charitable Funds
12. Information Governance

Each section provides commentary on the adjusted governance arrangements put in place and considerations for the Health Board to take into account as it plans for potential further Covid-19 peaks in the future.

Where we consider it appropriate we have suggested areas which should be given greater priority.

Strategic Governance

Board and Committee Meetings

What we found

Our review identified the following:

- The frequency of the formal bi-monthly Board meetings wasn't adjusted but the intervening Board development sessions were utilised to focus on key Covid-19 issues;
- Board meetings were streamlined and papers focused on Covid-19 issues and generally met the guidance. However this wasn't put in place until the May 20 meeting as opposed to immediately for the March 20 meeting. This may be due to the timing of the Board meeting so soon after the outbreak of the pandemic, but if a second wave were to arise the learnings from the last few months can be adopted;
- Audit, QS&E and Finance committee meetings continued as planned with other committee meetings being postponed;
- Changes made to the Health Board's Standing Orders were considered appropriate and were subject to formal approval by the Board;
- QS&E and Finance agendas were partially adjusted to focus on Covid-19 issues whilst still covering other issues. However, Audit Committee agendas weren't significantly adjusted to focus on Covid-19 issues or pick up additional assurance areas from Committees that had been postponed;
- Board and Committee meetings were held virtually, ensuring compliance with regulations to exclude the public. A notice was published on the Health Board's website to confirm this;
- There were some initial technical challenges around virtual meetings but they then operated reasonably well. The Executives and IMs that we interviewed confirmed that they were happy with the operation of virtual meetings;
- Meetings have not been recorded or live streamed although it is noted that the Health Board is planning to introduce this in the future;
- The Board and Committee papers have been published on the Health Board's website prior to meetings. Minutes of meetings have also been published but this was not always done within a short time of the meeting. In these cases specific summaries of the meetings were published within the planned 3 day timescale; and

- The Board and Committees have begun to return to more normal business from the July meetings.

What could be done differently in the future

We advise that priority should be given to considering the following:

- Releasing the papers and minutes as soon as possible after Board and committee meetings. and
- Ensure plans are in place to review the agendas of the Audit and other continuing committees to ensure that they provide appropriate scrutiny and assurance over key areas that would normally be covered by other Committees that may be postponed in the future.

Furthermore, we suggest the following considerations as the organisation looks forward:

- Use suitable technology (maintaining privacy and security requirements) for Board and Committee meetings that is user friendly and available to all members and readily available for members of the public;
- Offer Freephone dial-in numbers for members of the public who may not have access to suitable conferencing technology;
- Take forward plans to live stream Board and Committee meetings. Review the possibility of recording the committee sessions (most video-conferencing software has this functionality), including written chat - this should help with recording accurate minutes (by reviewing the recording). Consider hosting this recorded session for the public to view post-meeting;
- Ensure all members / participants are suitably trained / offered training to the use the conference software;
- Consider using a separate individual to support Committee Chairs with the hosting of virtual meetings;
- Set out the arrangements at the commencement of each committee, e.g. muting microphones when not in use, the process for raising questions, introducing members and participants etc; and
- Consider commencing / streaming each meeting 10 minutes earlier than the scheduled time to allow participants / observers to address any technical problems.

Decision Making Arrangements

What we found

Our review identified the following:

- A decision log is in place recording all decisions taken by the Operational and Strategic Groups;
- The decision log effectively records the minute reference of the Strategic Group discussion / approval and the minute reference of the BGG for those decisions that required ratification;
- Review of a sample of decisions confirmed all were supported by a record of discussion / approval in the Strategic Group minutes;
- Brief guidance was issued around those decisions that require BGG ratification;
- Review of a sample of decisions that required BGG approval confirmed that they were all supported by a record of such approval in the Group minutes. However it is noted that the minutes for meetings pre May 20 didn't confirm the individual decisions approved just a general reference to decisions on the Log;
- The full Decision Log was presented to the May and July Board meetings. However, at the time of review the Decision log didn't record the details of those decisions that had been ratified by the Board; and
- Information / reports presented to the Strategic Group for the sampled decisions adequately supported the decision made and demonstrated the challenge and rigour of the scrutiny process.

What could be done differently in the future

We advise that priority should be given to considering the following:

- Further develop the guidance for what decisions should be recorded and the level of information required to be documented in the Decision Log and when this should be escalated to the BGG / Board. This can be used for future mobilisation of the process, in the event of a future pandemic.

Furthermore, we suggest the following considerations as the organisation looks forward:

- Include individual reference numbers for each of the decisions within the log in order to aid clarity of the audit trail as reference numbers could be quoted with minutes

- Ensure a specific record of each decision ratified by the BGG is included within all minutes. Recording the individual reference numbers for each decision would further aid this; and
- Ensure details of Board approval is recorded within the Log where required.

Command Structure

What we found

Our review identified the following:

- A Command Structure was introduced to enable the Health Board to ensure effective operational management of the Covid-19 pandemic. This included a daily Operational Group, twice weekly Strategic Group and weekly Board Governance Group (BGG) that acted as a Chairs Action group;
- The Health Board decided not to enact formal Gold Command in order to better operationalise decision making. It is noted that this approach differed to that taken by other Health Board's within Wales;
- The BGG took on a significant role in taking and approving decisions but this may have led to a lack of visibility / scrutiny / assurance due to the limited membership and private nature of the Group. It is however noted that the notes of each BGG meeting were shared with all members of the Board within a few days;
- The Command Structure was subject to retrospective scrutiny and approval by the BGG and full Board;
- The Command Structure was introduced reasonably quickly following the start of the Covid-19 pandemic. However the timeliness of bringing the Command Structure online should be reviewed post-pandemic, to ensure a swift re-activation (if required) in the future;
- The Command Structure allowed for rapid and agile actions to be taken at the Operational level whilst ensuring escalation of key decisions through the Executives and Board members. Discussions with IMs identified that some didn't initially feel fully engaged or utilised in the structure; and
- The frequency and role of the various Command Group meetings have been adjusted as the pandemic developed.

What could be done differently in the future

We advise that priority should be given to considering the following:

- A protocol pack, setting out the steps to take immediately, through to ongoing requirements (e.g. records required, meeting groups, Decision Log requirements) should be established in preparation for future events;
- Ensure more robust arrangements are included for reporting and oversight of the BGG to ensure effective transparency and scrutiny;
- The Health Board should carry out a review of the appropriateness of its decision to not invoke formal Gold Command and the effectiveness of the command structure introduced, in order to inform arrangements in the event of any second wave. The review could include a comparison against the structures introduced by the other Health Board's in Wales to identify if there would be any benefit in adapting the approach; and
- Any future command structure should include a more formal and effective way of ensuring all IMs are actively engaged from the outset. Not only to provide oversight and scrutiny but also to provide support to the Executive team where possible.

Risk Management

What we found

Our review identified the following:

- The Health Board introduced a specific Covid-19 Board Assurance Framework (BAF) highlighting the key Covid-19 related risks and associated current / planned controls and assurances;
- The Covid-19 BAF was reported to the Board Development session for review and assurance in April 20 and full Board in May 20;
- The Covid-19 BAF details the lead Executive and Committee for each of the key risks. However, at the time of the review the risks were not being reviewed by the identified lead Committees;
- Individual Covid-19 risk registers are in place for each of the 4 sites – UHW, UHL, DHH & Community; and
- A paper was reported to the July Board outlining the intention to move to an updated BAF covering all key risks to the delivery of the Health Board's objectives, including any on-going Covid-19 related risks. The updated BAF was then presented to the September Board.

What could be done differently in the future

We suggest the following considerations as the organisation looks forward:

- Ensure that the Health Board's key objectives and associated risks are continually updated in light of new developments and information;
- Ensure that key Covid-19 and non-Covid-19 risks are effectively reviewed by the relevant lead Committees; and
- Ensure appropriate plans are in place for the effective monitoring and reporting of risks in the event of any future Covid-19 outbreaks. This should also consider the likelihood of other non-Covid-19 risks increasing during the outbreaks, e.g. cyber-attacks.

Financial Governance

Annual Accounts and Reporting

What we found

Our review identified the following:

- The Health Board developed a revised timetable for the submission of the draft annual accounts, in accordance with the Welsh Government Guidance;
- Audit Wales' ISA260 report confirms that the Health Board complied with the revised timetable for submission of the draft financial statements and Accountability report by 22 May 2020; and
- Audit Committee dates were amended to reflect the revised timetable.

What could be done differently in the future

We suggest the following consideration as the organisation looks forward:

- The benefits of preparing the final accounts and completing the accompanying statutory audit remotely should be reviewed and retained for future financial years. Any efficiencies implemented to assist in the delivery should be retained / expanded upon.

Financial Systems and Processes

What we found

Our review identified the following:

- Specific Covid-19 Financial Governance arrangements were developed to adapt financial arrangements and disciplines during the pandemic. These were appropriately approved by the BGG and ratified by the Board;
- The Covid-19 Financial Governance arrangements were communicated through the Operational and Strategic Command Groups but our review of the Health Board's intranet could not identify if they were communicated more widely;
- Significant revenue and capital Covid-19 related investments have been appropriately recorded and will be re-deployed where possible after the pandemic;

- There was no up to date Business Continuity / Disaster Recovery plan in place for the Finance Department prior to the Covid-19 pandemic. The Department did however implement effective business continuity arrangements prior to lockdown and these ensured the continued delivery of core services whilst providing support to the Health Board in managing Covid-19;
- The Finance business continuity arrangements were documented at a high level and communicated to the Finance Committee for noting;
- Standard stock control processes were maintained during the pandemic to ensure the availability and security of key stock items; and
- There were no Covid-19 related Health Board losses or write offs recorded during the pandemic.

What could be done differently in the future

We advise that priority should be given to considering the following:

- A detailed Finance Department Business Continuity Plan should be produced, communicated and kept up to date. This should reflect the continuity steps implemented through the pandemic, any required improvements or additional plans in the event of a second Covid-19 outbreak and other general continuity arrangements to ensure continued service delivery across the broad services the Finance Directorate are accountable for.

Furthermore, we suggest the following consideration as the organisation looks forward:

- In the event of a second wave, introduce a more formal process for communicating the Covid-19 Financial Governance arrangements to all relevant managers across the Health Board to ensure consistent knowledge and compliance.

Covid-19 Expenditure (Revenue and Capital)

What we found

Our review identified the following:

- There were no changes made to the Health Board's Standing Financial Instructions or Authorised Signatory List as a result of Covid-19;
- The Health Board allocated authority to authorise Covid-19 related costs to the Operational and Strategic Command Groups. This was appropriately authorised by the BGG and ratified by the Board;
- The Health Board has effectively utilised its usual core financial processes (Oracle and ESR) for the processing of all Covid-19 related expenditure;
- Detailed weekly templates have been utilised to record all additional costs incurred by the Health Board related to Covid-19 and these have fed into a record of cumulative expenditure totals. These include all revenue, revenue workforce and capital expenditure and incorporate direct and indirect costs;
- The template records the description, cost, justification and method of authorisation for each of the items of expenditure;
- Our review of a sample of the recorded revenue and capital expenditure confirmed that sufficient information was available to support the decisions taken around authorisation. It was not however always straight forward to track the authorisation through the various groups where required;
- The Health Board has not assumed any additional funding for Covid-19 related expenditure until actually received from Welsh Government. We note that health boards were encouraged to spend as necessary, ahead of any approval;
- At the time of review, £12.5m had been approved by Welsh Government in relation to capital expenditure noting that the requests would have been scrutinised by Welsh Government (with assistance from NWSSP: SES) prior to payment;
- The Health Board has developed a process to record reductions in planned expenditure due to Covid-19, resulting mainly from reduced elective activity. This is taken into account when reporting the net expenditure due to Covid-19 within the monthly Welsh Government Monitoring Returns;
- There were no payments made in advance by the Health Board during the pandemic;

- The Health Board carried out appropriate demand modelling based on reasonable worst case assumptions to identify the level of additional bed capacity needed.
- The purchase of additional external capacity from SPIRE for the provision of elective cancer care was subject to appropriate scrutiny and approval;
- During the first 2 months of the pandemic, the members of the Health Board's Counter Fraud service were re-deployed to assist in the setting-up of the Dragon's Heart Hospital. They were however still available to provide counter fraud assistance and advice to the Health Board where required; and
- A Counter Fraud Steering Group and Management Group met weekly during the pandemic to discuss any fraud issues and various circulars and alerts were issued from Counter Fraud to the Health Board Chair, Audit Chair and Finance Director.

What could be done differently in the future

We advise that priority should be given to considering the following:

- Strengthen the process for recording and evidencing authorisation of the expenditure items from the COVID expenditure templates within the minutes of the various command groups. This can be used for mobilisation of the process, in the event of a future pandemic.

Furthermore, we suggest the following considerations as the organisation looks forward:

- Noting the guidance that was issued by the Welsh Government (Covid-19 decision making & financial guidance – issued 30 March 20), a retrospective report is presented to Audit Committee on contract awards made in response to the COVID-19 pandemic and an assessment of VFM / appropriate use of public money; and
- In the event of a second wave or future pandemic, the Director of Finance should consider the appropriateness of the redeployment of the Counter Fraud team and the impact on the provision of counter fraud advice and support to the Health Board.

Workforce

What we found

Our review identified the following:

- Effective workforce planning arrangements were put in place across the Health Board during the pandemic to ensure adequate staff were available to manage the provision of services;
- A recruitment campaign was implemented to redeploy and recruit required additional staff across the Health Board. The recruitments were subject to appropriate approval and pre-employment checks were carried out as required;
- Effective arrangements were in place to ensure that all recruited and re-deployed staff received adequate training to enable them to attain the core skills required; and
- Effective processes were in place to record and approve overtime and enhancement payments to senior managers. The level of payments made were deemed appropriate.

What could be done differently in the future

We have no suggestions as the organisation looks forward.

Budgets and Savings

What we found

Our review identified the following:

- A baseline budget for 20/21 has been appropriately set and approved in line with the Health Board approved IMTP;
- In spite of the pandemic, monthly financial reporting has continued uninterrupted with appropriate identification of the underlying operational position and additional net costs relating to Covid-19;
- Monthly Finance Reports are subject to appropriate review and approval by the Finance Committee and Board;
- The Health Board has refined its monthly budgetary and financial reporting procedures to reflect reporting requirements during the Covid-19 pandemic;
- Month 1 and 2 20/21 Monitoring Returns were submitted to Welsh Government in the required format and reflect Covid-19 and non-Covid-19 positions;
- The 2020/21 savings position is being effectively monitored via a tracker and reported via the Finance reports which are subsequently reported to Welsh Government; and
- It is noted that the Health Board acknowledged that the identification and implementation of schemes against the 20/21 savings target would be difficult during the Covid-19 pandemic. It has subsequently only identified £4m against the target of £29m.

What could be done differently in the future

We suggest the following consideration as the organisation looks forward:

- The Health Board will need to confirm the identification and implementation of savings plans where possible in order to assist the underlying financial position.

Other Areas of Governance

Partnership Arrangements

What we found

Our review identified the following:

- The Health Board carried out appropriate demand modelling based on reasonable worst case assumptions to identify the level of additional bed capacity needed;
- The purchase of additional external capacity from SPIRE for the provision of elective cancer care was subject to appropriate scrutiny and approval;
- Cross-border flows and other external contracts / long term agreements / service level agreements have been approved via the existing procedures; and
- Additional costs for primary care contractors are captured as part of the Covid-19 weekly expenditure templates.

What could be done differently in the future

We suggest the following considerations as the organisation looks forward:

- Ensure effective engagement with the local Care Home sector to ensure arrangements are confirmed and in place, in preparation for future outbreaks; and
- Continually review the capacity situation to ensure sufficient capacity is available in the event of a surge in demand for beds if there are further peaks.

Charitable Funds

What we found

Our review identified the following:

- At the time of the review no changes had been made to the Charitable Funds processes to account for Covid-19 donations. All donations received during the pandemic have been subject to the usual controls around receipting.
- We were unable to identify any additional communications made to Health Board staff reminding them of the processes to be followed when approached with offers of donations.
- Records have been retained of all Covid-19 donations received and these were reported to a special Charitable Funds meeting held in July 20.
- The meeting also received proposals for a bids process to receive and assess applications to spend Covid-19 donations. It is our view that the process would be appropriate to ensure effective governance over the allocation of the Covid-19 funds. The bids process was subsequently approved at a special meeting of the Board of Trustees.
- At the time of review none of the Covid-19 donations had been utilised.

What could be done differently in the future

We advise that priority should be given to considering the following:

- Ensure that the approved Covid-19 donations bids process is effectively implemented and utilised to appropriately scrutinise and approve bids.
- Ensure that the process is effectively publicised across the Health Board.

Furthermore, we suggest the following consideration as the organisation looks forward:

- Look to include a review of the Covid-19 donations bids process as part of the general audit of Charitable Funds scheduled to be undertaken by Internal Audit in Q3 20/21.

Information Governance

What we found

Our review identified the following:

- The Director of Informatics is involved in the Strategic Group meetings and appropriate operational level meetings;
- A consistent approach across Wales has been established via the National Information Governance Managers' Group (IGMAG), which helps set processes and guidance for the use of technology at home;
- Information governance advice and guidance has been provided as and when required throughout the pandemic;
- Privacy Impact Assessments (PIAs) and information sharing agreement protocols (ISPs) and privacy notices have been developed at a rapid pace for new measures implemented;
- Operational processes for cyber security have not changed during the pandemic;
- Encryption and other security measures were maintained during the increased numbers of laptops (and other IT equipment) issued;
- Existing security arrangements have continued (for example, monitoring mail for viruses / malware etc.); and
- The NHS liaised with the National Cyber Security Centre, with increased vulnerability assessments completed.

What could be done differently in the future

We advise that guidance is developed setting out:

- The need to maintain privacy in the household when using video conference / telephone call or other applicable work from other household members.
- Ensuring that laptops are locked when not in use / away from the desk. This is even more important in a public environment if agile working is to be promoted, for example, coffee shops. Consideration could be given to reducing the screen lock functionality within Windows.
- How physical copies of information are held and how they should be securely stored away from other household members / visitors.

- The risk that staff using their own devices at home are potentially more susceptible to malware / phishing attacks, as they may have insufficient security on their phones / home computers etc. This is likely to be more relevant with people able to access the OneDrive / Office 365 with just an internet connection from any device.

Appendix One – Guidance, Principles and Scope

Guidance and Principles

In its response (dated 26 March 2020) to a letter received on behalf of the Board Secretaries Group, Welsh Government agreed the Governance Principles that are designed to help focus consideration of governance matters.

The Principles are:

- public interest and patient safety;
- staff wellbeing and deployment;
- governance and risk management;
- delegation and escalation;
- departures from existing policies and processes;
- one Wales (acting in the best interest of the whole of Wales); and
- communication and transparency.

In particular, the Welsh Government reiterated the importance of continuing the role of both the Audit Committee and the Quality and Patient Safety Committee during the Covid-19 outbreak, in supporting the Board with discharging its responsibilities.

Further detailed guidance was issued regarding financial governance in 'Covid-19 Financial Guidance to NHS Wales' organisations and the Covid-19 Decision Making and Financial Governance Letter from Welsh Government dated 30th March 2020.

Scope of this Advisory Review

The advisory review assessed the adequacy and effectiveness of internal controls in operation during the Covid-19 outbreak, with particular regard to the Principles set out by the Welsh Government regarding maintaining financial governance.

This review focused on the following Principles:

- governance and risk management;
- delegation and escalation; and
- departures from existing policies and processes.

In particular, we undertook interviews and review of documentation:

- to ensure that appropriate key decisions are made through the revised management arrangements, with risk, impact and value for money adequately assessed;
- to confirm that the (revised) Scheme of Delegation and escalation requirements are adhered to;
- to ensure appropriate oversight and scrutiny remains by the Board over applicable matters – for example, the risk appetite level set;
- to ensure that departures from existing standards, frameworks, policies and procedures are appropriately documented and reviewed regularly, but still in accordance with the Principles; and
- to determine if the command structure established (i.e. Gold, Silver and Bronze) is appropriate – for example, achieving the Principles set out by the Welsh Government.

In our interviews with Board Members we discussed the remaining Principles and where appropriate commentary on those is include in the detail of this report.

The potential risks considered in this review are as follows:

- decisions are not completed in the best interest of the public;
- statutory requirements are not met;
- inappropriate expenditure and financial commitments;
- insufficient scrutiny of the risks associated with each key decision;
- the Welsh Government Principles are not adhered to; and
- inappropriate governance arrangements.

As this is an advisory review, the assignment is not allocated an assurance rating, but we have suggested some considerations for the future, should temporary governance arrangements be required in response to further peaks in the future.

Appendix Two – What we did

We undertook the following review activity:

- Interviewed the following:
  - Director of Corporate Governance;
  - Deputy Director of Finance;
  - Assistant Director of Finance;
  - Senior Charitable Funds Officer;
  - Deputy Director of Workforce & OD;
  - Director of Planning;
  - Chief Executive;
  - Chair of the Health Board;
  - Chair of the Audit Committee;
  - Chair of the Quality and Patient Safety Committee; and
  - Independent Member – Legal;
  - Information Governance Manager

- Reviewed notices, agendas and minutes of the Board, Audit & Assurance, QS&E and Finance Committees from March 2020.
- Reviewed the public availability of the respective committee papers and in particular the hosting of them onto the Health Board's webpage.
- Reviewed the risk register(s) for Covid and non-Covid risks.
- Reviewed evidence of assessment of committee business.
- Reviewed the SoRD and Standing Financial Instructions and any associated changes to the documents.
- Reviewed the Chair Actions relating to SoRD changes.
- Reviewed the papers / documentation / logs from the BGG, Strategic and Operational groups.
- Observed key committees.
- Selected a sample of key decisions from the Decision Log and reviewed the documentation of approval behind each of them.
- Reviewed the response arrangements and business continuity plans within Finance.
- Reviewed the Authorised Signatory List.
- Reviewed the revised timetable for reporting of annual accounts.
- Reviewed key financial control procedures.
- Reviewed the Monthly Monitoring Returns.

- Obtained and reviewed saving plans (including Covid and non-Covid savings).
- Reviewed the Oracle authorisation list.
- Reviewed the command structure for managing Covid arrangements.
- Reviewed the assets directly linked to the pandemic.
- Reviewed indemnity arrangements within the Health Board.
- Reviewed stock management arrangements.
- Reviewed workforce and establishment plans.
- Identified new starters and rates paid.
- Reviewed off-contract agency and overtime information.
- Identified and reviewed partnership arrangements, including additional capacity procured.
- Obtained capital project information, including expenditure incurred.
- Discussed charitable funds arrangements and any changes to policies.
- Shared information and emerging findings with Audit Wales for consistency.

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Report Title:	**Business of Other Committees and Review of Interrelationships**									
Meeting:	Audit and Assurance Committee						**Meeting Date:**	17.11.20		
Status:	**For Discussion**	**x**	**For Assurance**	**x**	**For Approval**		**For Information**			
Lead Executive:	**Director of Corporate Governance**									
Report Author (Title):	**Director of Corporate Governance**									

Background and current situation:

It is good governance and good practice for the Audit and Assurance Committee to receive a report on the performance and interrelationships of each of the Committees of the Board. This in turn provides independent assurance to the Board through the Audit and Assurance Committee.

Cardiff and Vale UHB Standing Orders states that 'the Board shall establish a Committee structure that it determines best meets its own needs, taking account of any regulatory or Welsh government requirements'. As a minimum the Board must establish Committees which cover the following aspects of Board business:

- Quality and Safety – (Quality, Safety and Effectiveness Committee)
- Audit – (Audit and Assurance Committee)
- Information Governance – (Digital Health Intelligence Committee)
- Charitable Funds – (Charitable Funds Committee)
- Remuneration and Terms of Service – (Remuneration and Terms of Service Committee)
- Mental Health Act requirements – (Mental Health Capacity Legislation Committee)

In addition to the above the Board has also established the following Committees of the Board:

- Finance Committee
- Health and Safety Committee
- Strategy and Delivery Committee

Executive Director Opinion/Key Issues to bring to the attention of the Board/Committee:

The Board can receive assurance from the Audit Committee, based upon this review that the Committees of the Board operated effectively during the year and they were aligned with the Board's assurance requirements. This can be demonstrated by:

- Committee and Board reviewed and approved Terms of Reference
- Committee and Board reviewed and approved Annual Work Plans
- Committee and Board reviewed and approved End of Year Annual Reports which feed into the overall Accountability Report
- Committee Effectiveness Reviews each reported to the Committees of the Board with actions plans for improvement moving forward.

Some of the end of year reviews did not happen due to circumstances explained within the body

of the report and also the impact of COVID-19 which disrupted some reviews due to timings of Committees and Committees being stood down in line with Welsh Government Guidance. Where this was the case the previous year's Terms of Reference remained in place as did the work plans which were reviewed 12 months earlier.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc.):

(a) Committee Terms of Reference and Workplans:

Committee	Terms of Reference in place and approved by the Board		Workplan in place and approved by the Board		Annual Committee Report completed and signed off by Committee Chair and reported to Board	
	2019	2020	2019	2020	2019	2020
Audit and Assurance Committee	Yes	Yes	Yes	Yes	Yes	Yes
Quality, Safety and Experience	Yes	No	Yes	No	Yes	Yes
Digital Health Intelligence Committee	Yes	Yes	Yes	Yes	Not a Board Committee at that time	Yes
Charitable Funds Committee	Yes	Yes	Yes	Yes	Yes	Yes
Remuneration and Terms of Service Committee	Yes	No	Yes	No	No	30.11.20
Mental Health Capacity Legislation Committee	Yes	No	Yes	No	Yes	Yes
Finance Committee	Yes	Yes	Yes	Yes	Yes	Yes
Health and Safety	Yes	No	Yes	No	No	Yes
Strategy and Delivery Committee	Yes	Yes	Yes	Yes	Yes	Yes

The Quality, Safety and Experience Committee agreed that they would wait to review their Terms of Reference until later on in the year this was due to the following:

(i) The publication of the Health and Social Care Bill in summer 2020
(ii) The outputs of the Quality Governance Self-Assessment
(iii) WAO piece of work on Quality Governance – delayed due to COVID-19
(iv) Executive Nurse Director and Medical Director reviewing the processes and structures associated with Quality Governance – delayed due to COVID-19
(v) Learning from Cwm Taf Maternity Services Review.

These areas could all impact upon the Terms of Reference therefore it was agreed that they

would be reviewed in light of these areas and at a more appropriate time and then a new Work Plan would also be developed aligned to the new Terms of Reference. The current Terms of Reference and Work Plan would remain in place until the review could be undertaken and at the time it was agreed this would take place by the September Quality, Safety and Experience Committee. This work has been delayed due to COVID-19 but is still ongoing with a new timeframe for the end of the financial year.

The Mental Health and Capacity Legislation Committee currently has an Interim Chair. The Interim Chair is undertaking, with the support of relevant professionals, a programme of training and is keen to ensure appropriate participation of service users within the Committee. Once the training is complete a review of the Terms of Reference will be undertaken. The time frame for this is now the end of the financial year. The current Terms of Reference and work plan have remained in place from the previous year.

The Health and Safety Committee Terms of Reference were due to be reviewed at the April Health and Safety Committee and reported to the May Board. However, due to COVID-19 the Health and Safety Committee was stood down and the May Board was reduced to an 'essential items' only agenda. This review will now take place by the end of the financial year. The Health and Safety Committee is not administered by the Corporate Governance Team currently but there is a need to move this within its remit to ensure that the end of year reporting all happens within a timely manner going forward, to provide independence in reporting of Health and Safety and to align it more effectively to the other Committees of the Board.

The Remuneration and Terms of Service Committee Terms of Reference were due to be reviewed at the May Committee and reported to the May Board. However, due to COVID-19 the Remuneration and Terms of Service Committee was stood down and the May Board was reduced to an 'essential items' only agenda. This will review will now take place by the end of the financial year. The current Terms of Reference and work plan have remained in place from the previous year.

Annual Reports from the Committees were presented to each Committee (with the exception of the Remuneration and Terms of Service Committee but this will be finalised by the end of November 2020) of the Board prior to sign off by the Board. These reviews fed into the Accountability Report at the end of the Financial Year.

(b) Committee Effectiveness Reviews

Committee	Effectiveness Review reported to Committee		No of areas where improvements required
	Yes/No	Date	
Audit and Assurance Committee	Yes	17.11.20	7
Quality, Safety and Experience	Yes	15.12.20	10
Digital Health Intelligence Committee	Yes	08.10.20	11 (first annual self-assessment)
Charitable Funds Committee	Yes	01.09.20	8
Remuneration and Terms of Service Committee	No		To be completed
Mental Health Capacity Legislation Committee	Yes	20.10.20	5
Finance Committee	Yes	25.11.20	10
Health and Safety	No		To be completed
Strategy and Delivery Committee	Yes	15.09.20	1

Each Committee Effectiveness Review undertaken this year has been or will be reported to their respective Committees. In addition to this an action plan for improvement is produced which is also compared to the previous years reviews where these took place. There are two outstanding reviews which will be completed before the end of the year and reported to their respective Committees with an action plan for improvement.

(c) Inter relationships

Risk

Within the Effectiveness Review of the Audit Committtee there is a question which asks

'Has the Committee formally considered how it integrates with other Comittees that are reviewing risk?'

80% of respondents to the review stated 'yes' and 20% stated 'no'.

Risk Management arrangements within the Health Board are now moving forward and developing. It will be important to report back to the Audit Committee at its Febuary meeting our plans in relation to Risk Management. This will include (but not limited to) the following:

Each risk on the BAF being reported to the relevant Committee of the Board to provide further challenge around the risk and further assurance to the Board. This is happening within the Strategy and Delivery Committee but also needs to happen in relation to other Committees which are aligned to BAF risks including:

- Finance Committee
- Quality, Safety and Experience Committee

In addition to this, risks on the Corporate Risk Register which are currently only reported to the Board also need to be reported to their respective Committees of the Board. This would provide further challenge around the Corporate Risks the organisation is managing in additon to further assurance to the Board.

In effect there will be a robust hierachy of risk reporting through the Committees to the Board.

Key Performance Indicators

The way we monitor and manage performance is developing and the ultimate aim it to provide an integrated performance report to the Board focussing upon key indicators in the areas of Quality, Workforce, Finance and Operations. These areas will be reported through the respective Committees of the Board such as Quality, Strategy and Delivery and Finance.

Clinical Audit

The Audit Committee is responsible to ensuring the effectiveness of the Clinical Audit and Quality Improvement function and that it meets the standards set for the NHS in Wales. The Audit Committee achieves this by reviewing the Clincal Audit Plan on an annual basis. This review is next taking place at the February Audit Committee.

Regulatory Compliance

Regulatory Compliance is now tracked through the Audit Committee but includes regulatory requirements from across the Health Board and those areas where other Committees of the Board have a responsibility for ensuring delivery for example HIW Inspections through the Quality and Safety Committee and Fire Safety Inspections through the Health and Safety Committee and Information Commission Office (ICO) Inspections through the Digital Intelligence Committee.

The Audit Committee reviews the Regulatory Tracker and can provide assurance to the Board on the oversight of these inspections.

Internal Audit Recommendations and Auidt Wales Recommendations

Internal Audit Recommendations and Audit Wales recommendaions are now also tracked by the Audit Committee and this has been happening routinely since September 2019.

Recommendations from Auditors will be reviewed, where relevant by the respective Commitees of the Board such as Finance, Strategy and Delivery and Digital Health Intelligence Committee thereby providing assurance to the Audit Committee and the Board. This will commence in the next cycle of business.

Recommendation:

That the Audit Committee:

(a) Review and note the outcome of this review to provide 'independent' assurance to the Board that the Board assurance requirements are appropriately aligned.
(b) Note the areas of development within the report to provide further assurance to the board on the Inter relationships between the Committees particularly in the areas of Risk, Regulatory Tracking, Performance Monitoring and Audit recommendations.
(c) Note the outputs of the Committee self-assessment and the action plans in place to improve effectiveness of the Committees and that where the self-assessments were not undertaken that they will be undertaken before the end of the year.
(d) Recommend approval to the Board that the Health and Safety Committee administration moves to the Directorate of Corporate Governance to align end of year reporting and independence from the Health and Safety function of the Health Board.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	x

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	x	Long term		Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Not Applicable

Report Title:	**Committee Effectiveness Review 2019-20 Results and Actions**								
Meeting:	Audit and Assurance Committee						**Meeting Date:**	17 Nov 20	
Status:	**For Discussion**	**x**	**For Assurance**		**For Approval**	**x**	**For Information**		
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Head of Corporate Governance / Corporate Governance Officer**								

SITUATION

It is good practice and good governance for Committees of the Board to undertake a self-assessment of their effectiveness on an annual basis, in line with the requirement of Standing Orders.

The questions in this year's self-assessment mirror those included in last year's review; they are key considerations in the Good Governance Handbook and this approach enables us to reflect on progress with last year's action plan. Some additional questions were also incorporated for this year's survey. Survey Monkey was again used as a tool to gather the feedback.

ASSESSMENT

Attached at appendix 1 are the results for the Committee Effectiveness review undertaken by Committee Members in addition to the Executive Director Lead for the Committee. Overall the responses show that the Committee has maintained standards and achieved improvement in a number of aspects of Committee effectiveness. 3 areas saw a deterioration which are highlighted. 12 new questions were included in this year's survey, and only 2 of these scored less than 100%.

Attached at appendix 2 is a proposed action plan to improve the areas in which the results fell below 100%.

RECOMMENDATION

The Committee is asked to:

- Note the results of the Committee's self-assessment Effectiveness Review for 2019-20.
- Approve the action plan for improvement to be completed by March 2021 in preparation for the next annual self-assessment which will feed into the 2020-21 Annual Governance Statement.

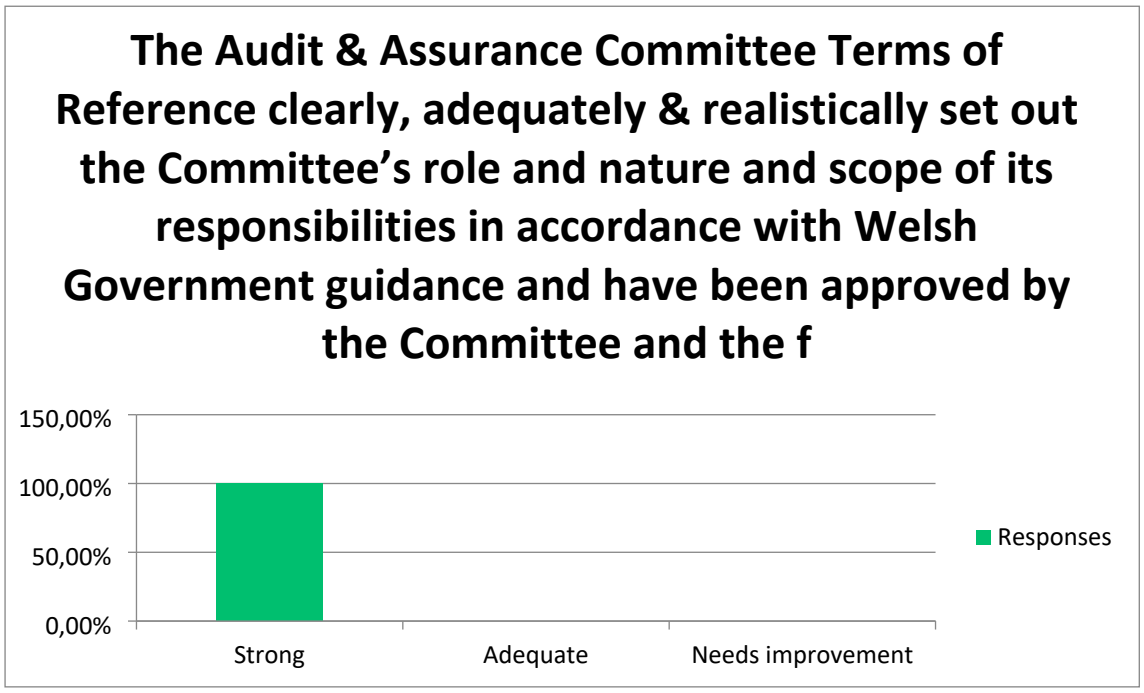
Shaping our Future Wellbeing Strategic Objectives *The UHB objectives relevant to this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	

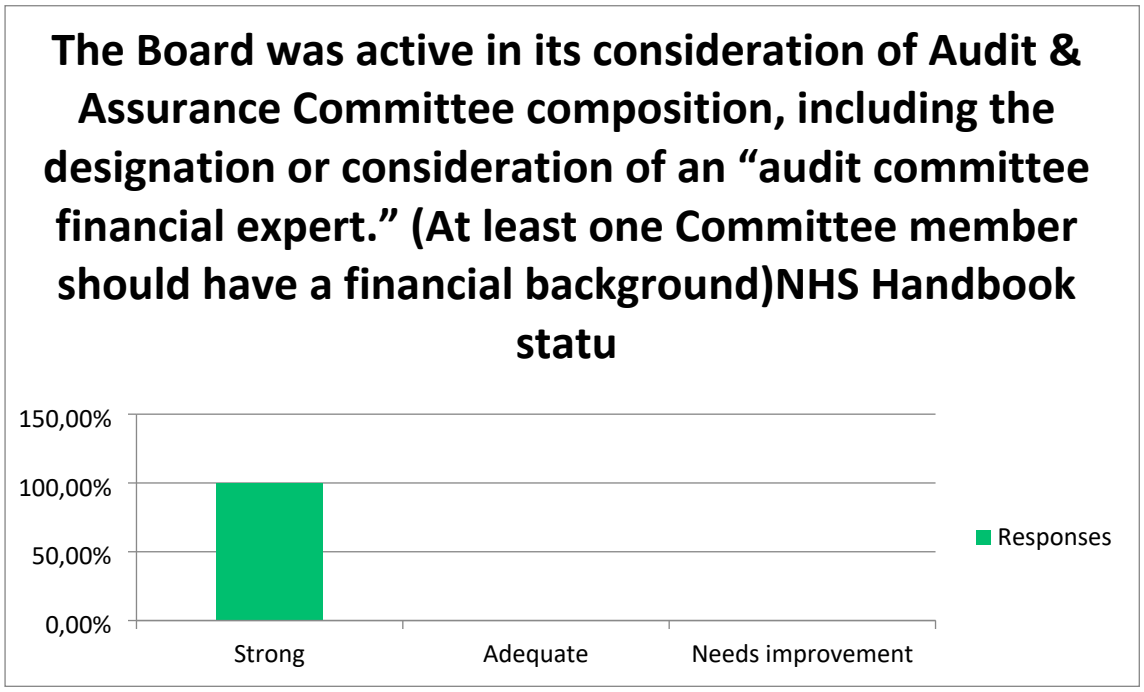
2.	Deliver outcomes that matter to people	x	7.	Be a great place to work and learn	x
3.	All take responsibility for improving our health and wellbeing	x	8.	Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4.	Offer services that deliver the population health our citizens are entitled to expect		9.	Reduce harm, waste and variation sustainably making best use of the resources available to us	
5.	Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10.	Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered									
Prevention		Long term	x	Integration		Collaboration		Involvement	
Equality and Health Impact Assessment Completed:	Not Applicable								

Appendix 1

Audit and Assurance Committee Effectiveness Results 2019-20





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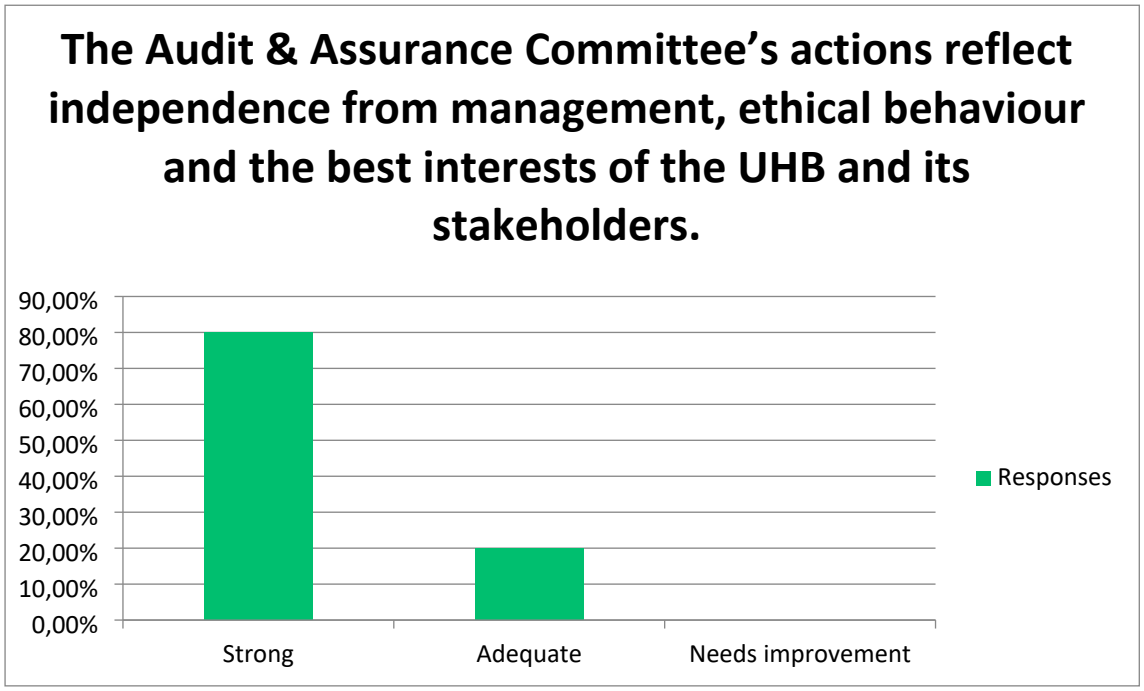
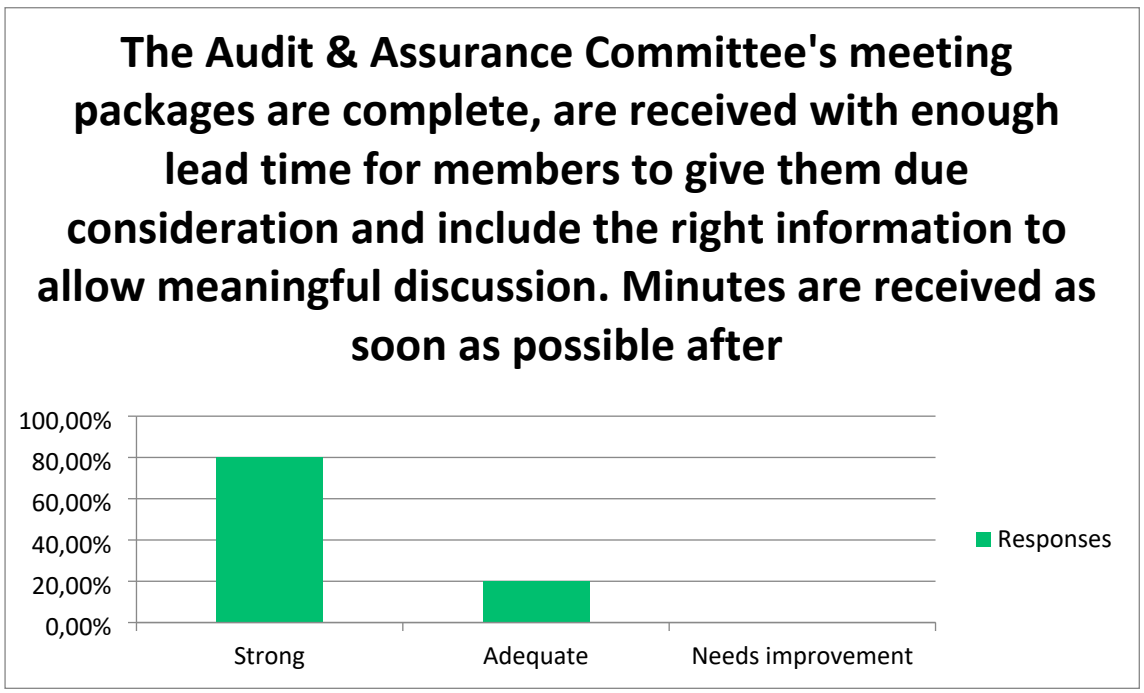
Audit and Assurance Committee Effectiveness Results 2019-20



* 100% responded "Strong" in last year's survey



* Slight improvement on last year

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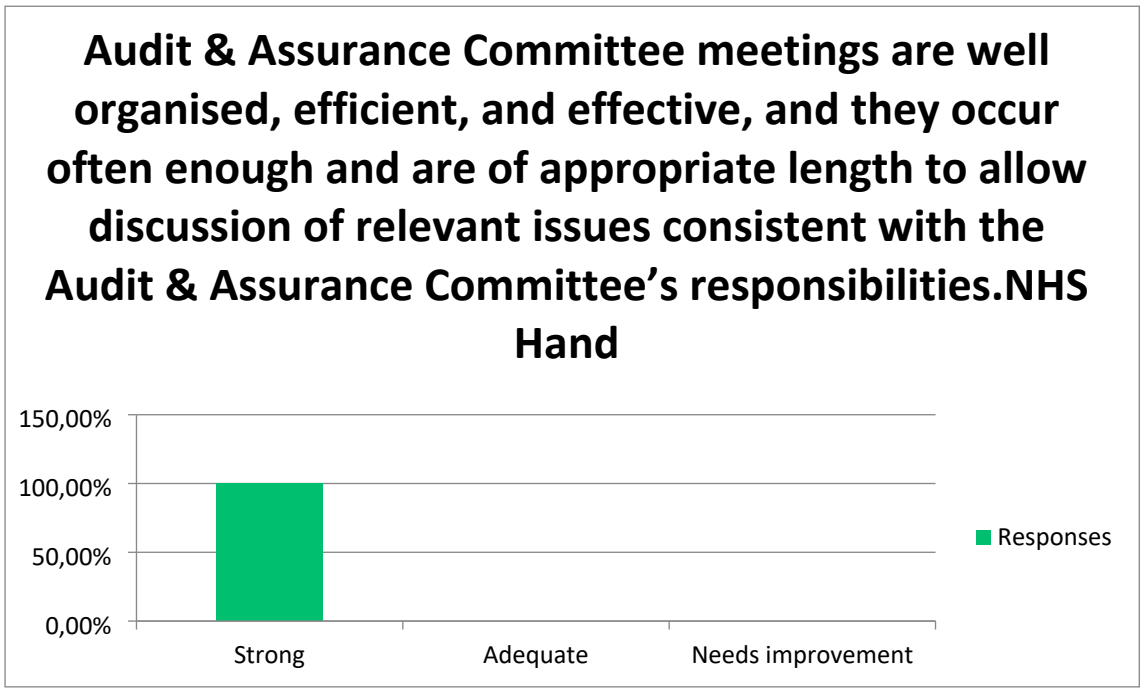
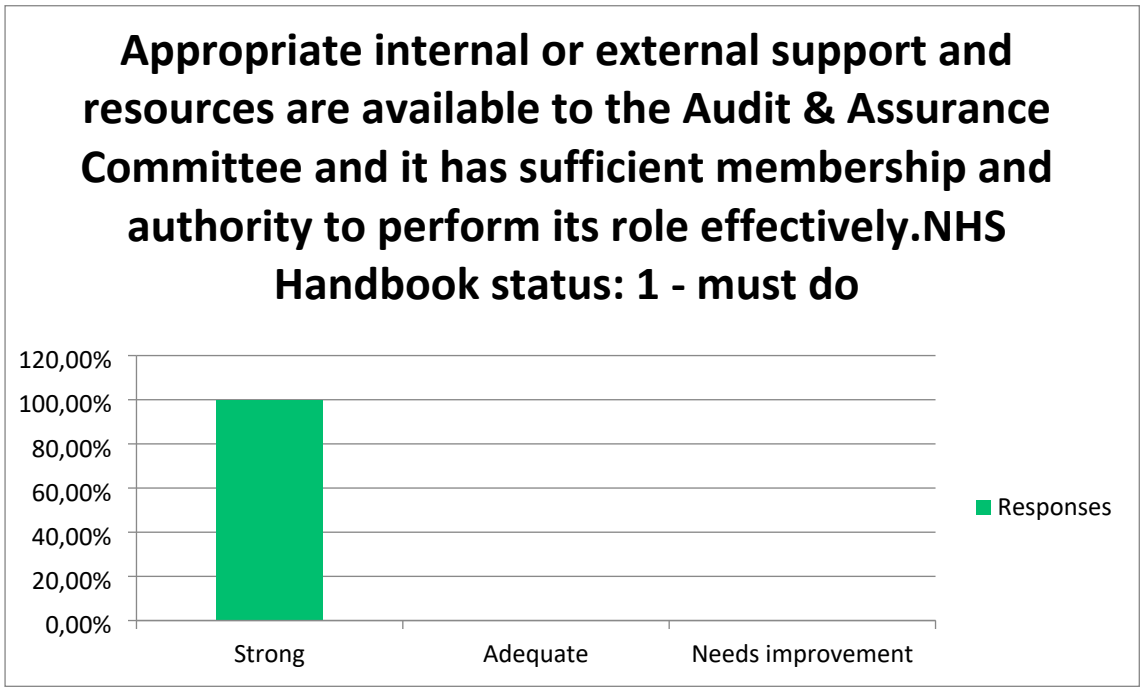
Audit and Assurance Committee Effectiveness Results 2019-20



* Improvement on last year



* Improvement on last year

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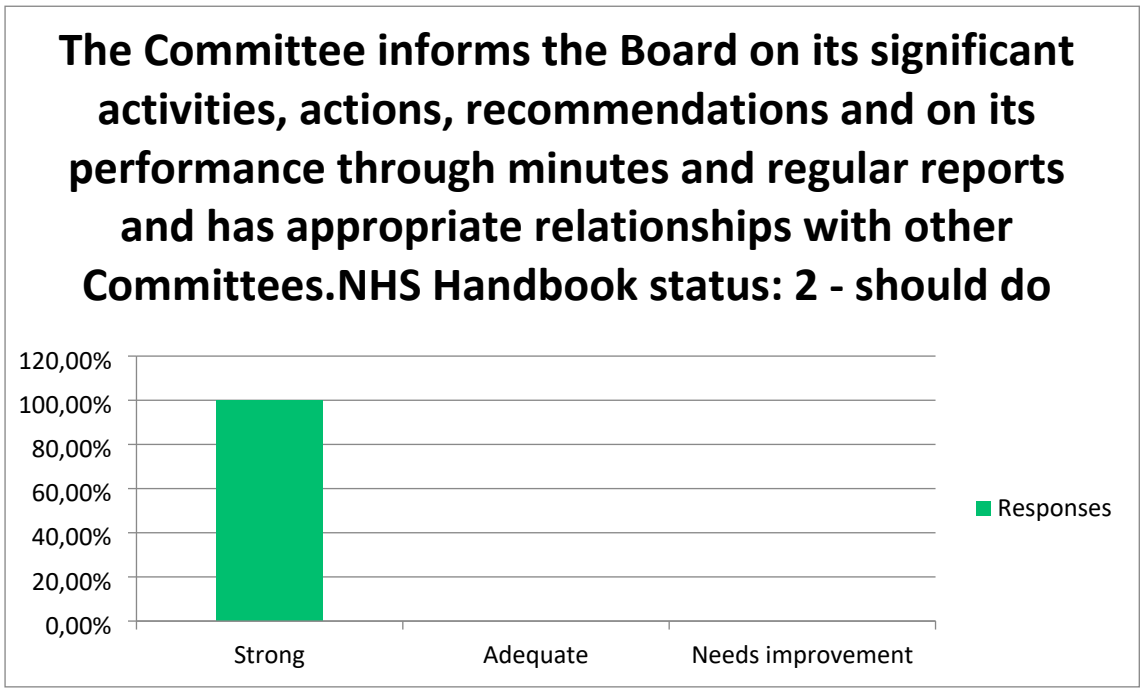
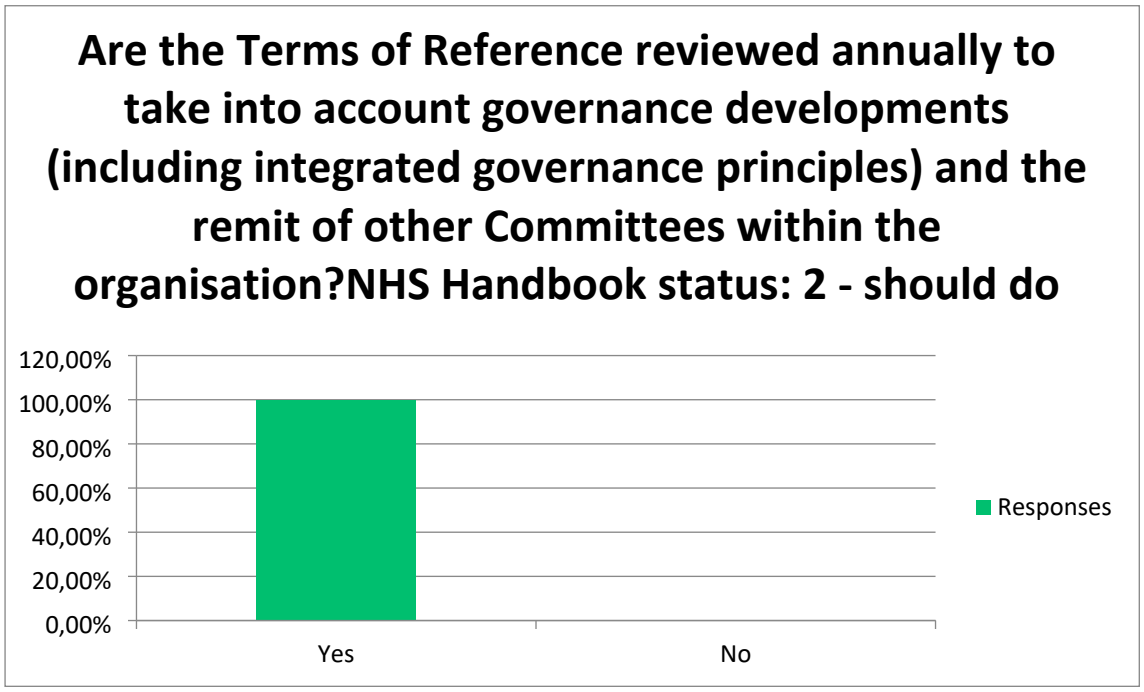
Audit and Assurance Committee Effectiveness Results 2019-20



* Improvement on last year



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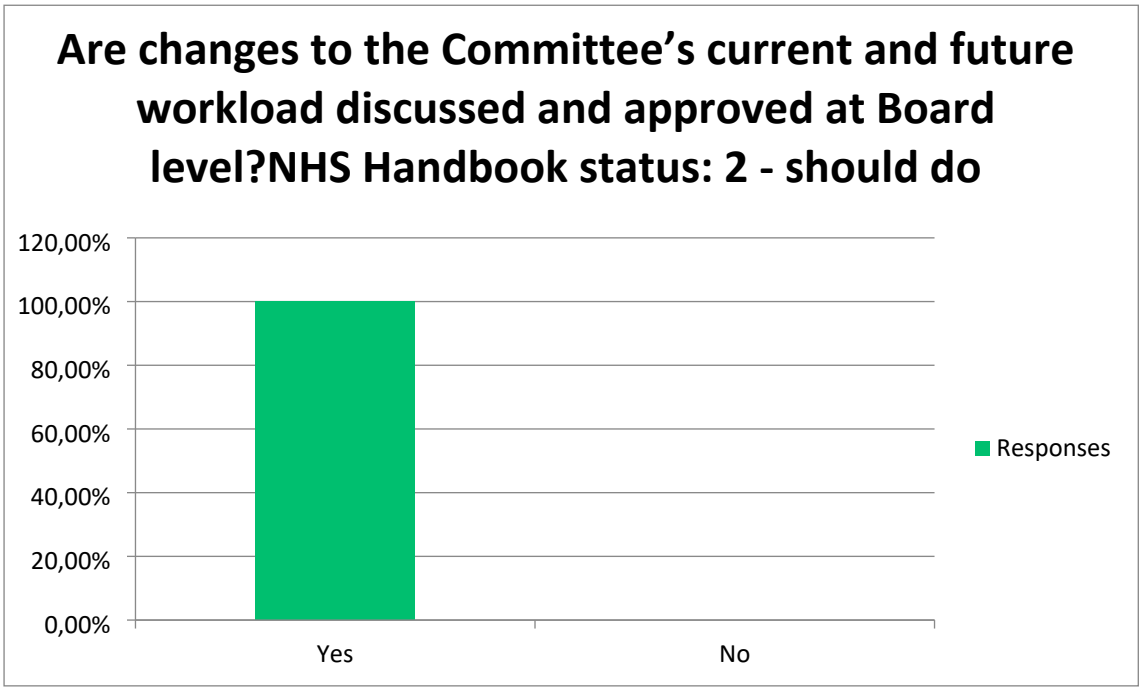
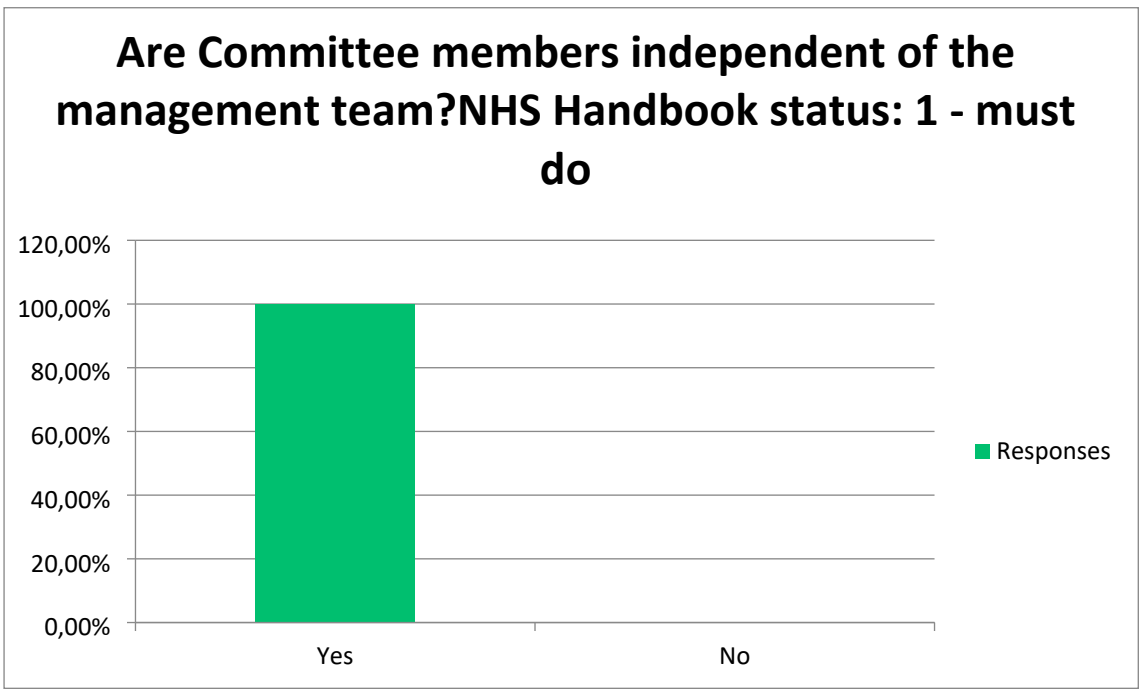
Audit and Assurance Committee Effectiveness Results 2019-20





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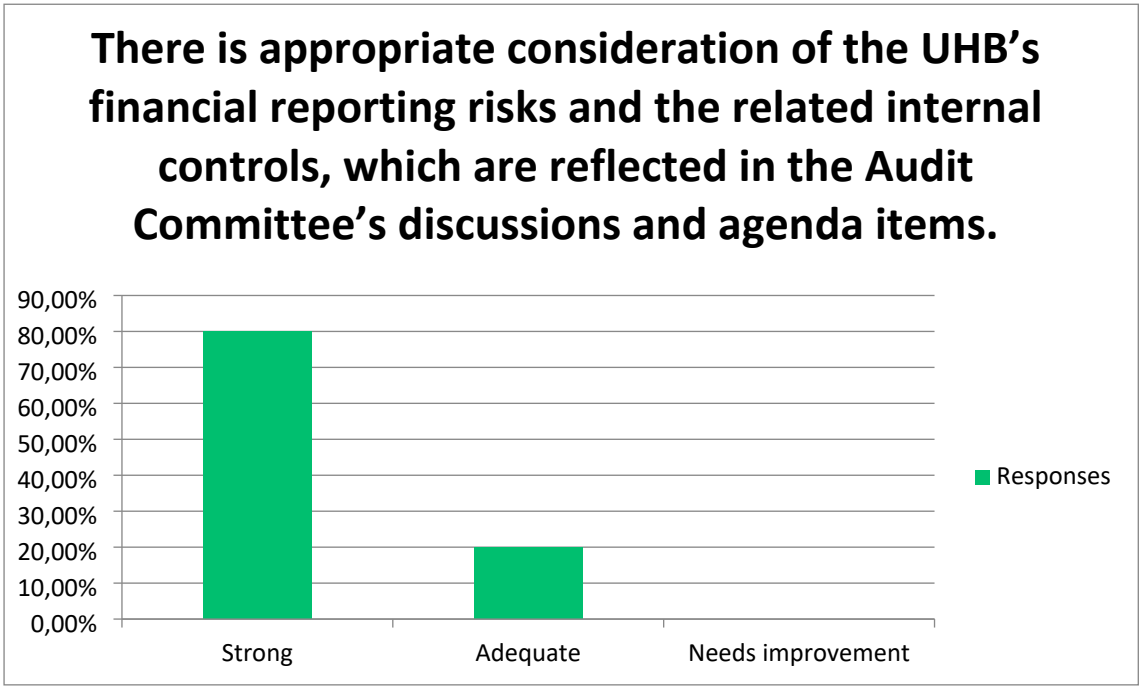
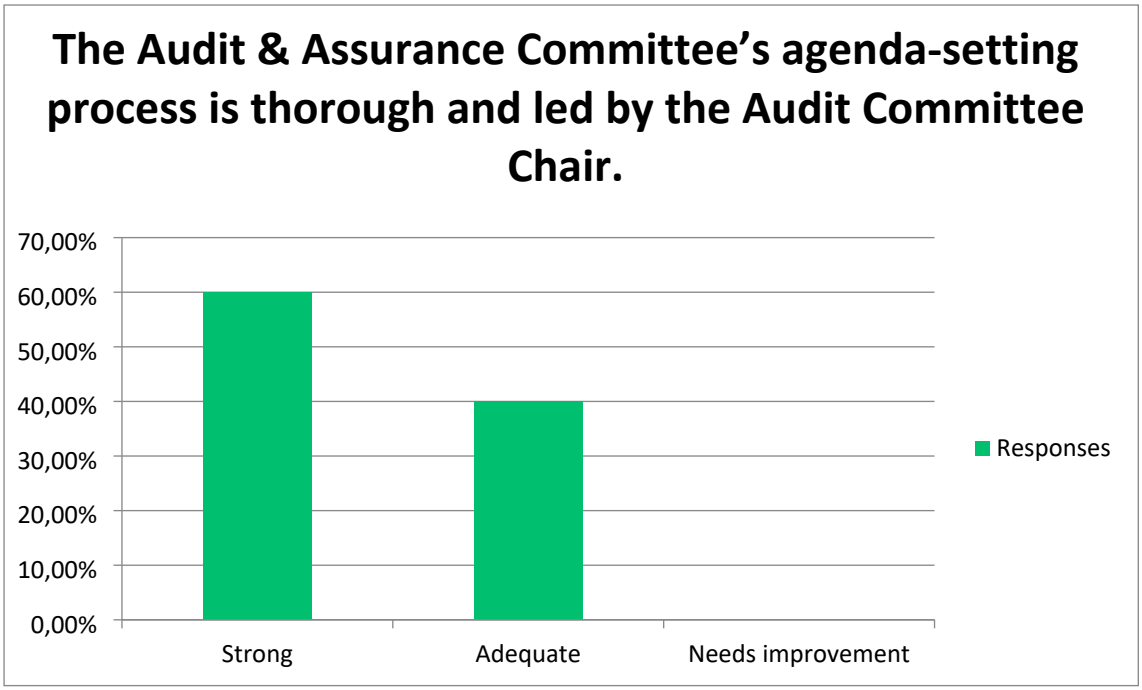


Comments

"Assurance on financial risks are obtained by the Finance Committee".

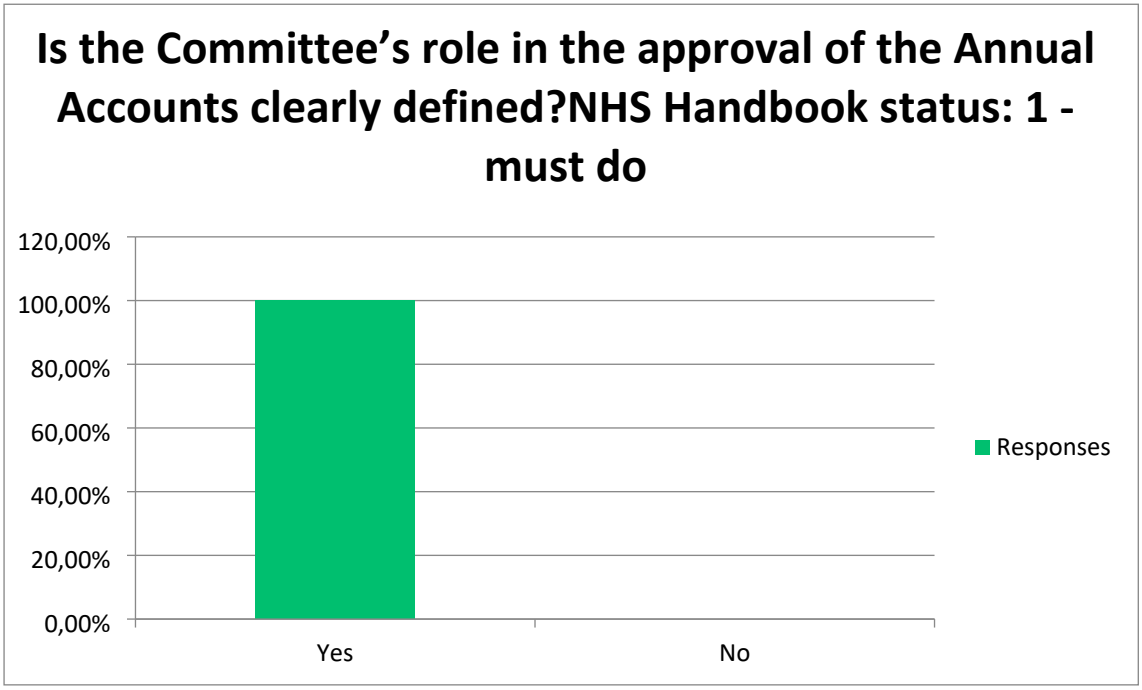
*Slight deterioration since last year

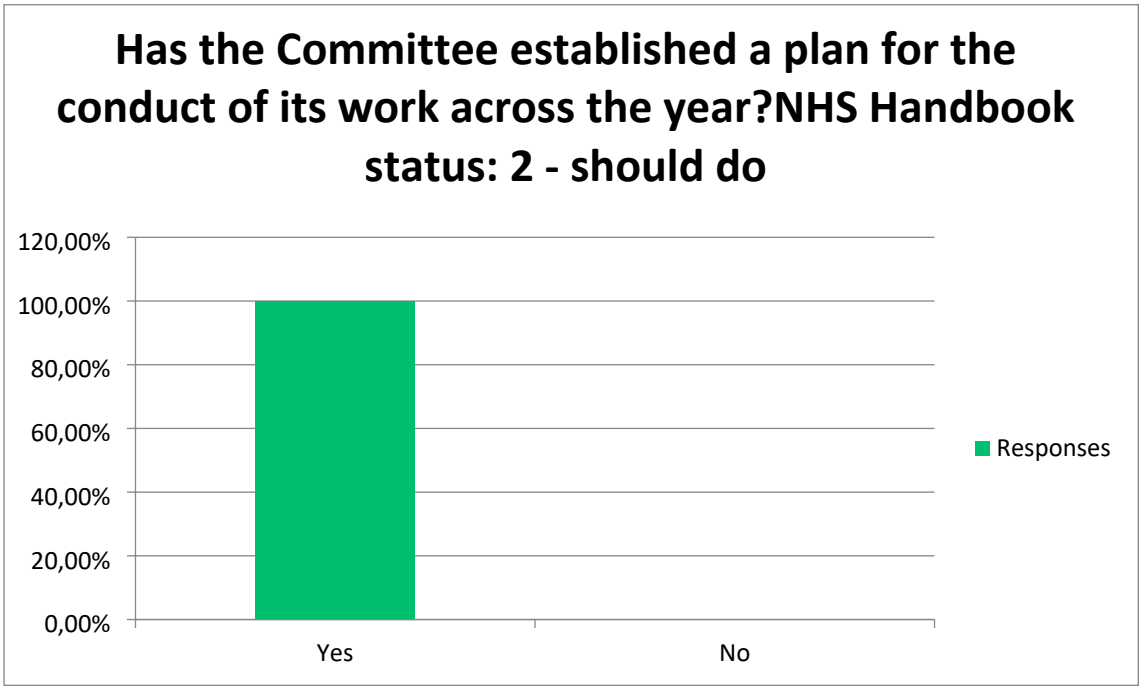


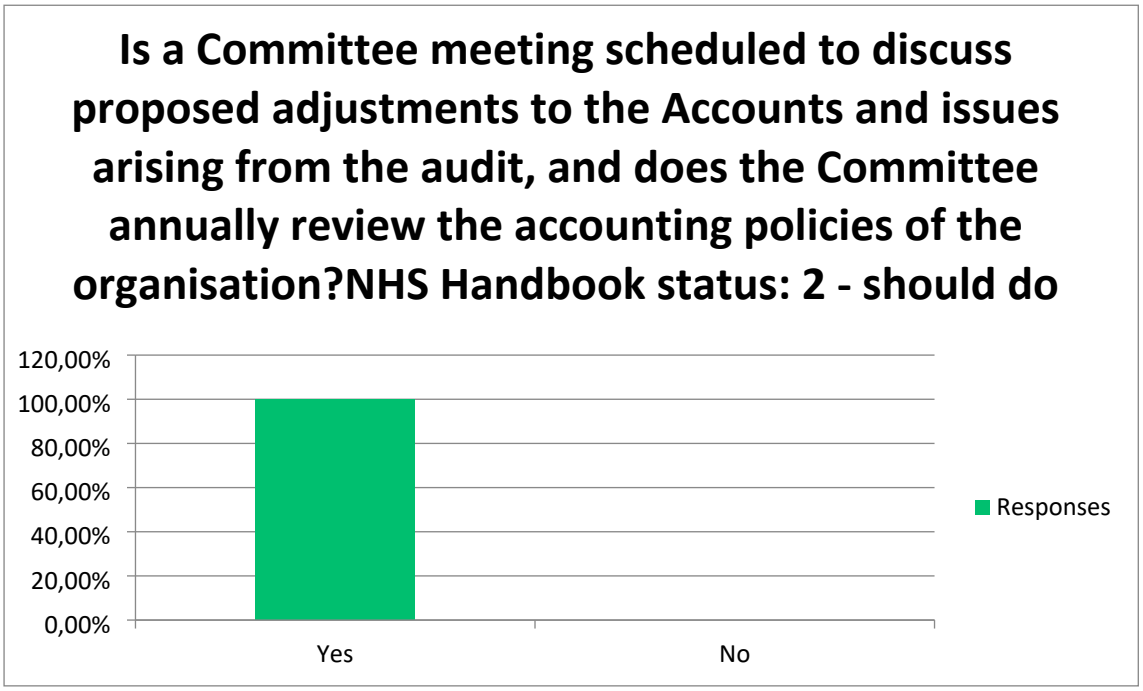
* Slight improvement on last year

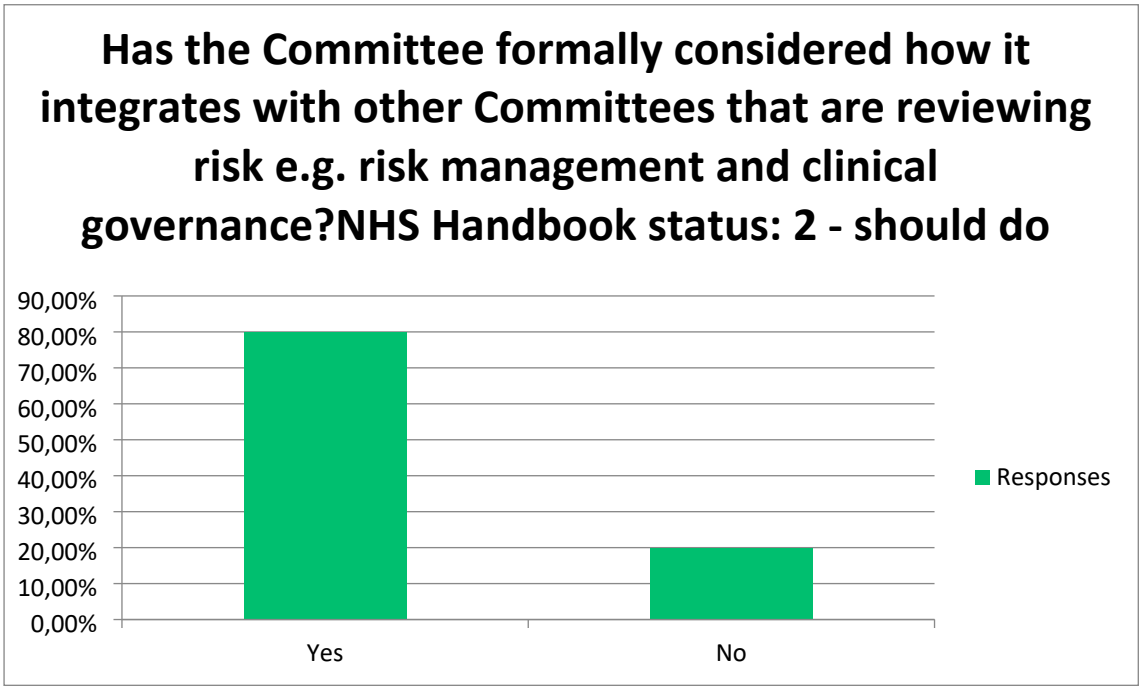
Appendix 1

Audit and Assurance Committee Effectiveness Results 2019-20









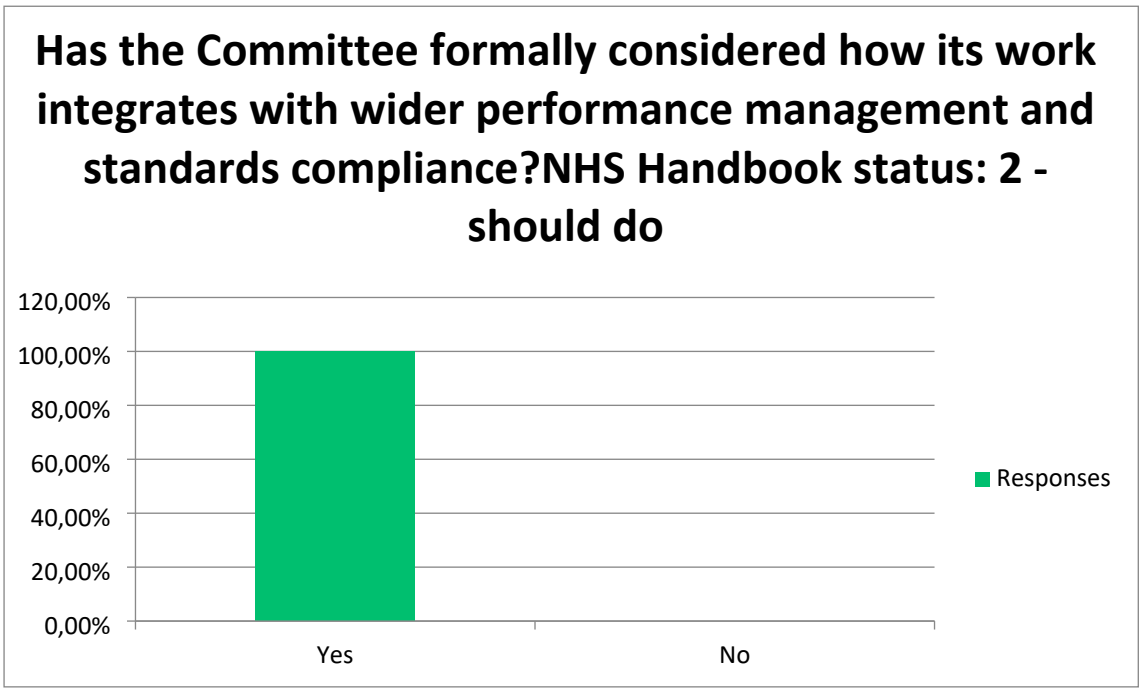
Comments

"This needs to be considered by Committee".

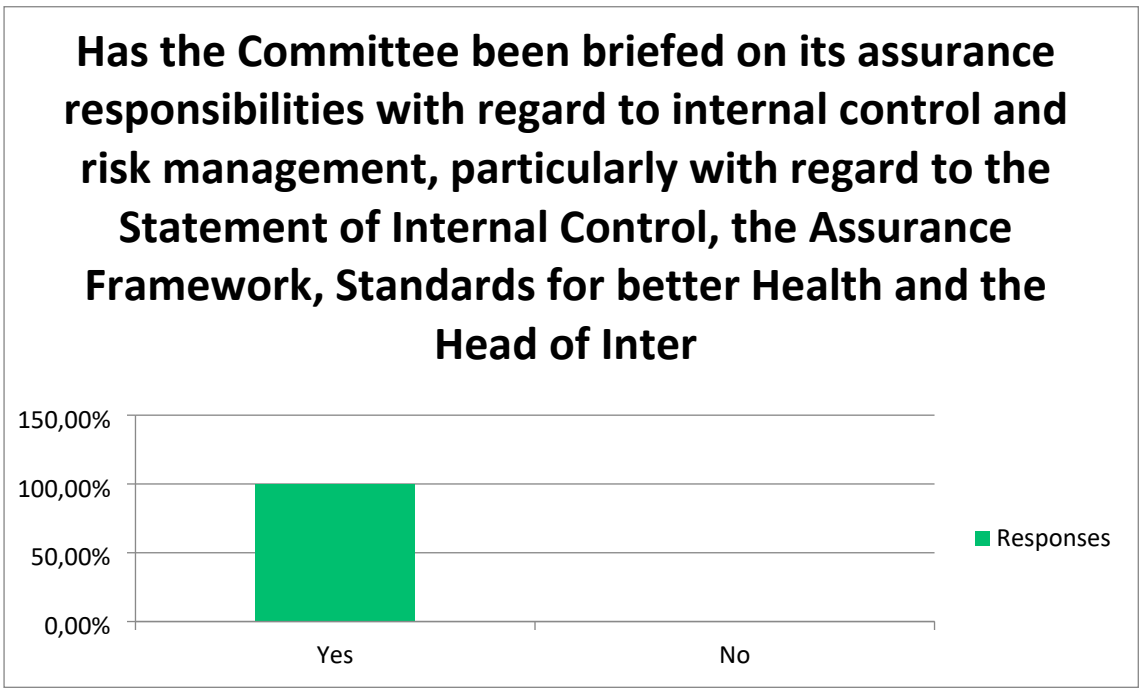
* 100% responded "Strong" in last year's survey

Appendix 1

Audit and Assurance Committee Effectiveness Results 2019-20

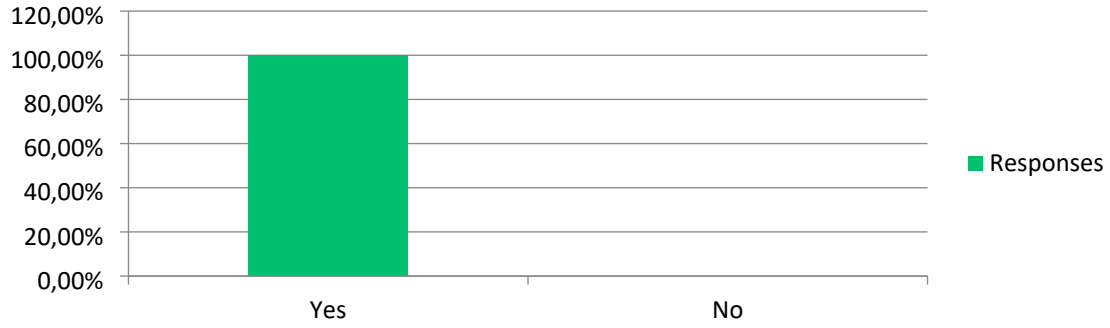


* Improvement on last year

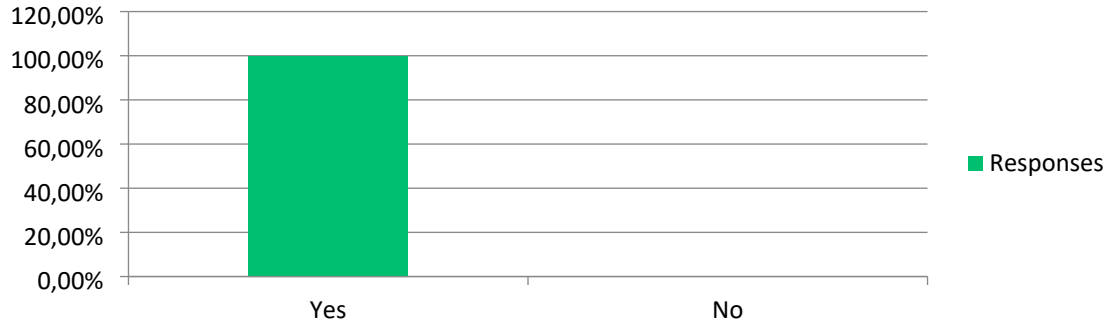


* Improvement on last year

Has the Committee reviewed whether the reports it receives (including assurance statements from the Head of Internal Audit) are timely and have the right format and content to ensure its internal control and risk management responsibilities are discharged



Does the Board ensure that Committee members have sufficient knowledge of the organisation to identify key risks and to challenge both line management and auditors on critical and sensitive matters?NHS Handbook status: 2 - should do



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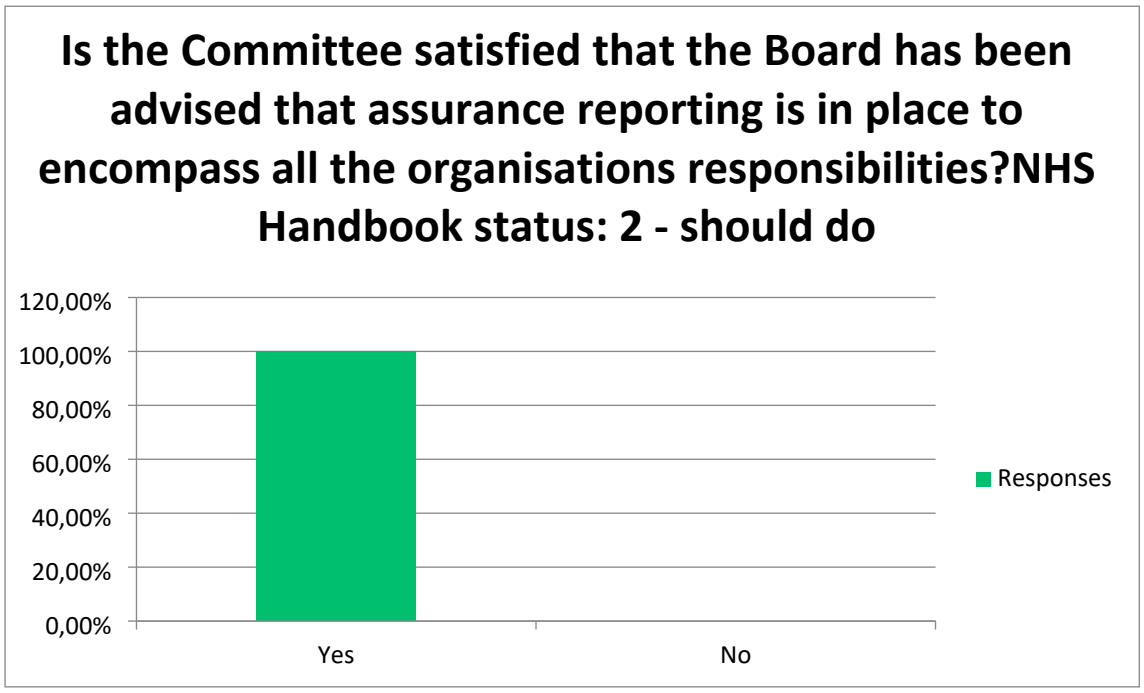
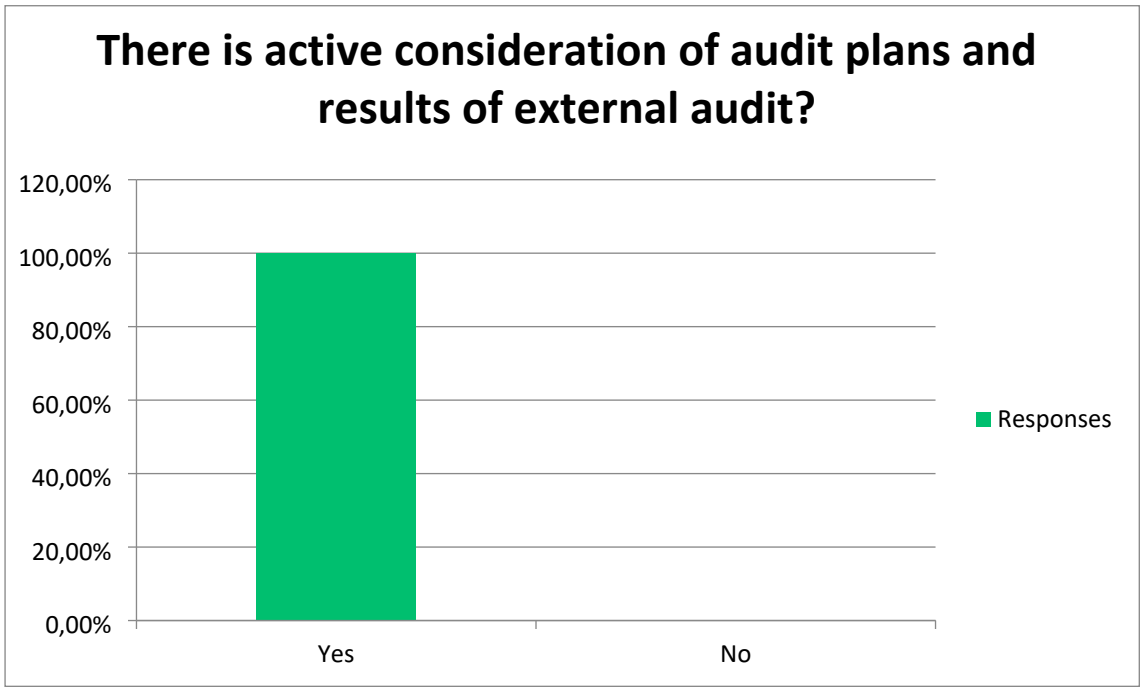


* Improvement on last year



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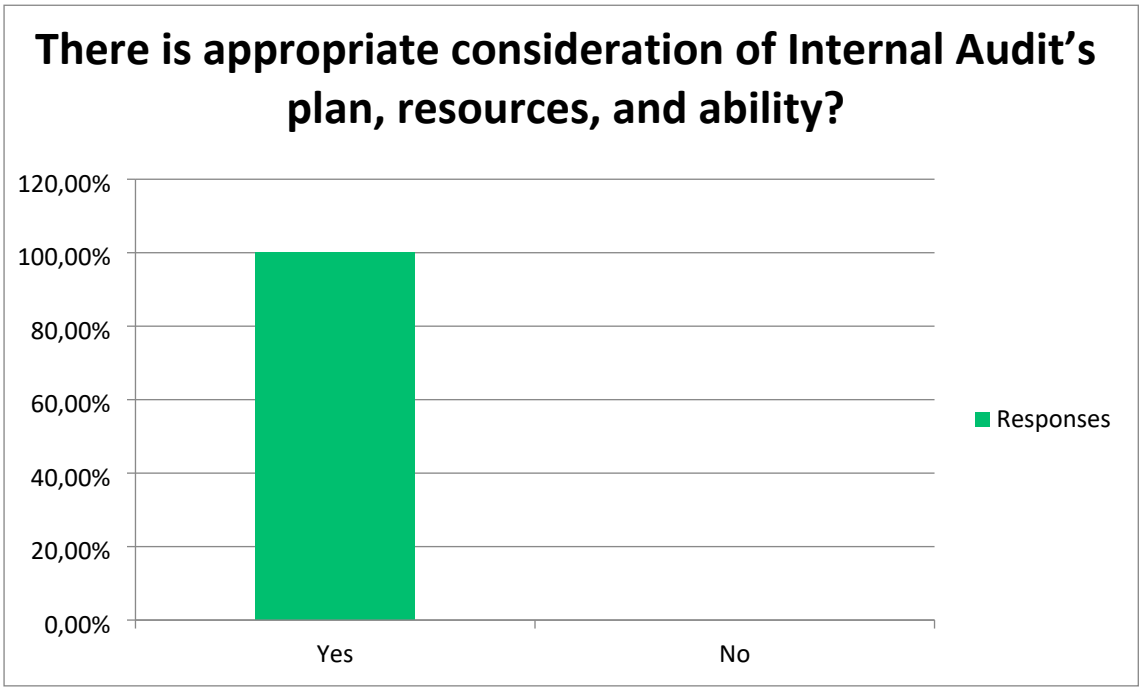
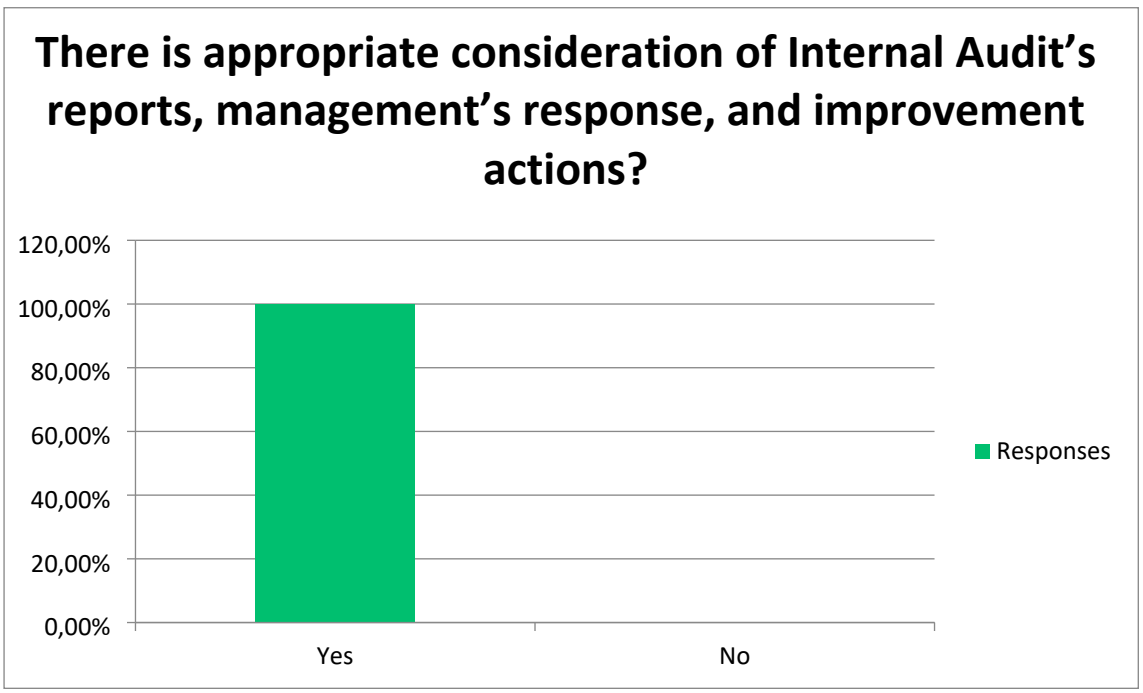
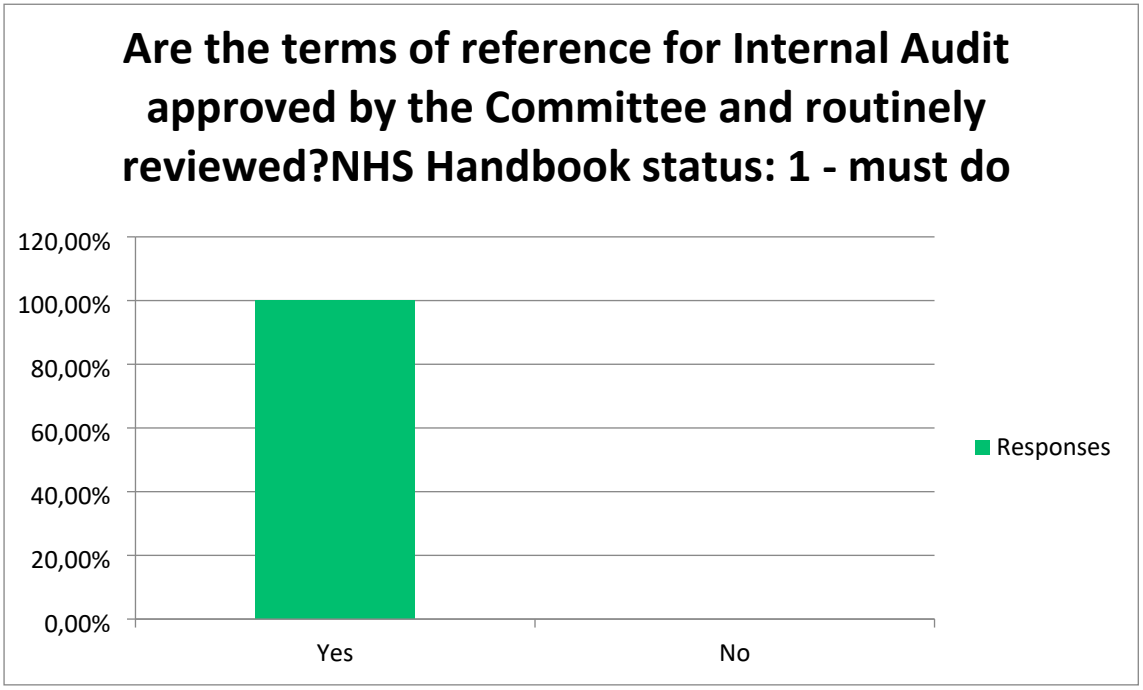
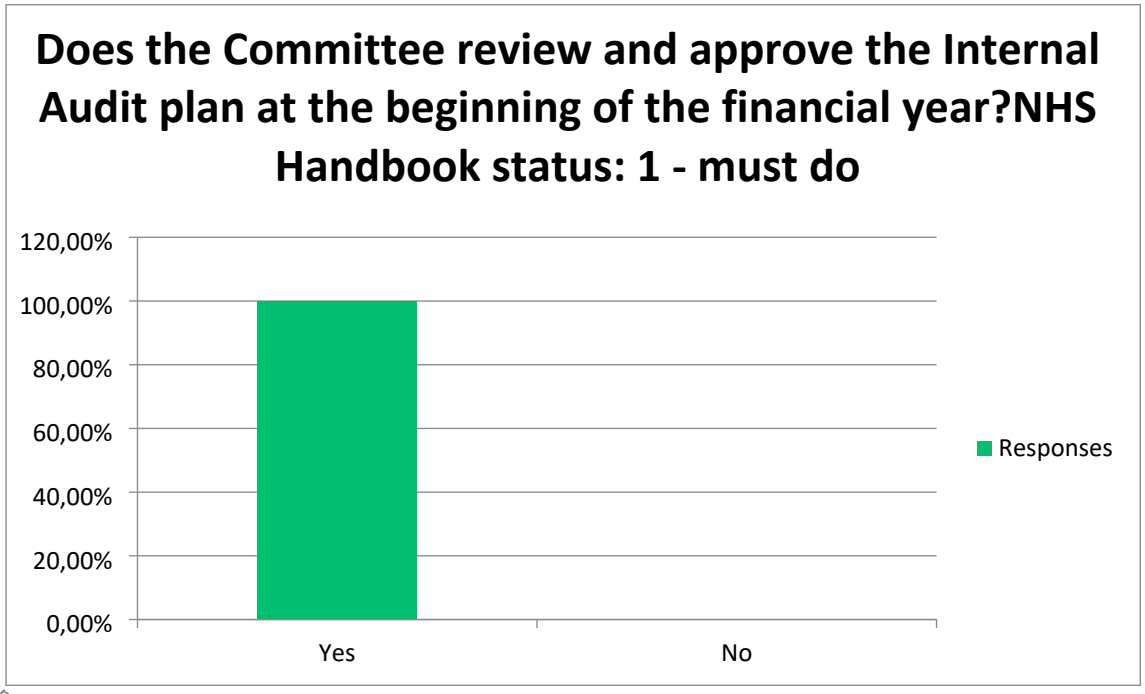




* New question for 2019-20



* New question for 2019-20



* New question for 2019-20

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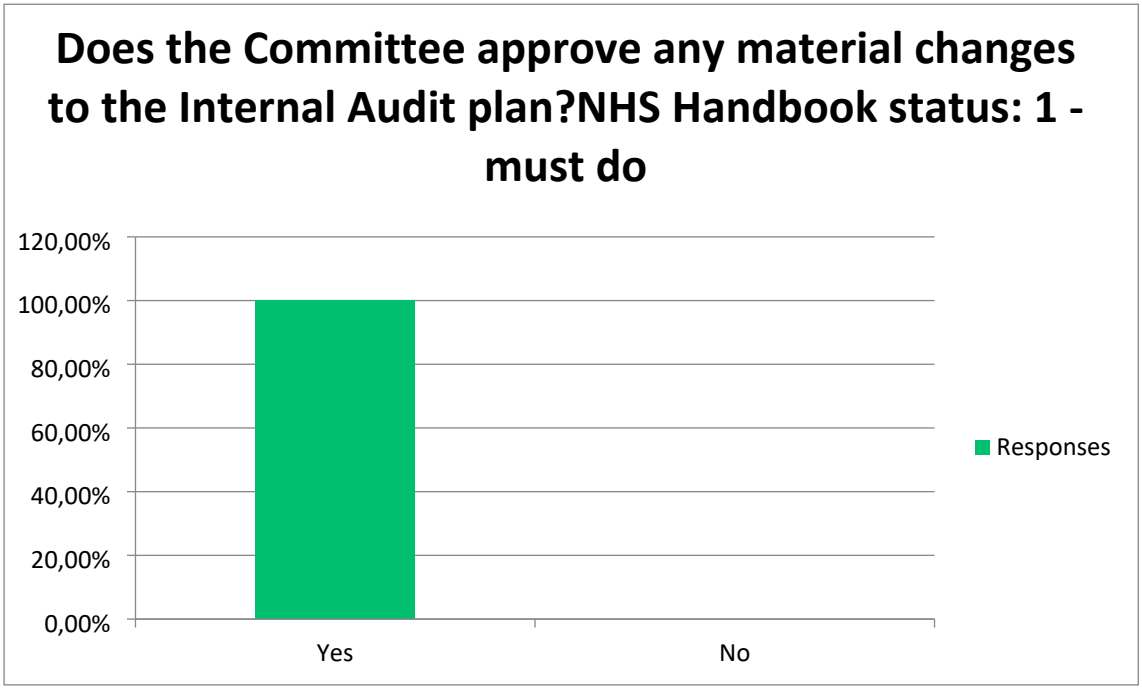
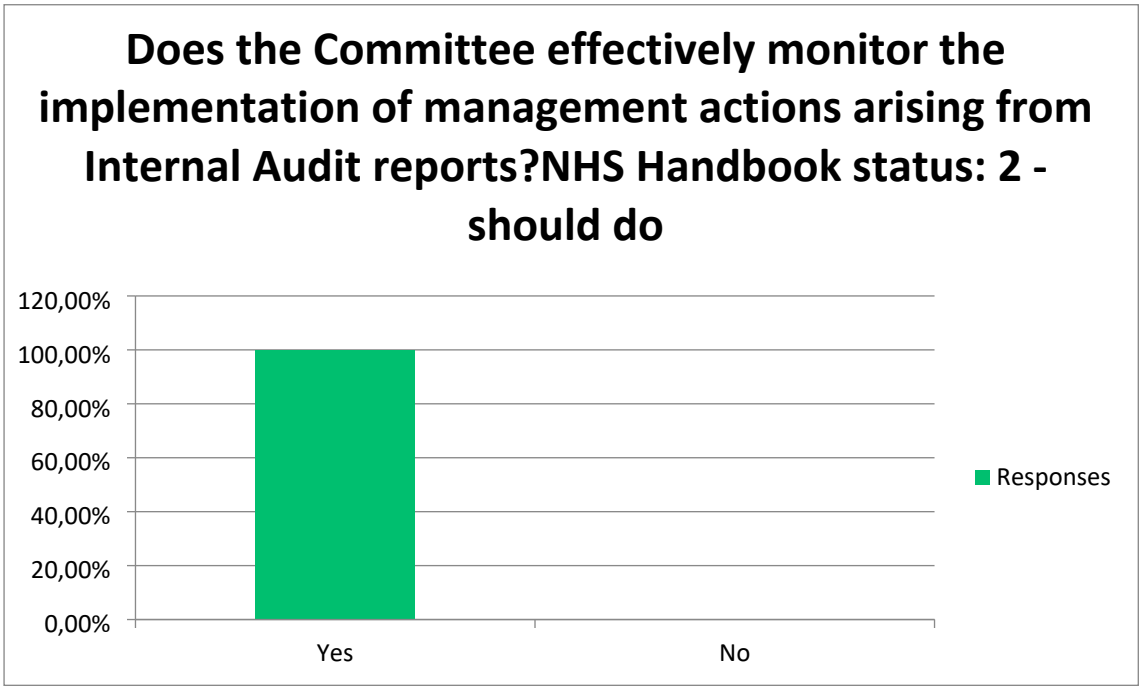


* New question for 2019-20



* New question for 2019-20

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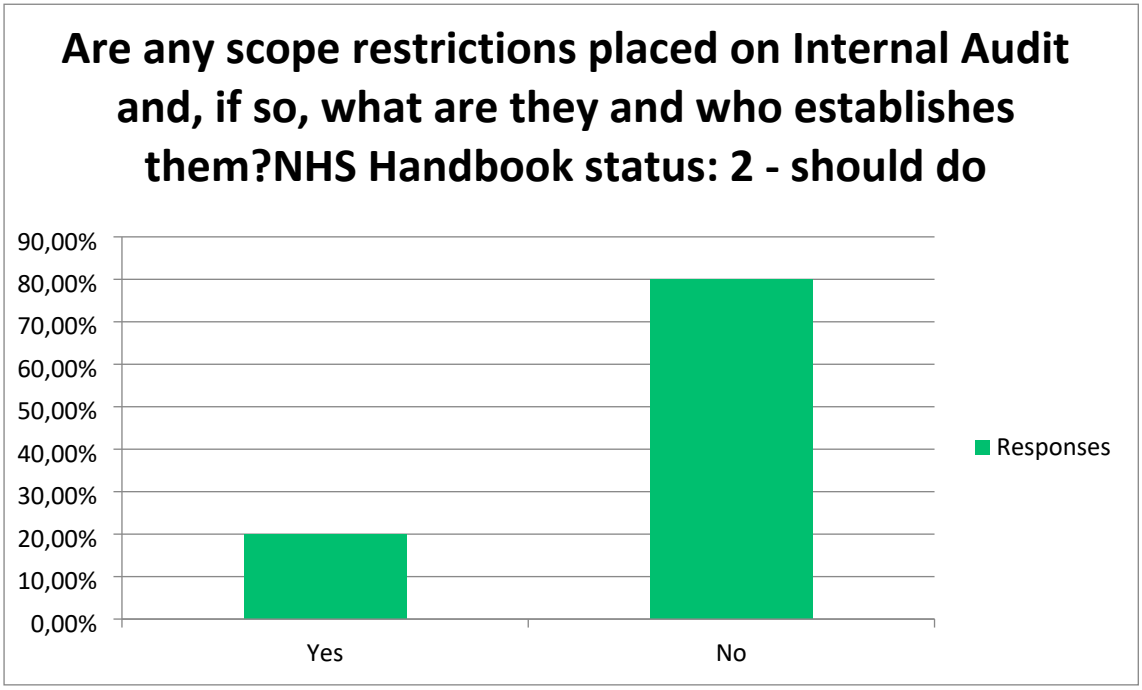
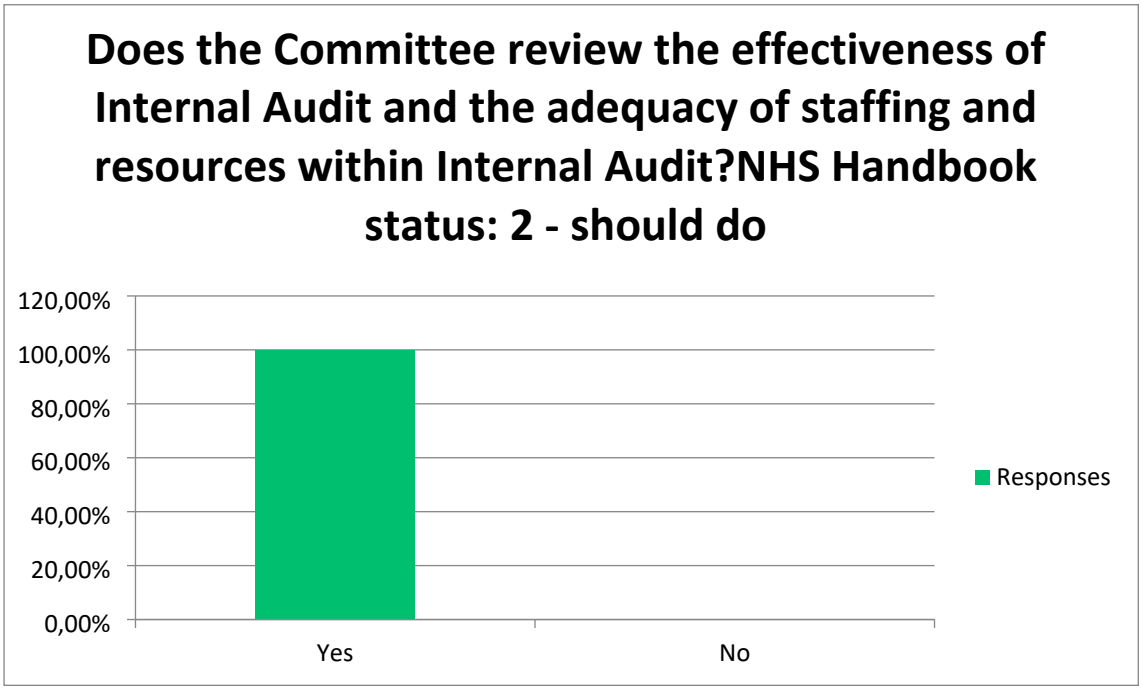


* New question for 2019-20



* New question for 2019-20

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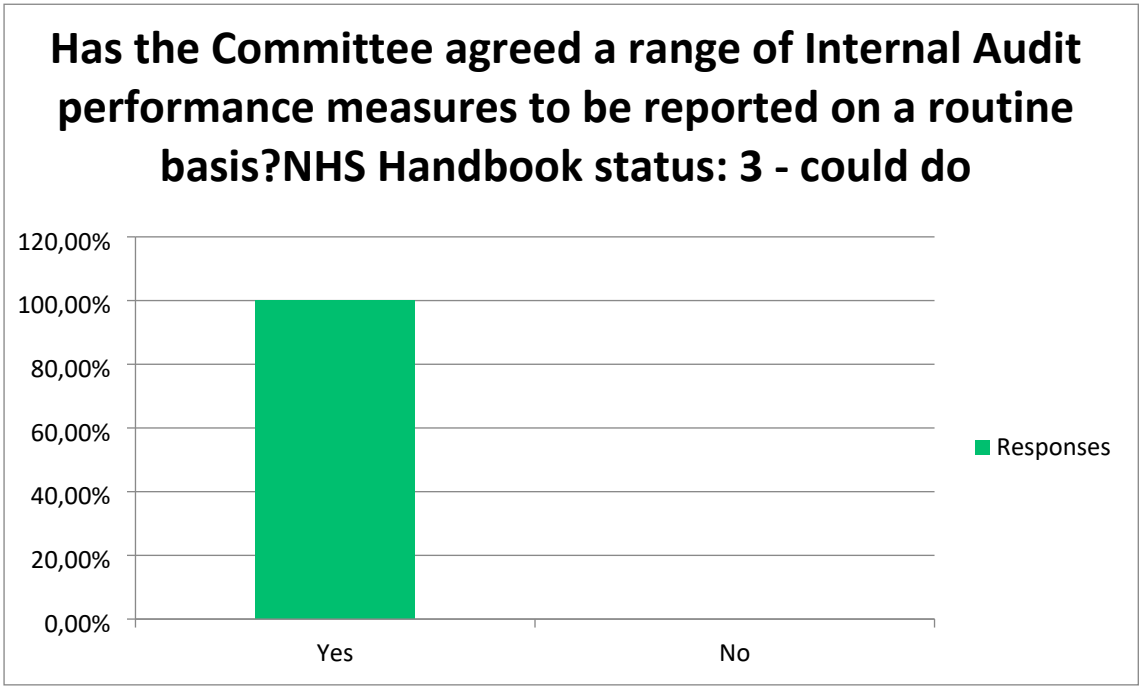
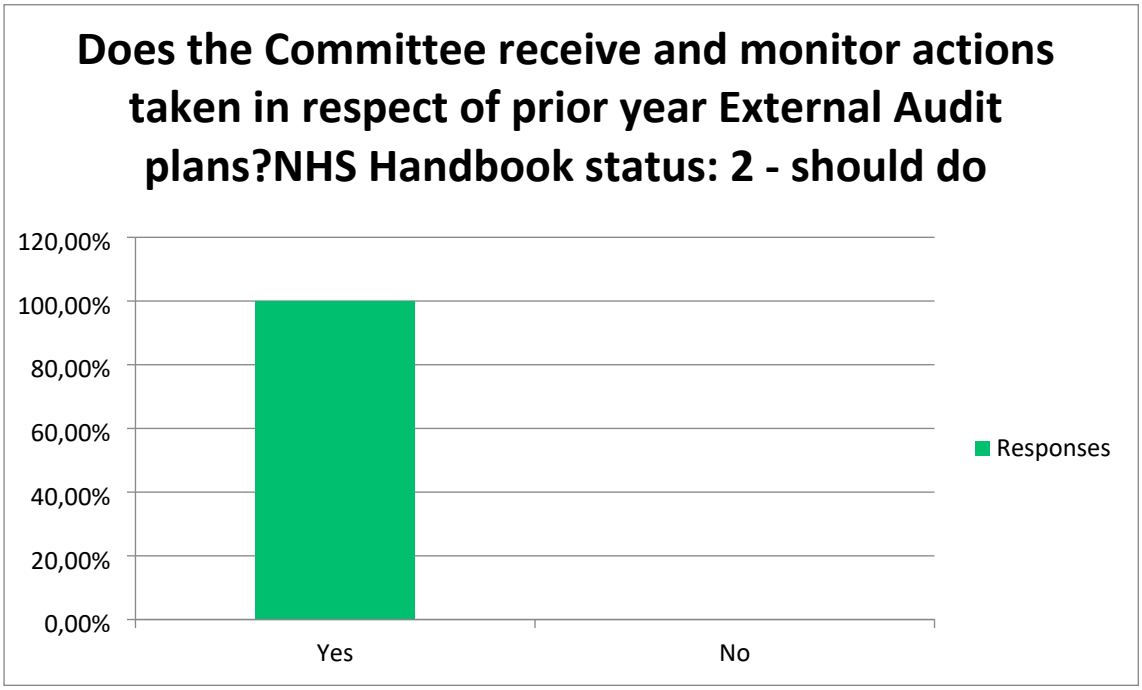


* New question for 2019-20



* New question for 2019-20

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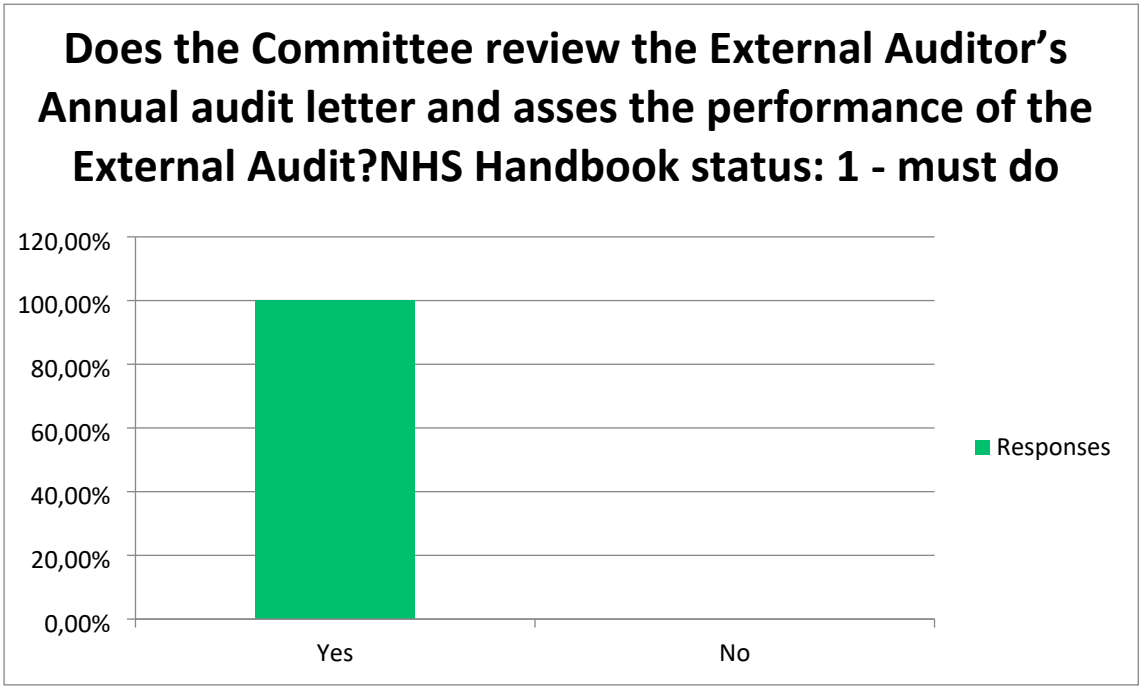
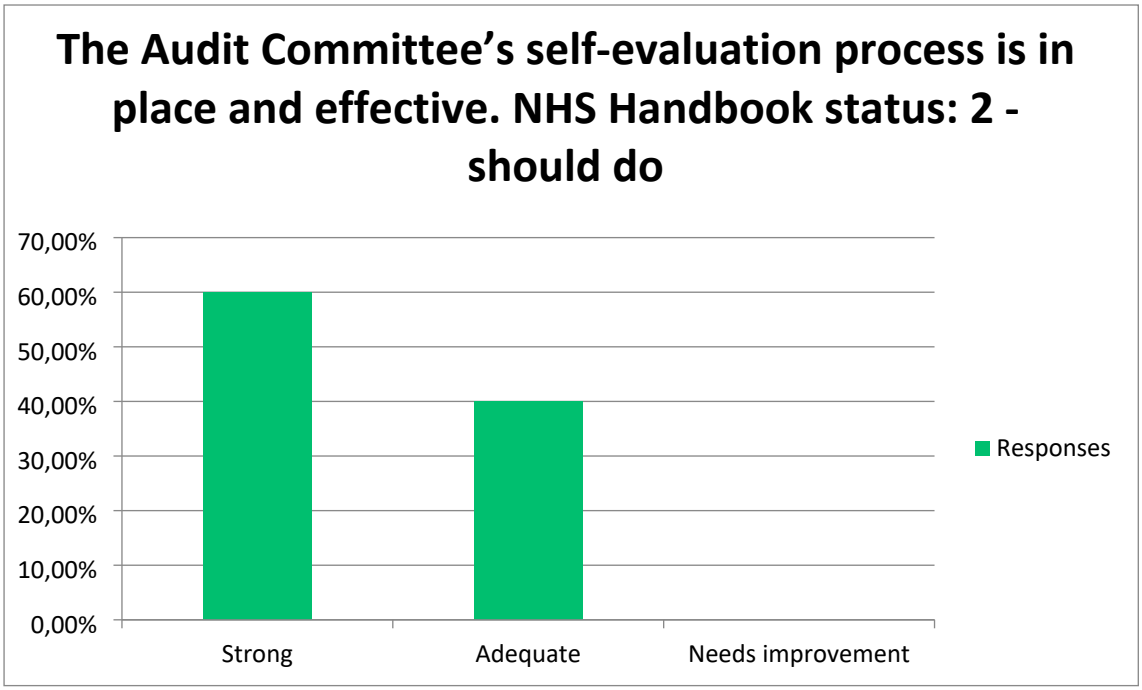


Comments
"The performance of the Audit Wales is not assessed".

* New question for 2019-20



* New question for 2019-20

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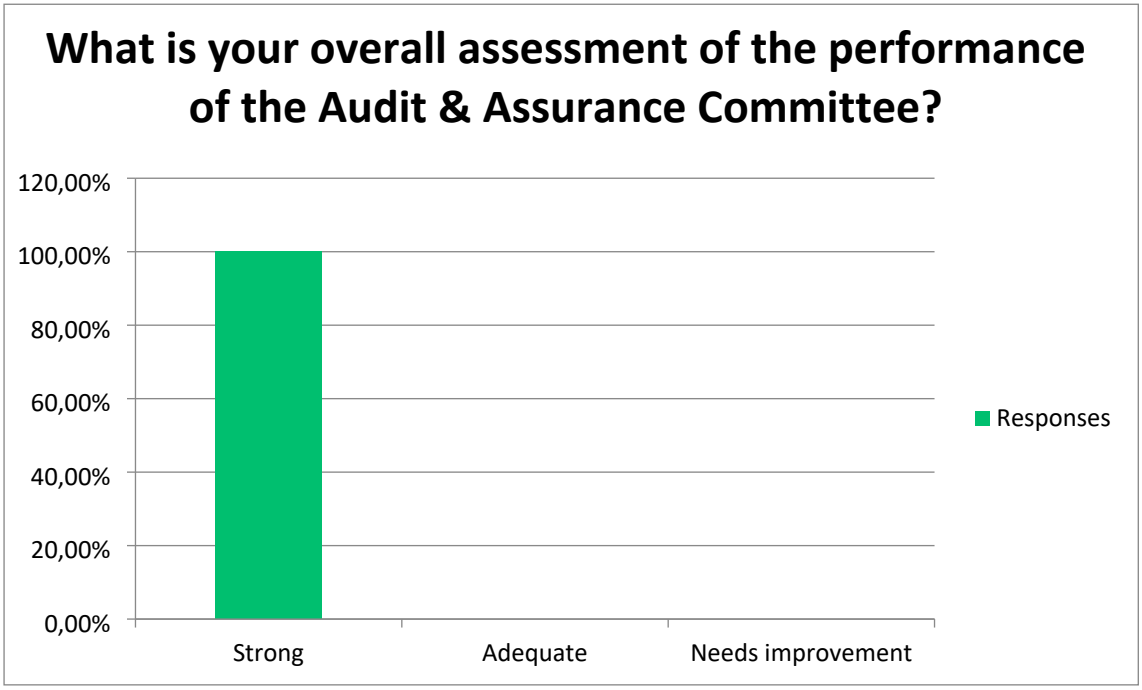


* New question for 2019-20

Appendix 2

Audit and Assurance – Self Assessment 2020 Action Plan

Question asked	Action Required	Lead	Timescale to complete
The Audit & Assurance Committee's actions reflect independence from management, ethical behaviour and the best interests of the UHB and its stakeholders.	The Chair and Vice Chair of the Committee are Independent Board Members and membership composition includes another Independent Member to ensure this standard is met.	Chair/Director of Corporate Governance	March 2021 for next review
The Audit & Assurance Committee's meeting packages are complete, are received with enough lead time for members to give them due consideration and include the right information to allow meaningful discussion. Minutes are received as soon as possible after meetings.	Meeting packages to be reviewed and uploaded within the timescales set out within Standing Orders. The Corporate Governance Department have clear timescales for delivery and Executive Directors are also required to ensure their reports are submitted on time. The Corporate Governance Department and Executive Director Teams are working closely to achieve this. The issuing of rules for submitting of papers, will further strengthen this in 2020.	Director of Corporate Governance / Committee Chair	From September 2020
There is appropriate consideration of the UHB's financial reporting risks and the related internal controls, which are reflected in the Audit Committee's discussions and agenda items.	The Committee work plan includes a financial focus and in addition to year end duties, review of losses, special payments and Single Tender Actions. Consideration at next agenda setting as to whether this can be strengthened.	Chair/Director of Corporate Governance/ Interim Executive Director of Finance	December 2020
The Audit & Assurance Committee's agenda-setting process is thorough and led by the Audit Committee Chair.	The Committee work plan supports this. The Chair, with the support of the Director of Corporate Governance, will lead the agenda setting and ensure that items are appropriate.	Chair/Director of Corporate Governance	From September 2020
Has the Committee formally considered how it integrates with other Committees that are reviewing risk e.g. risk management and clinical governance?	A review of this will be reported to Committee for its consideration in November.	Director of Corporate Governance	November 2020
Are any scope restrictions placed on Internal Audit and, if so, what are they and who establishes them?	The Annual Internal Audit plan is agreed by the Committee and a proactive approach taken to ensure Internal Audit work focuses on the Committee's assurance needs. Consideration at next agenda setting as	Chair/Director of Corporate Governance/ Head of Internal Audit	December 2020

	to whether this can be strengthened.		
The Audit Committee's self-evaluation process is in place and effective.	This is the second review of Committee effectiveness which has taken place. This will continue to be done annually with action plan developed for areas requiring improvement.	Director of Corporate Governance	March 2021 for next review

Report Title:	**Medical Job Planning Follow-up**							
Meeting:	Audit Committee Meeting					**Meeting Date:**	17th Nov 20	
Status:	**For Discussion**		**For Assurance**	**x**	**For Approval**	**x**	**For Information**	
Lead Executive:	Executive Medical Director							
Report Author (Title):	E Job Planning Project Manager							

Background and current situation:

Following on from the last job planning Internal Audit, an action plan was developed to address the limited assurance the audit had highlighted. The purpose of this report is to provide an update of actions taken to improve the assurance. Since the audit a dedicated project has been established with project activities and timelines as follows.

Executive Director Opinion/Key Issues to bring to the attention of the Board/Committee:

Key Updates:

- A Consultant and SAS doctor procedure has been drafted and is currently in discussion with the LNC and out for consultation.
- Introducing a new annualised job planning cycle to streamline and enhance compliance and alignment with business process.
- Allocate e-JP system purchased and currently being tailored to the CAVUHB requirements.
- Early engagement and communication work with all CDs and CBDs, including 2 x engagement meetings, 4 x demonstration and establishment of an e-JP user group.

Please refer to the attached presentation titled “e-JP Audit Presentation” with further detail.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc.):

The aim of the new Job Planning system is to ensure job planning is undertaken in a fair, reasonable and transparent way and it is aligned with prudent health care and the strategic objectives of the organisation. This project seeks to ensure consistency in job planning across the organisation, and is also delivered in a way ensuring an engaged and valued workforce.

Recommendation:

To approve and support the presented action plan as follow up from the limited assurance

Shaping our Future Wellbeing Strategic Objectives

This report should relate to at least one of the UHB’s objectives, so please tick the box of the relevant objective(s) for this report

1.	Reduce health inequalities		6.	Have a planned care system where demand and capacity are in balance	x
2.	Deliver outcomes that matter to people	x	7.	Be a great place to work and learn	x
3.	All take responsibility for improving our health and wellbeing		8.	Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4.	Offer services that deliver the population health our citizens are entitled to expect		9.	Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5.	Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10.	Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term		Integration		Collaboration	x	Involvement	
Equality and Health Impact Assessment Completed:	Not Applicable								

Job Planning Follow up

Internal Audit Committee Meeting

Medical & Dental E-Systems

Vision:

An aligned medical and dental workforce to the right place, at right time to deliver the best quality service for the patients in the most cost effective manner

Job Planning

Aim:

- To improve the quality and compliance of job planning through improved processes and the introduction of electronic Job planning software

Medical Productivity Programme

Not started	No outstanding Action
• Limited assurance of benefits • 1 – 2 actions outstanding	• No assurance of benefits • 2+ actions outstanding

To improve the automated systems, to support effective patient care, workforce planning & governance

- Job Planning
  - Job Planning Procedure
  - E-Job Planning System
- Rostering
  - E-Rostering
- Temp Medical Staff
  - Managed Medical Bank

Khan Raj
11/10/2020 10:24:19

Current State –Job planning

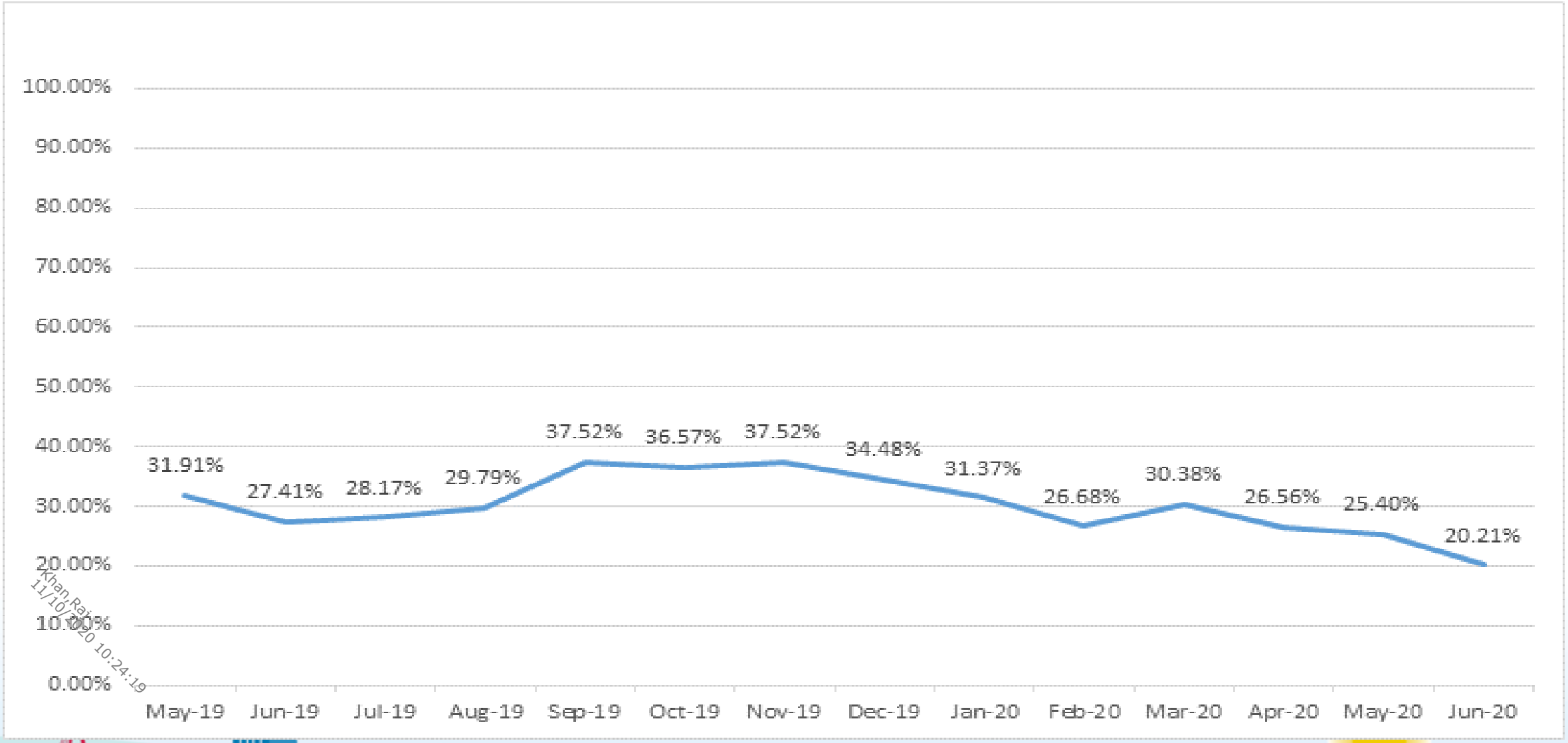
Limited Assurance for job planning from Internal Audit (31% Compliance)

Heavy manual paperwork exercise

No central point for job planning

Large variation in how job planning is completed

Job Plans Compliance % Consultants and SAS Doctors with 12 month reviewed Job Plans

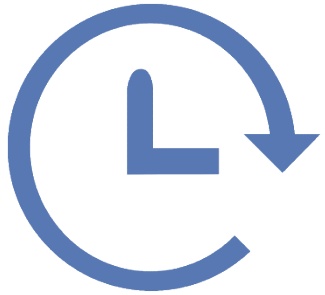


What are the benefits?

Improved Quality JP

Consistency across HB

Standardised Language



Time saving*

Automatic Reminders

Central JP repository

Improved accuracy in information

Improved Reporting

Annual Leave Planning

Improved capacity and demand planning

Updated Job Planning Procedure

- How will this support e-Job Planning?

  - Describe how Job Planning is expected to run through out the UHB
  - Support CDs and CBDs in interpreting the *Amendment to the National Consultant Contract in Wales*
  - Standardise language used across the UHB
  - Ensure a consistent approach is maintained across the UHB
  - Clarification of SPA roles
  - Appeals process as outlined in contract
  - Annualised Process

Developing an annualised job planning cycle

Quarter 2 – July to September	Clinical director sends out preparation for and invitation to job plan review with preparation guidelines, giving six weeks' notice.
Quarter 3 – October to December	Team job planning meeting to discuss and agree objectives, supporting professional activities list and any required rota changes. Individual job planning meetings take place. Job plans entered on electronic job planning system by 31 December. This allows three months for the mediation/appeals process.
Quarter 4 – January to March the following year	Mediation and/or appeals completed as soon as possible, in line with the timeframe agreed under the 2004 consultant contract. Pay progression and clinical excellence awards eligibility taken forward for all who have an approved job plan.
Quarter 1 – April to June the following year	Job plan effective 1 April.

Key Roles – JP Sign Off

Consultant / SAS Dr → Clinical Director → Clinical Board Director

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Clinical Champions & Super Users

Champions

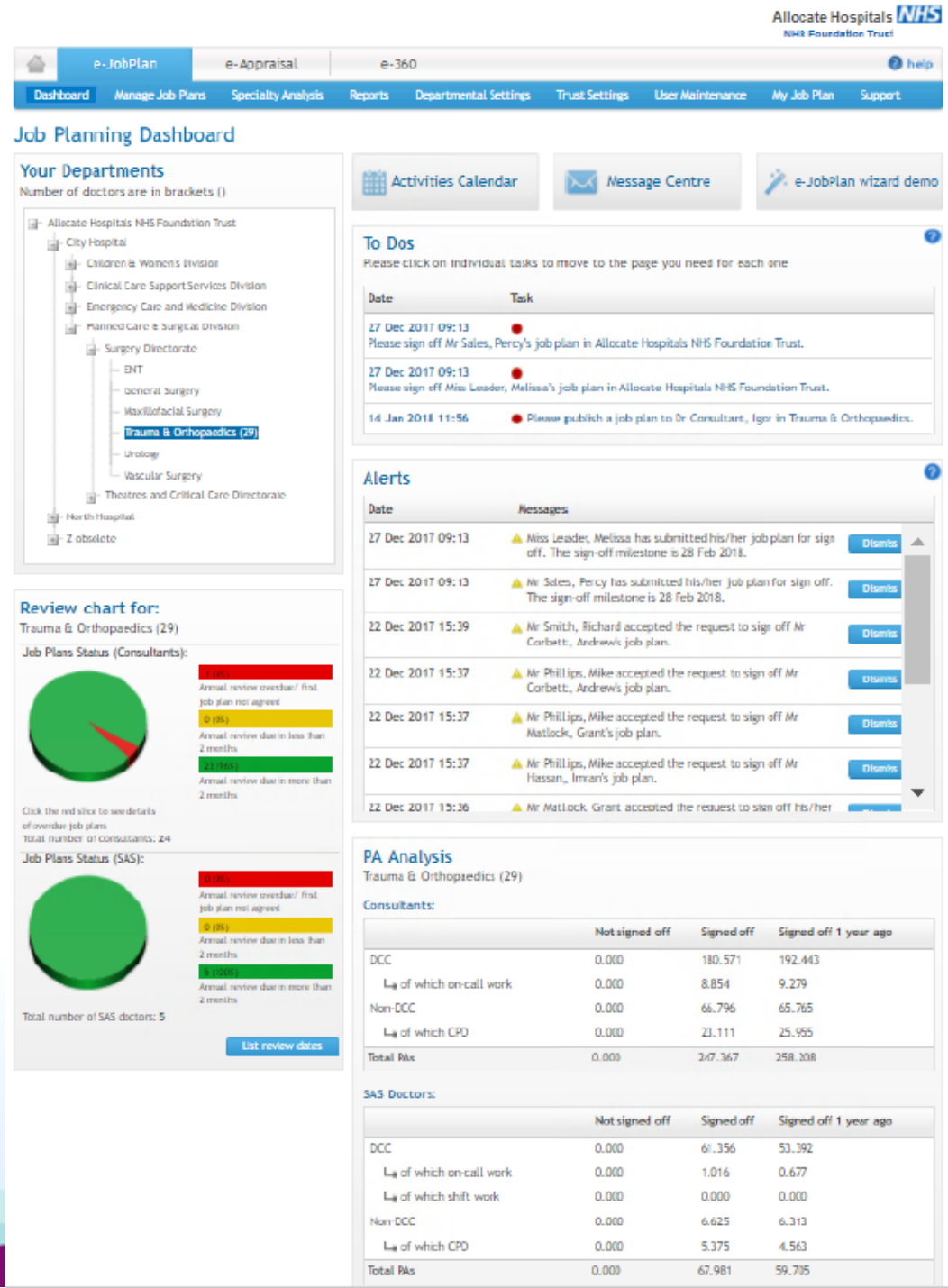
- Commit to improve job planning
- Introduce system to colleagues
- To lead the local implementation
- Consider best way of locally entering job plans into the system
- To shape the way we capture clinical and non clinical activity (template)

Super users

- To support the technical implementation of e-job planning
- Attend a 1 day training session
- To help enter job plans into the system and to help others (train trainer)

The System

Allocate:
e-Job Planning



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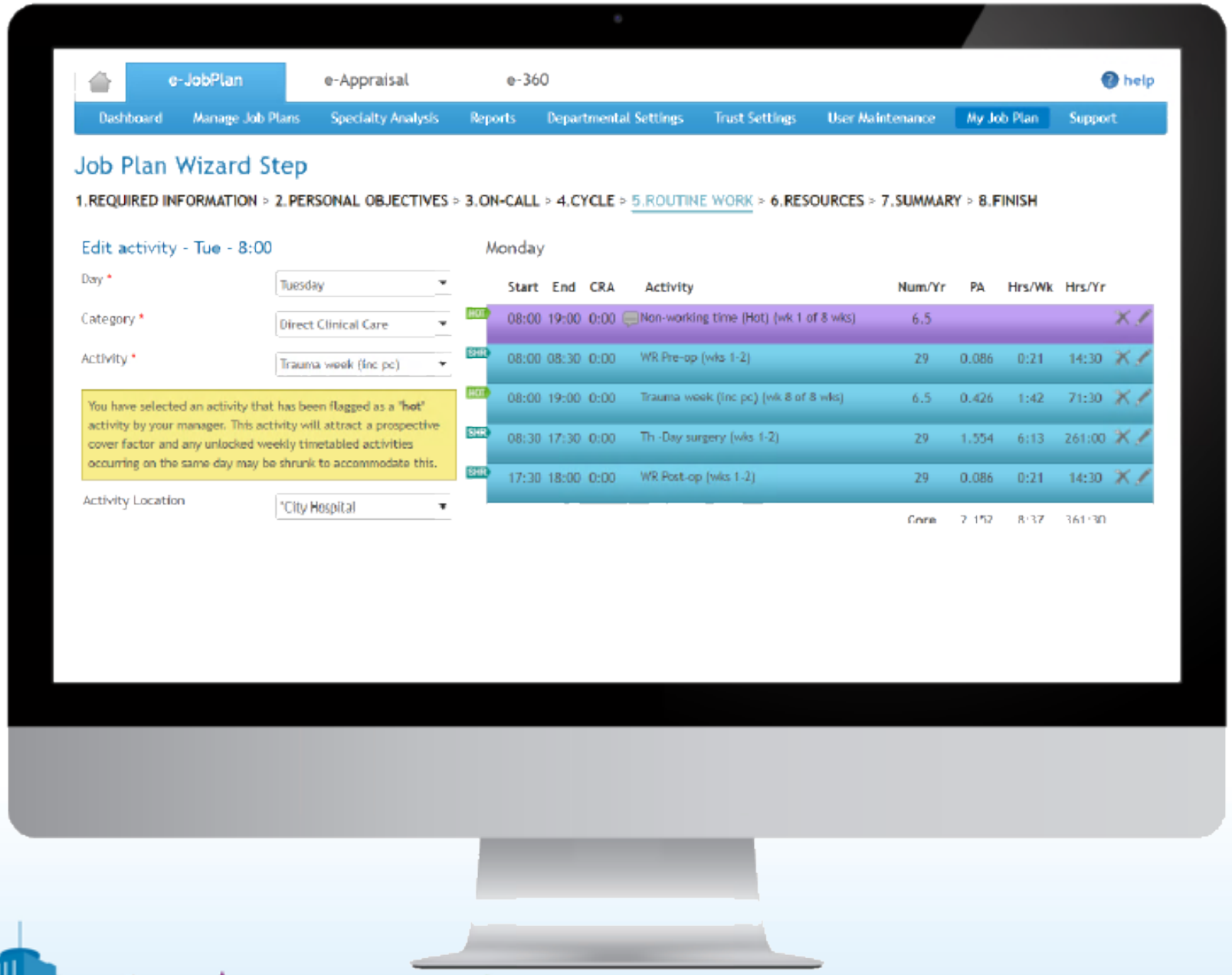
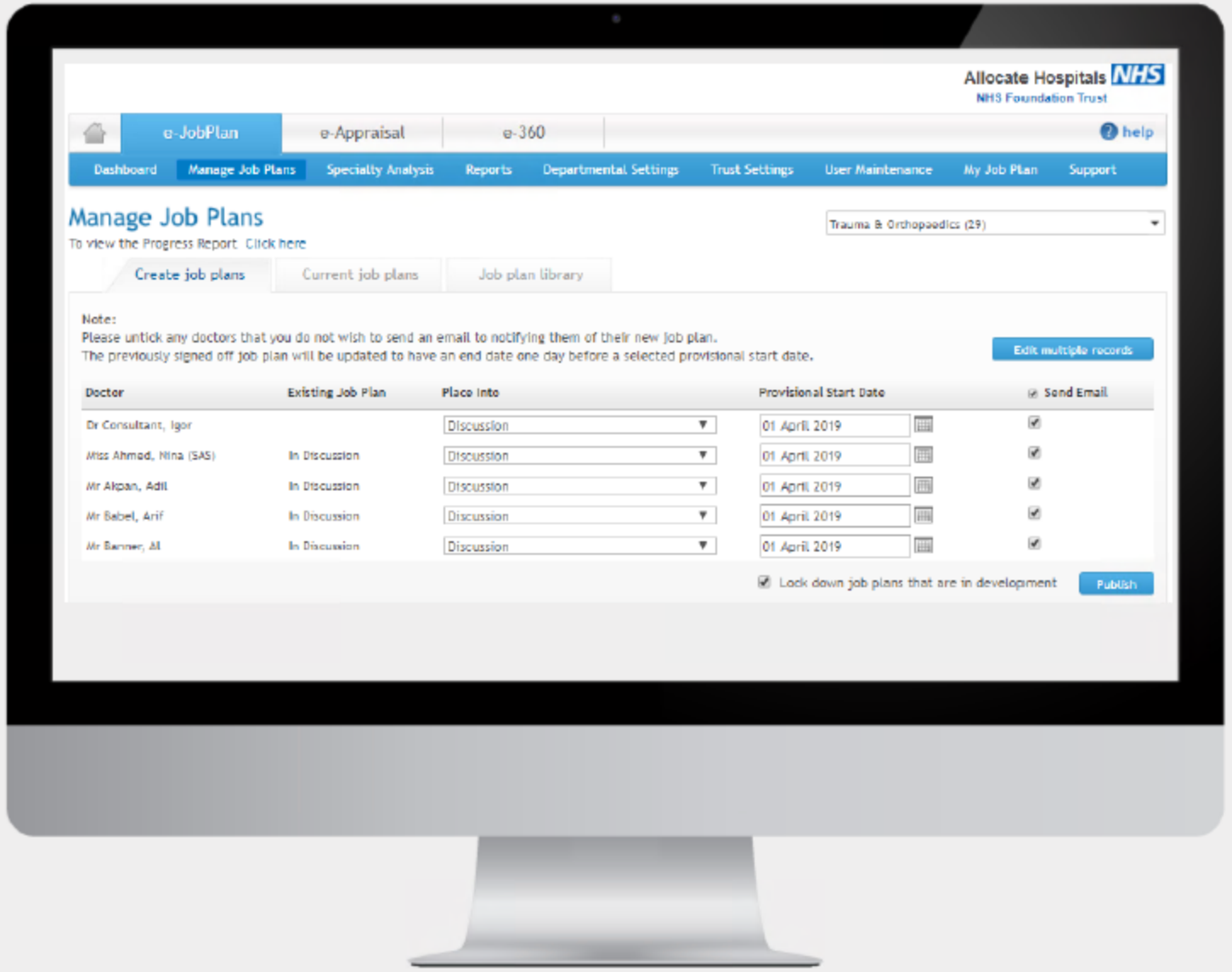


Notifications

- Automated email when JP ready for review



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Achievements so far

- All Clinical boards have engaged
- Successful recruitment of e-Systems Programme Manager (commence 16th November)
- Clinical Directors Engagement sessions
- Directorate Managers Engagement Session
- 5 Demos completed with 50 attendees and recordings to share further
- Identified super users for each Clinical Board
- Data Collection to build system is underway
- Training sessions booked for end of November

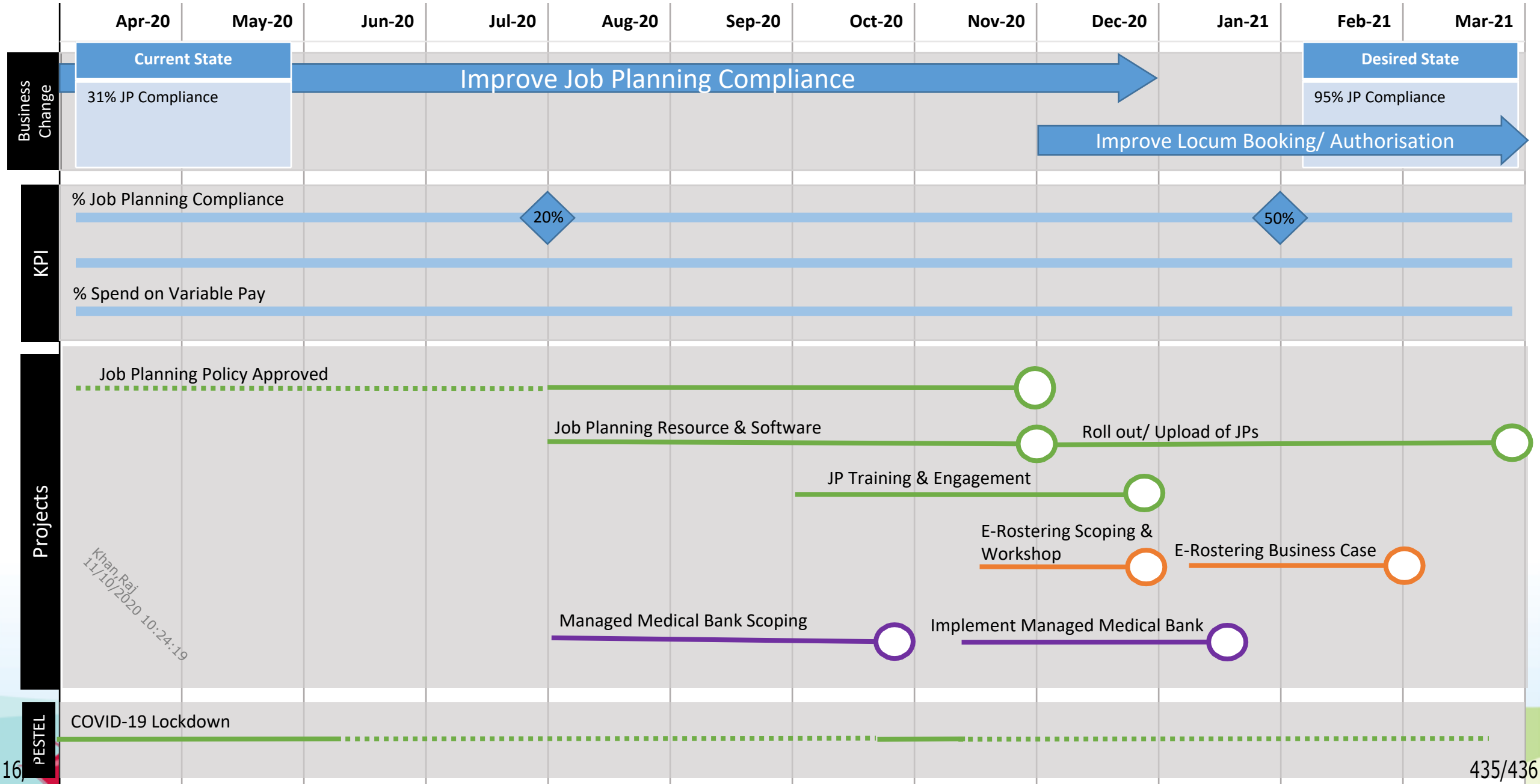
Up Coming activities

- Build e-JP system to CAV requirement
- Training sessions booked for end of November
- Formal internal communications on intranet
- System release to managers and go-live **30th November 2020**

Version 1.0
Last Updated: 27/11/2019

Medical Productivity Programme Road Map

TBC | OK | Low Risk | Med Risk | High Risk



E-Job Planning Timelines – Key Milestones

31ts Aug	09th Sep	17th Sep	30th Sep	7th Oct	14th Oct	22nd Oct	06th Nov	12th Nov	16th Nov	19th & 25th Nov	30th Nov	March 2021
CONTRACT STARTS	Kick Off Meeting	Internal User Group meeting	DM Meeting	Super User Demo	Clinical Champion /CD Lead Demo	Clinical Champion /CD Lead Demo	Complete Data Collection	Super User Training	Programme Lead Starts	Managers Training	System Go-Live	All JPs Uploaded to system

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